



# Study to Design a Mobility Management Program

Best Practice Research

**FINAL**

October 26, 2016

PCG | *Human Services*  
Public Focus. Proven Results.™

## TABLE OF CONTENTS

I. Introduction .....	4
Project Background.....	4
Gap Analysis Findings .....	4
Best Practice Research Overview .....	5
II. Literature Review.....	7
Key Themes and Findings .....	7
Human Service Transportation Coordination .....	8
Mobility Management .....	17
Conclusions.....	18
III. State-Level Coordination Case Studies .....	19
Massachusetts .....	19
History and overview .....	19
Participating State Agencies .....	21
HST Office Functions .....	23
Costs, Trip Volume and Funding.....	25
Florida .....	28
History/ Overview .....	28
Participating State Agencies .....	29
Costs, Trip Volume and Funding.....	29
Georgia .....	31
History and Overview .....	31
Participating State Agencies .....	31
Costs, Trip Volume and Funding.....	33
Status of RHST.....	34
IV. Mobility Management Strategies.....	37
One-Call/ One-Click Systems .....	37
Vehicle Sharing Among Providers .....	40
Agency Tailored Transit .....	41

---

Travel Training .....	42
Volunteer Driver Programs .....	43
Flexible Transportation Voucher Program .....	44
Taxi/TNC Voucher Program.....	45
State Mobility Management Initiatives .....	46
New York .....	47
Massachusetts.....	48
Wisconsin .....	49
Iowa .....	49
Utah .....	50
V. HCBS Waivers and Transportation .....	51
History and Overview .....	51
HCBS Settings Rule.....	52
HCBS and Transportation .....	53
Appendix: Works Consulted .....	57

## **FIGURES**

Figure 1: State Human Service Coordinating Councils

Figure 2: MA HST Areas and Broker Assignments

Figure 3: Organizational Structure of Florida's Coordinated Transportation System

Figure 4: GA RHST Spending (FY 2014)

## **TABLES**

Table 1: MA HST Fiscal Year 2015 Operational Summary

Table 2: MA HST Total Trip Costs by Agency (FY 2015)

Table 3: FY 2015 Cumulative Costs and Average Cost Per Trip

Table 4: FL CTD Operating and Financial Statistics (FY 2015)

Table 5: Georgia RHST Operational Statistics (FY 2010)

Table 6: New York Mobility Management Funding Sources

Table 7: HCBS Settings Guiding Principles

## I. INTRODUCTION

Findings from the Gap Analysis phase of the project indicate that fully utilizing all transportation resources and addressing unmet needs might best be achieved through coordination of human service transportation at the state level and/or more widespread implementation of mobility management strategies at the regional or local level. For this report, Public Consulting Group, Inc. (PCG) researched and documented examples of both comprehensive, state-level coordination models as well as mobility management strategies that could be implemented on a local/regional level in concert with or to complement state-level coordination efforts.

### Project Background

The Office for People with Development Disabilities (OPWDD) has retained PCG and partner, Nelson Nygaard for the Study to Design a Mobility Management Project, which began in March 2016. The project is a result of recently enacted legislation in the State Fiscal Year 2015-16 budget that supports the State's desire to assess its current transportation system and how it meets, or fails to meet, the needs of individuals with disabilities.

The primary goal of the project is to identify promising practices or models that utilize natural supports, shared-ride and /or other resources to address the transportation needs (and especially the employment-related and community inclusion transportation needs) of individuals with developmental, mental or physical disabilities who receive services from the Office for People With Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and/ or Department of Health (DOH), noting that DOH/Medicaid -sponsored non-emergency medical transportation is outside the scope of this project.

This Best Practice Research is the second of three deliverables. The Gap Analysis was the first deliverable for this overall effort, with the findings described below. The final deliverable will incorporate findings and analysis from the Gap Analysis and Best Practice Research into a comprehensive Recommendations Report, which will include recommendations for the design of a potential pilot program that seeks to maximize funding sources and support further community integration.

### Gap Analysis Findings

As part of the Gap Analysis, comprehensive stakeholder engagement activities took place across the State including over 40 interviews, five focus groups, and two surveys which reached over 1,000 direct service providers and transit providers. Through this extensive outreach effort, PCG connected with at least one agency, provider of service, or individual with disabilities in every one of New York State's 62 counties. The information gathered provided insight into current transportation resources available as well as existing transportation gaps and unmet needs.

Transportation was continually cited as a barrier to accessing all activities of daily life for individuals with disabilities. From attending medical appointments, participating in day services and programs, getting to and from work and school, or even to the grocery store or socializing with friends, a lack of transportation in many cases prevents people from doing such things and from being active members of their communities.

The findings from the Gap Analysis are distilled into 4 major themes as shown below.

			
<b>Vehicle Use</b>	<b>Transit Infrastructure</b>	<b>Laws and Regulations</b>	<b>Business Operations</b>
<ul style="list-style-type: none"> <li>• Age of Fleet</li> <li>• Replacement and Back-up Vehicle Availability</li> <li>• High Mileage on Vehicles</li> <li>• Vehicles Not Maximized</li> <li>• Accessibility of Vehicles</li> </ul>	<ul style="list-style-type: none"> <li>• Availability and Accessibility of Public Transit</li> <li>• Availability and Affordability of Paratransit and Accessible Taxis</li> <li>• Access to Employment Opportunities</li> <li>• Long and/or Unreliable Trips</li> </ul>	<ul style="list-style-type: none"> <li>• Restrictions on Hiring Drivers and Who Can Transport Specific Individuals with Disabilities</li> <li>• Difficult to Meet Funding Source Requirements</li> <li>• Medicaid-Only Transport Available</li> </ul>	<ul style="list-style-type: none"> <li>• Staffing and Driver Challenges</li> <li>• Increasing Costs</li> <li>• Decreased Funding</li> <li>• Data Management</li> <li>• Insurance Cost and Liabilities</li> </ul>

## Best Practice Research Overview

Human service transportation coordination and mobility management are occurring in varying degrees across states and localities throughout the United States. In order to better understand what is happening, this report is broken into four main sections: Literature Review, State-Level Coordination Case Studies, Mobility Management Strategies, and Home and Community Based Services (HCBS) Waivers and Transportation.

### Literature Review

PCG completed a literature review of over 40 transportation reports and websites to identify key themes, findings and conclusions for coordination and mobility management best practices. This information is provided in Section II and provides a comprehensive look at Federal programs, funding availability, coordination efforts and lessons learned in human service transportation efforts.

### State-Level Coordination Case Studies

This report also provides case studies for three states that currently coordinate human service transportation: Massachusetts, Florida and Georgia. While Massachusetts includes Medicaid transportation in their coordination model, the other two states do not, which provides an understanding of best practices under different models.

A snapshot of the coordination models is provided below with more detail in Section III.

#### Massachusetts

- Statewide coordinated, brokered transportation system for multiple state human service agencies including Medicaid non-emergency medical transportation (NEMT)



#### Florida

- Human service transportation and community transportation coordination, excluding Medicaid non-emergency medical transportation



#### Georgia

- State Department of Human Services transportation coordinated regionally; Medicaid NEMT coordinated regionally as well, but separately



### **Mobility Management Strategies**

Section IV provides descriptions of mobility management practices along with examples of best practices occurring in various localities throughout the country including specific examples from New York State. Specific mobility management strategies include:

- One-Call/One-Click system
- Vehicle sharing among providers
- Agency tailored transit
- Travel training
- Volunteer driver programs
- Flexible transportation voucher programs
- Taxi/ Transportation Network Company (TNC) voucher programs

In addition, this section explains mobility management initiatives in five states, all of which have either regional or county-based mobility managers: New York, Massachusetts, Wisconsin, Iowa, and Utah.

### **HCBS Waivers and Transportation**

Finally, Section V provides an overview and history of the HCBS Settings rule including information gathered from a review of HCBS amendments and transportation service definitions, with specific findings from Ohio, Maryland, New Mexico, and Utah.

## II. LITERATURE REVIEW

PCG reviewed over 40 documents and websites to extract information of relevance to the development of a human service transportation pilot program and expanded mobility management activities for human service agencies in New York. The literature review took into account national strategies around human service transportation brokerage models, including Medicaid NEMT; considerations regarding availability and accessibility of public transportation for individuals with disabilities; identification of funding sources and opportunities for mobility management and coordination programs as well as regulatory barriers; and best practices that address transportation needs of individuals with disabilities.

The purpose of the literature review included the following goals:

- Develop the foundation for best practice research both within New York and nationally
- Identify information useful for the development of pilot program recommendations
- Compile information for best practices case studies and state profiles

### Key Themes and Findings

Two major themes were the basis for the literature review: human service transportation (HST) coordination strategies (including brokerages), and mobility management. Key findings supporting these themes were identified and are depicted in the table below:

Theme	Key Findings
<b>Human Service Transportation Coordination (HST)</b>	<ol style="list-style-type: none"> <li>1. Human service transportation programs are often fragmented.</li> <li>2. Human service transportation needs are increasing.</li> <li>3. Coordination between HST Providers, or between HST and public transit services, can generate many benefits.</li> <li>4. While beneficial, coordination presents challenges.</li> <li>5. Medicaid NEMT plays an important role in coordinated services.</li> <li>6. There are many documented coordination success factors.</li> <li>7. Resources are available that can be used to address HST coordination challenges.</li> </ol>
<b>Mobility Management</b>	<ol style="list-style-type: none"> <li>8. Mobility management activities are essential to HST and HST/transit coordination.</li> </ol>

## HUMAN SERVICE TRANSPORTATION COORDINATION

Research shows that prior to human service coordination efforts, many conditions, issues and barriers exist, including:

- Multiple transportation providers and funders
- Similar target populations
- Separate delivery systems
- Duplication of services and administration
- Fragmented service and/or gaps
- Inefficient use of resources
- Poor service quality
- Unmet transportation needs<sup>1 2 3</sup>

The Government Accountability Office (GAO) determined that “Federal coordination of transportation services can lead to economic benefits, such as funding flexibility, reduced costs or great efficiency, and increased productivity, as well as improved customer service and enhanced mobility”.<sup>4</sup> There are tremendous benefits to human service transportation coordination, but with those benefits come challenges. In order to better understand the landscape and best practices, it is essential to understand the potential obstacles, successes, and lessons learned, which are distilled into seven key findings below.

### ***Key Finding 1: Human services transportation programs are often fragmented.***

In 2003, the GAO identified 62 federal programs that provided funding that could be used to support transportation services. In 2011, the GAO revisited their exploration of available transportation related funding programs and identified 80 such funding programs.<sup>5</sup> Of these 80 programs, “roughly two-thirds were unable to provide spending information for eligible transportation services offered in fiscal year 2010”.<sup>6</sup> Despite efforts at the federal level to remove barriers and encourage coordination among the agencies that support transportation, and well-documented coordination activities at the state and local levels, this signifies that the numbers of programs increased over 25% in eight years causing further fragmentation.

The federal programs tend to be fragmented with differing requirements spanning numerous federal agencies, including the Department of Transportation (DOT) and Health and Human Services (HHS). Outside of DOT, HHS is the largest purchaser of transportation services among federal agencies. Significant spending on transportation

---

<sup>1</sup>Transit Cooperative Research Program, *Economic Benefits of Coordinating Human Service Transportation and Transit Services* [TCRP Report 91], 2003.

<sup>2</sup> Transit Cooperative Research Program, *Toolkit for Rural Community Coordinated Transportation Services* [TCRP Report 101], 2004.

<sup>3</sup> National Conference of State Legislators, *Regional Human Service Transportation Coordinating Councils: Synthesis, Case Studies and Directory*, 2012.

<sup>4</sup> National Resource Center for Human Service Transportation Coordination, *An Inventory of Federal Funding for Coordinated Transit and Human Services Transportation*, 2012.

<sup>5</sup> National Resource Center for Human Service Transportation Coordination, *Federal Programs Available for Use in Coordinated Transportation Arrangements*, 2010.

<sup>6</sup> U.S. Government Accountability Office, *Transportation Disadvantaged Populations: Coordination Efforts Are Underway, but Challenges Continue*, GAO-14-154T, (Washington DC, 2013).

services comes from the Centers for Medicare and Medicaid Services (CMS), the Administration for Children and Families (ACF), Health Resources and Services Administration (HRSA), and the Administration on Aging (AOA).

Some of the specific programmatic and “system obstacles [include] incompatibility of software systems, regulatory barriers, and lack of uniformity with respect to measures”.<sup>7</sup> These issues impact programmatic efficiency, but also create uncertainty as to the level of funding that is available and being spent on human service related transportation. In order to address this fragmentation, state and local stakeholders have suggested 1) requiring non-DOT programs to specifically identify the dollar amounts they spend on transportation services, [which] would promote more effective coordination; and 2) inclusion of clear language in other federal programs’ authorizing statutes, similar to the language found in federal transit law related to coordination with non-DOT programs.<sup>8</sup>

Program fragmentation is not only an issue at the Federal level, but State, local, and nonprofit funded programs also support transportation services and often face similar challenges such as: competing systems, lack of funding, no mandate to coordinate resources, agency attitudes, lack of understanding, and cultural differences.<sup>9</sup>

While issues with disjointed programs exist, being aware and strategic when encountering potential overlap and fragmentation will make coordination more seamless and efficient.

### ***Key Finding 2: Human services transportation needs are increasing.***

The number of individuals considered transportation disadvantaged (older adults, individuals with disabilities, people with low incomes, other people accessing human service agencies) is increasing<sup>10</sup>. Not only are the populations increasing, but programmatic changes result in a greater need for comprehensive transportation options. Specifically, as human service delivery systems move towards person centered planning and community inclusion, transportation services are needed to provide access to employment and community life to help people remain independent<sup>11</sup>.

Funding shortfalls, policy and implementation failures, and lack of coordination often leaves many who need transportation with few or no options. This results in individuals who need transportation to access essential services and participate in community activities unserved or underserved.<sup>12</sup>

### ***Key Finding 3: Coordination between HST providers, or between HST and public transit services, can generate many benefits.***

Coordination of human service transportation, or HST and public transit services, can help to stretch resources by eliminating or reducing duplication of services or administrative efforts, increasing vehicle productivity, and ensuring that the most cost-effective and appropriate mode is used for each trip.

---

<sup>7</sup> National Center for Transit Research, *Evaluating the State of Mobility Management and Human Service Transportation Coordination*, 2014.

<sup>8</sup> National Resource Center for Human Service Transportation Coordination, *An Inventory of Federal Funding for Coordinated Transit and Human Services Transportation*, 2012.

<sup>9</sup> National Conference of State Legislators, *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*, 2014.

<sup>10</sup> U.S. Government Accountability Office, *Transportation Disadvantaged Populations: Coordination Efforts Are Underway, but Challenges Continue*, GAO-14-154T, (Washington DC, 2013).

<sup>11</sup> Report and Recommendations of the Olmstead Cabinet: A Comprehensive Plan for Serving People with Disabilities in the Most Integrated Setting New York State, Andrew M. Cuomo, Governor, October 2013.

<sup>12</sup> National Conference of State Legislators, *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*, 2014.

While some agencies may see significant savings as a result of coordination, most coordination partners will be able to generate funds through increased efficiency to serve more customers or address unmet needs such as those listed above.

### **Economic Benefits**

In addition to improved efficiency, the economic benefits of coordination between HST and public transit services include:

- Additional funding (more total funding from a greater number of funding sources)
- Improved financial sustainability
- Achieving benefits from economies of scale
- Enhanced mobility (e.g. increased access to jobs, health care)
- Increased levels of economic development or employment benefits due to better access to employment<sup>13</sup>

### **Example from Florida**

Based on two university studies, the benefits of Florida's coordinated transportation system were estimated at an overall return on investment (ROI) of \$8.35 per dollar. The system's five most common trip types (medical, employment, education, nutrition and life-sustaining) saw estimated ROI between \$4.64 and \$11.08 per dollar invested. Beyond ROI, economic benefits include lower public health and assisted living costs due to improved access to health care and healthy food and more opportunities for independent living, lower welfare costs and increased sales tax revenues from higher employment, and increased sales tax revenues from dollars earned and spent to purchase goods and services.<sup>14 15</sup>

### **Service Expansion and Improvements**

A particular benefit of coordinating human service transportation with public transportation services is that many federal transit grant programs, especially Sections 5310 and 5311, are serving individuals of human services programs, and rely on financial involvement from those programs to meet necessary project expenses. Thus, transportation services available to all residents of a community are expanded as a result of HST/public transit coordination.<sup>16 17</sup>

Other known benefits of coordination reiterated throughout the literature include improved service quality through consistent standards for safety, training or vehicle maintenance, expanded days/hours of service or service areas, and/or centralized sources of information on transportation options.

---

<sup>13</sup> Transit Cooperative Research Program, *Economic Benefits of Coordinating Human Service Transportation and Transit Services* [TCRP Report 91], 2003.

<sup>14</sup> James F. Dewey. "Florida Non-emergency Medicaid Transportation Waiver", (University of Florida, Bureau of Economic and Business Research 2003).

<sup>15</sup> Dr. J. Joseph Cronin, Jr. "Florida Transportation Disadvantaged Programs Return on Investment Study", (Florida State University College of Business, 2008).

<sup>16</sup> Transit Cooperative Research Program, prepared by Texas A&M Transportation Institute. *Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination*, [TCRP Report B-44, Interim Report], 2014.

<sup>17</sup> National Resource Center for Human Service Transportation Coordination, *An Inventory of Federal Funding for Coordinated Transit and Human Services Transportation*, 2012.

**Key Finding 4: While beneficial, coordination presents challenges.**

Transportation resources typically exist in many areas, and coordination among providers can be very beneficial. However, coordination is not always easy to achieve. Trust among coordination partners is a crucial building block, and relationships take time to develop. Another hurdle is that transportation and human service agencies have different missions and measure the success of their programs and services through varying performance measures. Differences in basic programmatic goals and objectives, jargon, and requirements imposed by funding sources may hinder communication.

Absent some of the success factors mentioned below, coordination efforts may lose steam before any results are realized.

**Federal Transit Barriers**

Challenges are often encountered at the federal level related to administrative and regulatory requirements including:

- Revenue from non-DOT federal programs may be treated as the non-federal share of project costs for most Federal Transit Administration (FTA) grant programs, which makes it much easier for grantees to leverage their FTA dollars. However, other federal agencies do not provide corresponding guidance to their grantees.
- Agency and state-specific guidelines on procurement and contracting lead to inconsistency about the terms and conditions under which non-FTA dollars may be used to contract for or purchase transportation services from FTA grantees.
- Some funding mechanisms used by federal programs, such as individual reimbursements or tax credit financing, do not readily lend themselves to collaborative arrangements across multiple organizations.
- Human services agencies and advocates often have little input into transportation planning processes and planning decisions. Conversely, transportation providers are not involved in human services decisions regarding transportation or related issues such as the location of programs or facilities.<sup>18</sup>

**Cost Tracking and Allocation**

Cost tracking and allocation presents a major coordination challenge for human service transportation providers. For coordination efforts to succeed, potential coordination partners need to analyze their services and costs using comparable data and to share those costs in a clear and equitable manner.

Issues related to human services transportation cost recording and reporting include the following:

- Transportation costs are often not reported as a separate and distinct cost category
- Overall transportation expenses tend to be significantly underreported and inaccurate
- Payments for transportation services may or may not have any direct relationship to the costs of providing services
- Staff travel for the purpose of transporting individuals often is not reported as a transportation expense but as an administrative or case-management cost

---

<sup>18</sup> National Resource Center for Human Service Transportation Coordination, *An Inventory of Federal Funding for Coordinated Transit and Human Services Transportation*, 2012.

- Identifying the specific federal or state program dollars used for funding transportation services may be difficult because of the blending of state and federal funding sources at the local level.<sup>19</sup>

Toolkits and other guidance for tracking and allocating HST costs and setting equitable rates for shared services are available and documented in the coordination literature including state models from Florida, North Carolina, and Oregon.<sup>20 21</sup>

### **Key Finding 5: Medicaid NEMT Plays an Important Role in Coordinated Services**

The coordination literature documents the importance of Medicaid Non-Emergency Medical Transportation (NEMT), which normally generates the highest number of trips and significant transportation expenditures in any area, to successful coordination efforts. Medicaid is the largest funding resource for transportation services across the country.<sup>22</sup> In fiscal year 2013, combined state and federal NEMT expenditures totaled approximately \$3 billion. However, NEMT is typically less than one percent of Medicaid program expenses.<sup>23</sup>

The inclusion of Medicaid NEMT in coordinated services generates benefits for the Medicaid agency, transportation providers, and communities, particularly rural communities that may depend on the matching funds to FTA grants that Medicaid dollars provide to make sustainable community transportation networks feasible. Access to shopping, social activities, day care, education, jobs, and recreation for all residents can be enhanced when NEMT service is included in a coordinated system.<sup>24</sup>

#### **Brokerage Model**

As of 2012, 39 states and the District of Columbia use a broker to provide NEMT<sup>25</sup>. Alternative structures for delivering service now in use include: in-house management, managed care, statewide broker, regional broker, fee for service and managed care, Fee for Service (FFS) and broker, and a combination of broker and managed care.<sup>26</sup>

A current issue in the literature is the impact of the trend among states to implement separate brokerages for the provision of NEMT services, either through managed care organizations or statewide or regional brokers, particularly the impacts on public transportation providers. Transit providers may have to deliver service at less than a fully allocated cost. Capitated rates may provide incentives for a broker to ensure that recipients use public transit and paratransit service while the broker pays only the fare for those services. Transit providers that have historically used NEMT funds as match to federal transit and human services funding may lose resources and be unable to provide the former level of service in their communities.<sup>27</sup>

<sup>19</sup> Transit Cooperative Research Program, *Sharing the Costs of Human Services Transportation Volume 2: Research Report* [TCRP Report 144], 2011.

<sup>20</sup> Ibid.

<sup>21</sup> Transit Cooperative Research Program, *Sharing the Costs of Human Services Transportation Volume 1: The Transportation Services Cost Sharing Toolkit* [TCRP Report 144], 2011.

<sup>22</sup> Transit Cooperative Research Program, *Transit Agency Participation in Medicaid Transportation Programs* [TCRP Synthesis 65], 2006.

<sup>23</sup> Transit Cooperative Research Program, prepared by Texas A&M Transportation Institute. *Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination*, [TCRP Report B-44, Interim Report], 2014.

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> U.S. Government Accountability Office, *Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed*, GAO-15-110, (Washington DC, 2014).

<sup>27</sup> Transit Cooperative Research Program, prepared by Texas A&M Transportation Institute, *Review and Summary of Relevant Literature*, [TCRP Report B-44], 2014.

As such, many still believe that coordination of NEMT service is limited and there is fragmentation, overlap, and potential for duplication. Strategies for demonstrating federal leadership in coordination included developing and approving cost-sharing guidance that facilitated the sharing of vehicles and rides.<sup>28</sup>

### Example from New Jersey

The New Jersey statewide broker uses transit providers for subscription, grouped NEMT trips at negotiated rates that cover marginal costs—this approach is beneficial for both the broker and the providers. This change “enabled the transit providers to increase their productivity per hour and general revenues with minimal additional cost”.<sup>29</sup> According to a 2012 Community Transportation Association of America (CTAA) report, “one county system added 15 additional passengers to three existing vehicle runs while still meeting its maximum ride time standard for the first boarding passenger. The broker reduced its cost by more than 50% of what the reimbursement would have been under the existing livery reimbursement contract”.<sup>30</sup>

### Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 and the subsequent final rule (12/19/08, effective 1/20/09) amended regulations regarding NEMT brokerages which are relevant to a consideration of the expansion of New York DOH Transportation Managers to broker other types of transportation services.

States no longer must obtain a 1915(b) freedom of choice waiver to operate a brokerage and receive federal reimbursement at the typically higher FMAP rate (50-83%). Brokerages must be cost efficient, use competitive procurement, perform auditing and oversight, and provide licensed, qualified, competent, and courteous transport personnel. States may still provide NEMT as an administrative expense (more flexibility, but reimbursed at the typically lower administrative rate of 50%) or an optional medical expense (less flexibility, but reimbursement at FMAP rate) or seek a 1915(b) waiver to operate a brokerage without the restrictions imposed by the DRA final rule.<sup>31</sup>

The final rule supports coordination of NEMT with other transportation services as long as there is no conflict with Medicaid policies and rules; regulations note that Medicaid funding must be matched by non-federal funding; Medicaid funds may only be used for Medicaid services for eligible recipients (i.e., shared transportation costs may not be charged to Medicaid); states must comply with Medicaid regulations even if they hinder coordination efforts. Medicaid must pay no more for public fixed route transit trips than any transit user (i.e., the fare level); Medicaid may pay more than the fare for a paratransit trip, but no more than other human service agencies are charged.<sup>32</sup>

Despite statutory and regulatory changes, states and localities still cited additional challenges to NEMT coordination such as: lack of leadership or guidance at federal level, state and local officials' perceptions of agency rules and effects of improved NEMT coordination.<sup>33</sup>

---

<sup>28</sup> U.S. Government Accountability Office, *Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed*, GAO-15-110, (Washington DC, 2014).

<sup>29</sup> Transit Cooperative Research Program, prepared by Texas A&M Transportation Institute, Review and Summary of Relevant Literature, [TCRP Report B-44], 2014.

<sup>30</sup> Fittante, Steve. "Medicaid Brokerage: The Opportunities and Challenges for Community Transit." *Urgent Issues: Medicaid Transportation*. 2012

<sup>31</sup> Transit Cooperative Research Program, prepared by Texas A&M Transportation Institute, Review and Summary of Relevant Literature, [TCRP Report B-44], 2014.

<sup>32</sup> Ibid.

<sup>33</sup> U.S. Government Accountability Office, *Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed*, GAO-15-110, (Washington DC, 2014).

**Key Finding 6: There are many documented coordination success factors.**

Numerous states and localities have undertaken coordination planning and implementation efforts. Using their lessons learned, approaches and innovative ideas can help spur thinking and determine the best next steps for New York.

**State-level Coordinating Councils**

Throughout the country, 22 states have active transportation coordinating councils (see Figure 1). Of these active councils, 12—including both of Idaho’s councils—are operating under the requirements of current state legislation or statute.

Coordinating councils tend to be comprised of “groups of diverse organizations that actively work together on an ongoing basis to better coordinate and provide transportation services to people who have mobility challenges” and the “most common responsibilities and tasks include assessing current statewide transportation needs, identifying gaps and duplication of services, and maximizing the efficient use of resources”.<sup>34</sup>

**State Examples**

The transportation coordination efforts of Florida, Georgia and Massachusetts are considered national best practices and potential models for replication. These efforts are explained in more detail in the case study section of this report, but in order to lay the groundwork for the progress in these states, the background of their state-level coordinating councils is described below.

In addition, the coordinating council efforts in New York are described to understand the current landscape and structure.

- **Florida** – The “Florida Commission for the Transportation Disadvantaged (CTD)” is an active, statutory council. It is funded by the Transportation Disadvantaged Trust Fund which was established within the state treasury and administered by the commission. Revenues from the trust fund are legislatively appropriated to the commission and must be used to carry out the commission’s responsibilities and to fund its administrative expenses.<sup>35</sup>
- **Georgia** – The “Georgia Coordinating Committee for Rural and Human Services Transportation (RHST)” is also active and statutory with administrative expenses of the committee borne by the Governor’s Development Council.<sup>36</sup>
- **Massachusetts** – The “Statewide Coordinating Council on Community Transportation (SCCCT)” is also active but has no legal authority. The council was formed in 2013 and is meeting voluntarily under a Memorandum of Understanding between MassDOT and the Executive Office of Health and Human Services (EOHHS). It replaced the Community, Social Service and Paratransit Transportation

**State Coordinating Councils Are:**

- **Multidisciplinary**  
They coordinate among diverse transportation and human services providers.
- **Statewide**  
They coordinate across the entire state and focus on state agencies, policies and programs.
- **Ongoing**  
They engage in active, ongoing coordination, not just intermittent or annual activities.

**SOURCE: STATE HUMAN SERVICE COORDINATING COUNCILS: AN OVERVIEW AND STATE PROFILES, NCSL. 2014.**

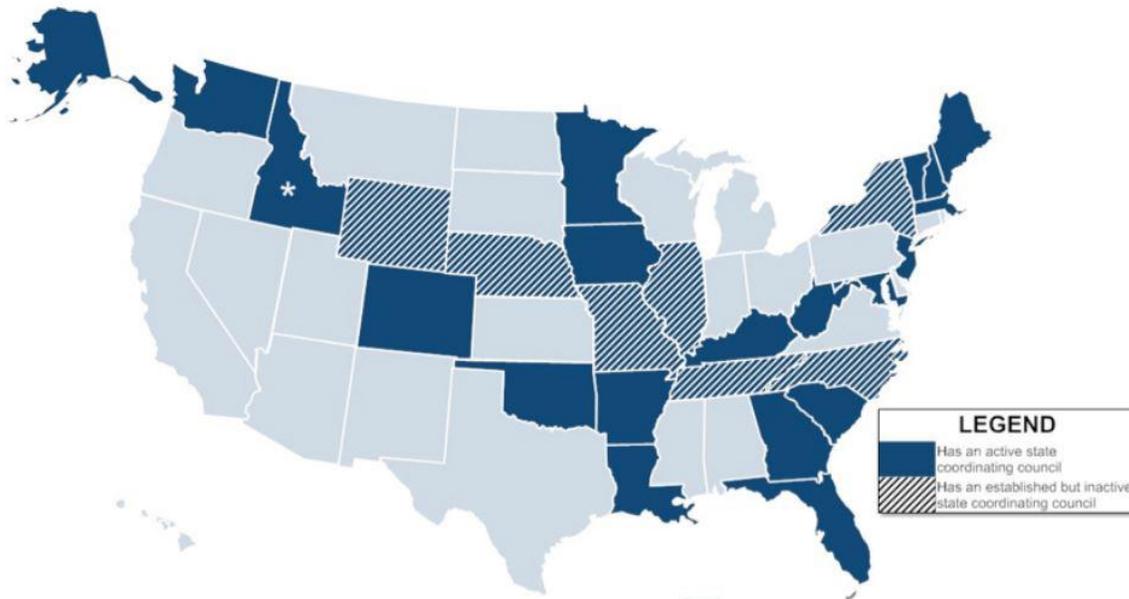
<sup>34</sup> National Conference of State Legislators, *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*, 2014.

<sup>35</sup> National Conference of State Legislators, *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*, 2014.

<sup>36</sup> Ibid.

Commission, which was established by executive order in 2011 (2011 Executive Order 530) and expired in 2012. There is no dedicated funding for this council.<sup>37</sup>

- **New York** - The "Interagency Coordinating Committee on Rural Public Transportation" was established in state law in 1986 (Transportation Law §§73-A to 73-P), but is currently inactive. Three bills have been introduced in New York's legislature concerning the committee. One would change its duties and members (Senate Bill 7222). The other two would repeal it altogether (Senate Bill 4511 and Assembly Bill 7568).<sup>38</sup>



**FIGURE 1: STATE HUMAN SERVICE COORDINATING COUNCILS**

Source: State Human Service Coordinating Councils: An Overview and State Profiles, NCSL. 2014.

<sup>37</sup> National Conference of State Legislators, *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*, 2014.

<sup>38</sup> Ibid.

## Regional Coordinating Councils (RCCs)

Regional Coordinating Councils (RCCs) are also now mainstays in state and locality human service transportation coordination. As of 2011, RCCs existed in 29 states. These councils help coordinate the effective, efficient provision of transportation services to those who most need them, with a focus on addressing the service issues and needs of their unique regions.<sup>39</sup>

Best practice models from Florida, Colorado, and Iowa are described below.

### State Examples

- Florida** - The Florida Commission for the Transportation Disadvantaged (CTD), described in the previous section, selects a metropolitan planning organization (MPO) to be the designated official planning agency. The MPO then appoints and staffs a local Coordinating Board. The chair of the board must be an elected official. The Coordinating Board serves as an advisory body in its service area, identifying local service needs, provides guidance for service coordination, and recommends a community transportation coordinator (CTC) to the CTD. The CTD contracts directly with the CTCs, which are responsible for coordinating transportation services in each county. As of Dec. 2011, 51 CTCs provide coordination for Florida's 67 counties; most CTCs cover one county, but several coordinate across county boundaries.<sup>40</sup>
- Colorado** – As one of only 13 states where human service programs are administered at the county level, regional and local coordinating councils play an important role. There are at least seven regional councils throughout Colorado. One active RCC, established in 2005, is in Denver (Denver Regional Mobility and Access Council, or DRMAC). The goal of DRMAC is to “address specialized transportation needs in the greater Denver metro area and to reduce barriers to mobility and access in the region by fostering inter-organizational collaboration”. Typically, RCCs are “housed within government entities”, but DRMAC is unique in that it is a non-profit organization.<sup>41</sup>
- Iowa** – Regional coordination began in Iowa in 2006 with the creation of 15 regional Mobility Action Planning Workshops around the state. Stemming from attendance at these workshops, many transit systems and planning agencies formed RCCs called Transportation Advisory Groups (TAGs). The role of TAGs is to “guide the regional coordination planning efforts of the state’s metropolitan planning organizations (MPOs) and regional planning affiliations (RPAs) with support from the state department of transportation [and] identify service gaps and inefficiencies; propose solutions; prioritize projects based on available funding; and implement coordination and mobility management initiatives in their regions. Iowa now has 21 TAGs that serve all of its 99 counties.”<sup>42</sup>

#### REGIONAL COORDINATING COUNCILS ARE:

- Multidisciplinary**  
*They coordinate among diverse transportation and human services providers.*
- Regional**  
*They coordinate across multiple cities, counties or other local jurisdictions.*
- Ongoing**  
*They engage in active, ongoing coordination, not just coordination planning or other intermittent activities.*

**SOURCE: REGIONAL HUMAN SERVICE COORDINATING COUNCILS: SYNTHESIS, CASE STUDIES, AND DIRECTORY, NCSL. 2012.**

<sup>39</sup> National Conference of State Legislators, *Regional Human Service Transportation Coordinating Councils: Synthesis, Case Studies and Directory*, 2012.

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

**Key Finding 7: Resources are available that can be used to address HST coordination challenges.**

Human Service transportation coordination literature documents a wide range of tools and resources that can be used to increase the success of coordination efforts. The types of resources available are summarized below, with the full list of works consulted in the Appendix.

Human Service Transportation Coordination Resources
Financial resources from a number of federal funding programs
Federal-level coordination guidance and support through the Coordinating Council on Access and Mobility and its member agencies
Case studies from successful state models
Information and technical tools to assist with coordination in rural areas, development of volunteer driver programs, travel training services, and other coordination and mobility management strategies
Cost tracking and allocation guidance
Rate-setting methodologies
Vehicle sharing program solutions
Information-sharing through state DOT websites, the National Center for Mobility Management (NCMM), the National Aging and Disability Transportation Center (NADTC) and ongoing national research projects

**MOBILITY MANAGEMENT****Key Finding 8: Mobility Management activities have an essential role to play in HST and HST/transit coordination.**

The term mobility management is sometimes used interchangeably with human service transportation coordination, but usually means a range of strategies that are designed to connect individuals with the best transportation options for their needs, and to promote the development and use of a “family of services” that can meet a variety of transportation needs.

Mobility management programs and services, such as centralized sources of transportation information that may also offer trip planning and booking assistance, travel training, rides provided by volunteer drivers, carpool/vanpool/shared mobility programs, and voucher programs can complement traditional transit and paratransit services and can increase the mobility and efficiency benefits of HST and public transit service coordination.

A variety of mobility management strategies and a network of mobility managers are at work in NYS, funded primarily with federal and state transit grants. These services benefit individuals with disabilities as well as older

adults, people with low incomes, and other groups. Although effective strategies are in place, there is room to expand those efforts to serve more areas and individuals.<sup>43</sup>

A comprehensive description of mobility management strategies and best practice examples from throughout the country are provided in Section IV.

## Conclusions

This literature review reveals several key points with implications for the development of a mobility management program and pilot for human services agencies in New York State.

- Research confirms that the transportation gaps and challenges experienced by individuals with disabilities in New York State are seen throughout the country
- Accurate transportation data gathering, cost tracking and funding allocation are important elements in successful HST coordination. Guidance and tools are available to help NYS human service agencies accurately identify the cost of their transportation services and account for those costs in the context of coordinated services
- Coordination with public transportation networks improves the cost-effectiveness of HST services
- Inclusion of Medicaid NEMT in a coordinated system can contribute to increased efficiency, lower transportation unit costs, and strengthened local transportation networks that benefit all residents in rural and urban areas alike
- Mobility management is a valuable complement to HST/public transportation coordination

---

<sup>43</sup> KFH Group, Inc., prepared for New York State Department of Transportation. *New Freedom Mobility Management Development in New York: Final Report* (December 2013).

### III. STATE-LEVEL COORDINATION CASE STUDIES

This section provides case studies for three states that currently coordinate human service transportation: Massachusetts, Florida and Georgia. The case studies include a history and overview of the coordination model, identification of state agencies participating in the model as well as transportation costs, trip volume and funding levels.

#### Massachusetts

##### HISTORY AND OVERVIEW

Human services transportation (HST) coordination in Massachusetts transformed greatly over the last fifteen years, and includes a multi-agency collaboration approach as well as a partnership with the state's public transit entities.

Massachusetts established a Human Service Transportation (HST) Office in 2001, and that office has evolved over time to include not only Medicaid NEMT, but also the transportation programs of five other human service agencies as well including Department of Developmental Services and the Department of Public Health's Early Intervention program, the Massachusetts Commission for the Blind, the Massachusetts Rehabilitation Commission and the Department of Mental Health. The HST Office resides within Massachusetts' Executive Office of Health and Human Services (EOHHS), which is the umbrella entity comprised of 16 agencies that collectively deliver and administer most of Massachusetts' health and human services and programs to the state's 1.5 million most vulnerable populations.

The HST Office is staffed with a management and professional team with extensive background and experience in human services and transportation. The Office receives guidance and support through a secretariat-level Advisory Board comprised of senior managers from the following agencies:

- Executive Office of Health and Human Services (EOHHS) – Chair
- Executive Office of Elder Affairs (EOEA)
- Massachusetts Department of Transportation (MassDOT)
- Office of Medicaid (MassHealth)
- Department of Developmental Services (DDS)
- Department of Public Health (DPH)
- Massachusetts Rehabilitation Commission (MRC)
- Massachusetts Commission for the Blind (MCB)
- Massachusetts Department of Veterans' Services (DVS)
- Department of Mental Health (DMH)

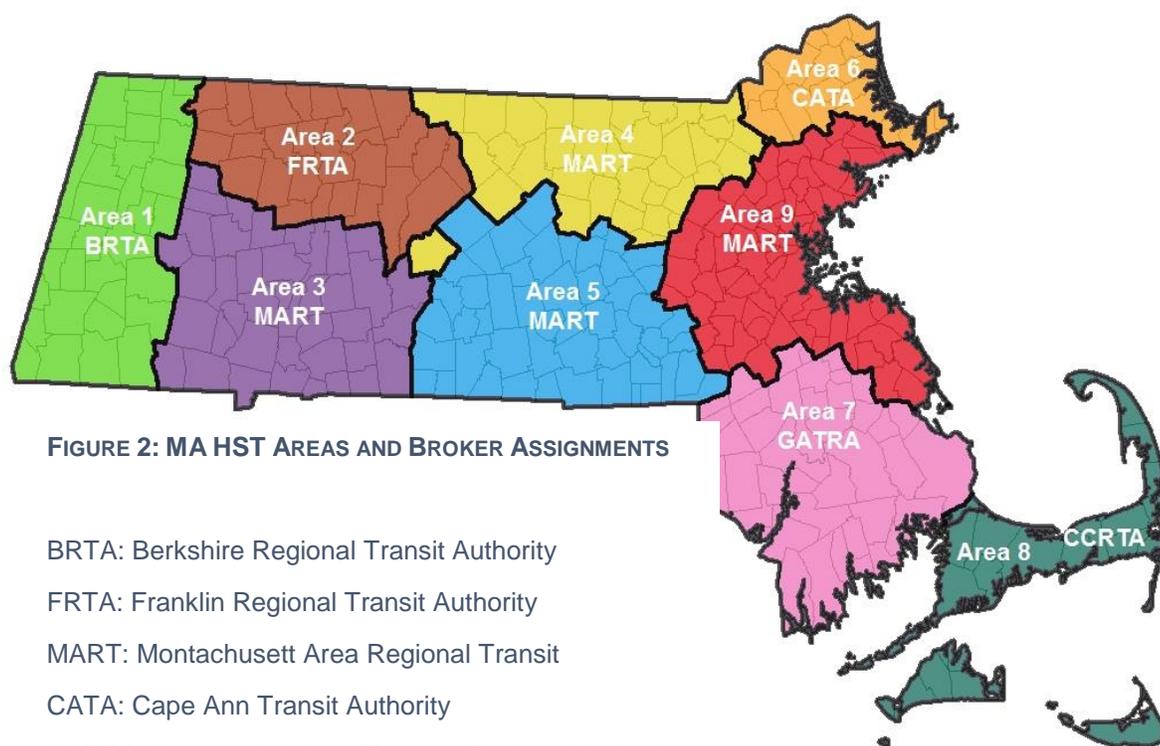
##### HST Brokerage Model

In order to carry out the provision of transportation service to its 50,000 customers, the HST Office manages a statewide brokered transportation system, which contracts with six Regional Transit Authorities (RTAs) that act as regional brokers. The decision to create a public-public partnership model and contract with public transit agencies was intentional and was done in order to facilitate enhanced use of public transit where appropriate and accessible to EOHHS' customers.

Nine geographic areas were established for this HST system (based on historical Department of Developmental Services service areas) and select RTAs provide HST brokerage services in multiple HST areas including outside their transit service regions. All HST transportation brokers are required to adhere to high quality performance standards with specific outcome measures that have been established and are monitored by the HST Office. The primary responsibilities of brokers include:

- Verifying eligibility and arranging consumer trips
- Contracting for services with local providers
- Monitoring and ensuring service quality through on-site inspections, consumer surveys, etc.
- Developing routing and other strategies to increase system efficiency, shared rides and cost effectiveness
- Tracking and reporting system usage and costs and monitoring performance benchmarks

In Massachusetts, transportation providers are under contract with the broker and not state agencies. The broker, in turn, enters into subcontracts with each transportation provider who must meet certain qualifications in order to perform the direct transportation service. See Figure 2 below for HST areas and broker assignment:



**FIGURE 2: MA HST AREAS AND BROKER ASSIGNMENTS**

BRTA: Berkshire Regional Transit Authority

FRTA: Franklin Regional Transit Authority

MART: Montachusett Area Regional Transit

CATA: Cape Ann Transit Authority

GATRA: Greater Attleboro/Taunton Regional Authority

CCRTA: Cape Cod Regional Transit Authority

Transportation is provided to eligible consumers, as determined by their funding agency, via two service models: "demand-response" and "program-based".

- Demand Response Service Model – This model involves single or non-recurring trips for consumers in need of transportation to and from varying destinations. Consumers or authorized funding agency staff schedule these trips directly with the broker.
- Program-Based Service Model – This model typically involves a route-based service that occurs on a regular schedule (e.g. daily) going to a common destination with a consistent transportation provider and driver. Consumers are escorted to and from the vehicle by facility or residential staff and can never be left unattended. The funding agency specifies the consumer’s trip schedule on the transportation authorization; consumers do not schedule their own trips.

As seen in Table 1, the HST brokerage system managed over 7.5 million trips and provided service to almost 50,000 EOHHS consumers in fiscal year 2015.<sup>44</sup>

**Table 1: MA HST Fiscal Year 2015 Operational Summary**

<b>Operational Summary</b>	<b>FY 2015</b>
<b>Consumer trips</b>	7,762,221
<b>Consumers served</b>	49,477
<b>Percentage of accident free trips</b>	99.99%
<b>Percentage of complaint-free trips</b>	99.70%
<b>Local transportation vendors</b>	473
<b>Vehicles (including chair cars)</b>	3,973
<b>Drivers</b>	3,922
<b>Monitors</b>	368
<b>Broker on-site service inspections performed</b>	7,434
<b>Avg. number of vehicles on the road daily (Mon. thru Fri.)</b>	4,636
<b>Avg. number of vehicles on the road (Saturday)</b>	2,421
<b>Avg. number of vehicles on the road (Sunday)</b>	1,906

## **PARTICIPATING STATE AGENCIES**

Currently, there are six state agencies participating in the HST brokerage system. HST participating agencies maintain full control and responsibility for the following activities:

- Determining consumer eligibility

<sup>44</sup> <http://www.mass.gov/eohhs/docs/hst/hst-annual-report-fy15.pdf>

- Determining facilities or locations to which consumers will be transported
- Determining service areas for consumers (distances that consumers may be transported)
- Ensuring adequate funding of approved transportation services
- Reimbursing the brokers for consumer trip costs (see funding/costs section for additional information)

The participating agencies, program service descriptions including the types of transportation provided are summarized below:

Participating Agency	Service Description
<p><b>1. MassHealth (MA Medicaid agency)</b></p>	<p>Any MassHealth member within a category that includes transportation-eligible coverage can qualify for non-emergency medical transportation (NEMT) to and from MassHealth-covered services when public or private transportation is not available or accessible.</p> <p>Services people can receive transportation to/from include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Medical appointments</li> <li>• Counseling</li> <li>• Day habilitation</li> </ul>
<p><b>2. Department of Developmental Services (DDS)</b></p>	<p>Massachusetts has a comprehensive system of specialized services and supports to give individuals with intellectual disabilities the opportunities to live the way they choose. DDS is the state agency that manages and oversees this service system. Specialized services and supports are provided to approximately 32,000 adults with intellectual disabilities and children with developmental disabilities.</p> <p>Transportation is provided for adults enrolled in day habilitation, day service, supported employment and residential support programs.</p>
<p><b>3. Department of Public Health’s Early Intervention Program (EI)</b></p>	<p>Early Intervention (EI) in Massachusetts is a statewide, integrated, developmental service available to families of children between birth and three years of age. Children may be eligible for EI if they have developmental difficulties due to identified disabilities, or if development is at risk due to certain birth or environmental circumstances. EI provides family-centered services that facilitate the developmental progress of eligible children. EI helps children acquire the skills they will need to continue to grow into happy and healthy members of the community.</p> <p>For a child to receive the greatest benefit from EI, regular attendance for services identified on the Individualized Family Service Plan (IFSP) is very important, and DPH provides transportation services to children and families enrolled in certified EI programs.</p>

<p><b>4. Massachusetts Rehabilitation Commission (MRC)</b></p>	<p>MRC is responsible for Vocational Rehabilitation Services, Community Living Services, and eligibility determination for the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) federal benefits programs.</p> <p>Transportation for individuals with disabilities to vocational rehabilitation services, community services and other MRC-authorized locations or programs is provided.</p>
<p><b>5. Massachusetts Commission for the Blind (MCB)</b></p>	<p>The Massachusetts Commission for the Blind (MCB) provides the highest quality rehabilitation and social services to individuals who are blind, leading to independence and full community participation. MCB accomplishes this critical mission by working in partnership with consumers who are legally blind, families, community agencies, health care providers, and employers.</p> <p>Transportation is provided for blind individuals to social and rehabilitative programs and services, as well as to other MCB-authorized locations or programs.</p>
<p><b>6. Department of Mental Health (DMH)</b></p>	<p>As the State Mental Health Authority, the Department of Mental Health (DMH) assures and provides access to services and supports that are person-centered and recovery-focused to meet the behavioral health needs of individuals of all ages, enabling them to live, work and fully participate as valuable, contributing members of our communities. The Department's network provides services to approximately 21,000 individuals with severe and persistent mental illness across the Commonwealth, including children and adolescents with serious emotional disturbance and their families through a continuum of care.</p> <p>Transportation is provided to DMH-authorized locations for consumers of DMH Clubhouse services. Clubhouse services provide employment and education support services, housing support services, and other support services to help individuals live a productive and stable life in the community.</p>

## HST OFFICE FUNCTIONS

Although the HST Office manages the provision of transportation to EOHHS consumers receiving funding directly from state agencies for authorized services through its brokerage system, there is a broader population in need of assistance and support for accessing transportation to participate in community life. In order to address these needs, the HST Office created two additional "arms" of its management mission: Technical Assistance to State Agencies and Mobility Management Support and Outreach.

## Technical Assistance to State Agencies

The HST Office offers a range of technical assistance to state agencies whose primary mission is not transportation, and whose transportation programs or program components are not directly managed through the brokerage. Technical assistance activities can include an assessment of current transportation programs, or development of innovative solutions to consumer transportation needs.

For example, the HST Office completed a variety of technical assistance activities benefitting MassHealth. A cost assessment and associated recommendation to MassHealth that the agency could realize upwards of \$1M in savings if non-emergency fee-for-service (chair car and non-emergency ambulance) transportation was transitioned to the HST brokerage from a stand-alone service within the agency were completed. Additionally, recommendations were made regarding the improvement of programmatic internal controls for the transportation authorization process, and the HST Office also provided guidance to MassHealth in devising a site visit form for non-brokered, non-emergency transportation providers for Affordable Care Act implementation.

The HST Office also works with agencies and organizations not participating in the HST Brokerage system. For example, the Department of Early Education and Care (EEC) reached out to EOHHS through its HST Office for its assistance to provide information regarding the operations of the HST brokerage system to see if any applicable aspects of the system could be replicated at EEC. Through this effort, HST staff assisted EEC with developing a survey to assess current transportation programming at the Department. Additionally, HST staff worked with the Massachusetts Developmental Disabilities Council to offer possible transportation strategies for employment transportation options for staff members who provide weekly trainings to adults with developmental disabilities at a range of locations across the Commonwealth. The Council, residing within the Executive Office of Administration and Finance, works to effect changes in policy and practice so that people with developmental disabilities and their families are empowered and supported to be more personally independent and economically productive. Transportation options offered included a potential pilot program through the HST brokerage system.<sup>45</sup>

## Mobility Management Support and Outreach

In FY12, the HST Office began implementation of a two-year \$600,000 federal grant to build and sustain a statewide mobility management information network and thus created MassMobility, which still operates today via grant funding from the Massachusetts Department of Transportation.

MassMobility is an initiative to increase mobility for seniors, people with disabilities, veterans, and others who lack transportation access in Massachusetts. MassMobility helps to build the capacity of the Massachusetts community transportation network by raising awareness of existing services, fostering collaboration among programs, and sharing best practices. This mobility management work includes the following three components:

### **Information Hub:**

- Hired a Mobility Information Specialist to research and develop resources to help community agencies around Massachusetts provide more efficient and effective community transportation services and to help their consumers find transportation options.
- Updated the HST website, including launching new webpages on veterans' transportation services, resources on transportation for workforce development, and a calendar of upcoming events.
- Developed and disseminated resources on veterans' transportation as part of the Office's participation in the Massachusetts Veterans Transportation Coalition (MVTC), including an updated brochure on services offered by Regional Transit Authorities and a fact sheet on federal tax incentives for employers that hire veterans.

---

<sup>45</sup> <http://www.mass.gov/eohhs/docs/hst/hst-annual-report-fy12.pdf>

**Outreach:**

- Hired a Mobility Outreach Coordinator to help increase the number of stakeholders involved in mobility management and transportation coordination efforts across the state and foster new efforts in underserved regions.
- Expanded the membership of the MVTC and attended many outreach events on behalf of the Coalition. MVTC members include state agencies, Regional Transit Authorities, Veterans' Service Officers, and other stakeholders committed to improving veterans' access to transportation services in Massachusetts.
- Built a partnership with Easter Seals Project ACTION, a national provider of technical assistance on issues related to accessible transportation. Worked to raise awareness in Massachusetts of the value of travel instruction.
- Maintained and deepened relationships with the cross-sector regional transportation coordination teams that originated in the Work Without Limits (Work Without Limits is a CMS-funded statewide network of engaged employers and innovative, collaborative partners that aims to increase employment among individuals with disabilities) Transportation Coordination Institute of 2009.

**Technical Assistance and Policy:**

- Responded to direct inquiries from consumers and community agency staff seeking help identifying transportation services in their areas.
- Subcontracted Work Without Limits to assist with policy research and technical assistance grant activities.
- Identified key topics to research in order to help community partners across the state overcome barriers to providing more effective and efficient services to their consumers. Topics include vehicle share agreements, volunteer driver programs, travel instruction and insurance products.<sup>46</sup>

Mobility management activities that occur within the HST Office also have a strong partnership with the Statewide Mobility Manager housed at the Massachusetts Department of Transportation (MassDOT), which is further discussed in Section IV.

**COSTS, TRIP VOLUME AND FUNDING**

There are both costs associated with managing the HST brokerage system, as well as costs for providing the direct transportation service.

As shown in Tables 2 and 3, the HST brokerage managed over \$181.6 million in costs in fiscal year 2015, which includes both direct trip costs and administrative costs (broker management fee plus HST administration costs), resulting in a total cost per trip of \$23.39.<sup>47</sup>

---

<sup>46</sup> <http://www.mass.gov/eohhs/docs/hst/hst-annual-report-fy12.pdf>

<sup>47</sup> <http://www.mass.gov/eohhs/docs/hst/hst-annual-report-fy15.pdf>

**Table 2: MA HST Total Trip Costs by Agency (FY 2015)**

Agency	FY15 Total Trip Costs (millions)
MassHealth PT-1 (Demand Response)	\$63.4
MassHealth Day Habilitation (Program Based)	\$85.8
MassHealth Early Intervention (Program Based)	\$2.9
DDS (Program Based)	\$18.4
DPH Early Intervention (Program Based)	\$0.98
DMH (Program Based)	\$1.6
MRC (Demand Response)	\$0.6
MCB (Demand Response)	\$0.001
<b>TOTAL</b>	<b>\$173.8</b>

**Table 3: FY 2015 Cumulative Costs and Average Cost Per Trip**

	Total (millions)	Average Cost Per Trip
Trip Costs	\$173.8	\$22.39
Administration (Broker mgt. fee + HST administration)	\$7.8	\$1.00
<b>TOTAL</b>	<b>\$181.6</b>	<b>\$23.39</b>

**Broker management fee**

EOHHS pays a fixed amount to each broker each month through an electronic transfer of funds for brokers to administer all brokerage services required under the contract, which include appropriate staffing levels, communication capabilities, and other necessary resources to provide system management and oversight. Agencies participating in the brokerage system are required to contribute to a chargeback account which funds the broker management fee as well as HST Office administrative (staffing) costs. The amount of the chargeback is based on historical annual agency trip volume and costs and can be increased or decreased due to extreme fluctuations in volume and/or costs via contract amendment.

**Direct Transportation Costs/ Rates**

The broker management fee does not include reimbursement for any direct transportation costs. Rather, the broker bills each funding agency directly for trips provided to its consumers. The HST Office works with each participating agency to develop targeted average rates, which are based on historical and projected trip volume and costs, including anticipated utilization, are agreed to annually and are established via contract amendments. Each agency

rate is a blended rate for both ambulatory and chair-car consumer trips and supports all service models (demand-response and program-based).

Payments for trips are for actual costs as invoiced by subcontracted transportation providers to the Broker, and are billed to the funding agency on a one-way trip basis using an average trip rate. There is a separate calculation of each billing period's average trip rate for each agency. The broker calculates the total actual transportation costs per funding agency for each billing period regardless of how the transportation provider is paid (route, trip, mileage, hourly, etc.), and divides by the actual number of billable one-way trips provided for that agency's consumers (not including absences). This will yield the average one-way trip rate for that billing period.

### **Cost savings model**

One exception to average trip rates for all participating agencies is the establishment of an HST Cost Savings Rate for MassHealth NEMT demand-response services. While program-based routes are put out to bid on a long-term basis, demand-response transportation services are secured near real-time, which takes advantage of competitive bidding from provider to win trips and economies of scale of the number of transportation providers trying to win trips. Instituted in FY2009, the shared cost savings rate is a blended average rate that is determined by the HST Office based on historical data and projected growth. With the cost savings rate, the broker has the opportunity to generate retained savings through efficient management of transportation provider costs that result in an average cost per trip billed to the broker that is less than the broker's contracted cost savings rate. If the broker can keep actual costs below the contracted rate, then the broker may accrue and retain a certain percentage of savings through this process that are then used for HST brokerage system related program development such as call center enhancement, additional service inspections, or supplementary training programs.

### **Cost allocation**

For all grouped/shared routes and trips, the broker allocates costs equitably across all agency and non-agency consumers. In order to assure appropriate cost allocation strategy, the HST Office approves cost allocation methodologies by the brokers. For routes that include consumers from different funding agencies, the broker completes a calculation at the vehicle/route level to allocate the appropriate costs to each agency. On the last day of each billing period, the broker determines the percentage of each agency's consumers that were assigned to that mixed route and multiply that percentage by the actual route cost for that billing period to determine the allocation of costs to each agency. Each agency's share of mixed route costs is added to its total non-mixed route costs to generate the agency's total monthly transportation costs.

## Florida

### HISTORY/ OVERVIEW

Human service and public transportation services in Florida have been coordinated for decades, beginning with a legislative mandate for coordination in 1979. In 1989, the Florida Commission for the Transportation Disadvantaged (CTD) and the coordination structure that is used today were created (see Figure 3).

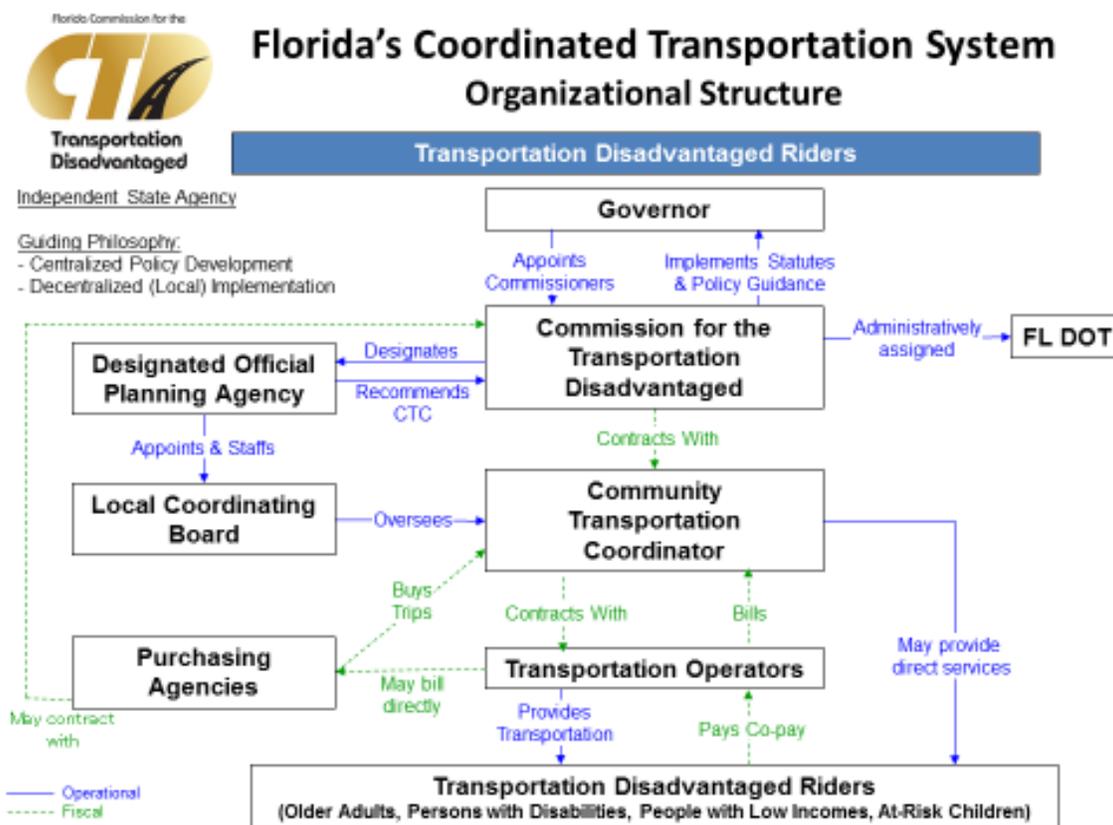


FIGURE 3: ORGANIZATIONAL STRUCTURE OF FLORIDA’S COORDINATED TRANSPORTATION SYSTEM

Source: Florida CTD, 2015 Annual Performance Report, January 2016

The seven CTD members include business leaders, people with disabilities, and older adults. An ex-officio advisory committee is comprised of state human service agency representatives and a county manager or administrator.

The Commission for the Transportation Disadvantaged designates a Community Transportation Coordinator (CTC), with the assistance of a designated planning agency, to coordinate public and human service agency paratransit services in each of Florida’s 67 counties. A Local Coordinating Board (LCB) in each county oversees the CTC. CTCs can be a single designated service provider/operator, a non-profit agency, a coalition of organizations, or a for-profit entity. The CTC either provides transportation services directly, contracts with local transportation

operators, or does both. It also should be noted that many of the CTCs make use of the public transit system to the extent possible.

Under Florida law, state and local agencies are required to participate in the appropriate coordinated transportation system if they receive local, state or federal funds for the transportation of transportation-disadvantaged persons.

### **PARTICIPATING STATE AGENCIES**

Individuals are considered to be transportation-disadvantaged if they are unable to transport themselves or purchase transportation because of age, disability, income, or other reasons, and are therefore dependent on others for access to health care, employment, education, shopping, social activities, and so forth, or are children considered to be at risk. In order to receive subsidies from the state Transportation Disadvantaged Trust Fund, individuals must be transportation-disadvantaged and not be sponsored by an agency for the particular trip that they need to make.

Participating state agencies that purchase trips from each CTC include:

- Departments of Transportation
- Elder Affairs
- Health
- Children and Families
- Community Affairs
- Education
- Juvenile Justice
- Agency for Workforce Innovation

Originally, the Florida Agency for Health Care Administration (Medicaid) was also a participant in the coordinated system. However, in 2014, Florida transitioned to a managed care model for Medicaid services, including NEMT. Managed care organizations are now responsible for providing necessary transportation for Medicaid recipients, and typically contract with brokers to provide those services, who may or may not purchase trips from the coordinated services provided by the CTCs. Withdrawal of NEMT from those services that must be obtained from the coordinated transportation system resulted in a decrease of over \$45 million in Medicaid revenues and 2.2 million trips from that system between fiscal years 2013-2014 and 2014-2015, when the transition to managed care was completed.

### **COSTS, TRIP VOLUME AND FUNDING**

A key feature of Florida's coordinated transportation system is the Transportation Disadvantaged Trust Fund, which provides planning grants to local planning organizations and operational grants to CTCs to supplement funding for transportation services from human service agencies. The fund's revenue sources include a state vehicle registration fee, the state's public transit block grant program, voluntary contributions of \$1 made by vehicle registrants, temporary accessible parking fees, the state's Transportation Trust Fund, and the state's Highway Safety Operating Trust Fund. In fiscal year 2014-2015, the TD Trust Fund provided \$41 million to Florida's 67 counties, or 16 percent of the cost of providing services overseen by the CTD.

Table 4 presents information and the operations, costs, and revenues of Florida's coordinated transportation system in 2015.

**TABLE 4: FL CTD OPERATING AND FINANCIAL STATISTICS (FY 2015)**

<b>Trips by Trip Purpose</b>	
Medical	5,440,070
Employment	2,703,968
Education/Training/Day Care	3,210,375
Nutrition	1,322,867
Other	5,103,674
<b>Total Number of Trips</b>	<b>17,780,954</b>
Number of Vehicles	4,691
Total Expenses	\$250.4 Million

## Georgia

### HISTORY AND OVERVIEW

The provision of human service transportation in Georgia is carried out through a variety of systems and agencies. Referred to as “the Big 3”, the Georgia Department of Transportation (GDOT), the Georgia Department of Human Services (DHS) and the Georgia Department of Community Health (DCH), each operate their own transportation systems. However, the establishment of an overall human service transportation system called Rural and Human Services Transportation (RHST) provides a platform for coordination across all three agencies and programs with the goal of achieving cost efficiencies and limiting service duplication for transportation-disadvantaged populations. Through these agencies and programs, transportation is provided to eligible Georgians to services such as medical appointments, employment and education across the state’s 159 counties. While the three agencies operate independent transportation programs, efforts have been underway since 2007 to develop and coordinate all services under the auspices of the RHST.

Working together, agencies participating in the RHST system utilize public transit, private transportation providers and non-profit agencies to provide services, with a focus on utilizing public transit systems whenever available and accessible.

### PARTICIPATING STATE AGENCIES

#### Department of Community Health (DCH)

Like all state Medicaid departments, Georgia’s DCH operates with the mindset and mission that Medicaid members must be able to access health care services provided under the Medicaid program, and transportation to those services is essential in achieving optimal health outcomes for members.

The DCH transportation system was established in 1997, when the agency transitioned from a fee-for-service system to a NEMT broker model to administer transportation services to eligible Medicaid members to eligible services. The state was organized into five regions, on which bids for NEMT broker management were solicited and awarded through a competitive bidding process. Two brokers, LogistiCare LLC and Southeastrans Inc. currently manage the service in the five statewide regions – North, Atlanta, Central, East and Southwest. Brokers are paid a capitated rate for each eligible Medicaid member residing in their region(s).

Georgia’s DCH brokers are responsible for the following activities:

- Transportation provider recruitment and contracting
- Payment administration Gate keeping and verifying trip need
- Trip reservations and assignment
- Assuring quality and safety
- Overseeing administration and reporting

The current brokerage system has proved to be a more effective method of delivering NEMT to Georgia’s Medicaid members than the fee-for-service model that was in place prior to the implementation of brokers in 1997. The broker system provides transportation services in areas of the state where there was no transportation for Medicaid members who had no other transportation options prior to 1997. This system has also been successful in reducing fraud and abuse of the NEMT services for the State of Georgia<sup>48</sup>.

---

<sup>48</sup> Coordinated Public Transit – Human Services Transportation Interim Plan, 2010. Georgia Department of Transportation.

Georgia's NEMT program provides transportation for eligible Medicaid members requiring access to medical care or services that are covered under the State's Medicaid Plan or through waivers. Similar to Medicaid transportation programs in other states, the program only provides services to members when other transportation (i.e. public transit, family or friends) is not available. As such, the brokerage system provides medically necessary transportation for any Medicaid member who has no other means of transportation available to any Medicaid eligible service for the purpose of:

- Receiving treatment
- Medical evaluations
- Obtaining prescription drugs
- Medical equipment<sup>49</sup>

### **Department of Human Services (DHS)**

The DHS coordinated transportation system serves the consumers of four of Georgia's human service agencies:

- Division of Aging Services (DAS)
- Division of Family and Children Services (DFCS)
- Department of Behavioral Health and Developmental Disabilities (DBHDD)
- Georgia Vocational Rehabilitation Agency (GVRA)

These agencies and programs include senior services and Temporary Assistance for Needy Families (TANF), that fund or sponsor client-related transportation, as well as FTA Section 5310 which contracts transportation services for seniors and persons with disabilities. Other departments with an RHST role include Department of Labor, Department of Corrections, Veterans Services, and Department of Education.

In the DHS model, the state is divided into three Districts and 12 regions. Three Field Operations Coordinators (FOCs) oversee the Regional Transportation Offices. Each FOC is responsible for the oversight of four regional offices. The 12 Regional Transportation Offices (RTOs) are responsible for the daily programmatic administration of transportation in their geographical areas. The RTO is the focal point within each region and is responsible for transportation provider monitoring and compliance; funding management; fleet management, and transportation coordination efforts.

The coordinated system operates through a series of purchase of service contracts within each region. Providers are a mix of governmental entities, for-profits, and private non-profits. In many regions, a lead provider is the prime contractor, such as a Regional Commission, which provides overall contract management in coordination with the RTO and subcontractors. Although much of the DHS transportation provision is accomplished through subcontracting with local transportation providers, state-owned vehicles are also utilized to transport DHS consumers in this system. The Department of Administrative Services' (DOAS') Office of Fleet Management is charged with centralizing Georgia's motor vehicle fleet management functions. DHS works closely with DOAS Fleet Management as well as with the 12 Regional Transportation to provide oversight, education, and guidance in the acquisition, transfer and disposal of state owned vehicles for DHS consumer transport.

Each region also has a Regional Transportation Coordinating Committee (RTCC). The purpose of the committee is to establish policies and procedures, identify transportation needs and available funding and conduct the annual contract evaluation process which approves transportation subcontractor renewals on a yearly basis.<sup>50</sup>

---

<sup>49</sup> Georgia Department of Community Health. Part II Policies and Procedures Manual for Non-Emergency Transportation Broker Services, 2016

<sup>50</sup> <https://dhs.georgia.gov/transportation-services>

### Georgia Department of Transportation (GDOT)

A key player in the RHST system, GDOT is responsible for administering state's public and paratransit systems. Additionally, the department administers the rural public transportation program funded through the FTA Section 5311 program, as well as other FTA funding programs that support urban public transportation.

Under the Section 5311 program, Federal Transit Administration (FTA) funds are allocated to states on a formula basis, and can be used for capital assistance, operating assistance, planning, and program administration. The goal of 5311 is to provide rural areas with funding to provide transportation services which improve access to business, commercial and activity centers. In Georgia, GDOT is responsible for administering the program and is the recipient of those funds. As the 5311 oversight entity in the state, GDOT provides funding to local communities for mobility expenses and implemented programs provide necessary transportation options in the state's many rural areas<sup>51</sup>.

### COSTS, TRIP VOLUME AND FUNDING

As shown in Figure 4, Georgia spent an estimated \$146.6 million in FY 2014 on RHST programs, and provides over 8.2 million trips.<sup>52</sup>

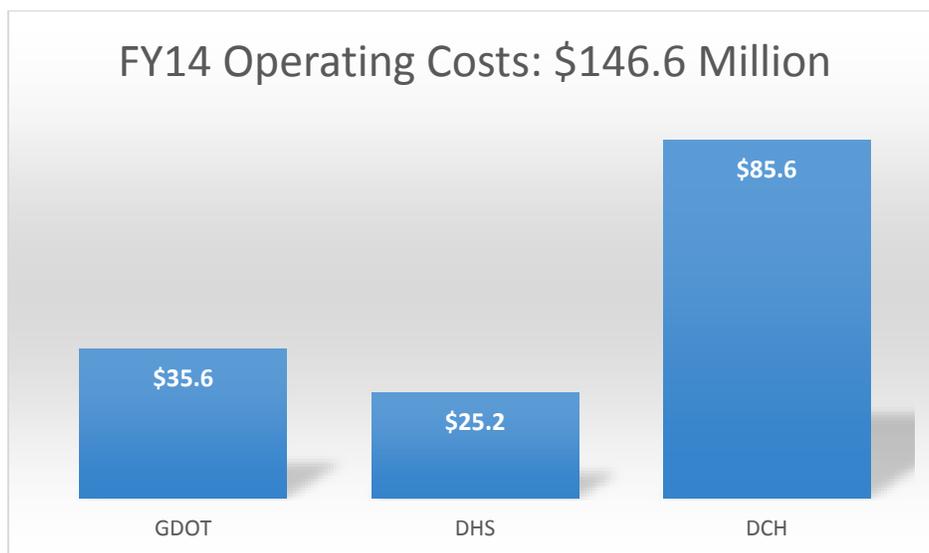


FIGURE 4: GA RHST SPENDING (FY 2014)

<sup>51</sup> Coordinated Public Transit – Human Services Transportation Interim Plan, 2010. Georgia Department of Transportation.

<sup>52</sup> Coordinating Rural and Human Services Transportation in Georgia, 2015 Report. Prepared for the Governor's Office of Planning and Budget. Created by the Governor's Development Council and the Georgia Coordinating Council for Rural and Human Services Transportation, August 2015.

**Table 5: Georgia RHST Operational Statistics (FY 2010)** <sup>53</sup>

	GDOT	DCH	DHS
<b>Payment Approach</b>	“fully allocated” eligible cost	“capitated rate”	“per trip”
<b>Number of Regions / Providers</b>	114 providers	5 Brokers, 100+ providers	12 regions, 100+ providers
<b>Agency Staffing</b>	7	2.25	27
<b>Program Cost</b>	\$26.8 million	\$80.9 million	\$30.1 million
<b>Number of Trips</b>	1,924,007	3,104,756	2,491,373
<b>Average Cost per Trip (statewide average)</b>	\$13.96	\$26.05	\$13.91

## STATUS OF RHST

The RHST concept was developed and initiated by the GDOT within the Georgia Rural and Human Services Transportation (RHST) Plan 2.0, which is an update to the Coordinated Public Transit – Human Services Transportation Plan originally completed in 2007. In order to maintain momentum and progress on coordination activities, the Transportation Investment Act of 2010 requires annual reporting on RHST activities, and reports identify opportunities for enhanced RHST system utilization.

The 2011 Rural and Human Services Transportation Study – Phase I Implementation Plan<sup>54</sup> identifies the following major obstacles and challenges to coordination in the existing environment:

Obstacle	Description
<b>Inconsistent service in all areas</b>	Rural public transportation does not operate everywhere, is limited in terms of service days and hours, and may not always be available.
<b>Inconsistent Program Boundaries</b>	DHS works within 12 regions, which coincide with Regional Commissions, while DCH's has established five brokerage regions. While county boundaries typically serve as functional service areas, the boundaries of the 12 DHS regions do not correspond into the five DCH brokerage regions. Meanwhile, GDOT's service areas tend to focus at the city or county level because service is provided locally.
<b>Duplication of services/trips</b>	In some of regions there are examples of service duplication with three different networks of providers offering similar services to the same areas.

<sup>53</sup> Rural and Human Services Transportation Study – Phase I Implementation Plan, May 2011. Prepared for Georgia Department of Transportation. Prepared by HNTB Corporation.

<sup>54</sup> Ibid.

<b>Need for expanded stakeholder engagement</b>	In some regions where stakeholders meet to discuss transportation issues, the group is not always as inclusive as needed and/or focuses more on agency concerns rather than the broader network of RHST services.
<b>Lack of consistent administration</b>	Administration is not consistent within DHS: some transportation grants go to the DHS regional office and are administered by them; some are transferred to the Regional Commission and administered by the RC; and some have a combination of both. Not all DHS transportation programs are included in all regional grants and service provider contracts. This is not only the case for the various DHS programs, but also those funded by GDOT and Medicaid.
<b>Inconsistent Rates/Fees from Providers</b>	Some DHS programs (i.e., TANF) reimburse service providers at a higher trip rate than other programs. This means that most providers are likely to prioritize higher paying trips over lower paying trips.
<b>No consistency in programs</b>	Service providers in uncoordinated regions sometimes have taken on the mantle of coordinating compatible trips funded by different programs. It is these providers who often decide what program(s) to charge for the transportation of a certain trip. On the positive side, this flexibility often enables the provision of transportation services to customers/clients who otherwise wouldn't be transported. On the negative side, these decisions sometimes favor the financial interests of the service provider which can sometimes result in certain customers not being able to access services at desired/needed times.
<b>Large number of existing grantees for GDOT</b>	Managing 5311 grants for 114 grantees is a major administrative undertaking.
<b>No set procedures for cost allocation/cost Sharing</b>	With the exception of the Coastal Georgia and Southwest Regions, there is a lack of consistency in how costs are allocated/shared in cases where trips funded by different funding streams are co-mingled
<b>No common software to support coordinated service</b>	GDOT is undertaking a procurement effort that may lead to the use of – or interface with -- one software product to support RHST providers.

Along with the identification of obstacles and barriers within the current system, the 2011 report also identified a list of state level recommendations for Georgia to consider as it continues to work toward a seamlessly coordinated RHST:

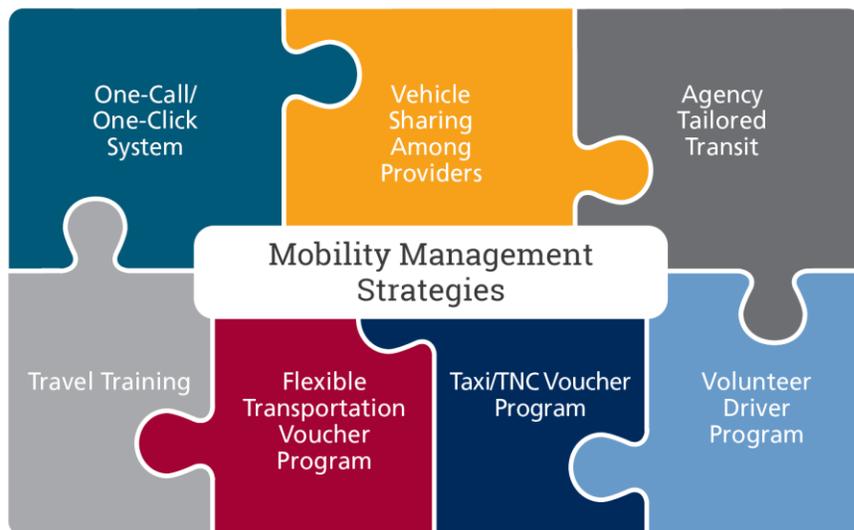
- The State should designate an RHST office and state-level Mobility manager
- The State should create an authorized body (the proposed State Coordinating Council) to facilitate coordination of programs and requirements of GDOT, DHS, DCH, etc.
- Empower Regional Commissions to become Regional Mobility Managers through adoption of an RHST Infrastructure
- Delineate uniform boundaries for multiple program service areas with consistent Regional Commission boundaries and the DHS boundaries

- Develop streamlined and consistent reporting/program requirements across programs while fulfilling federal requirements
- Designate a source of ongoing funding for O&M and capital for public transportation
- Develop a standardized set of program policies and procedures across programs while fulfilling federal requirements
- Establish a common cost allocation methodology across programs
- Develop consistent contracts and contracting process for third party operators
- Allow greater flexibility to bundle program and non-program funds for transportation
- Provide technical support in the form of scheduling software (this is currently being accomplished through an effort by the DOT)
- Provide technical support to the Regional Commissions

While some of the recommendations above are in progress, Georgia is still in the process of analysis and implementation in order to effectively carry out the mission of its RHST.

## IV. MOBILITY MANAGEMENT STRATEGIES

Mobility Management is a broad term that is used to cover a number of activities, including comprehensive transportation coordination efforts and lower level, complementary programs and services. Mobility management strategies can be utilized disparately by one or more organizations that are involved in the provision of transportation services in an area, or combined into a comprehensive program administered by an individual or entity with the title of “Mobility Manager.” Mobility Managers can be individuals who help customers identify transportation options, plan trips and perhaps make arrangements for those trips, or entities that have a wider range of responsibilities aimed at improving coordination among transportation programs and services and increasing mobility options.



The Mobility Management strategies described below could be implemented independently or to complement more comprehensive, structural changes in the delivery of human service transportation.<sup>55</sup>



### One-Call/ One-Click Systems

One-Call / One-Click is a broad term for a centralized information repository on a range of transportation services.

These systems may provide the following:

- program information
- transportation itinerary planning
- trip eligibility assistance
- available transportation service information
- trip booking

One-Call / One-Click systems occur along a spectrum of functionality. On the one end is an online or over the phone directory of service information that includes a list of transportation providers in an area, a description of their services, and their contact formation. While in the past many of these repositories were simple, cost-effective printed directories, such guides are no longer recommended as a best practice as information can quickly become obsolete. Digital or phone repositories provide a more valuable resource for users, but protocols to maintain accurate information need to be established or information may fail to be accurate.

<sup>55</sup> After extensive research and conferring with transit subject matter experts, no promising mobility management strategies were found internationally.

Digital service directories can offer more specific information on what services are available to individuals. Repositories at the medium level of functionality use location based information or trip triaging to narrow the field of available or appropriate transportation resources, and to identify the most appropriate means of transportation.

For example, the online 211 LA County system allows a person to narrow their transportation options by filtering available service by zip code and by transportation mode. An additional feature of many repositories at this mid-level is a trip planning function that allows a person to enter his or her origin and destination and to specifically identify what services may be used to get there. In systems offering both types of trip planning assistance, however, users must still contact providers to book a trip.

At the highest levels of functionality, a One-Call / One-Click system provides information on the transportation services that are available for an individual, assists in identifying a provider, and schedules that trip, all without having to consult a second resource. These systems may be automated using a website, smart phone app, or a phone menu, or may be personalized with a phone operator. Though personalized systems provide the best outcomes for some users, they are costlier per user and for best practices should be used in concert with an automated trip scheduling service in order to lower costs.

### Best Practice Examples

Location	Program Name	Website
New York	511-NY	<a href="http://www.511ny.org">www.511ny.org</a>
Schuyler County, NY	Transportation Link-Line	<a href="http://www.schuylercountytransit.org/Link-Line">www.schuylercountytransit.org/Link-Line</a>
Central Pennsylvania	FindMyRindPA	<a href="http://www.findmyridepa.com">www.findmyridepa.com</a>

### 511 NY



Operating at the medium level of functionality, 511 NY serves as the official telephone and web-based information provider for transportation services and travel conditions throughout New York State. The information provided includes alerts on traffic incidents, transit service availability, weather conditions, rideshare matching, and more.

The service, which began in 2009, offers localized transit trip planning for seven different areas of the state on its website, while the 511 phone service offers an interactive, automated system that can be managed by using phone keys, or controlled by the user's voice. For users that need to access more personalized information, the system can transfer users of the phone system to outside agencies whose information is used on the website. The information is also available via smartphone app, and designed to meet the needs of a variety of different travelers from daily commuters to long-distance commercial vehicle operators. Links to more local information resources are also available on the 511 website. The website additionally provides a search function that allows users to find available transit or paratransit services for any particular county or 511 regions.

**Transportation Link-Line: Schuyler County, NY**

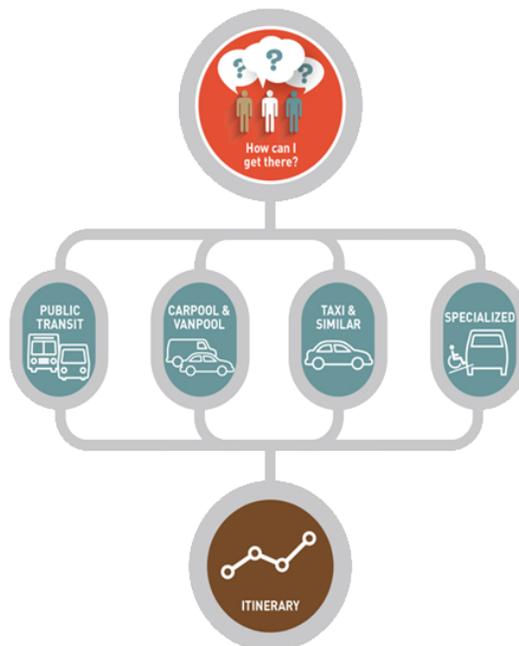
Transportation Link-Line is a free information and assistance service that connects people in Schuyler County and neighboring communities with transportation options. On the higher end of the functionality spectrum, Transportation Link-Line also provides public outreach, transit orientation and responds to public inquiries regarding transportation options. Call-takers at Link-Line help connect callers with specific services and assist with trip booking as needed. Link-Line includes scheduling and routing software, a central repository of information, and a multimedia marketing and outreach campaign to educate the public.



The online platform is operated by the ARC of Schuyler and is funded by a Veterans Transportation and Community Living Initiative grant from FTA, NYS Department of Transportation, and Schuyler County Office for the Aging.

**FindMyRidePA: Central Pennsylvania**

FindMyRidePA is a service from the Commonwealth of Pennsylvania that offers trip planning and matching for customers looking for a ride, and is designed to help anyone identify and evaluate transportation options to meet their travel needs. FindMyRidePA was initially implemented in central PA, and is now available in seven different counties with the service to be expanded to five more counties in the near future. In addition to identifying services that match customer needs, FindMyRidePA helps with trip planning, and if the transportation service happens to be the county-based coordinated system, it can help with booking a trip. Customers enter their trip requirements and are presented with trip options and cost estimates for those trips. There is also a feature for those with specialized transportation needs in which seniors, people with disabilities and low income individuals can take shared-ride services, which are provided free of charge or at highly discounted rates. FindMyRidePA grew out of an initiative to make transportation options more readily available to veterans, active military personnel and their families, but now serves anyone who needs transportation in the counties served.



FindMyRidePA offers some of the highest functionality of a One-Call / One-Click system by providing an automated digital system with a website as well as a smartphone app. Trips can be designed for fixed-route bus systems, and even booked using shared-ride services. Further, for customers who cannot access the digital system, a personalized phone service is also available to schedule trips. FindMyRidePA was developed with funds from the Pennsylvania Department of Transportation and the Federal Transit Administration.



## Vehicle Sharing Among Providers

Human service agencies that have complementary needs can share vehicles with one another in order to lower overall transportation costs for each organization. These programs can be operated in a variety of ways depending on who owns the vehicle and how it is shared, though typically two agencies purchase a vehicle together and use it at complementary times. Vehicles used by organizations that end service in the early evening could be shared with organizations that run service late into the evening. And organizations that do not provide weekend service could share vehicles with other nearby organizations that do offer weekend

service. A lead agency is typically identified to store, maintain, and insure the vehicle, while the “borrowing” organization utilizes the vehicle on a predetermined schedule, paying an hourly or daily fee.

While this arrangement reduces capital investments, it can also be used as a group back-up vehicle or as a bridge until a new replacement arrives. Additionally, if organizations jointly apply for FTA capital grants like 5310 funds to purchase a vehicle, this coordinated approach may enhance the likelihood of the application being funded.

### Best Practice Examples

Location	Program Name	Website
Otsego County - NY	Otsego Express	<a href="http://www.otsegoexpress.com">www.otsegoexpress.com</a>
Ada/ Canyon County, ID	GoRide Vehicle Sharing	<a href="http://www.valleyride.org/special-services/goride/index.htm">www.valleyride.org/special-services/goride/index.htm</a>

#### Otsego Express: Otsego County, NY



Otsego Express is the primary operator of public bus transportation in Otsego County, and operates several routes in coordination with ARC Otsego, a human service agency that provides support to individuals with developmental disabilities. This relationship involves coordination of fixed route design in the county, as well as the shared use of vehicles which are supplied by both organizations.

While several routes operated by Otsego Express were implemented with ARC Otsego customers in mind, all routes are available to the public. The system is supported by federal and state grants, local funding, and private donations.

#### The GoRide Vehicle Sharing Program at ValleyRide: Ada and Canyon County, ID

The GoRide Vehicle Sharing Program at ValleyRide (Valley Regional Transit, or VRT) in Idaho offers a pool of vehicles for human service agencies and non-profit organizations in Ada and Canyon counties to use when needed. The GoRide fleet includes a variety of vehicle sizes and vehicles with wheelchair lifts. Agencies and organizations can join the GoRide Vehicles Sharing program and must have a least one driver certified by VRT. All drivers operating a GoRide vehicle must be approved prior to the agency or organization requesting a vehicle. There are three types of memberships: Annual Donating, Annual Participating and Participating. A Donating Member is an agency or organization that currently has a vehicle but does not need it seven days a week, or only uses the vehicle during the day or evening. The Annual Donating Member donates their vehicle to the GoRide Vehicle Sharing

Program. In exchange, VRT insures and maintains the vehicle. GoRide staff use Kelly Blue Book trade-in value for cars and vans and resale value for buses to determine the value of the donated vehicle. At this point, VRT becomes the owner of the vehicle and the van or bus goes into service as a shared vehicle. The value of the vehicle is credited toward the cost of the Donating Members annual membership cost. These services are designed to assist older adults in the region. Funding is provided by federal grants, local donations, and payment for vehicle services.

### Agency Tailored Transit



Agency tailored transit is a straightforward method of human service agencies working with transit agencies to request routing changes or improvements that better serve customers. Improvements might include a better bus stop location or a routing change that comes closer to the door of residences and agency destinations. Some transit agencies have implemented special services called service routes or community bus routes, which are fixed-route, fixed-schedule transit routes that are based on the origins and destination of seniors, and using vehicles and specially trained drivers more conducive to the target population. By making transit more useful and customer friendly, agencies can rely less on costly agency-operated or contracted paratransit service. Additionally, these types of trips may be provided with no further cost to a human service agency, and may in fact lower the overall costs to a transit provider by accessing a new customer base.

#### Best Practice Examples

Location	Program Name	Website
Essex County, NY	Essex County Public Transit	<a href="https://www.co.essex.ny.us/wp/transportation/">https://www.co.essex.ny.us/wp/transportation/</a>
Lane County, OR	Lane Transit District	<a href="http://www.ltd.org">www.ltd.org</a>

#### Essex County (NY) Public Transit

Essex County Public Transit is a local transit system that operates in the Champlain Valley. The transit system uses a variety of strategies to improve access to their services, particularly for seniors, individuals with disabilities, and veterans. All Essex County buses are fully accessible, and there is flag down service along all fixed routes (as well as deviated fixed route service). Riders may be picked up along the route if they are not near a bus stop, lowering a potential barrier for many individuals. Similarly, riders may request a drop-off at a more convenient location than the scheduled bus stop. Further solutions include offering seniors and veterans free transportation for medical trips on the regular fixed routes. In concert, these strategies greatly expand access to the transit service, and encourage its use as a viable transportation option for many riders. Essex County Public Transit is supported by a mix of federal, state, and local funding.

**Lane Transit District: Lane County, OR**

In Lane County, OR, where Eugene is located, the local Goodwill staff convinced Lane Transit to implement an agency “tripper” service. Thus, at key program times on weekdays, the bus route will deviate to the Goodwill a couple of blocks off the typical route to better serve the Goodwill facility. Virtually all of the individuals who formerly arrived on expensive paratransit to get to or from Goodwill now travel by the bus. Lane Transit works with the Goodwill staff on timing, and keeps in contact with Goodwill staff to make sure that any changes in program start and end times are accommodated.



**Travel Training**

Travel training is a way to train an individual or a group to use public transit services for a particular trip, or to better understand the transit system to the point where an individual can navigate – and feel comfortable riding on -- the system. There are several different types of travel training for individuals and groups. One-on-one travel training for individuals with cognitive disabilities is a very effective around the country as has group training involving older adults. In addition, volunteer bus buddy programs are popular in assisting older adults get more comfortable using public transportation.

The motivating idea behind travel training is to give an individual the ability to use transit and provide that individual with more independence, and an increase in his or her involvement in the community. Travel training additionally stretches available transportation funding because it reduces an individual’s dependence on more expensive paratransit or other on-demand services.

**Best Practice Examples**

Location	Program Name	Website
New York City	Travel Training	<a href="http://schools.nyc.gov/Academics/SpecialEducation/D75/departments.htm">http://schools.nyc.gov/Academics/SpecialEducation/D75/departments.htm</a>
Sacramento, CA	Paratransit, Inc.	<a href="http://www.paratransit.org">www.paratransit.org</a>

**NYC Department of Education**

The New York City Department of Education funds and provides one-on-one travel training for eligible high school students with cognitive or physical disabilities throughout the city. Members of the staff accompany the student on their specific commuting route, up to a 2-hour trip each way, for up to two weeks. Up to ten years after the training, approximately 87% are still traveling on public transit alone.

**Paratransit, Inc.: Sacramento, CA**

Under its Mobility Training Program, Paratransit, Inc. in Sacramento, offers specialized training for seniors and individuals with disabilities who may have difficulty traveling on Sacramento Regional Transit (RT) buses and light rail vehicles. Training is usually provided in a one-on-one setting, but is also done in small groups for facilities such as senior housing complexes. Training includes familiarization with the Sacramento RT system, route planning, use of wheelchair lifts and securement devices, landmark identification, bus rules, and safety issues.

This program is implemented using local funding, federal grants, private contracts, Medicaid and Medicare funding, and private donations.



**Volunteer Driver Programs**

Volunteer driver programs are a commonly used strategy for rural transportation. Volunteer drivers may use their own cars or operate agency vehicles. The most common program of this latter type are the Disabled American Veteran programs across the country. Volunteer driver programs can be consolidated or combined into a centrally managed or coordinated service that does not compete for the same drivers. Further these programs can also use new technologies such as digital ride boards to connect users and rides. With a larger, more coordinated program, a volunteer driver program's brand becomes more marketable and the policies and

practices more consistent.

**Best Practice Examples**

Location	Program Name	Website
Westchester County, NY	RideConnect	<a href="http://www.rideconnectwestchester.org">www.rideconnectwestchester.org</a>
Portland, ME	Independent Transportation Network (ITN)	<a href="http://www.itnportland.org">www.itnportland.org</a>

**RideConnect: Westchester County, NY**

Family Services of Westchester operates a mobility management program within the county called RideConnect. RideConnect is meant to solely service Westchester County residents with limited mobility, and was created in 2010 through grant funding.

RideConnect is a free service whose aim is to help clients stay active in the community. 90% of RideConnect's clients are older adults, and over the age of 80 years. The program relies entirely on volunteers to provide transportation, usually with their own vehicles. RideConnect is a small program that must service a larger group of people. Currently there are a total of five staff (one full-time call taker, two part-time call takers, a Mobility Coordinator, and the Program Director). There are 140 volunteer drivers, with some being more active than others.

The program offers no mileage reimbursement but if the volunteer is 55 years of age or older, he or she is eligible to get a stipend through the Retired & Seniors Volunteer Program (RSVP), part of Volunteer NY. Some remediation is given in the form of a gift card every 6 months. This policy was instituted after it became too cumbersome to reimburse all of the volunteers for mileage. RideConnect has experienced tremendous growth over the past 5-6 years. In 2011 there were 993 rides and referrals provided. In 2015 this number was 12,511, with over 16,000 projected for 2016.

**Independent Transportation Network (ITN): Portland, ME**



ITN is a nationally franchised, membership – based nonprofit program that connects volunteer drivers with individuals with disabilities and older adults. ITN was first established in Portland, Maine as a means of providing seniors with rides in exchange for trading in the cars they rarely used. The value of the donated car is credited to the senior’s debit account, which is drawn on each time a ride is requested. The account can be contributed to by family members or friends through cash donations, volunteering their time or donating their own cars. According to the organization the average charge for the service is \$11 per trip, while an annual membership fee of \$50 is also required or \$60 for a family.

Seniors who are still able to drive may volunteer and receive credit for future rides when they are no longer able to drive themselves, functioning as a sort of transportation savings account. The rides may be used for medical appointments, shopping trips or social visits or events. Maine has enacted legislation that enables ITN to sell its surplus vehicles and reinforces an earlier law prohibiting insurance companies from raising premiums for volunteer drivers.

This organization is funded by community supported private donations, as well as the fare payments from users.



**Flexible Transportation Voucher Program**

Flex vouchers are similar to taxi vouchers but can work on any participating service including volunteer driver and even family members. Under these programs individuals are issued or sold vouchers, according to eligibility, that can be used to pay for transportation services from taxis, transportation network companies (such as Lyft or Uber), or volunteer drivers. Under such a system, sponsoring agencies can subsidize the cost of a trip but can also cap the amount contributed. Flex vouchers are particularly useful for transportation services in rural areas, where available transportation services are inconsistently available.

These voucher programs are also helpful by offering an individual the ability to use whatever service or person is available to make a trip, and by making it affordable for that person. Finally, the larger the program, the more services tend to participate, which increases the pool of resources.

No best practice examples were identified in New York.

**Best Practice Example**

Location	Program Name	Website
Logan, Utah	Bear River Association of Governments	<a href="http://brag.utah.gov/">http://brag.utah.gov/</a>

### **Bear River Association of Governments: Logan, UT**

In Northeastern Utah, The Bear River Association of Governments (BRAG) launched the BRAG Medical Voucher Program in June 2014. The program provides an innovative non-emergency medical flexible transportation voucher program specifically targeted at helping individuals who were not being served by current transportation resources in the region. BRAG serves as the program administrator, which involves coordinating with partnering / referring organizations, participant and trip eligibility determination, issuing flex vouchers, and reimbursing trip providers. Referring agencies, such as local non-profits, connect clients who meet disability and financial eligibility criteria to the relevant program. Participants are then allocated a maximum of \$400 per year to pay for transportation to medical appointments; vouchers are distributed based on need every six months. The customer arranges for the particular mode of travel and provides vouchers to an eligible provider or driver. The eligible driver accepts the voucher as payment for the rides provided and redeems the voucher for the cash value from the BRAG program administrator. Voucher trips can be arranged with individual drivers, private operators, and non-profit or human services transportation operators. The program launched in 2014 with a \$10,000 budget, and was granted an additional \$100,000 shortly thereafter to expand the program to several additional groups and geographic regions.



### **Taxi/TNC Voucher Program**

Municipalities, transit agencies and human service agencies have long used taxi voucher and taxi subsidy programs to provide a real-time on-demand service for their customers. With new technologies available, many are now partnering with the transportation network companies or TNCs (most notably Uber and Lyft) to provide similar kinds of programs. The general idea is that taxis and TNCs have the infrastructure to provide on-demand services, and are beginning to provide more and more specialized and accessible service. Further, these services are generally

available to go where and when more traditional services do not.

The key to these services is to make mobility options more affordable by offering to pay a portion of the fare, and in most cases, the sponsoring agency caps that amount thereby guaranteeing a limit to the subsidy per trip. The financial bet these organizations make is that the savings accrued by diverting trips from more expensive services like ADA paratransit is greater than the subsidies of new trips that are generated by these new programs. In many cases the programs pay for themselves through the savings from deferred use of more expensive paratransit type services.

### **Best Practice Examples**

Location	Program Name	Website
North Hempstead, NY	Project Independence	<a href="http://www.tonhprojectindependence.net/transportation.aspx">http://www.tonhprojectindependence.net/transportation.aspx</a>
Chicago, IL	Taxi Access Program	<a href="http://pacebus.com/sub/paratransit/TAP.asp">http://pacebus.com/sub/paratransit/TAP.asp</a>

### **Project Independence: Town of North Hempstead, NY**

The Town of North Hempstead in Nassau County operates a program called Project Independence with the aim of enabling and assisting older residents of the Town to remain in their homes and communities. The program offers a variety of services including social and recreational activities, information assistance on federal benefit programs, and transportation. For this latter service the Town offers taxi rides for North Hempstead residents age 60 or older to access grocery stores and medical appointments. Two days a week residents can take scheduled trips to designated shopping centers in North Hempstead between the hours of 10 a.m. and 2 p.m. While these trips must be scheduled with the Town's 311 service at least a day in advance, the trips are offered to residents free of charge. For shopping trips, riders are allowed to bring three bags per person due to space limitations as there are often multiple riders per vehicle.



Meanwhile, for non-emergency medical transportation, residents must schedule a trip at least one day in advance, but can use this service any day of the week. Medical trips are also scheduled using North Hempstead's 311 system, and allow for a resident's personal aide to ride along as well. These medical taxi trips are offered at a 50% discount to residents, and the costs vary according to the length of the trip. According to the Town, the taxi rides are also provided via a negotiated special discount rate with local taxi companies. The service is only available for destinations in the Town of North Hempstead with some exceptions for nearby medical facilities.

This service began with assistance from a 5317 New Freedom grant, and is currently supported by a mix of grants and local funding.

### **Taxi Access Program: Chicago, IL**

Pace, the paratransit and suburban bus transit provider in the Chicago area, and the City of Chicago, offer customers with a disability a flexible option to use instead of the costlier ADA paratransit service. Under the Taxi Access Program (TAP) customers can use vouchers to take taxi trips at reduced rates for trips that originate within the City of Chicago. Eligible riders can purchase one-way taxi rides up to \$13.50 for the price of \$5.00, though only one TAP trip may be used to pay toward the one-way fare. Pace has implemented the use of swipe cards to make the purchase of trips simpler. Trips may additionally be purchased online, through the mail, or in person.

Trips may be provided with a wheel chair accessible vehicle, and up to 30 trips may be purchased a week. Various limitations on the service exist, but it has proven to be an effective means of lowering individuals' reliance on costly paratransit services.

## **State Mobility Management Initiatives**

The mobility management strategies discussed above can be combined into a comprehensive program overseen by a mobility manager, usually an individual (with the support of additional staff) and sometimes an organization. Mobility managers are tasked with connecting individuals to transportation services by providing information about options, assisting with trip planning and reservations, offering programs and services that make transportation services more accessible and useful, and working with other stakeholders in the region to improve coordination.

Several states that have instituted regional or county-based mobility managers include New York, Massachusetts, Wisconsin, Iowa, and Utah. Mobility Management efforts in those states are summarized below.

## NEW YORK

Mobility managers, or mobility management programs or services, are in place in at least 26 counties in New York State. Mobility management activities are documented in local public transit-human service transportation coordination plans, required for use of FTA's Section 5310 funding. Local coordination plans in New York are prepared at the county level.

A review of the 60 plans that have been developed or updated since 2008 show that most commonly utilized mobility management strategies in New York include the following:

- Regional or county-level One-Call / One-Click directory system
- Travel training program
- Volunteer driver program
- Web-based rideshare and vanpool to serve employment hubs
- Partnerships with employers, institutions, and universities
- Coordination and collaboration between and among transportation operators
- Identification/hiring of a mobility manager
- Marketing through social media

The utilization of strategies typically varies with the size and type of community being served. For instance, Fulton County, a largely rural area on the south edge of the Adirondack Mountains, employs mobility management strategies that are more heavily focused on coordination between county agencies, private transportation providers, and local schools and hospitals to improve transportation in the area. Meanwhile, the strategies recommended for the New York Metropolitan Transportation Council's three sub-regions involve a greater reliance on improved access to existing transit services. Despite these differences, some strategies are consistently used across different geographies, with many areas focusing on improved centralized repositories of information, and continued improvements to coordination efforts across regions.

Entities housing the mobility managers across New York State include public transit systems, county Offices for the Aging or Departments of Social Services, rural health networks, local chapters of NYSARC, municipalities, and nonprofit organizations.

Most mobility management agencies across the state use a variety of different funding sources including federal, state, and local funds to implement different coordination and mobility management strategies. These funding sources are summarized in Table 6 below.

**Table 6: New York Mobility Management Funding Sources**

Federal Programs	State Grants	Other	Revenues
Medicaid	Department of Health	Donations	Advertising
Medicare	Developmental Disabilities Planning Council	Private foundations / non-profits	Contracting
Section 5307	Office for the Aging		Fares
Section 5309	Office of Mental Health		
Section 5310	State Operating Assistance (STOA)		
Section 5311			
SNAP Employment and Training			
Temporary Assistance for Needy Families (TANF)			

## MASSACHUSETTS

In Massachusetts, mobility management activities are carried out at the regional level by 16 Regional Coordinating Councils (RCCs) that cover the state. RCCs are composed of a variety of regional and local transportation stakeholders. Each RCC is spearheaded by one or more lead organizations and membership includes regional transit authorities, nonprofit transportation providers, planning agencies, independent living centers, regional offices of state human service agencies, nonprofit advocacy organizations, municipalities, and workforce or community development organizations.

Examples of some of the activities undertaken by RCCs include:

- Transportation needs assessments
- Service inventories and directories
- Education and outreach events
- Travel training

Assistance to local mobility managers, who work closely with the RCCs, is provided by a statewide mobility manager, housed at the Massachusetts Department of Transportation (MassDOT) and several mobility specialists housed at the Human Services Transportation (HST) Office of the Executive Office of Health and Human Services, with funding provided by MassDOT.

## WISCONSIN

Mobility management in Wisconsin began in October 2005, with a Governor's directive to state agencies to work toward the elimination of barriers that prohibited transportation coordination. As of 2015, sixteen different areas across the state, encompassing 35 counties, funded mobility management strategies in Wisconsin using 5310 funding.

WisDOT, the state's Department of Transportation, does not mandate the style or direction of local mobility management projects, leaving that to the discretion of the local agencies. Specific projects and activities are usually defined through the local coordinated planning process. Typical activities include coordinating or brokering transportation services, providing travel planning assistance to customers, working with local organizations to build partnerships that increase coordination, and developing coordination plans. Some mobility managers also encourage land use policies that facilitate transit-oriented development, effective transit services, and pedestrian access.

In a survey of Wisconsin mobility managers, over 90% reported using the following strategies:

- Coordinate services or programs
- Transportation marketing
- Promote collaboration
- Identify customer needs

A wide range of organizations also house mobility managers in Wisconsin, including transit agencies, human service agencies, independent living centers, aging and disability resources centers, local governments, employment and economic development councils, and community action programs.

## IOWA

The Iowa Department of Transportation operates a mobility management program across the state, with mobility coordinators available at the state, regional, and municipal levels.

There is currently one statewide mobility coordinator, five regional mobility coordinators, and two municipal mobility coordinators. The state is split up into 16 different regions, with mobility coordinator representation in each region, ensuring coverage for all of Iowa's 99 counties.

Iowa mobility coordinators are tasked with identifying transportation options and service providers for individuals, as well as educating local communities on how to use public transportation. Additionally, they provide assistance to local stakeholders and help to find solutions to other individual mobility needs.

Supported with federal funds through the Iowa DOT and local matching funds, mobility coordinators must have a transit agency affiliation, but can be housed within a wide variety of organizations, including Area Agencies on Aging, Community Action Programs and regional transit agencies.

The Iowa DOT manages the Iowa mobility management program and contracts with individual regions for mobility coordinators. It created broad job descriptions, but does not strictly govern how positions develop. According to the statewide mobility coordinator, mobility coordinators are to:

- Bridge the gap between transportation and human service agencies, bringing transit to the table and gaining insight on how to provide service to meet a range of customer needs
- Provide one-on-one guidance to the customer, locating the appropriate transit option within the community

- Attend regional and community meetings, convene Transit Advisory Groups, assist with trip planning, conduct travel training, handle education and outreach, and create and plan new services

## UTAH

Mobility management in Utah operates at the regional level, with mobility managers housed at seven of the state's regional associations of governments. One county has its own mobility manager.

Mobility management consists of short-term planning, management activities, and projects for improving coordination among public transportation and other transportation service providers. This is generally carried out by a recipient or sub-recipient through an agreement entered into with a person, including a governmental authority, but excludes operating expenses.

FTA funding assistance is provided by the Utah Department of Transportation's Public Transportation Team, which coordinates with regions of government to fund mobility management positions.

## V. HCBS WAIVERS AND TRANSPORTATION

### History and Overview

As summarized by Samantha Crane in the September 2014 Policy Brief, “Defining Community: Implementing the New Medicaid Home and Community-Based Services Rule”, state Medicaid programs are able to offer home and community-based services as opposed to services provided in institutional settings since the early 1980s. Such services can include case management; homemaker services such as house-cleaning, meal preparation, and laundry; home health and personal care services; adult day health services; habilitation (both day and residential); and respite care. States can also provide other services, such as transportation and decision-making support services, as necessary to help individuals live in the community.

The HCBS Final Rule is strongly linked with and supports the 1999 Olmstead Decision (*Olmstead v. L.C.*, 527 U.S. 581), which held that services for individuals with disabilities must be provided in the most integrated setting appropriate to a person’s needs, with the goal of shifting the model of care from institutional to community-based so that individuals with disabilities can live as full and integrated lives as possible. A key component to the work of complying with Olmstead was for states to develop concrete methods for individuals with disabilities to transition to community settings by identifying key components for such transitions to be successful. Thus, because many of the supports required under Olmstead can be funded through HCBS waivers and state plan amendments, states have relied heavily on such programs to work toward achievement of Olmstead compliance.

States have taken various approaches to achieving Olmstead and HCBS Final Rule compliance. In New York State, Executive Order Number 84 created the Olmstead Development and Implementation Cabinet in 2012, which was charged with developing a plan for New York to comply with the requirements of Olmstead. New York State is also in the process of implementing its 5-year Statewide Transition Plan (STP)<sup>56</sup> for the federal 1915(c) HCBS Settings Final Rule, which clarified for states the expectations for achieving full community integration in both residential and non-residential settings for people receiving services funded through the Medicaid waiver and state plan authorities for HCBS. The due date for Final Rule compliance is 3/17/19.

The overarching goal of achieving HCBS integration is to ensure that people receiving services are provided personal choice and control over the services in which they participate. This includes opportunities to seek employment, work in competitive and integrated settings, engage in community life, control personal resources and receive services in the community to the same degree as people who do not receive Home and Community Based Services. The requirements of the New Rule not only focus on the physical, residential setting for an individual within a community, but also on the person’s daily activities and experiences.<sup>57</sup> Research has shown that, “compared with those who live in larger congregate settings or institutions, people with disabilities who live in small, community-based settings have more friends, more opportunities to make choices about their lives, more opportunities to develop and maintain skills, and higher satisfaction with their living arrangements”.<sup>58</sup>

---

<sup>56</sup> New York State Department of Health, *New York State’s Statewide Transition Plan for HCBS Settings*, [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/state\\_trans\\_plan\\_cms.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/docs/state_trans_plan_cms.pdf).

<sup>57</sup> Samantha Crane. “Defining Community: Implementing the New Medicaid Home and Community-Based Services Rule.” *Autistic Self Advocacy Network*. Policy Brief, September 2014.

<sup>58</sup> Centers for Medicare & Medicaid Services (CMS), *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*, <https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider> (Jan. 16, 2014).

## HCBS Settings Rule

The HCBS Settings final rule is based on the requirements of solid person-centered planning and requires that states examine the places (i.e. settings) in which services are delivered. Essentially, all services provided under HCBS must be provided in “truly integrated” community settings, and are based upon the following five guiding principles as shown in Table 7 below.

**Table 7: HCBS Settings Guiding Principles<sup>59</sup>**

Principle	Description
<b>1. Community Integration</b>	<p>Individuals who receive HCBS must have the same level of access to the larger community as those who do not receive these services. According to the New Rule, access to the community must include opportunities for individuals with disabilities to:</p> <ul style="list-style-type: none"> <li>• Seek competitive integrated employment</li> <li>• Engage in community life</li> <li>• Control their own personal resources</li> <li>• Receive services in the community</li> </ul> <p>A key factor for determining whether settings are truly integrated or not is whether access to transportation or supported employment services exists.</p>
<b>2. Individual Choice</b>	<p>Individuals receiving HCBS must be offered a choice of services in “non-disability-specific” settings, and the options for consideration must be documented as part of the individual’s person-centered planning process or as part of their individual service plan.</p>
<b>3. Individual Rights</b>	<p>HCBS settings must always safeguard individuals’ rights to “privacy, dignity and respect, and freedom from coercion and restraint.”<sup>60</sup> According to Crane, “this component of the new rule is consistent with the input of self-advocates, who identified the absence of privacy and the use of coercion and restraint as a major factor determining whether a setting was institutional or community-based”.</p>
<b>4. Optimizing Autonomy</b>	<p>HCBS settings must allow individuals to make their own choices, rather than supplying people with a list of options or pre-determining someone’s daily activities and services.</p>
<b>5. Choice Regarding Services and Providers</b>	<p>HCBS settings should not pre-dispose individuals to receipt of unnecessary or unwanted services.</p>

<sup>59</sup> Samantha Crane. “Defining Community: Implementing the New Medicaid Home and Community-Based Services Rule.” *Autistic Self Advocacy Network*. Policy Brief, September 2014.

<sup>60</sup> 42 C.F.R. §§ 441.301(c)(4)(iii), 441.530(a)(1)(iii), 441.710(a)(1)(iii), <https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-non-residential.pdf>

## HCBS and Transportation

As described above, transportation is a key factor in determining whether or not people receiving supports and services through the HCBS state plan and waiver authorities are able to live a truly integrated life in the community of their choosing. If an individual cannot access transportation to the community and for the receipt of HCBS supports and services to achieve their desired outcomes, then the intent and provision of essential services cannot be accomplished. As such, HCBS service planning takes this into account and a “reliable” source of transportation to HCBS settings must be included in the individual’s person-centered service plan if natural supports such as driving themselves, public transportation, walking, friends or family are not available.

The Centers for Medicare and Medicaid Services include non-emergency medical transportation (NEMT) as a benefit for eligible Medicaid members to access Medicaid-funded services and providers. States have the option of determining how NEMT is provided and this often is accomplished through the implementation of waiver programs. Under the HCBS Settings Final Rule, eligible individuals are also entitled to receive non-medical transportation to HCBS services. Because the implementation of HCBS Settings final rule is still in progress in most states (Final Rule compliance is slated for 2019), only a limited number of states have begun to develop new services within their existing waiver programs which more fully support community integration including transportation directed at obtaining and maintaining employment. As part of transportation research that Public Consulting Group conducted on behalf of Indiana’s Division of Disability and Rehabilitative Services (DDRS) in 2015, which was used to develop a proposed employment-related transportation service definition in Indiana’s Community Integration and Habilitation (CIH) waiver, PCG reviewed other state HCBS amendments and transportation service definitions, particularly non-medical transportation for DD services. Below is a summary of findings, which includes transportation waivers in Ohio, Maryland, New Mexico, and Utah.

State	Waiver(s)	Description
Ohio	<p><b>Individual Options</b></p> <p><b>Self-Empowered Life Funding (SELF)</b></p> <p><b>Level One</b></p>	<p><b>Non-Medical Transportation:</b> Available to enable waiver participants to access the following waiver services, as specified by the Individual Service Plan:</p> <ol style="list-style-type: none"> <li>1) Adult Day Support</li> <li>2) Vocational Habilitation</li> <li>3) Supported Employment-Waiver</li> <li>4) Supported Employment-Community</li> </ol> <p>Whenever possible, family, friends, neighbors, or community agencies that can provide this service without charge shall be used. All transportation services that are not provided free of charge and are required by enrollees in HCBS waivers administered by the Department to access one or more of these four services shall be considered to be Non-Medical Transportation services, and the payment rates, service limitations and provider qualifications associated with the provision of this service shall be applicable.</p>
	<b>Individual Options</b>	<p><b>Transportation:</b> Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, as specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the</p>

		individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized. Transportation services may be provided in addition to the Non-Medical Transportation services that may only be used to enable individuals to access Adult Day Support, Vocational Habilitation, Supported Employment-Enclave and/or Supported Employment-Community waiver services.
	<b>Transitions DD</b>	<b>Supplemental Transportation Services</b> are those transportation services not otherwise covered by the Ohio Medicaid program that enable an individual to access waiver services and other community resources specified on the individual's service plan. Supplemental Transportation Services include assistance in transferring the individual from the point of pick-up to the vehicle and from the vehicle to the destination point.
<b>Illinois</b>	<b>Waiver for Adults with DD</b>	<b>Non-Medical Transportation</b> is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under the Code of Federal Regulations (42 CFR §431.53) and transportation services under the Medicaid State Plan, defined in the Code of Federal Regulations at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized. Excluded is transportation to and from covered Medicaid State Plan services. Also excluded is transportation to and from day habilitation program services.
<b>Minnesota</b>	<b>DD Waiver</b>	<b>Transportation</b> is covered in order to enable participants to gain access to waiver and other community services, activities and resources, specified in the community support plan. Whenever possible, family, neighbors, friends, or community agencies who are able to provide this service without charge will be utilized. This service does not replace transportation services covered by the state plan (e.g., to medical appointments) or supplant transportation that is available at no charge. This service does not cover transportation provided by providers for which the cost of transportation is included in their rates.
<b>Utah</b>	<b>Community Supports Waiver</b>	<b>Transportation Services</b> provide waiver participants with the opportunity to access other waiver supports as necessary to encourage, to the greatest extent possible, an independent, productive and inclusive community life. Whenever possible, individuals receiving waiver services should use available transportation services offered through natural supports that can provide this service without charge. If these transportation options are not available or do not meet the needs of the waiver enrollee, waiver non-medical transportation becomes an option.

		<p>Medicaid payment for transportation under the approved waiver plan is not available for medical transportation. In addition, Medicaid payment is not available for any other transportation available through the State Plan, transportation that is available at no charge, or as part of administrative expenditures. Additional transportation supports will not be available to community living, day habilitation, or supported employment providers contracted to provide transportation to the site(s) of a day program when payment for transportation is included in the established rate paid to the provider.</p> <p>Transportation may not be offered to those who receive residential or supported living services that include transportation, as well as to those who receive day supports or supported employment services (specifically customized employment or supported employment individual or supported employment co-worker that include transportation). Transportation includes both a per trip rate for the purposes of habilitation in the community as well as a daily rate that provides for transportation to and from organized day-supports or supported employment activities.</p>
<p><b>Maryland</b></p>	<p><b>Community Pathways</b></p>	<p><b>Transportation services</b> are designed specifically to enhance a participant’s ability to access community activities in response to needs identified through the participant’s Individual Plan. Services shall increase individual independence and reduce level of service need. Services are available to the participant living in the participant’s own home or in the participant’s family home. Services can include mobility and travel training including supporting the person in learning how to access and utilize informal, generic, and public transportation for independence and community integration. Transportation services may be provided by different modalities, including public transportation, taxi services, and non-traditional transportation providers. Transportation service shall be provided by the most cost-efficient mode available and shall be wheelchair-accessible when needed.</p> <p>Transportation is limited to \$1400 per year per person for people not self-directing. Transportation services may not be covered if other transportation service is available or covered, including under the Medicaid State Plan, IDEA, the Rehabilitation Act, other waiver services or if otherwise available. Payment for transportation may not be made when transportation is part of another waiver service such as day habilitation, community learning services, employment discovery and customization, prevocational, supported employment or residential habilitation services. The Program does not make payment to spouses or legally responsible individuals for furnishing service. Payment for services is based on compliance with billing protocols and a completed service</p>

		report. Payment rates for services must be reasonable and necessary as established or authorized by the Program.
<b>New Mexico</b>	<b>Mi Via-ICF/MR</b>	<b>Transportation:</b> (As referred to in the overview of the new framework and approach for the Mi Via program in the Renewal Section 1. Major Changes.) Transportation services are offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. Transportation services under the waiver are offered in accordance with the participant's service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a), and does not replace them. Transportation services provided under the waiver are non-medical in nature whereas transportation services provided under the State plan are to transport participants to medically necessary physical and behavioral health services. Payment for Mi Via transportation services is made to the participant's individual transportation employee or to a public or private transportation service vendor; payment cannot be directed to the individual participant. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Although the aforementioned states have begun to address HCBS transportation through various waiver programs, states in general have not fully explored the link between coordination of HCBS non-medical transportation and Medicaid NEMT. The potential coordination of these human service transportation programs is most likely a key strategy to achieving full community integration by people with disabilities as well as yielding great benefits to states including increased cost efficiency and utilization of existing resources, and limiting service duplication.

## APPENDIX: WORKS CONSULTED

Community Transportation Association. (2005). *Expanding Mobility Options for Persons with Disabilities: A PR actioner's Guide to Community-Based Transportation Planning*.

National Center for Mobility Management: <http://nationalcenterformobilitymanagement.org/>

National Center for Mobility Management. (2013). *Promising Practices in Mobility Management: Developing Coordinated Transportation Plans*.

National Cooperative Highway Research Program. (2011). *Research Results Digest 354: A Review of Human Services Transportation Plans and Grant Programs*.

NCSL. (2012). *Regional Human Service Transportation Coordinating Councils: Synthesis, Case Studies and Directory*.

Prepared by Frank Douma and Thomas Garry, H. H. (2013). *Vehicle Sharing Among Human Service Providers in Minnesota: Steps to Address Barriers*.

Prepared by the Iowa Department of Transportation, i. c. (2014). *Transportation Coordination in Iowa, Report to the Iowa General Assembly and Governor Terry E. Branstad, per 2014 Iowa Code section 324A.4*.

Prepared by Transit Plus for the Colorado Interagency Coordinating Council for Transportation Access and Mobility. (2008). *Handbook for Creating Local Transportation Coordinating Councils in Colorado*.

Transit Cooperative Research Program. (2014). *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*.



[www.publicconsultinggroup.com](http://www.publicconsultinggroup.com)