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**Integrating Americans with Disabilities Act Paratransit Services  
and Health and Human Services Transportation**

*This TCRP digest explains the impact of the implementation of ADA paratransit requirements on public and human services transportation, presents an overview of federal and state coordination activities, and summarizes selected ADA/HHS coordination models. The digest was written by Rosalyn M. Simon Ph.D., as part of TCRP [Project J-6](#), "Quick Response for Special Needs."*

**PURPOSE**

Public transit operators have to be in full compliance with all service criteria for the Americans with Disabilities Act of 1990 (ADA) paratransit services by January 1997. This digest will help public transit operators coordinate ADA paratransit and Department of Health and Human Services (HHS) transportation programs in an ongoing effort to reduce the cost of providing ADA services.

This digest examines the impact of the implementation of the ADA paratransit requirements on public and human service transportation, presents an overview of federal and state coordination activities, summarizes selected ADA/HHS coordination models, and presents suggestions for further research. Information presented in this digest is derived from a review of the literature, as well as telephone and in-person interviews with transit, health and human services, and federal government staff.

**BACKGROUND**

In light of the critical financial situation facing public transit operators as they attempt to comply with the paratransit provisions of the ADA (42 U.S.C. 12101) and the potential benefits of coordination with HHS transportation programs, *Integrating Americans with Disabilities Act (ADA) Paratransit Services and Health and Human Services (HHS) Transportation* was selected as a TCRP J-6 quick-response initiative. This digest is intended to provide

- a historical perspective and current status of public and human service transportation coordination;
- an overview of federal and state coordination initiatives; and
- a summary of model coordination programs.

**INTRODUCTION**

The transportation provisions of the ADA took important steps toward integrating people with disabilities into existing transportation systems by requiring all fixed-route services and facilities to be accessible to individuals with disabilities, including wheelchair users. Priority is given to providing transportation in the same vehicles and facilities used by the general riding public. Complementary paratransit systems are also required, but only as a "safety net" for individuals whose disabilities prevent them from using accessible fixed-route services. ADA complementary paratransit must be comparable to fixed-route service in terms of service area, days and hours of service, and fares. Transit systems are required to provide "next day" service, and trip purpose restrictions and

capacity constraints are prohibited. Transit operators are allowed a 5-year period (1992-1997) to reach full compliance with all service criteria.

Implementing regulations of the U.S. Department of Transportation (DOT) specify the circumstances under which individuals with disabilities may use ADA complementary paratransit services (49 CFR Part 37). ADA paratransit-eligibility criteria focus on the passengers' functional ability to use fixed-route transit. Transit operators are provided with explicit directions to develop and implement procedures to determine ADA paratransit eligibility. The rigid eligibility requirements (pre-ADA paratransit-eligibility criteria were more lenient) ensure that ADA paratransit is available for individuals with disabilities for whom it is appropriate. The majority of paratransit users (senior citizens and individuals with disabilities) are now considered on a par with riders who have qualified for current ADA eligibility.

## **PART I IMPACT OF ADA ON PUBLIC AND HUMAN SERVICE TRANSPORTATION**

The ADA paratransit requirements became effective January 26, 1992; full implementation is required by January 26, 1997. After a few years of local-level practical experience, the paratransit provisions have proven to be the most expensive recurring cost of ADA implementation in transportation; funding is an important and necessary element for effective implementation. Public transit operators are faced with the challenge of financing ADA complementary paratransit service while demand continues to increase and funding sources continue to decrease. There is also local political pressure to continue to provide paratransit service delivery to both qualified riders and Non-ADA-eligible

users. This is further complicated by the 1997 deadline for the elimination of ADA paratransit-capacity constraints.

Government spending on domestic programs is being drastically reduced. Proposed Medicaid reform may result in the reduced availability or elimination of nonemergency medical transportation funds. Human and social service program budget cuts may decrease the availability of agency-sponsored transportation, and limit transportation options for older Americans. Collectively, the convergence of these dynamics could have serious implications for public transit operators. Increased paratransit demand would further constrain the capacity of transit systems that are already overburdened. Declining financial conditions, rising paratransit demand, and imminent ADA deadlines create an urgent need for public transit operators to maximize all available community transportation resources.

**Reduced federal operating assistance and increased paratransit demand threaten the viability of smaller public transit systems.** Public transit operating assistance is derived from local, state, and federal government and passenger revenues. In larger urban systems, the smallest percentage of operating assistance typically comes from the federal government. In small systems, federal operating assistance may compose as much as 30 percent of total operating budgets (Rucker 1991). Paratransit costs primarily are operating expenses (86 percent). ADA paratransit is more expensive to operate than pre-ADA paratransit services because of the added expense of the service criteria and increased administrative and eligibility determination procedures.

The growth in demand has fueled transit systems' spending and continues to consume a growing share of operating budgets. Some transit operators have reported that ADA paratransit costs

represent as much as 10-15 percent of their operating budgets (FTA 1995). Reduced levels of federal operating assistance may severely limit transit systems' ability to meet ADA compliance. The federal share of transit system operating assistance has steadily declined, decreasing \$802 million to \$400 million over the past 2 years (Dougherty 1995). Annual paratransit operating costs are estimated at \$700 million to \$1 billion. This amount exceeds the Federal Transit Administration's (FTA) total 1996 fiscal year budget for transit system operating assistance (Simon 1996, p. 6; American Public Transit Association (APTA) 1995).

**Proposals to reform Medicaid may magnify paratransit demand and costs.** In 1994, the nation's public fixed-route operators certified 1 million individuals with disabilities as ADA-eligible and provided them with 33 million one-way ADA paratransit trips. An estimated one out of five of these trips provided transportation for medical, human, or social service purposes (FTA 1995). HHS spends more than \$1 billion on human service transportation through various programs. A recent HHS-sponsored survey indicated that three federal programs--Aging, Head Start, and Medicaid--have a collective fleet of approximately 50,000 vehicles operated by 8,000 local human service transportation providers (NGA 1995).

### **Medicaid Program**

The largest HHS-funded transportation program expenditure is nonemergency medical transportation services under the Health Care Financing Administration's (HCFA) Medicaid Program (GAO 1994). Created under Title XIX of the Social Security Act of 1965 (42 U.S.C. 1396, et seq.), Medicaid is a federal health care program for low-income individuals, seniors, people with

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disabilities, and single-parent families with dependent children. According to the Kaiser Commission (1995), the demographic breakdown of Medicaid recipients is as follows:

- 3.7 million seniors,
- 4.9 million individuals with disabilities,
- 7.4 million adults, and
- 16.1 million children.

Medicaid is funded through a federal/state partnership. The federal government contributes a minimum of 50 percent based on the state poverty population. In 1969, nonemergency medical transportation became an allowable Medicaid cost. Agencies are not required to provide transportation, but they must ensure clients transportation to and from necessary medical appointments. Agencies are given flexibility in the method of transportation provision but are directed to reimburse for the least costly transportation service. Most Medicaid transportation is contracted through nonprofit and private providers and taxi companies. Although the majority of clients live in areas with available public transportation, most use the more expensive paratransit or taxis for medical trips; only 30 percent of these trips are made using fixed-route services (Hayes and Burkhardt 1995).

The cost of nonemergency medical transportation under Medicaid is steadily increasing, rising at a rate of 10 percent annually. This cost already consumes more than 1 percent of the entire Medicaid budget. In FY 1995, almost \$1 billion was spent to provide 3.4 million Medicaid clients with 103 million nonemergency medical trips, 80 percent of which were provided in urban areas (Hayes and Burkhardt 1995). It is highly likely that many of these trips could have been made on public fixed-route services. The price charged to Medicaid by private transportation providers may or may not reflect the actual trip cost. Most human service agencies do not identify the fully allocated costs and do not know what the total transportation expenditures are. Client abuse, fraud,

and improper administration and billing practices have also been identified as contributing to rising costs (Hayes and Burkhardt 1995).

If current congressional proposals to offer Medicaid to the states through block-grants become law, federal protection for beneficiaries would be eliminated, placing recipients at risk for health care and access to nonemergency medical transportation. In the absence of an entitlement, funding for transportation may be greatly reduced or eliminated (Zeilinger, Sept/Oct. 1995). If funding for nonemergency medical transportation is eliminated, smaller cities and rural communities would not have the financial resources to continue providing nonemergency transportation. The elimination of funding for nonemergency medical transportation could have serious repercussions for public transit operators.

**HHS program funding reductions are likely to spur "client dumping."** The social reforms of the 1960s significantly increased federal financing of health and social programs. Before a federal policy existed that required the provision of public-accessible transportation services for individuals with disabilities, health and human service agencies met the transportation needs of their clients by initiating specialized transportation services as early as the late 1960s. Human and social agencies have provided or have been reimbursed for more paratransit service than the nation's public operators (Einstein 1981).

Congress, in its budget-driven efforts to reduce federal spending, is proposing significantly reduced levels of funding for health and human service programs. In Louisiana, for instance, the Louisiana DOT's Title XIX proposed budget for FY 1996 represents a drastic cut, from \$67 to \$23 million. Head Start funding will be rolled back to FY 1994 levels. The Administration on Aging (AoA) Title III B Supportive Services & Senior Center funding, which provides direct funding to local area aging agencies (AAA), will receive a 5 percent cut. Funding for the Administration on Developmental Disabilities' (ADD)

programs will be reduced by 37% (Zeilinger 1995). As program funds are reduced, client transportation services may be reduced or eliminated. The loss of HHS benefits-related transportation has the potential to fuel public paratransit demand.

Transit systems are already reporting "client dumping" by HHS agencies. To maintain service delivery levels, some social service agencies are eliminating agency-run client transportation programs, reducing transportation reimbursements, reimbursing only for the public-system passenger fare, or simply referring the client to the public transit system without accompanying transportation funds. This almost always results in increased paratransit demand and in higher costs because many HHS clients are also eligible for ADA paratransit services.

**Seniors are likely to be displaced by ADA-eligible riders.** Americans 65 years and older represent a growing segment of the population. (The growth rate for Americans 85 years and older is even faster.) Projections indicate a 66-percent increase in the senior population by 2020. Seniors are living longer and want more mobility (Alliance for Transportation Research et al. 1995). Access to transportation is critical to maintaining the quality of life of this group.

Transportation for seniors is primarily funded through Title III of the Older Americans Act, as amended (42 U.S.C. 3001 *et seq.*), which provides more service to older Americans than public transit. Public transit systems receive no set-aside funds for seniors, yet older Americans (without disabilities) constituted the majority of pre-ADA paratransit ridership (Rosenbloom 1993). Approximately 40 percent of current senior paratransit users may qualify as ADA-eligible, but due to lack of additional ADA transportation funds, transit operators will most likely have to deny service to noneligible seniors (Rosenbloom 1993). The ADA does not proscribe transit operators from providing paratransit to

noneligible seniors and people with disabilities; most transit systems lack the financial resources to do so. In the short run, most transit systems are "grandfathering" (granting eligibility to) existing paratransit riders, including seniors, because of local political pressure. However, several transit operators indicated that they would have to deny service to seniors based on eligibility by reducing paratransit service areas and transferring funds previously used for senior transportation services to riders with eligible disabilities because of their limited budgets and federal obligation to serve eligible passengers with disabilities.

Service area changes may pose significant problems for older Americans. Over 10 million seniors do not drive and almost one-half (44 percent) of older Americans live in suburban communities or low-density areas. When ADA paratransit service areas have to be reduced because of ADA paratransit service criteria or limited fixed-route service, suburban areas are sometimes eliminated from the ADA service area. Such changes will decrease seniors' access to paratransit.

Local senior agencies appear concerned about reduced funding for their transportation programs. For example, a local AAA staff member indicated that her AoA-funded transportation program had not received a budget increase since 1980. Funding was not available to replace old vehicles and regulatory barriers prohibited the use of other program funding to assist with senior transportation. The lack of funding may ultimately result in the demise of their transportation services (Personal communication, Participant, APTA Mini White House Conference 1995).

Human service transportation must comply with ADA's Title III statutory requirements and regulatory requirements for private transportation providers (49 CFR Part 37.101). These rules require that human service transportation operators provide equivalent transportation service to all clients, including those with disabilities who require an accessible vehicle.

Although the purchase of accessible vehicles is not required, some may have to purchase accessible vehicles in order to comply with the law. The added costs to ADA requirements may result in reduced service levels or the elimination of agency transportation services.

Even without pending budget reductions and regulatory requirements, which may limit the availability of human service transportation, it does not meet all transportation needs for seniors. Human service transportation programs are designed to meet the agency-related transportation needs of their clients and do not match the range of transportation services provided by public transit. Due to such guidelines, many seniors do not have transportation for shopping and other necessities.

### Summary

Pending budget cuts and unexpected paratransit demand have created serious challenges for public operators as they attempt to meet the compliance requirements of ADA. In this type of environment, it is essential to begin to consider integrating and using all available resources to meet the transportation needs of the community. Better planning and coordination of public and human service transportation are necessary alternatives to consider. The next section presents a historical perspective of past and present efforts to coordinate public and human service transportation.

## PART II COORDINATION

Transportation has always played a critical role in human services delivery because the success of the programs depends upon the client's ability to access the services. In rural and small urban areas, a lack of adequate human service transportation has been a longstanding problem. Getting clients to services can be expensive and most human service agencies had limited budgets for transportation services (NGA 1995). During the mid-1970s, the concept of combining or coordinating

transportation resources emerged to respond to the need of human service agencies to provide client transportation (CTAA 1992). In this discussion, coordination refers to "cooperative arrangements between transportation providers and organizations needing transportation services, which improves mobility by improving the effectiveness and efficiency of community transportation" (CTAA 1994). Coordination may include combining vehicles and other equipment, financial resources, and administrative functions such as eligibility determinations, scheduling, and dispatching.

### Advantages of Coordination

Many benefits can be derived from coordinating transportation resources. Coordination and combining or sharing available resources reduces duplication and fragmentation of services, improves program oversight and administration, service quality, and reduces costs (Center for Systems and Program Design 1989). Coordination of services expands capacity for the agency or provider and increases mobility for the passengers. Pooling transportation resources can increase vehicle use and decrease fleet size requirements and ultimately increase operating efficiencies and decrease costs.

### Disadvantages of Coordination

Although the benefits of coordination have been widely noted, some have argued that coordination may increase the availability of transportation but does not reduce costs (Burkhardt 1995). Public transit operators have noted that the costs to encourage coordination among area agencies may outweigh the benefits of combining service delivery (Simon 1995). The National Association of Medical Transportation Providers (1995) argues that it is not appropriate to coordinate all levels of paratransit and Medicaid-funded transportation. Public transit operators and human service agencies should recognize that many of these services are beyond the

scope of the public operator and may not be "public transportation." For example, public transit is not equipped to provide ambulance, nonemergency stretcher, or door-through-door, wheelchair-assisted service. The organization also cautions transit and human service agencies considering coordination to recognize the distinctions that exist in cost, training, and vehicle requirements at various levels of service. Finally, transit operators have reported passengers' dissatisfaction with sharing rides with program beneficiaries (Simon 1995).

### **Efforts to Coordinate Public and Human Service Transportation Services**

Over the past two decades, the benefits of interagency coordination of public and human service transportation have been recognized by federal, state, and local governments. The need for a federal mandate to force coordination at the state level to improve efficiency and effectiveness has been recommended by various groups and organizations for more than a decade. Although the federal mandate has yet to become reality, many programs and initiatives have been implemented to address this concern. The subsequent discussion provides a historical perspective of federal and state coordination initiatives.

### **Federal Efforts to Promote Coordination**

Since the 1970s, congressional and federal government departmental programs and initiatives have been implemented to improve human service transportation and promote coordination (GAO 1977, CTR 1991). Over the years, Congress has enacted legislation to encourage coordination of transportation services.

### **Legislation**

Congressional recognition of the need for coordination of specialized transportation services grew out of a concern over the lack of public transit in

rural areas. Following a 1973 U.S. Senate report, which highlighted the lack of public transportation in rural areas and its impact on rural seniors, Congress enacted Section 147 of the Federal-Aid Highway Act of 1973, as amended (23 U.S.C. 142). It encouraged the development of rural public mass transit by funding demonstration programs. To increase productivity and reduce duplication of services, several of these programs demonstrated the benefits of coordinating social service transportation services (Center for Systems and Program Development 1989).

In 1974, Section 16(b)(2) of the Urban Mass Transportation Act, as amended (49 U.S.C. 1612) established a program to provide capital assistance to private, nonprofit organizations to provide transportation to seniors and people with disabilities. Section 16(b)(2) transportation programs are administered by designated state agencies and emphasize and require coordination when feasible.

### **Interdepartmental Agreement**

By 1975, the former Department of Health, Education, and Welfare's (HEW) AoA had entered into its first working agreement with the DOT to improve interdepartmental coordination. Central to the agreement was an emphasis on coordinating public mass transit and special transportation services for seniors and individuals with disabilities (GAO 1977, p.43). As part of this alliance, HEW and DOT sponsored several demonstrations, reports, and studies on human service transportation coordination.

### **GAO Study**

Later that year, the lack of coordinated transportation services in rural areas was highlighted during hearings before the former Senate Committee on Public Works. Attention to this issue led to a committee recommendation for a U.S. Government Accounting Office (GAO) review of federally funded transportation programs. In 1977, GAO identified 114 different

HHS programs providing financial support for transportation, 58 of which spent more than \$300 million annually. Many federal barriers to coordination were identified through the study. Most respondents were uncertain about the extent of coordination allowable because of a lack of federal guidance explaining congressional intent about coordination. Clarification was needed to determine if and to what extent specific program transportation funds could be used for transporting individuals other than designated program beneficiaries. The GAO report neither endorsed nor recommended mandatory coordination, but did acknowledge the benefits of coordination, as long as there was appropriate cost-sharing and service accountability. The report recommended regulatory guidance for coordination from the U.S. Office of Budget and Management (OMB).

### **Rural Public Mass Transit**

Before 1978, all federal transit financial assistance went to urban areas (CTAA 1994). In 1978, Congress amended the Urban Mass Transportation Act of 1964 by passing Section 18, the Surface Transportation Assistance Act, a formula grant program providing capital and operating assistance for public transit in nonurban areas.

Section 18 marked the first time that DOT considered grantees responsible for including human service clients in public transportation service delivery (Urban Systems 1988). The legislation required coordination between Section 18 programs and other public and private transportation resources "to the maximum extent feasible" (Garrity 1979). Further progress was made toward coordination through a 1978 amendment to Title III of the Older Americans Act, as amended (42 U.S.C. 3001, *et seq.*). This amendment authorized state and local area agencies to act as brokers or coordinators of all community resources for seniors, which included public and human service transportation (Center for Systems and Program Development 1989).

### **First AoA/UMTA National Conference**

In 1983, in order to establish a formal mechanism to sponsor a joint national conference, it was necessary for AoA and the former Urban Mass Transportation Administration (UMTA) to sign a working agreement, which provided the foundation for future collaborative work. The First UMTA and AoA National Conference on Transportation for the Elderly and Handicapped was held in Orlando, Florida, in October 1984. The first appeal for a federal mandate for state-level coordination of transportation services was made at this conference. Participants identified the need for a designated point of contact within HHS for transportation activities, including increased communication and technical assistance; common bidding contracts for public and private transportation providers and flexibility in the final regulations implementing Section 504 of the Rehabilitation Act of 1973 (49 USC 794). Recommendations from the conference called for increased funding, coordination of state and local transportation funds, agency role definitions, technical assistance for transportation operators, and information-sharing among the two departments. Conferees further recommended that AoA and UMTA reaffirm their commitment through a new working agreement to serve as a nucleus for an Interagency Federal Task Force on Transportation, implement a series of regional conferences, and identify and disseminate best-practice models in transportation service delivery to seniors and individuals with disabilities (AoA and UMTA 1985).

### **Joint DOT/HHS Coordinating Council on Human Services Transportation**

After nearly a decade of consistent incremental progress toward coordination, DOT and HHS formalized their relationship in an "Agreement on the Coordination of Transportation Services"

in October 1986 (DOT/HHS Coordinating Council). The Joint DOT/HHS Coordinating Council on Human Services Transportation serves as a federal policy forum for the discussion of issues that affect coordination of public and human service transportation. Originally focused on coordination of rural public and human service transportation, the council expanded its goals in 1995 to include coordination of public and human service transportation in urban areas and ADA implementation.

Since its inception, the Coordinating Council activities have made significant strides toward improving human service transportation delivery and coordination through several initiatives. The council has successfully

- Established a network of 10 federal regional working groups to collect and disseminate data and information on coordination at the state and local levels,
- identified and eliminated federal barriers to coordination,
- funded the 8-state Region IV Consortium to facilitate coordination at the state level, and
- established a permanent relationship between AoA and the FTA through the signing of a "Memorandum of Understanding to Improve Transportation Services for Older Americans" in 1990.

The council disseminates information on successful coordination practices and supports training, technical assistance, and research initiatives on coordination.

### **National Transit Resource Center**

The National Transit Resource Center is funded by the FTA and administered by the American Public Works Association (APWA) in conjunction with the Community Transportation Association of America (CTAA). The center disseminates information and provides technical assistance on all aspects of coordination to the transportation industry. Information can be accessed through a toll-free telephone hotline, e-mail, and computer.

### **CTAP**

Since 1991, CTAA has also operated the Community Transportation Assistance Project (CTAP), in conjunction with Project ACTION (Accessible Transportation in Our Nation) of the National Easter Seal Society. This is an FTA-funded national research and demonstration program that improves transit accessibility for people with disabilities, helps transit operators implement the ADA, and promotes cooperation between the disability community and the transit industry. CTAP receives joint funding from DOT and HHS to provide technical assistance and information on coordination and to assist human service transportation providers in complying with the ADA.

Over the years, the federal government has continued to demonstrate support for increased coordination of public and human service transportation services. However, this encouragement and support has never resulted in federal coordination.

### **State Coordination Activities**

State DOT's are the agencies designated to administer federal transportation funds at the state level, and are in a pivotal position to encourage and require coordination of transportation resources. Because most local barriers to coordination are primarily the result of competing or conflicting state-level regulations, policies, and administrative practices, the state is the entity that has the authority to remove these barriers (Region IV Consortium 1987, Walther 1990). Federal legislation governing state DOT allocation of Section 16(b)(2) and section 18 funds requires coordination. As early as 1974, a number of states initiated coordination efforts, particularly in rural areas, to improve the availability, cost-effectiveness, and quality of human service transportation (Ecosometrics 1985).

State-level approaches to coordination vary. Although many states have formal coordination plans, policies, and agreements adopted at the policy-making level, most have voluntary coordination agreements (Mathias 1995). Sixteen states (Alabama, Arkansas, California, Colorado, Delaware, Florida, Illinois, Iowa, Kansas, Maine, Missouri, New Jersey, North Carolina, Texas, Virginia, and Wisconsin) mandate coordination through state legislation or gubernatorial executive orders.

Arizona, New York, and Pennsylvania require some level of coordination through partially mandated coordination arrangements. Arizona and New York coordinate only senior transportation services, while Pennsylvania mandates coordination only in rural areas. In this group, Pennsylvania is the only state that has dedicated funding; its paratransit for seniors and people with disabilities is funded through the state lottery (Center for Systems and Program Development 1989).

Thirty-one states do not have formalized mechanisms for coordination, but most of these support coordination through goals and/or policies. Voluntary coordination efforts include state-level agreements (South Dakota) and memoranda of understanding (Vermont). Four states (Georgia, Louisiana, Michigan, and South Carolina) have conducted coordination studies. Other states use a variety of approaches to voluntary coordination, such as shared vehicles (New Mexico); joint workshops and vehicle purchase incentive funding (Ohio); American Indian tribal coordination (Oklahoma); statewide brokerage (Rhode Island); and human service transportation brokerage (Washington) (Mathias 1995, CTAP 1994). In light of increasing capacity needs and decreasing funds, most state DOTs have now recognized the benefits of coordination as a means of maximizing community transportation resources.

### **PART III DOT/HHS MODEL COORDINATION PROGRAMS**

The literature is replete with summaries, case studies, and descriptions of pre-ADA models of coordinated transportation programs. Although transit systems have implemented coordinated programs in response to ADA paratransit requirements, little has been published describing these new models so far. The most recent comprehensive compilation of best practices in coordination is DOT/HHS Joint Coordination Council-sponsored *Best Practices in Specialized Transportation* prepared by the Center for Systems and Program Development (1989). The programs that are described in *Best Practices* remain as models of innovative coordination. The following discussion describes three of these programs, focusing on ADA paratransit enhancements, and reviews two coordination models from the 1992 ADA Paratransit Plans and 1993/1994 ADA Plan updates.

#### **Florida State Model**

Florida has been recognized as a leader in coordinated transportation since the 1980s. In 1979, the Coordinating Council for the Transportation Disadvantaged was established as the state-designated coordinating entity for specialized transportation. Council members were appointed by the governor. In 1984, a state law (Chapter 427 Florida Statute) was enacted to require transportation coordination at the county level.

The law required full coordination of all 67 county transportation services by July 1, 1992. In 1989, the coordinating council was upgraded to a commission. The commission, a successful public/private partnership, is coordinating transportation in all 67 counties and meeting ADA paratransit demand.

The commission coordinates transportation funds and services for eligible transportation-disadvantaged individuals. Costs savings are achieved by expense pooling and grouping trips. Participating agencies contribute to the commission's budget and are required to include transportation as a line item in their individual budgets (Mauney 1994). The largest funding source is Medicaid, which provides 40 percent of the operating budget. Additional funding is derived from state agencies with responsibility for at-risk children, seniors, individuals with disabilities, veterans, rehabilitation, and education; this contributes \$200 million to the commission's budget (Bell and Hutchinson 1995).

The commission's annual \$23 million budget and trust fund is financed with a percentage of all public block grants and revenue generated by the sale of handicapped parking permits (Burkhardt and Hayes 1995). Transportation for nonagency-sponsored clients and increased ADA paratransit services is funded from automobile license revenue. The commission was successful in getting an additional \$1.00 added to the cost of automobile license tag fees, which generated \$14 million in FY 1994. The additional funds were used to provide 1.4 million additional paratransit services.

#### **JAUNT**

JAUNT is a specialized rural transportation system servicing one city, one urban county, and four rural counties; it is the ADA complementary paratransit provider for the Charlottesville Transit System. The agency runs a successful consolidated model of coordination that combines all transportation service delivery. All passenger trips are scheduled and provided together and overhead expenses are reduced by sharing the costs with participating transit and

human service agencies. Paratransit is a curb-to-curb service, but door-to-door service is available. A flexible, fixed-route-type deviated service meets the needs of regularly scheduled daily group trips. JAUNT requires that all passengers use seat belts, children under 40 lb be secured in child safety seats, and passengers using 3-wheel scooters transfer to seats.

The success of the program is largely due to the high-quality customer service delivered. Agency and passenger satisfaction is evaluated annually. Passenger trips have increased consistently since 1986, with no increase in administrative staff since 1982. Forty-three vehicles, 20 of which are lift-equipped buses and mini-vans, provide all the trips. The per passenger trip cost is \$6.41; the participating agency cost is \$22.97 per vehicle hour (TRB 1993).

### **Tri-Met**

Tri-Met has operated paratransit service since 1976, with a high percentage of dedicated social service agency trips. The LIFT provides curb-to-curb ADA paratransit service. Last July, the transit system entered into an agreement with the state to broker Medicaid nonemergency medical transportation. Tri-Met uses a brokerage model of coordinated transportation and multimodal trip planning. The model is cost-effective because it selects the least expensive mode of transportation to provide the trip, while still attending to the special needs of the passenger. ADA paratransit service is provided at the ADA fare, but door-to-door paratransit service is available for an additional charge. Tri-Met is now providing more than 60,000 trips per month using accessible vans, taxis, volunteer drivers, and transit system vehicles. More than 100 vehicles and providers provide more than 1,800 daily paratransit trips in the tri-county area (CTR, May/June 1995).

### **ADA Paratransit Research Results**

A review of 1992 ADA Paratransit Plans and 1993/1994 ADA Paratransit Updates yielded little information on

new coordination models to be used to implement the ADA paratransit provisions (Rosenbloom 1994). The plans indicated that smaller cities tended to report pre-ADA cooperative or coordinated arrangements with human and social service agencies more often than larger cities. Only 12 percent of the systems reported using coordination. In addition, 12 percent of the plans indicated that non-ADA-eligible senior citizens would not be served by their paratransit programs, while 18 percent stated that they would continue to serve seniors, even if they are non-ADA eligible. The following transportation systems were highlighted in the research as an example of successful pre-ADA coordination that would be maintained to meet ADA requirements.

#### *Tidewater Transportation District*

The Tidewater Transportation District in Norfolk, Virginia, is the regional transportation authority for the cities of Chesapeake, Norfolk, Portsmouth, and Suffolk. Tidewater was serving as the pre-ADA transportation broker, providing paratransit for several social service agencies and the local AAA. By 1993, one-third of all Tidewater paratransit trips were provided through local agencies contracts. At the time of the review, the transportation system reported success with the brokerage coordination model. Tidewater was then meeting ADA paratransit demand and did not anticipate any changes in service delivery or design (Rosenbloom 1994).

#### *Lane Transit District*

Prior to the ADA, Lane County Transit in Eugene, Oregon, was serving as the paratransit broker for all area transportation providers. The transit system has contracts with the Lane Council of Governments (L-COG) to arrange paratransit service through a nonprofit transportation provider, supplemented by taxi service for evening service. Post-ADA, the system has proven successful in meeting paratransit demand. L-COG contracts out all ADA

paratransit for the transit system and is paid by state and social service agencies for paratransit services for non-ADA eligible clients. The examples cited have demonstrated expanded capacity for ADA paratransit service, increased productivity, reduced trip costs, and improved services for passengers through various models of coordinated transportation.

## **PART IV RECENT PROGRESS TOWARD COORDINATION**

DOT and HHS have demonstrated their continuing commitment to coordination through the activities of the joint HHS/DOT Coordination Council. Serving as a national leader, the council has succeeded in bringing attention to and increasing industry awareness of the benefits of transportation coordination at many levels. As the need for coordination increases because of ADA implications and funding constraints, support for coordination has broadened as a result of council-sponsored regional meetings and research and demonstration activities. Currently, the Coordination Council is involved in the resolution of several policy issues affecting coordination, including investigating the use of Medicaid-purchased monthly transit bus passes to meet nonemergency medical transportation needs, and the feasibility of coordinating school bus transportation with public and human service transportation (*TD Access & Safety Report*, October 18, 1995).

### **Regional Roundtables on Coordination**

During 1995 and 1996, joint HHS/DOT coordination meetings have been held in 9 federal regions. The meetings have been successful in bringing senior-level human service and transportation officials together to discuss coordination and to produce state-level coordination plans. Upon completion, the Coordinating Council



will compile, publish, and disseminate the plans as a means of sharing coordination strategies.

### **Inventory of Federal Transportation Funds**

Many HHS-sponsored programs fund transportation services as a part of service delivery. For example, the Office of Human Development Services (OHDS) supports client transportation through the administrations of Aging; Children, Youth, and Families; Native Americans; and Developmental Disabilities. In the Public Health Service (PHS), client transportation is provided through the Health Resources and Services Administration, Bureau of Maternal and Child Health and Resources Development, and Indian Health Services. The Health Care Financing Administration (HCFA) oversees Medicare and Medicaid. Medicare only reimburses emergency transportation. The Social Security Administration (SSA) administers social security income (SSI), and social security disability income (SSDI) maintenance programs for seniors and individuals with disabilities. SSI and SSDI recipients make up a major portion of human service transportation users. The Family Support Administration (FSA) administers the Aid to Families with Dependent Children (AFDC) and Job Opportunities and Basic Skills (JOBS) programs (CTR 1991).

In these programs, HHS transportation expenditures have consistently been reported in aggregate estimates because state and local administering guidelines do not require itemization. The need to disaggregate and analyze federal transportation expenditures has long been recognized as necessary to determining the efficiency of coordination. In 1994, HHS provided funding for CTAA to conduct a comprehensive survey and inventory of federal spending for transportation services. Preliminary results indicate that CTAA has identified 99 federal programs that fund benefits-related transportation services (TD Safety Report, October 5, 1995).

### **Model ADA/Medicaid Coordination Demonstration**

In 1994, the FTA funded a project to demonstrate the feasibility of using Medicaid funds to expand the transit system ADA paratransit capacity. In addition, the project was planned to prove that the public transit operator could provide transportation more efficiently than HHS agencies, because using a publicly operated transportation brokerage would save the Medicaid program money, which could be applied toward ADA paratransit costs. The project involved collaboration between FTA, HHS, the Metropolitan Transportation Commission (MTC), Los Angeles County Metropolitan Transportation Authority (LACMTA) and the California State Medicaid Authority (TD Safety Report, November 9, 1994). As of this writing, the demonstration is on hold pending resolution of issues between the participants.

### **Senate Report on Coordination**

Many strategies have been proposed to produce a federal mandate for coordination; however, only a congressional committee request for a joint HHS/DOT coordination plan has been produced. In FY 1996, the Senate Appropriations Committee directed DOT and HHS to jointly prepare a strategic action plan for the coordination of DOT and HHS paratransit services. FTA and HHS Council representatives are in the process of preparing the report for submission to the Senate and House Appropriation Committees (APTA, August 16, 1995; HHS/DOT Coordinating Council 1995).

### **National Groups Endorse Federal Coordination Mandate**

Financial realities of ADA provision and deep funding cuts have caused transit operators to seek nontraditional funding sources and consider human service transportation as a viable option. Several activities held at the national level have

endorsed coordination of public and human service transportation.

### **APTA Mini-White House Conference On Transportation and Aging**

The APTA Mini-White House Conference on Aging held March 15, 1995, passed a resolution for the coordination of federal, state, and local public and human service transportation planning, funding, and services to maximize the mobility of older Americans (APTA Memorandum, March 30, 1995). Prior to hosting the conference, APTA had announced its organizational support for coordination. APTA disclosed plans to work toward inclusion of a federal mandate for coordination in the reauthorization of the Older Americans Act (TD Safety Report, January 4, 1995). Other changes to be sought by APTA are the elimination of a federal regulation that prohibits charging a passenger fare in AoA-funded transportation services, definition of the range of public transportation service options for seniors, and service obligations of public transit in the provision of human service transportation.

### **White House Conference on the Aging**

The White House Conference on the Aging, held in Washington, DC, on May 2-5, 1995, adopted eight transportation resolutions. The resolutions emphasized the importance of coordinated transportation services to improve mobility and transportation access for seniors (Alliance for Transportation Research et al. 1995). The White House Conference resolved to support policies that do the following:

- Promote and prioritize the importance of older persons' access to transportation as an essential component of a quality life;
- Encourage flexibility in funding to enable local governments with state and federal grants to conduct research in order to develop model programs to

establish or continue coordinated transportation programs designed to meet the needs of older transit disadvantaged persons, especially those with disabilities;

- Require appointment, at all levels, of older persons and persons with disabilities, with knowledge of transportation needs, to boards making transportation decisions;

- Promote public-private partnerships that expand safe, affordable, and accessible transportation options and development of appropriate tie-downs, including the development of safer, more accessible vehicles, roads, and drivers;

- Maintain federally assisted funding of mass transportation (Older Americans Act, Medicaid, Veterans Administration, ISTEA, and Department of Education) and increase appropriations for the Mass Transit Assistance Act, the World Transit Assistance Act, and federal appropriations for Sections 16(B)(2), 9, and 18 of the Urban Mass Transit Act to provide transportation vehicles;

- Require coordination of all publicly supported transportation services, including schools, to increase efficiency and availability, and to assist community, religious, and civic organizations to provide volunteer drivers;

- Establish the Joint Council on Human Services Transportation by federal statute and expand it to include all federal agencies that provide funding for, regulate, or rely on transportation services in order to serve older persons; and

- Support federal legislation to broaden the Good Samaritan Act to include volunteer drivers who are affiliated with a program to serve elderly and disabled persons.

#### **Post-White House Conference Activities**

Several activities were held to respond to the White House resolutions. The Surface Transportation Policy Project held a Policy Forum on Transportation for Older Persons and People with Disabilities on September

27, 1995, in Washington, DC, to develop recommendations to implement the resolutions. Pennsylvania State University involved the private sector by holding a forum on October 4, 1995, in State College, Pennsylvania, in conjunction with Pennsylvania State Legislature public hearings on transportation and mobility of seniors. The Alliance for Transportation Research convened a forum, South Valley Community Elderly Transportation Project, South Valley New Mexico, on October 19, 1995, to seek community input on the resolutions. At each forum a recommendation was made for mandatory or requisite coordination of all publicly supported transportation services (Alliance for Transportation Research et al. 1995).

#### **TRB Workshop on ADA Paratransit**

In September 1995, the Paratransit Subcommittee of the Transportation Research Board (TRB) Committee on Mobility and Access held a workshop to identify research initiatives to assist ADA implementation. The need to identify federal strategies to promote coordination of public and human service transportation was prominent among the research statements developed.

#### **ADA Paratransit Forums I and II**

In response to congressional concern about the costs of ADA paratransit services, exacerbated by reduced federal operating assistance and other program budget cuts, the FTA requested Project ACTION to convene two national forums to identify solutions. Both forums were held in Washington, DC, in 1995 (ADA Paratransit I was held in July, followed by ADA Paratransit II in December). More than 100 representatives of the disability community and transit industry attended from rural and urban areas nationwide. The first forum focused on issue identification and preliminary recommendations for solutions. At the

second forum, a strategic action plan for the implementation of the ADA paratransit requirements was developed, based on ADA Paratransit I recommendations. Coordination of human service and public transportation was a major topic of discussion at both forums. Participants identified

coordination as a major strategy to reduce costs, expand ADA paratransit capacity, and improve paratransit service delivery, but recognized the potential problems of coordination in large urban areas. To promote coordination, forum participants recommended the following strategies:

- Federal encouragement through letters from the Secretaries of HHS and DOT to governors citing the need for and benefits of coordination;

- Inclusion of language promoting state-level coordination during the reauthorization of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA) and the Older Americans Act;

- The development of state-level coordination plans as a mandatory requirement of ISTEA community planning requirements; and

- Collaboration and coalition-building with the disability community at national and local levels, National Governors Association, National Conference of State Legislators, APTA, CTAA, and the National Transportation Consortium of States.

Other recommendations addressed travel training, improving paratransit productivity, increased technology and tools for determining ADA paratransit eligibility, and improving guidance for requesting temporary time extensions based on undue financial burden (Simon 1996).

#### **Summary**

Public transit operators, the nation's primary providers of public transportation, were charged by the federal government to provide ADA complementary paratransit for individuals who cannot use accessible fixed-route

service because of their disabilities. Many human service agencies, which receive federal financial assistance through categorical grants to state and local governments, are secondary providers of transportation. When these agencies provide client transportation as a means of facilitating their primary service delivery, they often do so without considering other forms of federally funded transportation services available in the community.

With federal funding cuts, the public transit requirement to comply with ADA paratransit provisions is creating financial difficulties at a time of increased demand, and coordination of transportation resources appears to be the most effective management tool. Human service agencies are concerned about the financial solvency of their programs and whether they will be able to maintain control over them.

The major deterrent to coordination of transportation resources is the lack of a federal mandate. Also missing from the ADA is a maintenance of effort clause, regulatory language directed at human service and other secondary providers of federally funded transportation services, to prohibit client dumping. In the absence of a federal mandate or incentive for coordination, it may well remain an elusive goal.

## **PART V SUGGESTED RESEARCH ACTIVITIES**

The majority of individuals interviewed for this digest strongly agreed that additional research in coordination was unnecessary. Most

indicated that this topic has already been sufficiently researched and that what is needed is to obtain a federal mandate for coordination. After further discussion, the following suggestions for research were identified.

### **ADA/HHS Best Practices Coordination Models**

Little current research is available on new coordination models designed in response to ADA. Further research is needed to develop and disseminate ADD/HHS coordination best-practice model programs demonstrating costs savings and service improvements.

### **Definitions for ADA Paratransit Service and Medical Transportation**

Concern was raised that transit operators do not have the experience to provide some levels of service that may be required in coordinated transportation. Further research is needed to examine different levels of paratransit service to determine the distinctions between ADA paratransit service and medical transportation. The research should identify when a required level of service is beyond the scope of ADA paratransit service.

### **Allocated Costs of Human Service Transportation**

Human service agencies have no way of determining the true costs of human service transportation. Further research is needed to develop a methodology for human service providers to measure their true transportation costs.

### **Other Federally Funded Benefits- Related Transportation**

Discussion of HHS funding levels for transportation raised the concern that additional federal funds are spent on transportation for individuals with disabilities in the Departments of Education, Labor, Division of Vocational Rehabilitation, and Veterans Administration. Further research is needed to expand this document to include a section on transportation benefits available to people with disabilities under other federal programs.

### **Informational Material for AoA/HHS Staff**

AoA and HHS staff did not seem to be aware of the financial implications of ADA paratransit service and the benefits of coordination to all participants. Further research is needed to develop informational material to help agency staff understand the impact and implications of ADA on paratransit services.

### **Informational Materials for Public Transit Staff**

Transit system staff requested guidance and assistance in determining the transit cost for an agency trip and type of human service funding that would be available to the public operator. It is suggested that a one-page flyer be developed and disseminated that identifies the statutes, the availability of funding, and a method to determine the cost of a trip to recover the full operating costs.

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