REPORT OF THE PARATRANSIT ADVISORY COMMITTEE

Findings and Recommendations for Coordination and Consolidation of Metro Mobility and Medical Assistance Special Transportation

Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, Minnesota 55101
(612) 292-2789

Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3853
(612) 296-7850

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ERRATA

page 21 The estimated cost for phase II should be shown as $200,000 in state funds and $200,000 in federal funds.

State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

February 10, 1992

The Honorable Patrick E. Flahaven
Secretary of the Senate
231 Capitol
75 Constitution Avenue
St. Paul, Minnesota 55155

Dear Mr. Flahaven:

Laws of Minnesota 1991, chapter 298, article f, section 9 directs the Regional Transit Board (RTB) to establish a paratransit advisory committee to study the feasibility of consolidating and coordinating existing Metro Mobility service trips with existing Department of Human Services (DHS) medical assistance (MA) trips in the metropolitan area. The legislation directs the chair of the RTB and the Commissioner of DHS to submit the report and recommendations of the committee to the Legislature and the Governor. Enclosed is the report of this committee. An additional six copies of the report are being forwarded to the Legislative Reference Library.

The Paratransit Advisory Committee recommended an approach that suggests establishing a coordination phase that will enable the two programs to move toward consolidation if possible. The committee recommended that a paratransit consultant work with the staff of the RTB and DHS to develop the plan for consolidation. Specific committee recommendations are shown below.

1. Immediately coordinate DHS and the RTB certification of functional eligibility. The certification of eligibility is the process used to determine a person's need for special transportation. In addition, coordinate complaints and quality issues, to the degree possible.

2. Fund a consultant to bring together DHS and the RTB to develop an implementation plan. The plan will determine if consolidation is possible given the paratransit resources and constraints in the metro area. The consultant will develop a plan that maximizes resources and services in the largest market. The consultant will make recommendations on how to accommodate all levels of need for service and how to reimburse the subcontracting van companies using a competitive market approach. The consultant will assist the two agencies in developing a strategy to educate the medical, special transportation provider, and paratransit consumer communities.

3. Fund resources within DHS and the RTB to work with the consultant.

4. Designate the RTB as the paratransit entity in the consolidation model to manage the transportation needs of MA transportation and Metro Mobility rides.

5. Include in the consolidation plan Metro Mobility rides and most MA special transportation rides. Exclude certain publicly funded reimbursable trips such as the Title III program and the MA special transportation trips provided by small non-profit social service agencies. These agencies often participate in these other excluded programs and collectively provide less than 5000 rides per year.

6. Adopt the following time line for coordination, the consultant plan, and consolidation. Coordination and consolidation will be phased in. Staff estimates that Phase I implementation would take approximately one year with the consultant study coinciding with the coordination phase. During 1994 the consolidation phase will be implemented.

PHASE I	**CONDUCTED BY**	**DATES**
Develop coordination plan	DHS and RTB	June 1, 1992
Develop RFP for consultation	DHS and RTB	June 1, 1992
Hire Consultant		July 1, 1992
PHASE II		
Implementation of Coordinated Approach	DHS and RTB	January 1, 1993
Consolidation Plan to 1993 Legislature	Consultant	February 1, 1993
PHASE III	**CONDUCTED BY**	**DATES**
Implementation of consolidation plan	DHS and RTB	July 1, 1994

The members of the Paratransit Advisory Committee contributed their invaluable knowledge and experience to the discussion of some very complex issues. The RTB and DHS thank them for their time and effort.

If you need additional information, please contact Patricia MacTaggart, Assistant Director, Health Care Management Division, DHS at 297-4671 or Cynthia Curry, Senior Program Manager, RTB, at 229-2714.

Sincerely,

MICHAEL EHRLICHMANN
Chairman
Regional Transit Board

Sincerely,

NATALIE HAAS STEFFEN
Commissioner
Department of Human Services

CONTENTS

Page

Executive Summary 1

I. Background and Legislation 3

II. Justification for Coordination or Consolidation 5

III. Barriers to Coordination or Consolidation 9

IV. Models Used In Other States 12

V. Coordination and Consolidation Approach 15

VI. Consultation Group Reaction to the Model 19

VII. Cost of Coordination and Consolidation Approaches 21

VIII. Committee Recommendations 22

IX. Conclusion 23

VIII. Appendix
- A. Comparison Between Medical Assistance and Metro Mobility
- B. Medical Assistance and Metro Mobility Functional Eligibility Forms
- C. List of Paratransit Advisory Committee Members
- D. Funding Sources for Transportation
- E. Articles about Wheels, Access and Washington State
- F. Agency Roles and Responsibilities
- G. Work Plan for Study
- H. Minutes of the Paratransit Advisory Committee

EXECUTIVE SUMMARY

The 1991 Minnesota Legislature created the Paratransit Advisory Committee to study the feasibility of coordinating or consolidating Metro Mobility and Medical Assistance rides in the seven-county metro area. The recommended approach suggests establishing a coordination phase that will enable the two programs to move toward consolidation. The consolidation approach will be developed by a consultant who will work with the staff of the Department of Human Services (DHS) and the Regional Transit Board (RTB).

The Paratransit Advisory Committee met from August through December 1991 and made the following recommendations:

1. Immediately coordinate DHS and the RTB certification of functional eligibility. In addition, coordinate complaints and quality issues, to the degree possible.

2. Fund a consultant to bring together DHS and the RTB to develop an implementation plan. The plan will determine if consolidation is possible given the paratransit resources and constraints in the metro area. The consultant will develop a plan that maximizes resources and services in the largest market. The consultant will make recommendations on how to accommodate all levels of need for service and how to reimburse the subcontracting van companies using a competitive market approach. The consultant will assist the two agencies in developing a strategy to educate the medical, special transportation provider and paratransit consumer communities.

3. Fund resources within DHS and the RTB to work with the consultant.

4. Designate the RTB as the paratransit entity in the consolidation model to manage the transportation needs of Medical Assistance transportation and Metro Mobility rides.

5. Include in the consolidation plan Metro Mobility rides and most Medical Assistance special transportation rides. Exclude certain publicly funded reimbursable trips such as the Title III program and the Medical Assistance special transportation trips provided by small non-profit social service agencies. These agencies often

participate in these other excluded programs and collectively provide less than 5,000 rides per year.

6. Adopt the following timeline for coordination, the consultant plan and consolidation. Coordination and consolidation will be phased in. Staff estimates that Phase I implementation would take approximately one year with the consultant study coinciding with the coordination phase. During 1994 the consolidation phase will be implemented.

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Implementation of consolidation plan	DHS and RTB	July 1, 1994

The 1991 Minnesota Legislature created the Paratransit Advisory Committee to study the feasibility of coordinating or consolidating Metro Mobility and Medical Assistance rides in the seven-county metro area. The Paratransit Advisory Committee met from August through December 1991 to conduct this study.

Both DHS and the RTB use public monies to purchase paratransit services in the seven-county metropolitan area. A comparison of these programs is described in Appendix A and below.

Metro Mobility

The RTB is the agency responsible for planning and oversight of public transit in the Twin Cities metropolitan area. The RTB holds contracts with the providers who deliver Metro Mobility trips. The RTB also contracts with the Metro Mobility Administrative Center (MMAC) operated by the Metropolitan Transit Commission. The MMAC certifies riders, monitors providers' service, and collects data as a part of this contract.

Metro Mobility currently provides paratransit services to approximately 19,000 individuals. These individuals must be mentally or physically unable to use regular bus services. Determining whether the individual needs paratransit services is made based on an application completed by the applicant and his or her health care provider. Financial status cannot be used to determine eligibility for Metro Mobility because it is public transportation for persons who cannot use regular route transportation due to a disability. Metro Mobility is not a social service program. Metro Mobility provides a ride for any purpose the rider requires.

Metro Mobility services are provided by 13 taxi and van companies. These companies must be certified by the Department of Transportation as special transportation providers. Providers are chosen through a request for proposal (RFP). Metro Mobility providers may define the geographical portion of the metro area their company serves. Providers are paid for each trip based on whether the recipient needed ambulatory or wheelchair lift service and geographic area in which the trip occurs. The payment to the provider for all types of trips averaged $8.65 per trip for calendar year 1990. The

provider also received between $1.00 and $3.75 as a fare from the recipient. The amount of the fare depends on the trip length. (The current base fare is $1.75 with a $.50 surcharge for crossing fare boundaries or for peak hour services.) Additional information on Metro Mobility rates is in Appendix A.

Approximately 27 percent of the Metro Mobility riders require a wheelchair lift vehicle. The remaining 73 percent of the riders are ambulatory. Metro Mobility drivers assist the rider through the first door of the building they must enter and exit. Riders who need assistance within the building they are traveling to must be accompanied by an escort, who rides free.

Metro Mobility receives 90 percent of its funds from the state. The additional 10 percent comes from fares collected from riders. In calendar year 1990, the state spent $14.7 million on Metro Mobility services. Farebox revenues added approximately $1.5 million. Metro Mobility provided 1.5 million one-way trips in 1990. Of this number, 1,036,500 were individual trips and 463,500 were group trips to and from day training and habilitation facilities.

Medical Assistance

The Medical Assistance Program funds transportation to and from covered Medical Assistance services. Approximately 15,400 individuals in the metro area received special transportation (paratransit) services in calendar year 1990. To be eligible for special transportation the person must be financially eligible for Medical Assistance. General Assistance Medical Care recipients who live in an institution for mental disease are also eligible. The rider must also need special transportation because of a mental or physical impairment that prevents him or her from using a bus or other type of common carrier. Riders must get a physician's statement verifying that special transportation is required.

Medical Assistance has 50 special transportation providers in the seven-county metro area. To enroll, the provider must have a special transportation certificate issued by the Department of Transportation. The company must also sign a DHS provider agreement. Providers are paid their submitted rate or the legislatively established base rate and mileage, whichever is lower. Currently the established base rate is $12.50 with $1.00 per mile. The average amount paid per one-way trip in the metro area is $20.50.

Riders may call any enrolled Medical Assistance provider. The call may be made several weeks in advance or the same day as the ride. Riders are provided the level of service they require. Medical Assistance will reimburse providers an additional $9.00 per one-way trip for an extra attendant supplied by the van company. This extra attendant is used to assist carrying a wheelchair-bound recipient up and down stairs.

Medical Assistance spent approximately $8.8 million for special transportation in the seven-county metro area in 1990. Fifty-three percent of the cost of this transportation is reimbursed with federal Medicaid dollars. The other 47 percent comes from state and county funds.

JUSTIFICATION FOR COORDINATION OR CONSOLIDATION

Over the last five years the demand for specialized transportation in the metro area has increased for a growing population of elderly individuals and persons with disabilities of varying ages. This growing demand, coupled with the escalating cost of providing transportation services with dedicated local resources and shrinking federal dollars, provides an opportunity for both DHS and the RTB to explore approaches to achieve coordination or consolidation.

The study has addressed several reasons for coordination or consolidation:

Provision of Paratransit Service in the Metropolitan Area

In the metropolitan area, paratransit service or specialized transportation service is provided by Metro Mobility, which is the regional door-through-door service for persons who cannot use regular route services due to a disability. In addition to Metro Mobility, other specialized paratransit programs provide transportation to these persons who need special transportation service.

Medical Assistance specialized transportation service under DHS was added as a Medicaid service to assure access to medical services for persons who could not use common carrier transportation such as buses.

The coordination or consolidation of the two separate programs, which provide trips to a common population that is functionally unable to use the regular bus service, leads to some compatibility and cost savings in coordination of existing state and federal funding.

Increased Ridership

Both programs have experienced large increases in ridership during the last five years. The Metro Mobility program assumed the responsibility for transportation of individuals who, in the past, were transported by nursing facilities, day training and habilitation center, families, or volunteers or who just did not travel from home because of the lack of public transportation. Table 1 identifies ridership figures for Metro Mobility from 1988 to 1990.

Table 1

Metro Mobility Ridership

YEAR	TOTAL RIDES	PERCENT CHANGE
1988	1,260,099	
1989	1,421,139	12%
1990	1,636,500	15%
Source: Regional Transit Board		

Table 2

Medical Assistance Rides

YEAR	TOTAL RIDES	PERCENT CHANGE
1988	281,004	
1989	306,705	9%
1990	380,228	24%

Table 2 shows ridership for Medical Assistance. Increases in ridership for Medical Assistance reflect an increase in the number of persons eligible but also an increase in the number of recipients who have moved from large treatment facilities to group homes in the community.

Funding

The increase in ridership has also created a significant increase in cost. Medical Assistance expenditures for special transportation in the metro area have increased from $6.5 million in 1988 to $8.8 million in 1990. Metro Mobility's expenditures have increased from $7.3 million in 1987 to an estimated $14.3 million in 1991.

Both programs have experienced budget cuts in previous years. Medical Assistance special transportation was one of the services that was subject to a budget cut in the 1991 legislative session. The base rate for special transportation was decreased from $16.00 to $12.50. This rate change was projected to reduce the statewide expenditures for special transportation by $641,000 in federal funds and $622,000 in state funds for FY 1992.

Metro Mobility began 1991 with a projected deficit of approximately $2.0 million.

Duplication of Effort

A. Trip Purpose

A recent consultant study conducted by Mary O'Hara Anderson for the RTB cited incidents of five to eight special transportation vehicles all parked at some of the major hospitals. As many as 12 van companies had vehicles at one hospital at the same time. Some of these vehicles were Metro Mobility carriers and some were Medical Assistance providers. She observed that each vehicle brought or picked up one passenger. This duplication of effort might be lessened by some sort of coordination of trips. Within Metro Mobility, some of this coordination of rides occurs but only when one company is fully booked and asks another to take the ride. The grouping of individuals for rides may occur within each company's rides but because the pool of riders for the company may be small, grouped rides to the same destination may not be a frequent option. Even this kind of coordination of trips may be impossible if the riders live in completely different parts of the metro area.

B. Joint Providers

Medical Assistance and Metro Mobility share ten providers. These ten companies provide between 40 percent and 50 percent of the Medical Assistance trips. The additional 50 percent to 60 percent are provided by 40 other special transportation companies or social service agencies. All these companies must buy and maintain vehicles, train drivers, buy insurance, pay staff and pay for garages for the vehicles. These are expenses that must be supported by the rates paid to providers by Medical Assistance and Metro Mobility.

C. Joint Recipients

Although the number of riders who receive rides from both the Medical Assistance Program and the Metro Mobility program is unknown, several assumptions can be made about the similarity of Medical Assistance and Metro Mobility rides.

1. Persons who need specialized transportation may use Metro Mobility for all trip purposes including trips to jobs, grocery stores and recreational activities.

2. A marketing research study on the Metro Mobility program within the Minneapolis-St. Paul area indicated that the greatest use of rides is for health related purposes. The 1990 survey indicated 98 percent of the riders use Metro Mobility for these trips. This use had increased from 87 percent in 1987. The second and third major trip purposes were shopping and visiting friends.

3. The same study identified half the Metro Mobility users as having an annual family income of less than $10,000.

D. Functional Eligibility for Special Transportation

Medical Assistance and Metro Mobility each have a separate physician's statement that is used to determine whether a rider needs special transportation services or whether he or she could use regular bus service. These forms are in Appendix B. This separate eligibility process is a duplication of effort if the rider uses both Medical Assistance and Metro Mobility transportation. It is time consuming for Medical Assistance providers who have to collect the forms and it is time consuming for physicians who have to complete two forms for the same recipient.

BARRIERS TO COORDINATION OR CONSOLIDATION

Differing Regulations Governing Transportation Programs

Conflicting purposes and regulations are always a barrier to coordination of transportation programs. Although the legislation requested that the Paratransit Advisory Committee look at the feasibility of coordination or consolidation of Metro Mobility and Medical Assistance medical rides, the committee reviewed other types of state and federally funded transportation programs. Funding sources for the metro area transportation are shown in Appendix D. This inventory of both state and federal programs indicates that each of these programs has a different target population, with different eligibility requirements and guidelines in which to operate. The limitation of who can access a transportation program based upon the different funding sources is a barrier when considering coordination or consolidation of either the Medical Assistance and Metro Mobility rides or the other programs on this chart.

Compatibility of Service

Service compatibility is a barrier in the following area:

A. Passenger Assistance

Medical Assistance does not have administrative rules that require the level of assistance being provided to riders today but this expectation of customized service is a barrier to change. Medical Assistance providers traditionally have provided a greater level of service to their riders than has Metro Mobility. Many small Medical Assistance providers are able to offer the same driver for each trip a recipient takes. This familiarity allows individuals who may be fearful of strangers or have difficulty with English to have the security of a friendly face.

In many Medical Assistance funded rides, the driver accompanies the rider up the elevator in a multistory medical building to the medical provider's office and signs them in at the reception area. In this situation, the rider is the only one in the vehicle because a driver could not safely leave other riders waiting in the van. Metro Mobility's

trips often involve more than one rider at a time because the driver only takes the riders through the first door of the building. Riders who need an escort within the building must bring along a friend, attendant or family member. Thus, the barrier to consolidation is that Medical Assistance recipients have come to expect more assistance than will be economical to provide in the future.

B. Same-Day Service

Medical Assistance recipients sometimes call for a ride the same day. The recipient may call to see a doctor for an unexpected acute medical problem or simply wait until the last minute to schedule the ride. Many Medical Assistance providers have enough slack time that they can accommodate these last-minute trips. Metro Mobility cannot assure a rider of service the same day. Metro Mobility now allows riders to schedule rides up to three weeks in advance, but the rider must call before 2:30 p.m. the day before the ride to be certain to get a ride.

C. Escorts

Medical Assistance providers are paid to provide an extra attendant to carry a person in a wheelchair down or up stairs. Metro Mobility requires that the rider provide an escort. Escorts provided by the rider ride free in both programs.

D. Trip Purpose

Medical Assistance funds trips only to or from a service covered by Medical Assistance. Metro Mobility does not restrict the trip purpose.

Large Number of Medical Assistance Enrolled Providers

There are 40 metro area Medical Assistance providers whose main business comes from providing Medical Assistance special transportation. These providers range from organizations that are part of hospital corporations to small businesses. To change the way special transportation is provided to Medical Assistance recipients could affect some of these businesses. The current reimbursement rate is a concern for all Medical Assistance providers. Some providers have indicated they may not be able to continue to provide services at this reimbursement level.

Changing Federal Funding Patterns

Other states, such as Washington, have recategorized Medicaid special transportation from a service under the Medicaid state plan agreement with the Health Care Financing Administration (HCFA) to an administrative expense. Administrative expenses are

reimbursed by HCFA at a 50 percent matching rate instead of the rate used for services. The current matching rate for services is 53 percent for Minnesota in FY 1992. The reason some states choose to categorize transportation as an administrative expense rather than a service cost is flexibility. If transportation is considered an administrative expense, a state may choose the most cost-effective providers and may contract with a limited number of transportation organizations. If the state treats special transportation as a service, all companies that meet enrollment criteria are allowed to provide services and recipients are free to choose among the enrolled providers. Minnesota handles common carrier transportation as an administrative expense and special transportation (paratransit services) as a service. At the current expenditure level, Minnesota would lose $357,000 in federal funds if transportation were changed statewide from a service category to an administrative expense category. The state would also have the option of applying for a waiver of Medicaid freedom of choice regulations in order to retain the higher funding level.

COORDINATION MODELS USED IN OTHER STATES

The committee contacted the Public Transportation Network (PPTN), a natioinal transportation organization, to gather information on other cities with similar programs. PPTN sponsored travel for representatives of two Pennsylvania transportation programs to attend the Paratransit Advisory Committee meeting on October 23, 1991. Rex Knowlton represented the Wheels program in Philadelphia. Keith Forestall is a transportation consultant who has worked with the Access transportation program in Pittsburgh.

Wheels

The Commonwealth of Pennsylvania contracts with Wheels Inc. to provide transportation to all Medicaid recipients in the city and county of Philadelphia. In Pennsylvania, all levels of transportation to and from Medicaid services are handled as an administrative expense rather than a service cost under federal Medicaid regulations. Minnesota receives a 53 percent federal Medicaid match for this service cost. Pennsylvania receives a 50 percent federal match because all of its transportation expenses are handled as administrative expenses. Even though the match is less, Pennsylvania is free to restrict Medicaid recipients to one contractor. States who use a service option must let all providers who meet certification or licensure enroll and must let recipients have free choice of all enrolled providers.

Wheels provides nine different levels of transportation. The lowest level is the reimbursement of bus fares for individuals who can use regular transit services. Wheels also provides taxis, vans, lift-equipped vehicles and escorts to meet the needs of a wide segment of riders. The Wheels program provides 8,000 one-way trips per day. It handles only the Medicaid funded rides. Philadelphia also has a lottery funded senior citizen transportation program and a Section 504 program similar to Metro Mobility. Thus Philadelphia has three paratransit programs that are not coordinated or consolidated.

The Wheels office provides centralized dispatching for its 18 van company subcontractors, and pays them on an hourly rate. Most rides are group trips, with as many as eight people in the van at the same time en-route to the same medical facility.

In some cases, riders who could use a lesser form of transportation are grouped with individuals who need a lift-equipped van. Since these non-disabled individuals are going to the same destination, the shared ride is less costly than other forms of transportation. Wheels also groups riders who need an escort. Escorted trips are the most costly ones because Wheels provides the escort. These trips are limited to certain times during the day and to trips where the escort is required by more than one person on the vehicle.

The van companies who contract with Wheels are allowed to bid on the different levels of rides they wish to provide. This means they could bid on only ambulatory rides or both ambulatory and lift-equipped rides. Companies bid on both the level of service and the parts of the city (zones) they wish to cover. The centralized scheduling and the use of this zone approach allows coordination of rides to and from various sections of the city. The rider does not choose the company that will pick him up. Instead, Wheels assigns the vehicle. One company may provide the ride to the appointment with another company bringing the rider home. Wheels vehicles are tightly scheduled and are seldom able to respond to requests for transportation the same day as the call.

Wheels has held the Medicaid contract since 1983. In the beginning, it had to use a massive public information campaign to educate the medical facilities and the riders about how Wheels schedules rides and the kind of assistance Wheels drivers provide. The time between pick-up at the rider's home and drop-off at the appointment may be as much as 60 minutes. During this hour, the driver picks up other riders. Drivers take riders up to, but not through, the first door of the facility. Staff from the medical provider have to pick up the rider at the door of the building if the rider needs assistance getting to the correct office. Vehicles are in radio contact with a dispatcher who calls the medical provider if the rider hasn't been met at the door or is not waiting at the door when the vehicle appears for the return trip.

Wheels is responsible for determining the rider's functional eligibility for paratransit services. This decision is based on a physician's statement. Wheels also determines the type of vehicle the rider needs and whether he or she needs an escort. The escort is provided by the rider or facility in which the person lives if there are fewer than three riders. Wheels provides the escort if three or more people who need an escort are riding. In addition, Wheels carries out all the management and transportation responsibilities required by the contract with the state except for actual operation of the vehicles. Wheels completes the bills for services to the state Medicaid agency and provides reports to help the Department of Public Welfare analyze services. Wheels has staff members who handle complaints from riders and staff who handle public information about the program. Wheels has the trip data in its computer to bill the department for services and to estimate the future demand for services. By having a record of standing orders and trips in each zone, Wheels staff have been able to estimate and contract with a sufficient number of van companies. Companies bid on their per hour cost for the levels of service they are interested in providing.

Access

The Access program in Pittsburgh provides paratransit brokerage services to Allegheny County. Access coordinates for-profit and non-profit carriers to serve human service agency clients, individuals 60 years of age or older and people with mental or physical disabilities. Funding for the rides comes from a variety of sources including Title III and lottery monies. As in Philadelphia, Access is just one of three paratransit programs in the community. Its brokerage extends only to a portion of the total paratransit rides in the area.

Access contracts with van companies and taxi companies. The subcontractors are paid on a per hour basis except for the taxi services. As the broker, Access contacts with the providers, negotiates rates, sets vehicle and insurance requirements, and handles invoicing to funding sources. Unlike Philadelphia, the rides are scheduled by each carrier. Access is not a mandated broker. Human Service agencies may still operate their own transportation programs.

Access, like Wheels, takes riders only to the first door of the building. Unlike Wheels, riders may receive service the same day as the request on a space-available basis. Access also provides community outreach to educate medical facilities about its services.

Neither Pennsylvania program provided all the paratransit rides in the area. However, Wheels, with its centralized dispatch and fully grouped rides, provides a model for efficient delivery of paratransit rides to medical destinations. This model is very different in some ways from the approach currently used by Medical Assistance and Metro Mobility.

Keith Forestall, who worked with Access and now is part of Multisystems consulting firm, has helped a number of cities develop paratransit systems. Mr. Forestall observed that the model has to fit the location.

COORDINATION AND CONSOLIDATION APPROACH FOR THE TWIN CITIES

With the information provided by the models used in other states, the technical staff began to work on the conceptual design of an approach for the Twin Cities. Several questions had to be considered before developing a coordinated or consolidated approach for the Twin Cities.

1. Should consolidation be the first and only approach or should coordination be the only approach?

2. Which programs would be involved in either approach?

3. How and when would either approach be implemented?

Coordination or Consolidation

After reviewing the reasons for coordination or consolidation, this information suggested looking at a coordination or consolidation approach of the Medical Assistance and Metro Mobility rides in the metro area that would achieve the following goals:

1. To achieve the most cost effective use of state and federal funds, and

2. To provide quality, reliable transportation services.

Reviewing these goals lead to the conclusion that one approach would not be sufficient. The recommended approach suggests establishing a coordination phase that will enable the two programs to move toward consolidation through a phasing method. Promoting coordination in this manner allows the two agencies to collect information that will be necessary in the consolidation phase. Having consolidation as the last step allows time to develop a comprehensive implementation plan. The plan would determine the feasibility and ramifications of consolidating Metro Mobility and Medical Assistance transportation. The plan would address the administrative and service changes needed to make consolidation successful and in terms of service efficiency.

Coordination/Consolidation of Transportation Services

One of the major decisions is which programs should be coordinated and consolidated. Appendix D has a description of the paratransit programs funded in the metro area. The coordination/consolidation approach would encompass the Metro Mobility program, the majority of the Medical Assistance rides and some medical taxi rides now administered by county human service agencies as part of Medical Assistance common carrier transportation. Medical Assistance special transportation rides now provided by small social service agencies would be excluded. These agencies serve special populations that may need language interpreters or other special services. Many of these agencies also provide Title III transportation and blend the Title III funds with Medical Assistance reimbursement to support volunteer driver programs. These agencies together provide fewer than 5,000 rides per year.

The other programs on the funding source table do not lend themselves to coordination with the Metro Mobility program and Medical Assistance transportation services, because of funding and eligibility criteria. Transportation services related to day training and habilitation (DT&H) services, was considered; however, DT&H service vendors are responsible for arranging or providing transportation services as they are necessary for authorized DT&H services. Payment rates approved by the commissioner include the costs of transporting clients to and from their homes during the day as a part of service delivery. This allows federal financial participation for the costs when the client lives in an Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR) or receives DT&H as a "waivered" service. Some group rides to and from DT&H services are provided by Metro Mobility and the cost is paid to DT&H vendors as an average transportation rate. Since Metro Mobility began charging DT&H vendors the total unsubsidized cost for these rides, the metro counties holding contracts with these DT&H vendors have required the vendors to choose more cost-effective alternatives. There are incentives in statutes for the counties to do this. Those alternatives include using the vendor's own vehicles and contracting with transportation providers. Future changes in the DT&H payment rate structure will further roll the cost of transportation into the overall cost of program services. This transportation cost will then be reimbursed as part of one of four hourly service rates. This type of rate structure would make any type of individual per trip reimbursement difficult and undesirable.

The Coordination Approach

The coordination phase is defined as a cooperative arrangement between DHS and the RTB that would allow the MMAC to perform the administrative functions of eligibility certification for Medical Assistance recipients and customer service for Medical Assistance riders. During the coordination phase, both programs would use the same criteria and processes to determine eligibility for paratransit services. The RTB will be

developing new eligibility criteria in conjunction with the federal Americans with Disabilities Act (ADA) regulations published earlier this year. Applying these criteria may involve a functional test administered by rehabilitation specialists. Having this function coordinated will enable the recipients to obtain only one certification, which will be valid for both programs. Providers would not have to obtain physician statements for recipients who had been determined eligible by the MMAC. An additional benefit would be the data collected about the level of service required by recipients. Levels of service include ambulatory rides, lift-equipped vehicle rides and escorted rides.

The coordination of customer service functions under the MMAC suggests a system of corrective action for rider complaints and would assist riders with provider and service information. This function is in operation at the MMAC.

Consolidation Approach

The consolidation approach will develop an efficient, cost-effective transportation service that combines the administrative and operational responsibilities for providing this service under one organization. The following decisions must be made as part of the implementation plan:

1. Should calls for service be centralized within the MMAC?
2. How should providers be paid?
3. What levels of service should be offered?
4. How should the need for an escort be handled and who supplies the escort?
5. How many providers does the consolidated system need?
6. Should the zone approach be used and if so how should the zones be defined?
7. Should providers bid for contracts based on the level of service they wish to provide?
8. What kind of computer is required to handle the calls and invoices?

The Paratransit Advisory Committee is recommending that a transportation consultant be hired to work with the staff of DHS and the RTB to develop a plan that addresse the issues mentioned above and determine if consolidation of any extent is possible. The consultant would assist in determining many of the details required to implement a consolidated program. The consultant would identify budget requirements, develop a competitive bid proposal for selecting providers and identify the cost savings and benefits for implementing such a program.

The recommendations from the consultant study would guide the two programs into a successful implementation process. At that point, the transition from current eligibility to the new ADA-mandated eligibility criteria will be underway. Medical Assistance contracts with prepaid health plans will have been implemented in Dakota, Hennepin

and Ramsey counties allowing elderly recipients covered by those plans to fall out of the fee-for-service population to be consolidated. Medical Assistance and Metro Mobility providers would have time to plan for the future and determine how they want to face the changing market.

Implementation and Timeframe

Coordination and consolidation will be phased in. Staff estimates that Phase I implementation would take approximately one year with the consultant study coinciding with the coordination phase. During 1994 the consolidation phase will be implemented.

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PHASE II		
Implementation of Coordinated Approach	DHS and RTB	January 1, 1993
Consolidation Plan to 1993 Legislature	Consultant	February 1, 1993
PHASE III	**CONDUCTED BY**	**DATES**
Implementation of consolidation plan	DHS and RTB	July 1, 1994

The technical staff presented the committee with this approach for the Twin Cities at its November 20, 1991 meeting. On December 3, 1991 it was presented to organizations that would be affected by this coordination and consolidation approach. Cost estimates were not yet available for these two presentations.

CONSULTATION GROUP REACTION TO THE MODEL

The legislation that established the Paratransit Advisory Committee required the committee to consult affected persons and organizations not represented on the committee. On December 3, 1991 technical staff and members of the Paratransit Advisory Committee discussed the proposed model with representatives of organizations that would be affected by coordination and consolidation. The weather prevented several of the major organizations from attending. However, DT&H provider organizations were represented at this consultation group meeting as were representatives of the special transportation providers. Representatives from the nursing home and ICF/MR associations were not represented at the meeting but were invited to the Paratransit Advisory Committee meeting on December 18, 1991 and also received the first draft of this report.

The following issues were raised during the discussion with the consultation group participants.

A. Coordination Issues

1. Providers responded favorably to coordinating functional eligibility. However, the providers asked how they could identify riders who had met the functional eligibility criteria. The options could be: a phone call to the MMAC, a computer hook-up with the center, or a call to the DHS electronic voice response system that will be implemented in 1993.

2. Providers expressed concern now about a smooth transition from the functional eligibility systems in place for both programs. Perhaps Medical Assistance physician's statements could be passed to the MMAC as an initial data base for Medical Assistance recipients who could possible be eligible for Metro Mobility.

3. A participant raised concerns regarding the data privacy implications of exchanging information on recipients between the two programs. This concern will require additional research.

4. Participants asked how much the coordination phase would cost. Would DHS and the RTB share the cost of administering the new functional eligibility criteria and process, as well as the cost of the consultant?

5. Providers asked whether some rides could be grouped now to save money so that the Medical Assistance rate could be increased. Providers were concerned that some Medical Assistance providers would go out of business soon and not exist at the time of consolidation.

B. Consolidation Issues

1. How will quality be maintained if Medical Assistance and Metro Mobility rides are consolidated? Currently Medical Assistance recipients are free to choose their provider and will change companies if they don't like the service. In a consolidated approach, where one company may handle a geographic area, the system must be monitored for quality because the freedom to choose a different provider is removed.

2. If rides are consolidated, recipients may no longer be able to use providers they know and who respond to their individual needs. Currently, these providers may shovel snow to clear a path to the door or send the same driver every time to reassure a hesitant rider.

3. DHS and the RTB would have to educate the medical community on coordinating medical appointments so that riders can be grouped for trips. Nursing homes and medical facilities would also have to have the rider dressed and waiting at the door for the ride.

4. The marketplace would dramatically change for Medical Assistance providers. Those who do not want to be, or are not chosen as Mobility providers, will have little business. One of the activities during the planning phase is to determine how many providers would be required to operate the system. Even if all the current Medical Assistance-only providers wanted to be part of the consolidated system, all of them might not be needed.

COST OF COORDINATION AND CONSOLIDATION

The following are the costs associated with each phase of the coordination and consolidation approach.

PHASE I	ESTIMATED COST
Consultant contract	$100,000
PHASE II	
Functional eligibility determination for Medical Assistance riders who are not Metro Mobility riders	$400,000 state funds $400,000 federal funds
PHASE III	
Consolidation	To be determined with assistance from consultant study

Both the RTB and DHS are developing a joint budget request for the 1992 legislative session to cover the costs of Phases 1 and 2.

The costs associated with the consolidation phase cannot be estimated until the detailed implementation plan has been developed.

COMMITTEE RECOMMENDATIONS

At its December 18, 1991 meeting, the Paratransit Advisory Committee made the following recommendations:

1. Immediately coordinate DHS and the RTB certification of functional eligibility. In addition, coordinate complaints and quality issues, to the degree possible. The MMAC will administer these functions.

2. Fund a consultant to bring together DHS and the RTB to develop an implementation plan. The plan will determine if consolidation is possible given the paratransit resources and constraints in the metro area. The consultant will develop a plan that maximizes resources and services in the largest market. The consultant will make recommendations on how to accommodate all levels of need for service and how to reimburse the subcontracting van companies using a competitive market approach. The consultant will assist the two agencies in developing strategies to educate the medical, special transportation provider and paratransit consumer communities.

3. Fund resources within DHS and the RTB to work with the consultant.

4. Designate the RTB as the paratransit entity in the consolidation model to manage the transportation needs of Medical Assistance transportation and Metro Mobility rides.

5. Include in the consolidation plan Metro Mobility rides and most Medical Assistance special transportation rides. Exclude certain publicly funded reimbursable trips such as the Title III program and the Medical Assistance special transportation trips provided by small non-profit social service agencies. These agencies often participate in these other excluded programs and collectively provide less than 5,000 rides per year.

6. Adopt the proposed timeline for coordination, the consultant plan and consolidation.

CONCLUSION

The purpose of this study was to determine the feasibility of consolidation and coordination of the Metro Mobility program and DHS Medical Assistance transportation services in the metropolitan area. Study findings indicated that between the Metro Mobility and Medical Assistance programs, there is a definite duplication of efforts of trips provided, providers and riders. Both programs are experiencing increased cost in providing transportation services and decreasing state and federal funding. These indicators signal a need to examine different approaches in service delivery, funding alternatives and cost-effective service provision.

In addition to these indicators, the ADA has implications for change in paratransit services. The rules and regulations under this new law have provided a framework and requirements in which paratransit services operate. The RTB envisions that Metro Mobility will become part of a coordinated, accessible, regional transit system that will meet all ADA requirements. New eligibility and certification procedures that are consistent with ADA will identify the potential users of a transportation service based upon functional ability. Redefining Metro Mobility will bring substantial benefits for persons with disabilities by expanding and enhancing paratransit services.

Medical Assistance transportation services across the country are moving to combine services with existing paratransit providers. Special transportation has become so expensive that many states are looking for approaches that can save Medicaid dollars while ensuring that recipients continue to receive services. Other states have chosen to fund transportation as an administrative option so they can contract with a selective number of cost-effective providers.

Efforts to coordinate or consolidate are not new and many cities are developing their versions of this concept. In the Twin Cities, the state needs to begin developing a system that will merge the two programs and provide the efficiency and quality service necessary. Coordinating the Metro Mobility eligibility and customer service functions into the Medical Assistance process is the first step. This coordination occurs at a good time because of the redefinition of Metro Mobility functional eligibility to meet the

requirements of ADA. Coordination also will assist the two agencies in collecting data on Metro Mobility riders who are also Medical Assistance recipients, as well as evaluate trip patterns and service needs of Medical Assistance clients. It will enable DHS and the RTB to develop procedures that will incorporate both functional and financial eligibility required under Medical Assistance. During this approach, DHS and the RTB can determine the total number of Medical Assistance riders, the estimated cost and prepare the implementation plan. The consolidation approach will be defined with the assistance of a consultant. The recommendations from the consultant's reports will define and detail the implementation of consolidation in the metro area.

APPENDIX

COMPARISON BETWEEN MEDICAL ASSISTANCE AND METRO MOBILITY

	Medical Assistance	Metro Mobility
Number of Riders	15,400 in calendar year 1990	19,800 (1991)
Number of Trips	380,228	1,516,500[1] (1990)
Average Length of Ride	8 miles	6.5 miles
Total Cost	$8,790,000[2] (federal and state funding)	$14.7 million[3] (1990) state funding
Average Payment Per Provider Total Cost Subsidy Per Trip	$20.50 per trip (1991)	$8.65 per trip (1990)
Average Payment Per Provider Percentage Wheel Chair Riders	Unknown	27.4% (1990)
Percentage Ambulatory Riders	Unknown	72.6% (1990)
Source of Funds for program (percentage):		
• Federal Funds	53%	
• State Funds	47%	89.6%
• Farebox Recovery		10.4%
Number of providers in metro area	50 (Number of providers that are Medical Assistance and Metro Mobility-10)	13
Financial Eligibility for Service	Eligible for Medical Assistance, or if live in an Institute for Mental Diseases can be GAMC eligible	None-Metro
Functional Eligibility for Service	Recipient must have a physician's statement verifying a mental or physical impairment that prevents him from taking a bus or taxi	Completed application by applicant and applicant's health care provider
Responsibility for Physician's Statement	The provider has to obtain the physician's statement and keep it in its files.	MMAC has on file
Destination of Ride	To or from a covered Medical Assistance service	No trip purpose

1 Less day training and habilitation trips an estimated 40,000 trips per month.

2 Does not include day training and habilitation dollars and HMO premiums.

3 Does not include fares and day training and habilitation revenues. Administrative cost ($762,989) is included in this total cost.

COMPARISON BETWEEN MEDICAL ASSISTANCE
AND METRO MOBILITY

	Medical Assistance	Metro Mobility
Criteria for Enrollment of Providers	Certified by Department of Transportation as a special transportation provider or has waiver of certification. A wheelchair lift van is not required.	Enrollment is restricted to contract period-providers must comply with terms of the contract and must be certified by the Department of Transportation as a special transportation.
Rate Paid for Service	$12.50 base & $1.00 mile for both ambulatory and wheel chair bound riders effective 7/1/91	**Individual Trips:** Area I / Area II Ambulatory $ 6.00 / $ 7.25 Wheelchair 16.75 / 18.50 **Volume Trips:** Ambulatory $ 3.50 Wheelchair 8.50
Rate Setting Methodology	Rate set by legislature. Originally set at a percentage of usual and customary rate for providers.	Rate set by RTB board based on legislative appropriation.
Door through Door	Provides as much passenger assistance as recipient needs.	Required
Complaints Handled by	Surveillance Utilization Review (SURS) if they are serious complaints or by program staff. Usually told to select another provider. Few complaints.	Complaints handled by Metro Mobility Administrative Center and providers
Provider Claims Processing	Claims submitted to DHS by providers on paper invoice or tape.	Trip vouchers are submitted to Metro Mobility Administrative Center for verification.
Fare Paid by Rider	None	$2 trip less than 8 miles; $3.50/trip length 8 or more miles (7/6/91)
Method for Booking Ride	Calls any enrolled provider	Calls provider in geographical region
Time frame for Booking Ride	Can book ride several days or weeks ahead or the same day as ride.	One day advanced call in
Application Fee	None	$10, plus $10 annual fee

prepared by the Regional Transit Board
November 1991

Administrative Center
560-6th Avenue North
Minneapolis, Minnesota 55411-4398
612-349-7480

TO THE METRO MOBILITY APPLICANT:

Metro Mobility is a subsidized door-through-door transportation service for eligible persons with disabilities. Persons must be certified by the Metro Mobility Administrative Center in order to use Metro Mobility service.

To be eligible for Metro Mobility, a person must meet at least one of the six Metro Mobility eligibility criteria. The six eligibility criteria are listed in the Medical Verification section (page 4) of this form. A medical professional, familiar with the person's disability, indicates whether or not the person is eligible for Metro Mobility by completing the Medical Verification section.

Please note that eligibility is based upon disability. The availability of regular route bus service is not a consideration in determining eligibility for Metro Mobility.

To apply for Metro Mobility certification, please fill out the enclosed Certification Form and have the Medical Verification section on page 4 completed and signed by your medical professional. Mail the completed Certification Form with a $10 certification fee (check or money order payable to Metro Mobility) to:

Metro Mobility Administrative Center
560 - 6th Avenue North
Minneapolis, MN 55411-4398

It will take approximately 2 to 4 weeks to process your application. Once you are certified, you g2 will receive an identification card, a Rider's Guide, and a list of transportation providers for your area with instructions for arranging rides.

If you have any questions regarding the completion of this form, please call the Metro Mobility Administrative Center at 349-7480.

FAILURE TO ANSWER ALL QUESTIONS WILL DELAY PROCESSING YOUR APPLICATION. PHOTOCOPIED FORMS WILL NOT BE ACCEPTED.

TO THE MEDICAL PROFESSIONAL:

Please complete the Medical Verification section on page 4 in its entirety. This information will be used to determine the applicant's (named on page 2) eligibility for Metro Mobility. Failure to provide this information may prohibit the applicant from becoming certified for Metro Mobility services.

Thank you for your cooperation.

Metro Mobility Administrative Center

METRO MOBILITY CERTIFICATION FORM

Remember to include your check or money order for $10, payable to Metro Mobility. Return to: Metro Mobility Administrative Center, 560-6th Avenue North, Minneapolis, MN 55411-4398

Office Use Only
Certification #_____
Disability Code_____
Zone_____

PLEASE TYPE OR PRINT CLEARLY

1. Name _____
first middle last

2. Address _____
street number street name city/suburb state

3. _____ 4._____ 5._____ 6. Telephone _____ / _____
zip code apt. no. medical assistance no. home work

7. Does your weight, size or wheelchair pose any special considerations? Yes_____ No_____

If yes please explain: _____

8. Sex: Female_____ Male_____ 9. Date of Birth: _____
month day year

10. In case of emergency, please notify (name): _____

Emergency contact home phone: _____ work phone: _____

11. Is this the first time applying for Metro Mobility? Yes_____ No_____

12. Please explain how your disability prohibits you from use of regular route bus service:

_____

_____

13. Are you in need of an escort/attendant when traveling? (You may bring one guest even if you do not need an escort.)

Yes _____ No_____ If yes, please explain: _____

_____

Some persons may be issued certification that requires them to be accompanied by an escort when traveling on Metro Mobility. Escorts are not provided by Metro Mobility.

Office Use Only

☐ Code_____ ☐ Post_____ ☐ Label_____ Check Number_____
☐ Number_____ ☐ Zone_____ ☐ Card_____ Standing Order _____
☐ Book_____ ☐ Enter_____ ☐ File_____

14. Do you use a wheelchair when you travel? Yes _____ No_____ If yes, are you able to propel your own wheelchair independently? Yes _____ No_____ transfer to an auto? Yes _____ No_____

15. Are you able to enter a van or bus without the use of a ramp or lift? Yes _____ No_____

16. Do you require a raised/high door van? Yes_____ No_____

17. I use the following equipment when I travel outdoors:

_____ None	_____ Crutch(es)	_____ Walker
_____ Wheelchair, Manual	_____ Artificial Limb	_____ Guide Dog
_____ Wheelchair, Powered	_____ Portable Oxygen Tank	_____ Other (describe) _____
_____ Brace(s)	_____ Orthopedic Cane	_____
_____ 3-wheeled Power Mobility Device (Amigo, Lark)	_____ Hearing aids	_____
	_____ White Cane	

(Metro Mobility does not provide wheelchairs or any other mobility aids)

Please describe any special considerations (walk slowly, wide wheelchair):_____

_____

_____

18. What means of transportation do you currently use, other than Metro Mobility?_____

_____

I certify that all information on this application form is accurate. I understand that misinformation or misrepresentation of facts will be cause for disqualification or rejection of my application. I also understand that the Metro Mobility Administrative Center may contact my medical professional to clarify or obtain additional information required to determine my eligibility or unique service needs.

Is applicant able to sign Metro Mobility vouchers? Yes _____ No_____

_____ _____
Signature of Applicant (Signature required if applicant is able to sign) Date

_____ _____ _____
Signature of Preparer (If other than applicant) Relationship to applicant Date

The information contained on this form is private data and is used by the Metro Mobility Administrative Center (MMAC) to determine program eligibility and by the MMAC and contract carriers to provide you with appropriate Metro Mobility service. The MMAC's ability to supply you with program service will be restricted if all information requested on this form is not provided.

MEDICAL VERIFICATION

This section is to be completed by a physician, licensed psychologist, certified physical therapist, licensed chiropractor, or orientation and mobility specialist. All requested information must be provided. Your prompt response will allow an expedient determination of the applicant's eligibility for Metro Mobility service.

A. Please indicate whether or not the following conditions apply to the applicant:
(respond to as many of the six criteria as you can verify.)

Yes	No		
☐	☐	1.	A permanent physical functional mobility limitation that prevents a person from walking independently for a distance of 1,000 feet without the aid of an assistive device such as a walker, cane, crutches, braces, a prosthetic device, or a wheelchair, or from negotiating the steps of a standard transit device.
☐	☐	2.	A medically demonstrable condition that seriously impedes or prevents a person from walking a distance of 1,000 feet; or that affects coordination and stability to the extent that it presents a risk of falling.
☐	☐	3.	An arterial oxygen tension (P_AO_2) of less than 60 mm/hg in room air at rest.
☐	☐	4.	A cardiac condition that is therapeutically classified according to standards set by the American Heart Association in one of the following areas:
☐	☐		a. Class D: Persons with cardiac disease whose ordinary physical activity should be markedly restricted.
☐	☐		b. Class E: Persons with cardiac disease who should be at complete rest, confined to bed or chair.
☐	☐	5.	A sensory impairment(s) that prevents the applicant from independently using regular route bus service. That is, the impairment prevents the applicant from using regular route service for **all** his/her travel needs.
☐	☐	6.	A mental functional limitation that prevents the applicant from independently using regular route bus service. That is, the impairment prevents the applicant from using regular route service for **all** his/her travel needs.

B. Please describe the applicant's disability as indicated above and how the disability affects the applicant's ability to use regular route bus service:

_____

_____

_____

C. Is applicant: Vision Impaired _____ Hearing Impaired _____ Mentally Disabled _____

D. If any of the criteria in Section A (above) apply to the applicant **only** during typical winter weather, please identify the specific criterion: _____

E. What is the expected duration of the applicant's condition(s) that is identified in Section A? (Be as specific as you can; this information is used to establish length of eligibility). _____

F. The applicant is able to:

	Yes	No
1. Travel from a protected setting to a protected setting without an escort/attendant	_____	_____
2. Comprehend and follow instructions	_____	_____
3. Communicate travel needs	_____	_____
4. Comprehend time of day for travel purposes	_____	_____

NOTE TO THE MEDICAL PROFESSIONAL: A **NO** response to item F.1 means that the applicant will require an individual (other than the driver) to escort the applicant when using Metro Mobility.

G. Please describe any behavioral problems which prevents the applicant's ability to travel independently:

_____

H. Date that applicant was last examined by you: _____

I certify that I have medical information to document the above statements and will provide such documentation at the request of the Metro Mobility Administrative Center.

_____ _____
Signature of Medical Professional Print or Type Name of Medical Professional

_____ _____ _____
Profession MN License No. Office Address

_____ _____ _____ _____ _____
Date Telephone Number City State Zip Code

Physician's Certification of Need For Special Medical Transportation

Special medical transportation is the transport of a MA/GAMC recipient with special needs to and from MA/GAMC covered services. In order to be certified for special medical transportation the recipient must be so mentally or physically impaired as to be UNABLE to use a bus, taxi, other commercial transportation or private automobile. The recipients who require life support (ambulance) transportation do not qualify for special transportation.

MA/GAMC recipients with special needs who require special medical transportation must be certified by a physician (M.D.) who is familiar with their level of impairment.

The special medical transportation provider must send or give this form to the appropriate physician. If the physician certifies the patient to be in need of Special Medical Transportation, the physician will return the form to the Special Medical Transportation provider identified on the form. The Special Medical Transportation provider must keep this certification form on file for all Medical Assistance and General Assistance Medical care recipients transported to and from medical care.

To Be Completed By Special Medical Transportation Provider: **(Physician will return signed form to this address)**

Special Medical Transportation Provider:		Telephone #: ( )
Street Address:		
City:	State:	ZIP Code:
Recipient's Name:		MA/GAMC ID#:
Street Address:		
City:	State:	ZIP Code:

To Be Completed By Physician:

1. Why is this patient incapable of using public transportation or private automobile to get to medical appointments?

   _____

2. Is this patient confined to a wheelchair? ❑ Yes ❑ No

3. Does this patient have a mobility impairment or limitation? ❑ Yes ❑ No
   If yes, diagnosis/symptoms which cause this impairment or limitation _____

4. Does this patient have mental illness or serious developmental disabilities which would prevent the use of public transportation or private automobile? ❑ Yes ❑ No
   If yes, diagnosis/symptoms which cause this impairment or limitation _____

5. Expect duration of disability to be (days, months, years or permanent) _____

NOTE: Certification expires when recipient no longer has a mobility impairment, unless disability is permanent.

I certify that I have current knowledge of this patient's mental or physical condition and limitations and this patient is incapable (due to mental or physical disabilities) of using public transportation or private automobile to get to and from medical care.

Physician's Signature:	Date:	
Type or Print Physician's Name:	Telephone Number: ( )	DHS-2910 (1-91) PZ-02910-02

PARATRANSIT ADVISORY COMMITTEE MEMBERS

Bruce Nawrocki
Metropolitan Transit Commission
1255 Polk Place
Columbia Heights, MN 55421
MTC Representative

Harlan Dahl
HealthEast MedKab
2900 Pleasant Avenue South
Minneapolis, MN 55408
Metro Mobility Provider Representative

Jerry Hayes
5560 Shore Road
Excelsior, MN 55331
Council of Disabilities Representative

David Jordal
Health One - Active Ride
167 Grand Avenue
St. Paul, MN 55102-2398
For-profit Providers Representative

Bette Undis
American Red Cross
100 South Robert Street
St. Paul, MN 55107
Non-profit Providers Representative

Donna Allan
MN Department of Transportation
815 Transportation Building
St. Paul, MN 55155
MN DOT Representative

Doris Caranicas
2425 East Franklin Avenue
Minneapolis, MN 55406
RTB Representative

Bonita Featherstone
908 Woodlawn Court
Burnsville, MN 55337
Metropolitan Council Representative

Morgan Grant
114 Fifth Street SE #301
Minneapolis, MN 55414
Consumer Representative

Patricia MacTaggart, Asst. Director
Department of Human Services
Health Care Management
444 Lafayette Road
St. Paul, MN 55155-3852
DHS Representative

Michael Ehrlichmann
Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, MN 55101
RTB Representative

Mary Kennedy, Director
Health Care Management Division
444 Lafayette Road
St. Paul, MN 55155-3848
DHS Representative

Bernard Skrebes
544 - 23rd Avenue NW
New Brighton, MN 55112
Senior Representative

Sue Warner
Abbott Northwestern Hospital
800 East 28th Street
Minneapolis, MN 55407
Consumer Representative

TECHNICAL STAFF PARTICIPANTS

Ed Kouneski
Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, MN 55101

Mary Fitzgerald
Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, MN 55101

Judith Hollander
Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, MN 55101

Cynthia Curry
Regional Transit Board
Mears Park Centre
230 East Fifth Street
St. Paul, MN 55101

Mary O'Hara Anderson
1920 Marshall Avenue, #203
St. Paul, MN 55104

Christopher Gran
Metro Mobility Administrative Center
570 Sixth Avenue North
Minneapolis, MN 55411-4398

Lyle Frerichs
Metro Mobility Administrative Center
570 Sixth Avenue North
Minneapolis, MN 55411-4398

Lisa Rotegard
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3852

Cyndie Mayer
MN Department of Transportatioin
Office of Transit
815 Transportation Building
St. Paul, MN 55155

Anne Shotton
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3852

Kathleen Cota
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3853

Linda Hennessey
Metropolitan Council
Human Services Department
230 East 5th Street
St. Paul, MN 55101

Susan Lapakko
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3852

1990 FUNDING SOURCES FOR TRANSPORTATION

Source of Funds	Eligibility Requirements	# Served	Amount Spent
Medical Assistance (MA)	Eligible for MA or GAMC while living in an IMD. Rides must be to or from a covered MA service. Must be unable to use bus or taxi.	15,400 riders 380,208 one-way trips	$8.79 million 53% federal 47% state
Medical Assistance (MA) Day Training & Habilitation (DT&H)	Lives in an ICF-MR or part of MA waiver. Rides must be to or from DT&H program.		 $5,640,694
Medical Assistance (MA) Common Carrier Reimbursements	Eligible for MA or GAMC Reimbursement for bus or taxi fares, parking, mileage expenses incurred for travel to a medical service.	unknown	$458,000 50% federal 50% state
Title III-Older Americans Act (federal) Metro Area Agency	Age 60+ "free and voluntary opportunity to contribute" - senior transportation rides are "general purpose", including doctor's visit and other medical purposes, social activities and congregate dining, grocery shopping and other needs.	9,039 147,541 one-way trips	$860,839 $403,755 (federal)
State & (General Funding Assistance) Exurban (special property tax outside transit taxing-state)	County/rural (population less than 2,500) special transportation services (for elderly & disabled persons).	239,807 annual ridership	$1,386,136 (state assistance) $399,412 (exurban) RTB share-65%
State Assistance (General Funding)	Determine by medical verification of applicant's condition and disability.	1,516,500 annual ridership	$14.7 million* does not include $679,018-DAC revenue
Section 18 (Federal)	Formula grant program for small urban and rural areas (under 50,000 population).		$1.5 million* (statewide) $594,312 (metro)
Section 16 (b) 2 (Federal)	Capital assistance program for private non-profit organizations to serve elderly and/or disabled people.	110 vehicles* (metro) 166 vehicles (Greater MN)	$278,118 $626,007*

*statewide

November 1991-Regional Transit Board

WHEELS, INC.

AN URBAN BROKERAGE MEETS THE CHALLENGES IN PHILADELPHIA

BACKGROUND

WHEELS, Inc. was selected in 1983 to manage Medical Assistance (MA)-funded transportation in the entire City and County of Philadelphia. The award resulted from a competitive procurement by the Pennsylvania Department of Public Welfare (DPW).

Statewide, the problems were severe. Transportation costs for MA clients were escalating yearly, and DPW had no organized means for controlling the level or nature of those costs. The State had no data to support problem analysis; it could neither identify transportation suppliers, nor control trip volumes. It was impossible to forecast, or to respond to complaints of poor service.

The first challenge to WHEELS was posed by the size of the program in Philadelphia, the fourth largest city in the United States. DPW estimated in 1983 that more than 400,000 persons were MA clients, including about 73,000 who were eligible for MA transportation. In 1983, 17 private carriers provided tens of thousands of MA paratransit trips as a major component of their operations each year. The annual DPW budget for Philadelphia MA transportation was approximately $6 million. Neither WHEELS, nor any other Pennsylvania transportation agency, had ever attempted to manage specialized transportation at this level or magnitude.

The second challenge to WHEELS lay in responding to DPW's requirements and needs. As the agent of DPW, WHEELS was mandated to carry out the Department's regulations covering client eligibility, trip-purpose eligibility, acceptable modes of passenger transportation, eligibility of costs for reimbursement, billing, record-keeping, reporting, and requirements for State approvals.

DPW's 1983 regulations prescribed methods for each county to use to conduct its work, but did not impose detailed operating plans. **And therein lay the third major challenge to WHEELS in 1983 - to design plans for managing and delivering transportation, and realizing those designs in practice.**

WHEELS' challenge was to:

- Implement an automated system to ensure delivery of services, while producing records and management reports needed by DPW;
- Respond to rapid changes in policy regarding client eligibility, client load, and temporary reductions in service volume, in addition to the day-to-day challenges; and
- Contain costs.

BEST PRACTICES: CENTRALIZED MANAGEMENT

WHEELS brought to the task decades of urban-area experience - experience with advance-reservation, door-to-door, driver-assisted transportation, scheduling, client registration, and management of client records. WHEELS also had experience handling fleets and drivers; experience with procurement and management of the services of private carriers; experience with meeting program sponsors' requirements; and experience with budgeting and financial management.

Centralization is the Key

WHEELS manages Medical Assistance transportation in Philadelphia under a concept of centralization used successfully in other programs. **Simply stated, WHEELS itself carries out all of the management and transportation responsibilities, except for on-street delivery of service.** On-street paratransit service is, however, scheduled by WHEELS for delivery by paratransit operators who are strictly regulated by their contract with WHEELS. Fare-paid service is available through Philadelphia's dense public transit and taxicab systems. Private automobile usage is at a bare minimum.

Control of activity leads to control of program

Source: U.S. Department of Transportation
U.S. Department of Health Services
Best Practices in Specialized and Human Services. Transportation Coordination-July 1989

expenses - including the formerly uncontrolled transportation expenses. WHEELS, the transportation broker, holds a contract with DPW under which it is reimbursed for all program expenses. The contract limit is supported by a detailed budget of estimated expenses. DPW interacts with WHEELS' executives and approves all carrier contracts before execution by WHEELS. The transportation broker prepares all reports and the comprehensive records needed to document operations and to verify client participation.

The transportation broker affords the program a single, central source of reference assistance, direction, and accountability. WHEELS is organized along functional lines. Line staff members report to one of four managers - fiscal, data, operations, or transportation (see Exhibit A for chart and descriptions of responsibilities).

The system currently employs a staff of about 45 persons. Paratransit services are performed by 14 carriers. WHEELS supplements formal agreements with management meetings, both internal and external, and written communications. The organization's executives and managers are in direct contact, as appropriate, with state and local DPW personnel, medical service providers, contracted carriers, clients, and its own staff. WHEELS is guided by a volunteer Board of Directors and an Advisory Board which includes consumers. This working relationship expands the network and input needed by WHEELS' management.

Automating for Centralized Transportation Management

WHEELS guided the creation of a unique computer system, producing an electronic tool which allows the broker to effectively manage client demand, supply, and cost control. Solution Systems, Inc. (SSI), designed the extremely "user-friendly" network. Like the spokes of a wheel, the system's 26 terminals located in the broker's offices are linked electronically with SSI equipment at SSI offices. Employees who use the system have access to printers which enable them to produce reports, schedules, analyses, and mailing lists (Exhibit B).

The system is extensive and comprehensive. The data base encompasses:

- Client identification;
- Trip information;
- Service schedules (stratified by carrier, vehicle, time , date, and client/service classifications);
- Fleet information;
- Driver information; and
- Rates and conditions of service.

Centralized Management of Client Demand

WHEELS cannot unilaterally control the volume of users or trips in the MA Transportation Program (MATP). Neither can it dictate trip location nor frequency. Each of these is a function of the DPW.

The prime contractor's approach is to use a centralized client registration process to maintain client information, to verify client status, to examine the validity of each trip request, to organize trip requests for scheduling, and to estimate trip volumes and the supply needed.

In practice, a series of steps puts WHEELS' principles into effect:

1. Centralized, documented and uniform registration of individual clients. The County Assistance Office decides which individuals receiving medical assistance are also eligible for MA transportation. However, the individual is not part of the transportation system, nor supplied any trips until a transportation registration is completed, submitted to WHEELS, accepted by it as valid, and recorded in the computerized system.

2. Centralized, documented and uniform acceptance of trip requests. A registered client (or a DPW medical service acting for a registered client) must ask WHEELS to supply a paratransit trip. The client cannot place a request with a carrier, with a DPW office, or with another party. WHEELS' centralization makes it easy for a trip requester: a single phone call or written request results in a trip being supplied. When appropriate, a standing order is filled, again based on a single request.

3. Centralized, documented and uniform reimbursement of non-paratransit client trips. WHEELS' registration process identifies clients who must travel by transit, taxicab or private automobile. Upon registration, each such client receives written and oral instructions on how to use modes and how to claim reimbursement. Each is supplied with forms to be used. At month's-end, each client submits the appropriate claim form. If verified by WHEELS, a check in the approved amount approved is issued to the client.

It is evident that WHEELS' registration records supply indicators of the volume of demand, as well as a basis for predicting amounts and kinds of trips which the broker must supply and manage. For transit users, reimbursement cannot exceed the cost of a monthly transit pass. Thus, it can be foreseen that the total for any one period can never exceed the dollar amount represented by the number of registered users, multiplied by the cost of a monthly transit pass. (In fact, most transit reimbursements are for amounts below the "cap".)

For paratransit, WHEELS' schedulers, assisted by computer programs, can use standing order registration data to produce a "template" of future service, which then predicts a daily forecast of the consumption of paratransit hours of service. These templates, plus WHEELS' experience, enable the prime contractor to contract for appropriate kinds and amounts of private-carrier paratransit service.

Centralized Management of the Supply of Paratransit Services

WHEELS' methods for managing MA paratransit services are consistent with its centralized approach. The organization designs the trips and distributes trip-delivery among contracted private carriers. No carrier acts unilaterally to provide an MATP trip in Philadelphia.

To obtain a citywide network of carriers, WHEELS conducts a competitive procurement. Those that win awards are the only carriers authorized to operate MATP service in Philadelphia. (For Fiscal Year 1989, DPW authorized several service centers to operate transportation for their eligible clients. Each center's operations are managed by WHEELS.) To obtain a citywide network to meet demand, each bidder names the preferred zones (five areas of the city defined by WHEELS). Each must accept trips in any zone, if assigned. Zonal assignments are awarded as "primary" or "secondary".

In managing supply, therefore, WHEELS first estimates its needs (the "demand"), and then puts into place a network sufficient to operate the trips (the "supply"). The control the organization achieves is fundamental to responsible management of the paratransit portion of the Philadelphia Medical Assistance Transportation Program.

Under the terms of the carrier contracts, WHEELS controls virtually every aspect of a carrier's MATP paratransit activity. The contract document, supplied with the request for proposal, describes the service and the distribution of activities. The carrier agrees to:

- Perform on the days and during the hours stated, throughout the service area.
- Provide specific assistance to passengers.
- Verify drivers' licenses and safety records.
- Have drivers complete specific training courses.
- Deploy and maintain vehicles which meet stated standards and pass inspection by WHEELS.
- Accept vehicle-by-vehicle daily schedules prepared by WHEELS and operate in accordance with those schedules.
- Report service results, using forms supplied by WHEELS (including drivers' logs following use in service).
- Maintain insurance at specified levels.
- Submit invoices to and accept reimburse - ment from WHEELS in accordance with rates established by the carrier's award.
- Meet with WHEELS' executives or their agents, as needed.

WHEELS receives per-vehicle-hour bids on six paratransit modes of service. Awards cite the rank

of each successful bid with respect to all bids received and in relation to the median rate of all bids considered.

Paratransit Cost Control : Some Techniques

In Philadelphia, purchase of transportation consumes at least 80 percent of all MATP costs. Within the purchase-of-transportation costs, 90 percent is consumed by paratransit services. The basic challenge to the prime contractor's management is evident: procure and deploy paratransit service at the lowest possible rates.

The array of accepted bids gives WHEELS one of its basic tools for centralized control of supply costs (e.g., assignment of the mode of service which produces the lowest cost per trip).

Modal Assignment/ Cost Strategy - WHEELS' subcontractors agree to reimbursement per vehicle hour per mode of service. WHEELS specifies the modal reimbursement rate for each vehicle's service each day, and shows the mode(s) assigned on the vehicle manifest. This practice supports a fundamental concept for containment of paratransit service costs: a day (tour) of split runs (cluster of trips) may, for example, have two runs to be reimbursed at mode five and one to be reimbursed at the costlier mode six. Hence the total reimbursement due for the tour is less than reimbursement for a full day of work at the costlier mode (see Exhibit C).

This practice results in another fiscal benefit. WHEELS' schedules specify that the vehicle used by the carrier on a given day must accommodate the needs defined by the mode assigned. If the carrier chooses to deploy a type of vehicle which costs more to operate than another which could equally well accommodate the mode, the rate of reimbursement is unaffected. If, for example, the carrier chooses to use a passenger van to accommodate loading which would be suitable for a sedan, the rate of reimbursement is geared to the sedan loading capacity, as specified by the mode assigned on the schedule.

Computer-Assisted Scheduling - It is evident that a computer is essential to manage the intricacies of scheduling and recordkeeping. WHEELS' sophisticated computer system enables a corps of four or five planners to accomplish the massive volume of daily scheduling of 4,500 paratransit trips.

The scheduling routines are organized by the computer to present a list of the requested trips by the time and zone. The planner has a logical basis from which to proceed. The computer fields of data include all the information pertinent to each individual trip. In addition to the obvious identifiers of client by MA number, times and addresses, the data include a unique reservation number, locator codes, zonal carrier codes, modal assignment, indicators of special needs, and other trip information.

WHEELS' internal procedures guide the planner with the sequence of steps in arranging the list of requests into vehicle tours. The planner has the opportunity to refine each tour until maximum productivity is achieved.

After several review stages, all of which can be conducted through viewing at the computer terminal, the vehicle manifests for each tour are printed. Enough manifests are produced to provide "hard copies" for both the carriers and WHEELS.

The computer processes also enable the planners to respond to circumstances which can change a preplanned tour, and to quickly construct new basic tours when standing orders expire. These and all the other possible variations which occur in "real life" can be handled with ease through the computerized system.

RESULTS

In 1983, WHEELS set out to remedy some serious problems plaguing the Philadelphia Medical Assistance Transportation Program. DPW had diagnosed the problems and prescribed local management as a solution, replacing the state-administered system.

WHEELS translated the prescription into a viable, cohesive program. Under WHEELS' management, DPW has assurance that all eligible trips are provided, and that operating methods contain costs. Not only does DPW have assurance, but the Department also has access to comprehensive files available for verification, auditing, and planning.

DPW trip costs were as high as $21.00 per trip - but WHEELS, in Fiscal Year 1989 anticipates a system cost of $5.59 per trip. WHEELS brought its management into the age of high technology by acquiring state-of-the-art computerized processes to support recording and management of each step.

CONCEPT TRANSFERABILITY

Organization and Management

WHEELS is structured to respond to the needs

of its client, DPW. Urban human services bureaucracies characteristically have unmanageable case loads; the procedures are often cumbersome, and more than likely, they are understaffed. Welfare departments must frequently respond to court orders, political pressures, and to emergencies requiring immediate relief of human suffering. The urban social and political environments usually do not tolerate inefficient contractors who make too many mistakes.

WHEELS is structured to ultimately ensure:

- Safe and cost-effective transportation to clients;
- Program planning, both long-term and short-term, thus allowing for flexible response;
- Monitoring, cost containment, and quality control; and
- Data management and coordination with the client, the carriers, and with the key constituents through the Board and Advisory Committee.

Quality Control

The service monitoring and evaluation function is critical to risk management, cost containment and WHEELS' quality standards.

- Trouble-shooters in the Operations Department monitor the paratransit providers daily. They receive reports of service difficulties, have authority to reassign trips, and directly instruct carriers.
- Inspectors review drivers' and dispatchers' performance, inspect vehicles, and prepare quarterly reports.

The monitoring system also requires reviews of invoices, as well as processing complaints.

Cost Containment

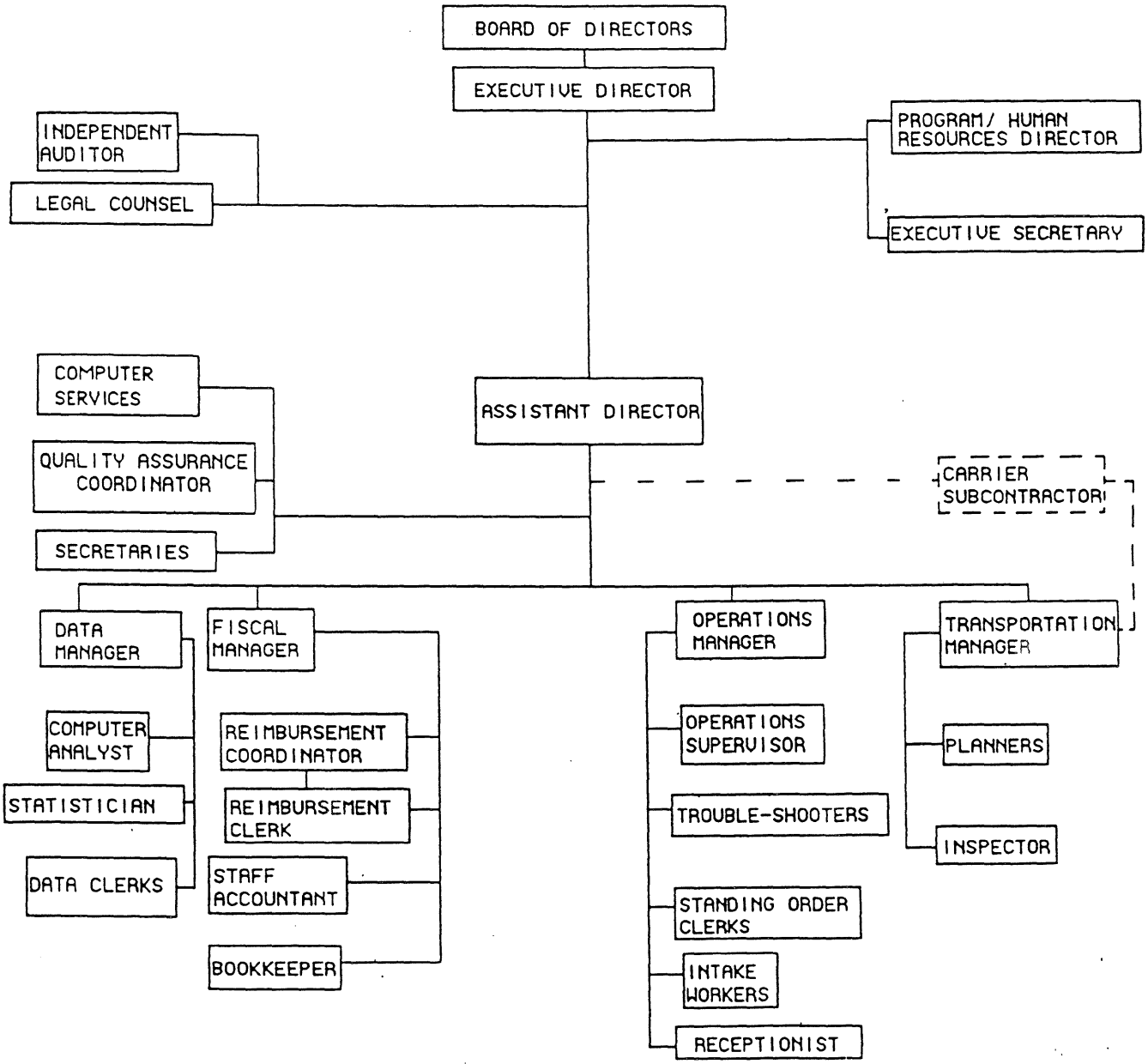
The Modal assignment strategy, described earlier, is a concept applicable to systems responsible for a wide variety of transit and paratransit modes.

Exhibit A

ORGANIZATION OF WHEELS INCORPORATED

for the

MEDICAL ASSISTANCE TRANSPORTATION PROGRAM



PROGRAM PLANNING AND MANAGEMENT

Overall responsibility for the Philadelphia MATP is held by WHEELS' Executive Director and Assistant Director. These Directors, together with the Program Director, formulate program plans and manage implementation of the entire program. They interpret DPW policies and guidelines, designing procedures and practices and assigning responsibilities to the staff. They act as liaison with DPW officials and obtain all necessary approvals from the Department, as well as from the WHEELS Board of Directors. They act for the program in all public presentations.

To manage and direct WHEELS' heavy involvement in almost every program activity, the Assistant Director is named as Project Manager. He supervises all aspects of daily implementation of the program, and maintains close contact with all organizations which are party to the program.

Professional Staff for MATP Program

WHEELS' professional staff for administration of the Medical Assistance Transportation Program in Philadelphia consists of one person in each of the following positions: Executive Director; Assistant Director/Project Manager; Program Director; Fiscal Manager; Transportation Manager; Data Manager; Operations Manager; and Quality Assurance Coordinator.

Program Responsibility and Relevant Experience

Executive Director, Sonia L. Shimer - Responsible for overall supervision of the program; coordinates future program development efforts; resolves problems with existing programs and organizations; maintains effective relationships with client agencies and other external organizations; provides interface with, and direction to, legal counsel; and reports to the WHEELS Board of Directors.

Assistant Director/Project Manager, Reginald K. Knowlton - Responsible for the overall achievement of the stated objectives for coordination of DPW's Medical Assistance Transportation Program in Philadelphia; primary liaison with DPW staff; submits monthly invoices and service reports; defines program requirements to WHEELS' line managers and staff; directs management of program and program staff; management of relations with subcontractors, including negotiation of subcontracts and monitoring performance; design and implementation of contracted programs; and provides assistance to Executive Director in external and Board relations.

Program Director, Suzanne Axworthy - Responsible for program planning and development, including long-range planning and integration of programs; external relations with, and monitoring of, organizations and programs offering opportunities for furthering goals; review and further development of internal operations and management; staff development and personnel policies; and direct assistance of Executive and Assistant Directors in program design, management, and external relations.

Transportation Manager, John Rolkowski - Responsible for efficient scheduling and use of lowest-cost transportation modes; field monitoring of program services; supervision/monitoring of carrier adherence to specifications for equipment, driver training and qualifications, and performance; assistance with negotiations with subcontractors and development of contract specifications; and staff/driver training in Passenger Assistance Techniques.

Data Manager, Steve Duffy - Responsible for management of data collection and statistical analysis, including client, subcontractor, and program data; record keeping, reporting and generation of client reimbursement payments; primary contact with consultant for computer system maintenance.

Operations Manager, Carolyn Adams - Responsible for eligibility determinations; supervision of reservationists and monitoring of in-service problems; determination of medical service provider eligibility/applicability to any client; staff training with respect to operational policies and procedures; supervision of reception and telephone operations.

Fiscal Manager, D. Steven Edwards - Responsible for accounting, financial reporting, disbursements to subcontractors and coordination of audits; financial analysis and technical assistance to staff budget planning and review of performance; cash management and investment analysis; liaison with subcontractors on fiscal matters; participation in the development of contractual terms for subcontracts and in negotiations with carriers.

Quality Assurance Coordinator, Francene D. Brown - Responsible for insuring quality of delivery of paratransit services in accordance with program standards; analysis and evaluation of carrier adherence to achievement of performance standards; recommendations for corrective actions to attain higher performance; assistance with evaluation of private carrier's bid proposals against quality criteria; liaison with medical sites on program performance; on-site observation of carrier performance; documentation of action and follow up on all complaints; provides assistance to Executive Director with external relations, including conducting workshops for consumers and meetings of MATP Advisory Committee.

Organizational Structure

As shown in the chart of Wheels' organization, WHEELS is organized along functional lines. WHEELS is guided by a volunteer Board of Directors, which also receives input from an advisory board which includes consumers. Day-to-day operations and all paid staff are under the Executive Director and the Assistant Director. Line staff report to one or four managers - fiscal, data, operations, and transportation. Additionally, the Quality Assurance Coordinator reports directly to the Assistant Director. The Program Director reports to and receives direction from the Executive Director.

Reference should also be made to the distribution of staff activities shown in the chart.

Job Descriptions, Support Staff

The support staff has many years of relevant experience in the provision of paratransit services. The services performed under each job are summarized below.

Computer Analyst - Maintenance of the computer system; liaison with computer system consultants; design and implementation of internal and external reporting documents; production of all computer-generated reports.

Statistician - Analysis and verification of driver logs returned by carriers; generation and maintenance of all statistics related to transportation programs; determination of hours payable and trips completed in the program.

Data Clerk - Inputting of data into the computer system on trips actually provided by paratransit operators; initial analysis of these data.

Reimbursement Coordinator - Maintenance of reimbursement operations and procedures; liaison for WHEELS with medical service providers on resolution of problems; obtaining current program information from those providers; preparation, recording, and execution of reimbursement checks; delegation and coordination of work of division.

Reimbursement Clerk - Verification and processing of MATP client and mileage claims; provision of eligibility forms to applicants and clients; provision of information and instructions to clients concerning client and mileage reimbursement.

Staff Accountant - Preparation of all journal entries; maintenance of all journals relating to a specific program; any and all reconciliations required.

Bookkeeper - Payroll records; processing of all invoices; generation of checks.

Operations Supervisor - Monitoring of the work load of operations staff; coordination with Transportation Department of computer entries of cancellations and deleted reservations; authorization of adjustments to service schedules to meet daily service problems; initial receipt of client, carrier or medical service provider complaints; research and follow up action on complaints; referral of complaints to the quality assurance coordinator when appropriate; coordination of acquisition and maintenance of office supplies and equipment; assistance to manager in training of operations staff.

Troubleshooter - Monitoring of in-service problems of paratransit operations; liaison among clients, carriers and medical service providers concerning day-to-day operating problems, such as vehicle breakdowns, delays, client no-shows or cancellations; replanning of client trips to respond to such in-service events.

Standing Order Clerk - Receipt and processing of requests for trips under standing orders (subscriptions) verification and input of client and program data; processing of requests for revisions to standing orders; maintenance of contact among clients, medical service providers, and paratransit schedulers concerning standing orders.

Intake Worker - Receipt and processing of transportation requests from clients or their authorized representatives; input of requests in computer terminal; verification of eligibility of requests; input of client maintenance information, with review for verification of eligibility and accuracy; referral of problems to operations manager; instruction of requesters on further information and verification needed, if any.

Receptionist - Initial receipt and screening of office telephone calls; reception of visitors; receipt, dating, and logging-in of applications for Medical Assistance transportation.

Planner - Using computer-assisted procedures, scheduling of paratransit vehicle operations; preparation of scheduled tour of each vehicle; assignment of tours to vehicles of specific carriers in accordance with subcontractor's modal and zonal assignment; responsibility for assignment of each trip to lowest-cost paratransit mode; review of schedules for further refinement; printing of each vehicle schedule; registering each carrier's receipt of schedule prior to day of operation.

Inspector - Monitoring of paratransit carriers' adherence to vehicle, driver, and performance standards; inspecting all paratransit vehicles, as scheduled or without prior notice; temporary or permanent removal from service of any vehicle or driver not in conformity with standards; maintenance of vehicle rosters and driver abstracts, including assurance of their receipt from carriers; receipt of certificates and monitoring of currency of carriers' insurance; on-site observation of carrier dispatching; reporting and offering suggestions to management concerning vehicle and driver standards, deployment of fleet, and operating practices.

Location of Staff

All of WHEELS' professional and support staff are located in, and work from, the WHEELS offices at 919 Walnut Street in center-city Philadelphia.

Exhibit B

COMPUTER FUNCTIONS

The principal function served by each of the 14 basic program may be summarized as follows:

Menu 1	Client File:	Enter/maintain identifications of individual clients
Menu 2	New Service Requests:	Enter client's request for non-standing order (i.e., non-recurring trips)
Menu 3	Standing Orders:	Enter/maintain client's requests for standing order (i.e., recurring trips)
Menu 4	Service Request Maintenance:	View/edit a client's trip request
Menu 5	Scheduling:	Create a schedule - a "tour" - for a specific vehicle for a specific date
Menu 6	Trip Status Input:	Record "after-the-fact" tour data (e.g., actual pick up time; total daily hours of vehicle service; etc.)
Menu 7	Administration:	Print daily vehicle schedules and create/print reports needed to manage the day's service and future scheduling
Menu 8	Maintenance:	Maintain and store files and records
Menu 9	Monthly Processing:	Prepare summaries of services for statistical and billing purposes
Menu 10	Labels:	Print mailing labels for selected groups
Menu 11	Financial:	Process and record reimbursements to clients who use public transit, taxicab or private automobile
Menu 12	Invoice:	Process pre-printed taxicab vouchers for reimbursements
Menu 13	Miscellaneous Report:	Generate/print reports on tour-hours (estimated, actual, and analysis of estimate vs. actual)
Menu 14	Troubleshooting Maintenance:	Create and document real-time trip changes, including scheduling of rides to fit into an existing tour

Exhibit C

DESCRIPTION OF MODES

WHEELS subcontracted transportation services are dealt with as 'Modes'.

Mode 1 Reimbursement of volunteer-driven trips

Mode 2 Reimbursement (mileage) for use of private vehicle

Mode 3 Reimbursement for use of fixed-route transit

Mode 4 Reimbursement for non-prescheduled taxicab trip

Mode 5 Carrier-driven sedan for non-group, ambulatory

Mode 6 Carrier-driven van for group, ambulatory

Mode 7 Carrier-driven lift-equipped van for non-group, non-ambulatory

Mode 8 Carrier-driven lift-equipped van for group, non-ambulatory

Mode 9 Carrier-driven van for non-ambulatory with escort

Mode 0 Carrier-driven van for ambulatory with escort

EXECUTIVE SUMMARY

DESCRIPTION OF THE PROJECT

The Pittsburgh Paratransit Brokerage Program was designed to test the feasibility of coordinating paratransit resources to improve the cost-effectiveness and level of service of specialized transportation for the elderly and handicapped. In the demonstration, paratransit services for the elderly and handicapped were coordinated through the establishment of a paratransit broker or agent in a role analogous to that of a private sector travel agent or real estate broker. The broker brings together willing suppliers and consumers of services, overcomes institutional barriers to the matching of supply with demand, and consummates a sale.

The role of the paratransit broker in Allegheny County was performed by ACCESS Transportation Systems, Incorporated, a wholly-owned subsidiary of Multisystems, Inc., under contract to the Port Authority of Allegheny County.*

The demonstration was conducted in Allegheny County, the metropolitan area surrounding and including the city of Pittsburgh, Pennsylvania. The recipient of the UMTA Service and Methods Demonstration grant was the Port Authority of Allegheny County, operator of the county's public transit service. The UMTA grant was awarded in July 1978, service was implemented in late February 1979, and the demonstration concluded in June 1982. The Port Authority decided to continue funding the project after that date.

As of May 1982, 42 human service agencies had purchased transportation services for their clients through ACCESS, accounting for 34 percent of all trips purchased. Some of these agencies used ACCESS exclusively to serve their clients, while others used the broker in conjunction with their own vehicles or other transportation arrangements.

Individuals not sponsored by a human service agency could also avail themselves of ACCESS service. Anyone 60 years of age or older, or any physically- or mentally-handicapped person of any age was eligible to use ACCESS. The Port Authority provided a 75 percent discount on the cost of the broker's service to people physically unable to board a standard Port Authority Transit vehicle. In May 1982, 61 percent of all trips purchased through ACCESS were taken with the Port Authority user-side subsidy. Those handicapped individuals who are able to board a vehicle paid for ACCESS service at full price. Service provided to full-fare patrons accounted for only 5 percent of all ACCESS trips in May 1982.

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*As of April 1982, Multisystems, Inc., became the Multisystems Consulting Division of Multiplications, Inc.

Source: UMTA Technical Assistance Program
Access: Brokering Paratransit Services to the Elderly and Hanicapped in Allegheny County, PA-December 1984

DEMONSTRATION OBJECTIVES

The primary sponsors of the Pittsburgh Paratransit Brokerage Demonstration project were the Port Authority of Allegheny County, which provided local funding for the project, and the Service and Methods Demonstration (SMD) Program of the U.S. DOT, which provided Federal funding. As in all projects sponsored by the SMD Program, the primary objective was to test innovative and promising improvements in transportation provision. A key element of these projects is the dissemination of information about the project as an aid to localities considering similar improvements. One way in which this information is provided is through a thorough evaluation of the innovation.

In this case, the following issues were identified and examined:

- The ability of the broker to overcome regulatory and institutional barriers to coordination;
- The effectiveness of the administrative procedures used by the broker and the cost of performing these functions;
- The effectiveness of the broker in improving the quality of paratransit resources in the community;
- The effect of the broker on the cost of transportation service;
- The response of human service agencies to the broker; and
- The effect of the project on the mobility of the transportation-handicapped population.

The Pittsburgh Paratransit Brokerage Demonstration tested the brokerage concept on a scale unprecedented in previous paratransit brokerage projects. Its scale is distinguished by three important features of Allegheny County -- the size of the potential demand pool, the physical dimensions of the service area, and the number of transportation providers and purchasers to be coordinated by the broker.

In addition, ACCESS was charged with the task of coordinating for-profit and not-for-profit providers into a unified delivery network where -- prior to the broker's intervention -- such cooperation between these two types of providers did not exist. In fact, regulatory action authorizing not-for-profit carriers to provide shared-ride service for passengers other than their clients was vigorously opposed by for-profit carriers.

In forming a unified delivery network, ACCESS was also confronted with the problem of expanding the capacity of for-profit carriers to serve nonambulatory passengers. Part of this task involved sensitizing the carriers and their drivers to the importance of service quality issues when

serving the disabled individual. The broker also had to convince human service agencies of the importance of good record-keeping, efficient scheduling, and productivity in general.

Besides assembling disparate groups of providers, ACCESS was called upon to market its transportation services to a number of different human service agencies that did not represent a cohesive group. Some agencies served the physically handicapped, others served primarily ambulatory elderly persons, and still others served the mentally-handicapped. Many of these agencies were concerned about the comfort of their clients sharing rides with persons from different groups, but such mixing constituted a basic premise of the project -- to coordinate and improve transportation for all elderly and handicapped persons.

ACCESS was also planned as a service for handicapped individuals not affiliated with human service agencies who would use the system for all purposes, with many of their trips being unique. Given these dissimilarities, the broker would be challenged to develop operational systems that could capture any potential cost savings from the coordination of demand by agencies and individuals.

ADMINISTRATIVE PROCEDURES AND COSTS

ACCESS solicits provider services by issuing a request for qualifications (RFQ) annually. Both for-profit and not-for-profit carriers may respond. The RFQ outlines the carrier qualifications necessary for becoming an ACCESS provider. Any carrier that meets these qualifications is eligible to become part of the ACCESS system by submitting a bid to provide service.

Soon after carriers submit qualification statements to ACCESS, the broker requests cost bids for providing service. The for-profit carriers submit bids on a vehicle-hour basis and the not-for-profit carriers submit bids according to the actual hourly cost of providing service. Negotiations with the not-for-profit carriers focus on service quality and improved productivity. Negotiations with for-profit carriers focus on these issues as well as on the level of the bids each carrier makes.

During the first round of carrier contracting in late 1978, ten contracts were initially negotiated and signed between carrier representatives and ACCESS management. After a period of adjustment, the ACCESS network had, by July 1979, stabilized with six carriers providing service, two for-profit and four not-for-profit.

The terms of compensation for for-profit carriers differ from those for not-for-profit carriers. The former, when providing dedicated service (a vehicle used exclusively for ACCESS service) are reimbursed on the basis of a fixed cost per hour out of the garage. Non-dedicated service, mainly taxi

service used by the carrier to provide trips that cannot be made on dedicated vehicles, is purchased by ACCESS at the meter rate regulated by the Public Utility Commission (PUC). Not-for-profit carriers are reimbursed on an actual-cost basis; ACCESS audits of these carriers provide the basis for setting a per-vehicle service-hour rate. Under some circumstances, ACCESS permits the pro-rating of costs of a carrier's vehicle that is used for both ACCESS and non-ACCESS trips.

In addition to negotiating compensation rates, ACCESS sets insurance requirements and manages accounting and invoicing, communications, general administration, and sale of the scrip that may be used by riders. The scheduling of trips requested by human service agencies is performed by the broker. Most other scheduling procedures are performed by the carriers.

IMPACT OF THE DEMONSTRATION ON PARATRANSIT SUPPLY

Pre-Implementation System Characteristics

Prior to the demonstration program, several agencies provided for the transportation needs of Allegheny County's elderly and handicapped.

The Port Authority of Allegheny County, through the Port Authority Transit (PAT), serves all Allegheny County and parts of four neighboring counties, covering an area of nearly 800 square miles and containing a service population of 1.29 million people. As part of its special efforts program for the elderly and handicapped, PAT has:

- Replaced its reduced-fare program with a free-fare program for the elderly, financed by the Commonwealth of Pennsylvania's state lottery proceeds;
- Assigned specially-equipped (non-lift) buses to routes around which high concentrations of elderly and handicapped persons reside;
- Established a training program to sensitize bus drivers to the specific difficulties of disabled riders; and
- Sponsored a program to educate the elderly in the proper use of the transit system and those vehicles designed for their needs.

Despite its efforts, much of PAT's service remains inaccessible to the county's elderly and handicapped individuals. Many of PAT's buses do not have handrails or adequate lighting in the stepwells and none are accessible to persons who cannot use steps. Furthermore, given the hilly Allegheny County terrain, many disabled people cannot reach PAT bus stops, even if they are able to use non-lift-equipped vehicles. Thus, PAT service is not a feasible transportation option for many severely transportation-handicapped individuals.

Complementing the PAT service prior to the demonstration were private, for-profit carriers and human service agencies. Seven private, for-profit taxi operators had been authorized to provide paratransit services in Allegheny County. They operated a total of 710 vehicles in 1977, with a total seating capacity of 7,496 and a total wheelchair capacity of 88.

These carriers, however, served overlapping geographic areas while many areas received no service. Overlapping service areas could be found in the city of Pittsburgh and its southwestern environs. This pattern reflects the higher density of demand for taxi services in these areas. It also reflects the PUC's decision to allow multiple carriers in these localities. The northwestern corner of the county, however, received little or no service.

In addition to these private operators, several human service agencies also provided transportation to the elderly and handicapped. The Allegheny County Adult Services/Area Agency on Aging (AAA) provided funding to both publicly and privately operated not-for-profit outreach centers throughout the county. These centers either supplied service in their own vehicles or purchased service from private carriers. In 1977, transportation was provided directly by 12 of the outreach centers, the costs of which were reimbursed by the AAA. Six centers utilized the AAA-subcontracted service with taxi operators only.

A second major funding source for paratransit was the Allegheny County Mental Health/Mental Retardation/Drug and Alcohol Program (MH/MR). MH/MR contracts with private not-for-profit organizations that operate 11 Catchment Area Centers around the county. In 1977, MH/MR operated its transportation services in much the same manner as the AAA. MH/MR-funded trips were provided with county-owned vehicles (vans and station wagons) with back-up and extra service purchased from for-profit taxi operators.

In addition to these two major funding sources, a multitude of smaller agencies provided special transportation services in 1977. Throughout Allegheny County, at least 53 not-for-profit agencies offered some sort of transportation for their clients (not including AAA and MH/MR centers). These agencies provided transportation either with their own vehicles or through for-profit carriers, as a complement to other services such as nutrition, medical, social, and recreational programs. The service areas of these not-for-profit agencies overlapped geographically but at the same time were very restrictive in that each served a narrowly-defined client group and made trips for particular purposes.

One agency, Magic Carpet - Open Doors for the Handicapped, offered transportation as its sole operation and was certified by the PUC to provide paratransit service for the general public. Magic Carpet was, and continues to be, subsidized by Allegheny County and City of Pittsburgh contributions, and has traditionally supplied service primarily to the elderly and handicapped.

In 1977, Magic Carpet drew its patrons mainly from a limited segment of the city of Pittsburgh. With six wheelchair-accessible vans, Magic Carpet served only a minimal number of ambulatory persons, concentrating its service efforts on the nonambulatory. It operated seven days a week and offered service during the evening hours. Despite its limited service area, Magic Carpet constituted an important and unique resource for Pittsburgh's handicapped population. Unlike human service agency services, which were limited to specific trip purposes, Magic Carpet was available for trips with any purpose. Further, Magic Carpet was subsidized and, unlike private providers, its services were economically accessible to the nonambulatory. In several ways, then, Magic Carpet can be seen as a forerunner of the Port Authority's ACCESS and user-side subsidy programs. It provided a visible, relatively unconstrained, and affordable service for the nonambulatory. Unfortunately, it was only available to a small segment of the Allegheny County population.

We can, then, draw some conclusions about the availability of paratransit supply before the demonstration. It is apparent that both for-profit companies and not-for-profit providers were important in offering services to the elderly and handicapped. Yet, not all areas of the county were well served; taxi paratransit services were not available in large sections of the county. Furthermore, for-profit providers owned only a total of 24 accessible vehicles, sufficient capacity for 88 wheelchair passengers at one time. Services provided by agencies were limited geographically, to particular clients, and for specific trip purposes.

Influence of the Broker on the Paratransit Industry

An important issue studied in the evaluation was the promotion of competition among carriers by the broker. Such promotion is important because competition encourages carriers to produce transportation services at the lowest-possible cost. There were a number of factors that inhibited the broker, ACCESS, from immediately taking advantage of competitive forces: the timing of the resolution of regulatory issues; a lag in the response of paratransit providers to regulatory changes; and the decision of the Port Authority to make service quality the highest priority of the broker. Because of these factors, competition among carriers to provide ACCESS service was slow to develop. Eventually, however, the broker was able to engender competition, as evidenced by the number of carriers participating and changes in carriers' service areas.

From 1979 to 1982, ACCESS relied heavily on two for-profit carriers for service provision. These two carriers joined the ACCESS network at its inception and have historically provided about 65 percent of ACCESS trips. Toward the end of the demonstration, three new existing for-profit providers were allowed to serve the ACCESS network, bringing the total number of ACCESS carriers to 11 by June 1982. These new carriers exerted competitive pressure on the more-established carriers, ultimately helping the broker to reduce its per-trip transportation expenses.

No new paratransit carriers, either for-profit or not-for-profit, entered the market as a result of the demonstration. Two factors may have discouraged new carrier entry. First, taxi companies providing paratransit service often rely on exclusive-use service for a major portion of their business. PUC regulation, which restricts entry into the exclusive-use market, may well have dampened entry by carriers wishing to serve both exclusive-use and shared-ride markets. Second, ACCESS' own carrier evaluation criteria and qualification guidelines may have thwarted entry for several years.

Despite the lack of new firm formation, by 1983 the service areas of ACCESS carriers overlapped to a greater extent than previously, reflecting the more competitive character of ACCESS service provision. Where possible ACCESS allows non-agency-affiliated individuals to choose among carriers serving their area.

One other objective of the demonstration was the coordination of human service agency vehicles with other paratransit resources. ACCESS' experience with this type of coordination suggests that it is more difficult to achieve than was perhaps previously believed. The broker has been successful in attracting only a portion of the human service agency vehicles in the county to its service network, and there is little reason to believe that additional coordination would either prove beneficial for the agencies or have a positive impact on the broker's transportation network.

Only a portion of the county's human service agencies have chosen to participate in the ACCESS network as carriers. Importantly, Magic Carpet, a visible symbol of community support for services to the handicapped, participates. Of the ten agencies providing service in the AAA network, two participate in ACCESS; within the MH/MR network, only one agency is affiliated (and this one provides transportation solely to its own clients); and of the many agencies outside the AAA and MH/MR umbrellas, only one participates in the ACCESS network. Other agencies were originally encouraged to participate (and some expressed interest) but no other agencies have served ACCESS as a carrier.

The number of trips provided by not-for-profit carriers has grown over time, but not to the extent the number of trips by for-profit carriers has. Since March 1981, the number of trips provided by not-for-profit carriers has remained close to 4,000 per month. Since that time, the average number of monthly trips by for-profit carriers has gradually increased, with over 14,000 ACCESS trips served by these carriers in June 1982.

The four not-for-profit carriers that participate actively in ACCESS have developed relationships with the broker that have remained basically unchanged throughout the demonstration. Three of the four carriers indicated in interviews that their relationships with ACCESS were beneficial. They believe that affiliation with ACCESS has allowed them to achieve higher vehicle productivities because they can mix other trip requests with those of their own clients, even though broker affiliation has imposed new demands,

particularly with respect to managing transportation programs. One agency, however, believes that serving ACCESS has done nothing to improve its productivity while it has created additional administrative rules and procedures.

Service quality has clearly benefitted from the demonstration, as evidenced by the following results:

- Prior to the demonstration, the overwhelming majority of agency trips were provided between Monday and Friday during agency business hours. Carriers supplied only a small amount of paratransit service after hours and on weekends. In contrast, most ACCESS trips can be taken between 6:00 a.m. and 12:00 midnight, six days per week, and three carriers provide service 24 hours a day.

- Prior to the demonstration, most paratransit services had a one-day-in-advance reservation requirement. ACCESS has continued this procedure from its inception, and in addition has begun to provide same-day service. This feature allows ACCESS patrons to place trip requests for Monday-through-Friday service with advance notice of two hours. Agencies must still schedule trips one day in advance, however.

- Vehicle productivity changes are difficult to measure because driver manifest data, recorded by taxi drivers, are flawed by incomplete or inconsistent records. In addition, trips served by ACCESS differ in important ways from the agency-sponsored trips served by private carriers prior to the broker demonstration. For example, 17 percent of ACCESS trips in January 1981 and 29 percent of ACCESS trips in December 1981 required the use of a lift. Only slightly more than 1 percent of trips in the "before" sample required the use of a lift. Given these changes in the trips served, it appears that the amount of ridesharing in the ACCESS system is slightly less than that obtained by carriers before the demonstration. However, ACCESS has been able to improve its utilization of dedicated vehicles on a fairly steady basis throughout the demonstration. Further, service quality under the ACCESS system, as measured by on-time performance and directness of trip, appears to be an improvement over the quality of service offered prior to the demonstration. (Of course, a number of other factors are also important determinants of service quality, including driver sensitivity, ease of scheduling trips, and the like. These issues are discussed below.)

During the demonstration the broker was able to reduce the cost of transportation service to its clients. In 1980, the average total cost of an ACCESS trip was $12.58. By 1982, the average total cost per trip had declined to $10.35. Expressing these figures in constant 1980 dollars using the Consumer Price Index, the average total cost per ACCESS trip in 1980 was $12.58, while by 1982 it had dropped to $7.20.

Statewide Medicaid Brokerage Reduces Costs, Increases Trips

By Barbara Rasin Price and Scott Maines

An increasing volume of Medicaid trips and escalating costs in the mid-1980s prompted Washington State's Division of Medical Assistance (DMA) to dramatically change the way it provides access to health care.

DMA set up a statewide transportation brokerage system that, in its first year, increased the number of trips provided by 36 percent and decreased the per trip cost by 32 percent.

According to Carree Moore, transportation program manager for the DMA, the original intent of the initiative was to increase outreach to recipients.

"We were aware of individuals who needed transportation, but they weren't aware that it was something we offered," says Moore.

The brokerage concept arose out of growing problems with traditional means of providing transportation. Client needs were not being met in many areas, and in the most rural sections of the state, there were no transportation providers. Operators were unhappy about the complicated claim forms they had to complete, as well as the long waiting time for reimbursement.

In addition, the old system of service delivery did not allow for oversight of vehicles and drivers, and there were no standards for passenger assistance training, maintenance of vehicles or access to drivers' police records.

Tackling the Problem

In 1984, a statewide task force of social service funding entities and transportation providers was formed to look at the problems. It recommended a statewide social services transportation brokerage system, with the initial phase focusing on medical transportation.

The DMA revised its state plan in 1987 to define medical transportation as an administrative rather than a medical service cost. While this move slightly decreased the federal matching dollars, at the same time it allowed the state to waive the recipient's right to freedom of choice over transportation providers, making it possible for a broker to assign the most appropriate but least costly method of transportation.

A series of pilot projects were set up in 1988 which were based on a block grant concept. However, the project funding proved difficult to administer, and the state found it impossible to project transportation usage.

Prior to 1985, DMA was using taxis and ambulances exclusively. They began using non-profit transportation providers in 1985, a move Moore credits to the Evergreen State Specialized Transportation Association.

"They carried the initiative to us and showed they could provide transportation of our recipients at a minimal cost. To me it's only logical. They're people who are oriented toward low-income people. Most of them have elderly and hadicapped training, passenger assistance training and they're very sensitive," said Moore.

Initiating the Brokerage System

DMA issued a Request for Proposal in 1989 that sought contractors to act as brokers for medical transportation. The same year, the brokerage system began operating throughout all of Washington except in King County, which began a year later.

The brokers' job is to screen all applicantsto verify eligibility, determine if they

have other means of getting to medical services, confirm that their medical service is covered by Medicaid and then arrange for transportation in the most appropriate and least costly way.

Brokers bid for their administrative costs separately from costs for providing and arranging transportation, and there are very clear lines between the two budgets. In the first year, DMA spent $749,357 on administrative costs and nearly $4 million on services.

Moore points out that the decentralized oversight works. "We quickly found a lot of misuse," she says, "and were able to save $150,000 in the first few months."

But she prefers to talk about cost avoidance rather than savings. She says that if they had left the system the way it was, DMA would have spent $3.7 million more in order to meet the demand last year, or double the actual costs.

Moore, who provides an eight-hour training session for all administrative staff, says that brokers need an amazing volume of medical information.

Brokers also contract with approximately 100 different transportation providers in their regions and reimburse them on a monthly basis as well as providing oversight. Currently the brokers are made up of area agencies on aging, non-profit agencies, a community action program and a for-profit provider.

Slightly apprehensive about who would become brokers, Moore was pleasantly surprised. "I got some real dynamite people," she says, "people who understand creativity and problem solving." With 400,000 Medicaid eligible people in the state, these are desirable qualities in contractors.

Entrepreneurial Broker with the Human Touch

Paratransit Services, a broker for Washington State's Division of Medical Assistance (DMA), is a non-profit agency with entrepreneurial instincts. With bases in Port Angeles, Bremerton and Tacoma this specialized transit system operates 83 vehicles and is one of the largest employers in Kitsap County.

Executive Director Barbara Singleton has been with the agency since it began in 1980 as part of the Kitsap Peninsula Housing and Transportation Agency. In 1984, it was spun off as Kitsap Paratransit and then changed its name again to Paratransit Services in 1986 when it began venturing outside of the county to deliver service.

Currently the agency provides 47,000 trips-per-month — a far cry from its 2,000 trips-per-month average 11 years ago. The three offices operate on a $6 million annual budget and employ 160 people.

Paratransit Services acts as both a broker and a provider of service. More than half of its trips are for medical purposes, and the majority of riders are disabled people, the elderly or the medically frail.

In addition to the medical transportation, Paratransit Services has contracts with three public transit systems, area agencies on aging and other local organizations.

The agency keeps detailed information on nearly 20,000 riders or prospective riders. All Medicaid clients' files need to be verified and updated every month. To help with recordkeeping and dispatching, the agency has developed its own software which is now on the market. This complex software is used for maintaining client files, scheduling, dispatching and billing purposes.

A good dispatcher is key to the system's efficiency. The agency uses one dispatcher for about 4-5 schedulers who, according to Singleton, "must be quick, decisive, demanding, able to keep five balls in the air at once and have an ego." The dispatcher's job can be very stressful, particularly when there are nine telephone lines ringing in at the same time vehicles are being dispatched via a two-way radio.

Singleton says the brokerage concept that Washington State is now using works extremely well. For one thing, she says, "Acting as broker, we're far more knowledgeable about the clients and can select the appropriate mode of travel."

In addition, she says her staff can better screen clients, report abuses and provide service for people who really need it.

The care and concern for riders comes through from the entire staff. Greg Wyman, who transported goods previous to joining Paratransit Services' Pierce County office, started as a driver and has worked his way up to manager. The work, he says, is highly rewarding.

"It's just wonderful to see how many people we can get out on time every day," he says.

It's easy to see why DMA lists Paratransit Services as one of its innovative brokers.

ROLES AND RESPONSIBILITIES OF AGENCIES INVOLVED IN TRANSPORTATION SERVICES IN THE METROPOLITAN AREA

1. **Department of Public Safety**

   A. Responsible for inspection of wheelchair securement devices in all vehicles certified to transport wheelchairs in Minnesota.

   B. Responsible for doing the criminal background checks for metropolitan area special transportation service drivers, as required by law.

2. **Minnesota Department of Transportation**

   A. Responsible for vehicle inspection of all vehicles with and without wheelchair securement devices certified to transport in Minnesota. Inspections must be done at least one time a year (Medical Assistance and Metro Mobility).

   B. Responsible to check all driver personnel and maintenance records at carrier's offices (Medical Assistance and Metro Mobility).

   C. Responsible for implementing driver training.

   D. Responsible for issuing certification of vehicles.

   E. Responsible for promulgating rules for operating and safety standards.

3. **Regional Transit Board**

   A. Has full policy, program and fiscal responsibility for Metro Mobility.

   B. Sets customer fares and provider reimbursement rates.

   C. Defines eligibility criteria.

   D. Holds contracts with a service administrator and multiple providers.

4. **Metropolitan Council**

   A. Prepares a regional policy plan that gives guidance to RTB and other transportation agencies.

   B. Approves RTB's Five-Year Implementation Plan.

   C. Appoints RTB board members.

   D. As the area agency for aging, grants federal Older Americans Act funding in Hennepin and Ramsey counties to support transportation for elderly.

5. **Metropolitan Transit Commission**

   A. Currently contracts with RTB for the administration of Metro Mobility.

   B. Under the guidance of ADA, to provide accessible service, as lit-equipped vehicles are purchased, on the MTC regular route system.

6. **Department of Human Services**

   A. Establishes policies and eligibility requirements for special transportation services reimbursed by Medical Assistance.

   B. Reimburses providers for trips eligible for reimbursement under Medical Assistance.

REVISED
STUDY WORK PLAN

Study Tasks

I. Define the roles and responsibilities of agencies involved in transportation services in the metro area.

II. Compare the Metro Mobility program and the Department of Human Services medical assistance services (i.e., funding, clients, providers, level of services).

III. Identify and present models of consolidated and coordinated transportation systems.

IV. Evaluate models to develop consolidated and coordinated paratransit options for the metro area.

V. Gather feedback on selected paratransit model through focus group research.

VI. Develop report and present final recommendations.

Minutes of the Meeting of the DEPARTMENT OF HUMAN SERVICES/ REGIONAL TRANSIT BOARD PARATRANSIT ADVISORY COUNCIL Friday, August 23, 1991

MEMBERS PRESENT: Co-Chairs Natalie Haas-Steffen and Michael J. Ehrlichmann, Doris Caranicas, Todd Paulson, Nancy Dagg, Donna Allan, Jerry Hayes, Bette Undis, David Jordal, Bonnie Featherstone, Morgan Grant, Sue Warner, Bruce Nawrocki, Harlan Dahl

MEMBERS EXCUSED: Bernie Skrebes

OTHERS PRESENT: Edward Kouneski, Cynthia Curry, Anne Shotton, Sue Lapakko, Mary O'Hara Anderson, Sherri Mortenson-Brown, Linda Hennessey, Lisa Rotegard, Linda Donahue, Jay McClosky, Chris Gran, Joe Morley, Larry Woods, Jim Conroy, Mary Fitzgerald, Person from Senator Frank's Office

Co-Chair Ehrlichmann called the meeting to order at 9:10 a.m. (Co-Chair Haas-Steffen had sent word that she was delayed and would join the group shortly.) Members of the committee and the audience were to asked to introduce themselves. Ehrlichmann explained that the process is intended to be as inclusive as possible. The group should be thought of as a task force with task-oriented challenges. It is not expected to continue after it has met the charge of the statute.

PURPOSE OF PARATRANSIT ADVISORY COUNCIL

Ehrlichmann said the Regional Transit Board (RTB) initiated this effort at the Legislature because the Department of Human Services' (DHS) Medical Assistance program and the RTB's Metro Mobility program have been evolving on separate tracks for some time. The agencies are facing the problem of managing diminishing resources. There is a general lack of understanding on the part of policymakers, legislators and consumers about the scope of the Medical Assistance and Metro Mobility programs. The issue of maximum utilization of federal resources must be addressed. Both agencies share the goal of providing the maximum in transportation opportunities for persons with disabilities who are eligible and need the services. We must set in motion a program for the future that will respond to the needs of consumers represented by the Regional Transit Board and the Department of Human Services (DHS) and use resources more efficiently. The bill received some debate by the Legislature.

RTB is also pursuing a separate initiative to deal with the Metro Mobility program. On September 3 staff will submit a work program to the board for reviewing eligibility and certification. Much of this will be affected by the forthcoming Americans with Disabilities Act regulations. RTB held a forum last week on those regulations; but publication of the final regulations was delayed. They are now expected to be published within the next few days. The Department of Human Rights is reviewing several challenges to the Metro Mobility program.

REVIEW OF WORK PROGRAM

Kouneski reviewed Hollander's June 10 memorandum regarding the draft work program of the council. A technical committee has been established. The representatives from

DHS will be Anne Shotten and Sue Lapakko and Judy Hollander and Edward Kouneski from RTB. It will meet every two weeks. A report to the Legislature must be completed by the beginning of the 1992 session. A lot of work will be needed to prepare information for the council. Focus groups may be conducted after some recommendations have been developed with a goal of obtaining as much feedback as possible.

OVERVIEW OF THE METRO MOBILITY PROGRAM

A fact sheet on the RTB's Metro Mobility program was distributed (Exhibit A). Day-to-day functions are performed at the Metro Mobility Administrative Center, which also certifies riders and provides customer service. The budget for administrative services is approximately $1,000,000 with the actual subsidy between $600,000 to $700,000.

The program was radically restructured in 1986. In 1980 it served Minneapolis, St. Paul and some first-ring suburbs--an area of 280 square miles. It now serves an area of 960 square miles, having tripled since 1986. In 1980 there were 2,300 riders. Currently there are over 19,000 certified riders. Last year the service provided 1,600,000 one-way trips. The program's growth has created operating stress. Kouneski said a Trip Assurance program was instituted to respond to a board policy of no trip denials. In reaction to significant funding shortfalls, mainline and paratransit fares were increased in 1991.

Ehrlichmann said the Trip Assurance Program program was a goal of the disability community. In negotiations with the Department of Human Rights, RTB was told that a program of no trip denials must be provided if a standing orders program is maintained. For administrative and financial reasons, the paratransit service cannot operate without scheduling standing orders. It has become much more difficult for vendors to maintain schedules because of longer, more expensive trips. Some modifications have been made that will improve scheduling. The new federal Americans with Disabilities regulations are expected to indicate whether trip guarantees are mandatory.

Mortenson-Brown said there is no representative of the developmentally disabled on the advisory council. Dagg said the various advocacy groups will be invited to participate in focus groups as the process moves forward. The work plan for this council does not contemplate including them in this group.

Kouneski said the service for developmentally disabled riders is experiencing the greatest shifts and the relationship with the vendors has changed. Last year legislation was passed that permits the habilitation and training facilities to provide service without competing with other providers.

OVERVIEW OF THE MEDICAL ASSISTANCE PROGRAM

Shotton reviewed the DHS Medical Assistance program (Exhibit B). Federal regulations require that states provide access to medical services. The state-wide special transportation service is reimbursed by the federal government at 53 percent to facilities that are part of the Medicaid Program. Some Metro Mobility providers are also Medical Assistance providers. Providers are certified and paid with a base rate plus mileage. In one-percent of the trips an attendant is paid to help carry the rider. A doctor's statement is required and certification is based on financial need. Many clients are also using Metro Mobility for other kinds of trips.

Undis said counties interpret regulations differently. In Ramsey County the rules are very specific. Shotton said that effective July 1, 1991 general assistance recipients became ineligible. Very few AFDC recipients need the service unless they are also disabled. The trips are eligible only if the medical service at the destination is covered by the Medicaid Program.

Grant said he doubts that most people with disabilities understand that they can use Medical Assistance for trips for such things as getting repairs made to wheelchairs. Undis said some elderly people do not want to admit that they are receiving medical assistance.

There was discussion of the "spend down" process and the "door-through-door" requirements for the two programs.

OTHER MATTERS

Kouneski said that at the next meeting staff would like input from the council members on what they wish to accomplish.

A member of the audience said there is a trend toward taking away individual choice of service. His clients are people receiving dialysis and members of the Hmong community. They can become confused and are more comfortable with a familiar driver who understands their needs. The larger companies cannot serve some individuals and they may get lost in the shuffle. Kouneski said this is an important philosophical question and in the coordination model may indicate a way to preserve the smaller providers.

Undis said the Red Cross merges its funds; if a portion of those funds are lost, Red Cross services for other clients will be affected. Some providers may be driven out of business.

In response to Dahl's question, Kouneski said the technical advisory committee will need to rely on as many sources as possible. The meetings will be working sessions and there will be a number of ways to provide input.

Natalie Haas-Steffen said the only possible meeting day is Thursday, September 26. (It was later determined that the meeting will be on September 25 from 9 to 11 a.m. at the Metro 94 facility.)

There being no other business, the meeting adjourned.

I hereby certify that the foregoing constitutes a true and accurate record of the Department of Human Services/Regional Transit Board Paratransit Advisory Council's meeting of August 23, 1991.

Respectfully submitted,

Mary Fitzgerald
Secretary

Approved this _____ day of _____ 1991.

Minutes of the Meeting of the
DEPARTMENT OF HUMAN SERVICES/
REGIONAL TRANSIT BOARD
PARATRANSIT ADVISORY COUNCIL
Wednesday, September 25, 1991

MEMBERS PRESENT: Co-Chairs Patricia MacTaggert and Michael J. Ehrlichmann, Mary Kennedy, Doris Caranicas, Cynthia Mayer, Jerry Hayes, Bette Undis, David Jordal, Bernie Skrebes, Morgan Grant, Sue Warner, Harlan Dahl

MEMBERS EXCUSED: Nancy Dagg, Donna Allen, Bonnie Featherstone, Todd Paulson, Bruce Nawrocki

OTHERS PRESENT: Sue Lapakko, Anne Shotton, Judy Hollander, Edward Kouneski, Cynthia Curry, Mary O'Hara Anderson, Bev Auld, Linda Hennessey, Jay McClosky, Chris Gran, Mary Fitzgerald

Co-Chair MacTaggert called the meeting to order at 9:20 a.m. and introduced herself to the group. She is Assistant Director of Health Care Management for the Department of Human Services and will replace Commissioner Steffen as co-chair of this council. Ehrlichmann explained that he could not stay for the entire meeting because he had to catch a plane.

Motion was made, seconded and carried to approve the minutes of the first meeting on August 23, 1991.

Co-chair MacTaggert restated the mission of the Paratransit Advisory Council:

> To conduct a feasibility study of the consolidation and coordination of transportation services of the Metro Mobility program and the Department of Human Services in the Metropolitan Area.

CONSULTANT OVERVIEW

Mary O'Hara Anderson introduced herself. She is a consultant for the Regional Transit Board and former executive director of the Metropolitan Center for Independent Living. She said that when she began her work in November 1990 she was not concerned about the medical assistance program, but it soon became a focal point of her study.

O'Hara Anderson said many passengers at medical facilities use Metro Mobility when the trip should have been charged to medical assistance. The trips are made on the same vehicles. Some riders are eligible for both programs and confused about the level of service.

Nursing homes say they are no longer allotted staff to accompany riders who cannot communicate and she found that vulnerable adult riders are riding alone on medical assistance trips. Therefore, passengers are put at risk. She credited drivers with ensuring that there has not been serious injury to the passengers, but they are being asked to provide service beyond the role that should be expected of them.

O'Hara Anderson cited an incident that involved a group home that has staff and a vehicle. A number of of their clients are developmentally disabled. The clinic was notified that

there is a "free" transportation service, only to discover a month after the fact in the billings that each ride cost the Medical Assistance program $60. Other states that have instituted coordination of trips have been able to meet the demands and save money. She met riders who will only use Medical Assistance, even though they have cars at home, because of cost, parking fees and other expenses associated with using their own vehicles.]

The area of misuse of the programs by nursing homes is particularly disturbing since people are put in the hands of drivers. In one case a vehicle was dispatched to Crystal to deliver a person across the street.

Ehrlichmann said the issue of the safety of vulnerable adults is a real concern and it is amazing how few instances were found of abuse through neglect. He asked what the obstacles are to coordinated routing that would lead to more efficient use of equipment. O'Hara Anderson said some providers are already doing it--it is the key and should be a simple process because of all the information stored in computers and the time periods involved. Passengers say they decide the same day that they need a Medical Assistance trip, which does not require scheduling the day before, so they cannot use Metro Mobility. In real emergencies there is another service to get people to doctors. If doctors realized what they are doing when they sign authorization papers, we may not have as many last minute trips. Many, if not most,. medical trips are scheduled well in advance and potentially could be part of a common routing.

There was discussion of the need to maintain flexibility. Hayes referred to discussion at the first meeting about Medical Assistance drivers taking the riders station to station rather than door through door. He asked if there is any regulation that says a provider must do that. "Station" refers to a department at a facility that is not necessarily close to the front door. The regulation only requires that the rider be taken to the site. Anything more is possibly a marketing tool of the provider. Hollander said that is a valuable asset along with the timeliness of Medical Assistance.

Co-Chair MacTaggert said the question is, "Who is responsible?" Dahl said the system developed because nursing homes do not have the time or the staff to take care of the Medical Assistance clients and wait with them at the door. O'Hara Anderson said some providers promised station to station service in return for all of a facility's business. The rising costs are driven to a great extent because of the expectations in areas that go far beyond transportation. Nursing homes and facilities need to address their own needs for staff. There are people sitting out in the van unattended, which is against the law, and they are at risk because the driver has to leave to deliver another passenger.

In response to Jordahl's question, O'Hara Anderson said recommendations will be the next phase of her report. The whole system is encountering problems because of the lack of a command post with computer linking of the agencies. The first step is dialogue between all the people with responsibilities for the programs.

Skrebes said that since Project Mobility was established in 1979 , most of the people do not know how to use it. People make medical appointments a month in advance and it would be helpful if they could notify Metro Mobility in advance so that a list of people going to the same general area could be prepared. O'Hara Anderson said the practice has been to schedule rides 24 hours before the service. ADA now allows people to call three weeks in advance, which will offer some opportunities.

The chair said that because of the time constraints she would allow members to ask questions, but observers' questions can be asked at the end of the agenda or after the meeting if time is available.

Skrebes said legislators expect the agencies to find ways to manage their resources and, if necessary, cut costs.

Undis said 95 percent of providers do a very efficient job or coordinating rides; they could not stay in business if they did not. The chair said some problems are outside the providers' control. Undis said demand response trips are different than group trips. At time there are two vehicles at the same facility, but their destinations are at opposite sides of the city. Metro Mobility users choose their provider.

Kennedy asked that copies of the report be mailed with the minutes of this meeting. O'Hara Anderson said minutes are available through Suzanne Hanson at the RTB. Kennedy suggested, and members agreed, it would be helpful for the committee to direct staff to prepare a report on rate-setting information.

Dahl said it is easier to see problems than achievements in any program. Metro Mobility is providing the most rides at the lowest cost in the entire country. The budget is big, but the cost per ride is much lower than other areas have been able to achieve. There is always room for some improvement.

O'Hara Anderson said she found no abusive drivers, although she expected to because of rumors. Drivers take their responsibilities very seriously and they are expected to provide a very high level of service. One issue is the demands put on the system that go far beyond the demands of a transportation system.

Jordahl said he thinks there is waste in the system and eliminating it will free up money. Grant said rates for both systems have come down and the issue is how many more people are placing demands on the systems, raising the total costs of the systems.

Warner said there is always room for communication to improve the system. The failure of the economy, which resulted in fare increases this year, penalized riders.

Hollander said she would be sorry, when this council has done its work, if timeliness, short-notice service and escort service to the ultimate destination were lost.

DISCUSSION OF STUDY WORK PLAN

The chair said literature about other models was placed on the table before the meeting. There should not be any perception that any of them will work for Minnesota, but it would be helpful for the group to find out what has worked. The timeline for the council to accomplish its work is short. At the next meeting DHS will make a presentation on rates.

Shotten presented written background information regarding Item 2 of the work plan for the members' consideration and distributed information on financial eligibility for Medical Assistance service. Undis commented that the passengers' costs should be included in the comparison. Curry said the comparisons refer to the agencies' costs only. There was discussion of the figures for rates paid for service and fares paid by the rider.

Hollander said the figures should be updated to reflect October 1991 estimates. MacTaggert congratulated staff on the work involved in prepare this information.

Curry reviewed the level of service comparisons. Kennedy, Shotton and Gran explained the driver and vehicle requirements. Undis said there is another group of people who receive reimbursement from the counties and information on that piece of medical assistance has not been Included. MacTaggert said that under Medical Assistance DHS pays for common carrier service, which is handled by the counties. O'Hara Anderson said that the Legislature directed Mn/DOT to develop special operating procedures, which were finally issues last week. The revised rules integrate the requirements on both systems much more closely. Mn/DOT will be taking a much more active role than it has in the past.

Shotton said there are instances where people use special transportation because they do not have enough money beforehand to pay taxi fare and wait for reimbursement. DHS is studying how to get control of the situation. Undis said a clear definition of "common carrier" must be agreed upon. O'Hara-Anderson said that years ago, before Metro Mobility and Medical Assistance, the Kidney Foundation provided rides for people who need them. That whole responsibility has been shifted.

The chair said the council needs to deal with the question of whether the agencies should manage the whole picture, including common carrier. She said that at the next meeting the council will deal with changes made to the information distributed at this meeting. Hollander said it would be helpful if a way can be found to acquire federal funds. Metro Mobility is wholly state-funded. The next meeting will be October 23.

OTHER MATTERS

There being no other business, the meeting adjourned.

I hereby certify that the foregoing constitutes a true and accurate record of the Department of Human Services/Regional Transit Board Paratransit Advisory Council's meeting of September 25, 1991.

Respectfully submitted,

Mary Fitzgerald
Secretary

Approved this _____ day of _____ 1991.

Minutes of the Meeting of the
DEPARTMENT OF HUMAN SERVICES/
REGIONAL TRANSIT BOARD
PARATRANSIT ADVISORY COUNCIL
Wednesday, October 23, 1991

MEMBERS PRESENT: Co-Chair Patricia MacTaggert, Doris Caranicas, Donna Allan, Morgan Grant, Jerry Hayes, Bette Undis, David Jordal, Sue Warner, Bruce Nawrocki, Mary Kennedy, Harlan Dahl

MEMBERS EXCUSED: Michael Ehrlichmann, Bonnie Featherstone, Bernie Skrebes

OTHERS PRESENT: Rex Knowlton, Wheels, Inc.; Keith Forstall, Multi-Systems Corporation; Anne Shotton; Mary Jo Nichols; Cynthia Mayer; Christopher Gran; Joe Morley; Linda Hennessy; Karen Lyons; Mary Fitzgerald

Co-Chair MacTaggert called the meeting to order at 9 a.m. and announced that Co-Chair Ehrlichmann had another commitment and would chair the meeting when he arrived.

Because of time limitations, the documents on the Study Work Plan distributed at the September 25 meeting will be discussed at the next meeting. MacTaggert acknowledged the work done by Donna Allen and other staff in bringing today's speakers to Minnesota for this committee. Two formal presentations will be made at this meeting with a question and answer session following the presentations. The guests will not discuss Minnesota-specific questions. Time will be allotted at the end of the meeting for members of the audience to participate.

PANEL DISCUSSION ON TRANSPORTATION MODELS

The Co-Chair introduced the speakers, who are sponsored by the Public Private Transportation Network (PPTN), an Urban Mass Transportation Administration Program (UMTA) Technical Assistance Program.

Rex Knowlton, Executive Director of Wheels, Inc. in Philadelphia described their program. Wheels currently provides 8,000 trips per day for Medical Assistance clients in conjunction with two other programs in the city: Southeastern Pennsylvania Transportation Authority (SEPTA), which has a paratransit program delivering 1,200 trips per day; and a program sponsored by the Department of Transportation for senior citizens, 65 years or older, funded by lottery proceeds. That program formerly provided 7,000 trips per day but is currently in a transitional state. The program was founded in 1959 as a private, non-profit agency. It still serves the "near poor" who do not receive other funds but have a need. In 1981 SEPTA, in conjunction with their response to Section 504 regulations, decided to try a paratransit operation. They issued an Request for Proposal (RFP) for South Philadelphia. Wheels and four private carriers responded and were awarded a contract. The program went city-wide two years later. Wheels contracted with carriers to deliver service and assumed responsibility for scheduling those trips.

In 1983 the city's Department of Public Welfare wanted a better system for Medical Assistance transportation and issued an RFP for a coordinated service. Wheels proposed an intake, scheduling of Medical Assistance trips with 18 carriers performing service delivery. They were a combination of private and non-profit organizations that use four

categories of service to align cost with the type of service delivered. In 1985 SEPTA decided that they would not issue an RFP for the paratransit service as they had in 1982. They elected instead to assume the brokerage responsibility internally and continued to provide a coordinated system using carriers in the community to deliver the service. Wheels lost that part of the business. In 1984 the Department of Transportation (DOT) introduced a lottery/ride program for people over age 65 who meet the criteria. Wheels could not continue the relationship. A decentralized network functioned until 1987 when DOT decided coordination was required to reduce costs and improve efficiency. They issued an RFP and Ketron was awarded the service but they were recently displaced by DOT. Ketron used a model of coordination wherein they did intake, tracking the trip requested. The carrier delivered service and split the responsibility for scheduling with Ketron.

Currently there are three different networks. Wheels coordinates all transportation through the state Public Welfare Department, SEPTA responds to 504, and Ketron coordinates service for people over age 65. One in four city residents are eligible for some sort of assistance. Knowlton reviewed the information in the packet that was distributed before the meeting started and described the services.

Keith Forstall, Vice President of Maintenance and Paratransit, Multi-Systems Corporation of Cambridge, Massachusetts, described his organization. Multi-Systems is part of the Pittsburgh program and has served as broker for the city for approximately 13 years. The firm provides consulting services and evaluates services and computer systems for scheduling. They act as a broker for the Pittsburgh program and have experience with both sides of service. There are several models of coordination in other cities that work and Forstall described the questions that must be answered and the elements that must be in place to coordinate demand and supply. Success depends on fitting the right model to the community situation. In the mid-1970s when they began planning their system there were very few models. Since then a great many approaches have been tried and there does not seem to be a standard in what kind of program will be followed. San Francisco's BART has evolved a decentralized approach whereas Dallas placed scheduling of 1,000 daily trips with the transit authority. Taxicab service is completely decentralized. Audits indicated significant fraud so Dallas purchased a computer to coordinate the service.

In the planning process in Pittsburgh in the late 70s there was a lot of skepticism on the part of community leaders because they had no models in the country to look to. That made the planning process very challenging. The thing that allowed planning to go forward was the need and requirement to change. The debate on fixed route was very strong at that time, but Pittsburgh decided to support paratransit and the transit authority made a commitment to provide it, coordinating the supply. Forstall invited people to ask for more material.

MacTaggert discussed the role of the nursing homes and the transporters. She asked the panelists to talk about the pick-up process and escort requirements. Knowlton said at the point the clients are registered and verified for medical assistance they determine which is the least expensive mode for which the client is eligible. A determination is made as to whether the client is eligible for fixed route transportation with reimbursement. If the person is ambulatory and eligible, he or she will be placed on regular route service. Ability to negotiate barriers independently is assessed. If assistance is required it is provided to the user. The carrier will provide an escort if there has been a determination that it is needed. Wheels is a door-to-door policy.

Among the ambulatory there are some clients who may need an escort because of age or extent of their particular medical treatment.

An escort is a paid person furnished by the carrier. In transporting clients with certain extreme mental impairments, an escort may be required, particularly in a group setting to maintain order during the transport. In nursing home cases specifically if they pick up only one or two people to take to treatment, they will not provide an escort, but will provide seat for someone to accompany the rider. An escort will be provided only for a group activity.

Forstall said the Pittsburgh operating premise is that they make a service available to the community. Participation is voluntary and was presented as a community resource. Not all the needs of the 100 or more agencies are provided through access services. They employ a door-to-door policy and arbitrate between the carrier and the rider to ensure that the distance between the door and the vehicle is as accessible as possible. They work with the carriers and riders, particularly where there is a difficulty for the rider in getting to the vehicle.

MacTaggert asked about same-day service. Forstall said they provide it on a "space available" basis. It is up to the carrier whether they can set it up. Knowlton said Philadelphia is not as flexible. It is not a call-on-demand service. A shared ride feature maximizes the number of rides available based on vehicle availability so same-day service is accommodated only when medical need so dictates. A doctor must call to authorize it or the need must be documented.

Forstall said one of the greatest problems with medical trips was scheduling the return trips and it took some time to resolve. The current system include the out trip at a specific time. Occasionally additional medical tests may have to be done and pro-active communication starts. It took a long time to get people in the medical area to understand the concerns of the clients. In Dallas a shuttle service is scheduled so that a van comes through on a regular basis to handle will-calls. Long waits are a major problem in the areas outside Boston that are less densely populated. The provider has had to wait for the client for one or two hours until the medical appointment is completed.

Knowlton described a "clean up" procedure that assures all the clients are back in their own homes.

Hayes asked for details about the escort services. Knowlton said carriers draw on backup drivers for the service. Their training requirements for drivers includes training on which kinds of disabilities they should look for. With a coordinated system they can minimize the number of escorts on the streets because the carrier is able to schedule the escort service during a specific part of the day. Negotiation is required with the carriers, medical providers and the clients themselves, i.e., the zone map indicates time restrictions so in the some zones service is available only at certain times. Once all the parties understood the philosophy, they began to work with Wheels on Medical Assistance trips. The 504 service is set up so the provider can refuse service. Wheels must make service available, albeit with certain restrictions. Hayes asked if there are escorts in the SEPTA program. Knowlton said there are not, therefore, Title 19 is funding of last resort. Because of that issue, there are a lot of people on Medical Assistance.

Undis asked if volunteers are used. How are clients assigned to the various services? How do you know who to bill? Do any systems have problems getting in on phones to the central facility? Forstall said volunteers are used to a limited extent in the office for surveys of rider satisfaction. They do not make the decisions on which funding source provides reimbursement. The agencies can buy script tickets for the different classes. The decision takes place at the point where they send in a mail order for the tickets under the lottery and 504 programs. When a social service agency calls in a trip it constitutes authorization to bill for the trip.

The system in Pittsburgh is decentralized so phone availability is not a problem. Undis asked if there are any systems doing well with a centralized system? Forstall said it is a matter of available resources. In centralized scheduling the biggest issue on the phones is passengers calling because their vehicles did not show up, which signals a much bigger problem and communities have tried various approaches to deal with it. Zoning is based on the client's resident and trips are arranged to avoid "deadheading."

Returning to the question of volunteers, Knowlton said they have drivers and volunteers through a variety of government-sponsored programs who do filing work and Wheels provides on-the-job training.

Regarding eligibility, it is a complex and difficult area. Experience has been that the political process gets in the way. Medical Assistance eligibility is the funding of last resort. Pennsylvania DOT eligibility is for those over age 65. Currently Public Welfare and DOT are in a turf war and there has been a terrific influx of clients onto Wheels. He explained the phone call routing procedure.

There are five zones in the city and carriers expect 70 percent of the work in that zone but they can move elsewhere. The carrier can work as a secondary carrier in another zone while he waits. The client may have two different carriers on a round trip.

The chair called a break at 10:40 a.m. and the meeting reconvened at 10:50 a.m.

APPROVAL OF MINUTES

A quorum now being present, Hayes moved and Allen seconded approval of the minutes of September 25, 1991. The motion was unanimously approved.

MEETING DATES

MacTaggert said the the next meeting of the advisory council will be November 20 in the MTC Board Room. Paratransit models for Minnesota will be on the agenda. Another meeting may be needed in December because of the short timelines. In November this group will go back over the handouts and nursing home rates. The December 18 meeting may be a problem for some people and a new date may have to be found.

Grant said it would be easier for him to attend meetings at MTC. Nawrocki said he cannot attend meetings on third Wednesdays of the month. MacTaggert said scheduling larger meeting facilities is a problem and members' concerns will be taken into account by the staff.

QUESTION AND ANSWER

Grant asked about maximum time allowed for tours for paratransit users and whether riders use multiple modes of transportation in a single trip. Are fixed route and paratransit fares comparable? Knowlton said maximum travel time is targeted at 60 minutes but realistically it may go to 75 minutes, at which point Wheels calls people to advise them of the problem. Single trips are accommodated. Grant asked, if the client lives away from regular route accessible service, does the client merge services, that is, part of the trip on regular route and part of the trip on paratransit. Knowlton said SEPTA tried hat for nearly a year, and found it did not work at that time. Part of the reason is the number of regular route accessible vehicles. With ADA it will not be a factor, but right now only one in three are accessible so clients experience excessive waiting periods. In certain key stations with high activity fixed route locations multi-modal trips were successful. SEPTA will take a client to a feeder station going to suburbs. The suburbs have an on-call system that will have accessible vehicles at the station. SEPTA rides are $1.50 on either fixed route or paratransit, but the escort costs much more.

Forstall said when their system started the regulations were different. Comparable fare was viewed in light of how comparable the service actually was. Paratransit fare was twice the base fare of the transit system. Over the years regular route fares tended to rise faster than paratransit. The 504 service has distance-based fares with a chart showing which tickets are needed.

Hayes asked for elaboration on the duties of the escorts. Knowlton said in Philadelphia it is door to door--the escort assists the driver in overcoming architectural barriers as needed. Usually the residence poses some problems. They do not take people to the doctor's door. There is a radio contact between the carrier and the vehicle so the driver can communicate with the dispatcher who can identify the problems. On the ambulatory side the escort secures children in car seats and keeps order.

Hayes explained that the purpose of this group is to consolidate Medical Assistance and Metro Mobility. He asked if any other communities are doing that. Knowlton responded that is happening in other cities. Forstall said in Pittsburgh Medical Assistance is coordinated with the rest of the service. A substantial portion of his program is Medical Assistance. Monthly they may provide 12 times more Medical Assistance service and communicate with the medical providers. Hayes asked if there is a model where 504 and Medical Assistance are under central administration or dispatching. Forstall said the State of Massachusetts is attempting a state-wide program and they are initiating negotiations with transit authorities to undertake this at a local level. Wheels did that from 1983 to 1985 but the program must be able to tap into more than one funding stream. In Orlando there is a model that does exactly what Hayes wanted to see. Two states have legislation mandating a central transportation authority.

Dahl asked Knowlton if nursing homes only ask for escorts for difficult steps or at other times. Knowlton said facilities tend to be more accessible and the concerns are over client behavior. The escort stays with the driver, they come and leave with the vehicle. The service is *door-to-door.* Escorts are needed more often in winter months because of ice and snow problems and escorts may be utilized for all trips in very severe weather. If there are only one or two clients on a trip, the nursing home must provide the escort. Wheels is a shared-ride program. That became an incentive for the clients so now nursing homes send an escort if the client needs assistance. Dahl asked Forstall if

Pittsburgh went through the effort of educating the medical community about door-to-door service. Forstall said that is a major effort and they had fewer problems integrating that program. It is similar to Wheels because they provide a range of services but there are bounds on how far they will go to provide a level of care. The quality of service would be compromised if the level of service were changed. It is a constant battle to get medical personnel to meet clients at the door. Knowlton said it is also a matter of educating new personnel.

Undis asked how many are group trips are demand/response. Knowlton said Wheels provides about 8,000 Medical Assistance trips and 4,500 paratransit trips. The rest can be accomplished by people using fixed route or trains. Of the 4,500, 85 percent are standing order trips and the majority of those are group trips. Undis asked who provides random trips. Knowlton said SEPTA 504 service is tailored more to the individual trips. Forstall said their figures are lower in both categories. They are lower in group trip numbers because they provide many more individual trips. In viewing themselves as a service organization, the challenge is to allow a variety of individuals and human services agencies to co-exist with their own particular needs within a system of overlying controls and find ways to share the resources through group trips. Knowlton said the function of a broker is to match like types. You can identify the most costly trips. The broker needs to foster an environment that equalizes the impacts of those trips on both parties.

Forstall said one of the benefits of their program is that since is sometimes there is a barrier between the caseworker and the dispatcher their professionally trained staff can communicate with both. Acting as a go-between has helped alleviate some of that friction that had developed in the past.

In response to Allan's question, Forstall said that under 504 it is not a capacity-constrained system. There was a question of phone response that may actually highlight a shortage of vehicles. Regarding ridesharing, they go through a cycle because they get political pressure and they urge carriers to become more cost-effective although that impacts on questions of quality. As a general rule, a group will demand to be a run. Trip cost is in range of nine to ten dollars.

Knowlton said turn-backs are a significant problem because the transit authority controls how many vehicle hours they can afford to provide. Once those are filled up, service is not provided. That is pre-ADA activity. If clients are denied service by the transit authority and are over age 65, they can use the other system. If they are on Medical Assistance, they can use Wheels. If they are neither, they are stuck. The cost per trip range is shown in the handouts.

Caranicas asked about escort assistance on steps and how transportation is provided for a client is confused. The Metro Mobility program has had instances of nursing homes placing a person with Alzheimer's disease on a van expecting the driver to provide care. Knowlton said the person on staff who deals with quality of service has a masters degree and the system can flag that kind of situation.

Jordahl asked about the providers' billable hours, bidding, and what is included in the RFP. Knowlton said the bids for ambulatory client trips without an attendant were about $20 per hour. The highest bids were for services that requires a lift, between $30 and $35 dollars. As long as the run continues the carrier is paid. If there is a break of an hour or more, payment stops. The tours average just over nine miles. The carrier bids on work in a particular zone and Wheels provides the opportunity to express a

preference in zone. Cabs are paid at the meter rate. They provide a meaningful and cost-effective way of responding to certain trip needs.

In response to Jordahl's question about vehicle standards and driver standards, Knowlton said basically the driver must have a clean abstract from Public Safety and experience in driving that type of vehicle for a year. Passenger assistance and defensive driving training is mandatory. They are concerned about the quality of vehicles and standards include random and quarterly inspections. Forstall said Pittsburgh requires that driver be trained; some of the training is done by the carriers themselves. They do background checks as well. The substance abuse program has been modified. The vehicle standards are designed to ensure safety and accessibility and the standards are written into the carriers' contracts. He offered to provide copies to anyone who cares to see them.

Hayes said he read that under some circumstances the rider pays up front and accumulates invoices for the rest of the month. He asked if that is a problem for people who cannot accumulate funds. Knowlton said that was a significant problem. Wheels felt it was essential under Medical Assistance to go to a reimbursement program. It was very difficult to implement. Because of the requirements for an audit trail, reimbursement coincides with the sale of bus passes for fixed route service.

Kennedy asked if the state requires the Medical Assistance program to contract with Wheels, Inc. Knowlton said either party is free to leave or be replaced each year. She asked about the experience with yearly rate increases. Knowlton said it is a difficult process that is done annually and takes six to eight negotiating sessions to complete. They have to assure the service and demand is fairly unpredictable. With the recession the number of eligible people has escalated. The contract can be renegotiated if there is a significant influx of new clients.

Noting the time, Co-Chair MacTaggert thanked the guests and adjourned the meeting at noon.

I hereby certify that the foregoing constitutes a true and accurate record of the Paratransit Advisory Council meeting of October 23, 1991.

Respectfully submitted,

Mary Fitzgerald
Secretary

Approved this _____ day of _____ 1991.

Minutes of the Meeting of the
DEPARTMENT OF HUMAN SERVICES/
REGIONAL TRANSIT BOARD
PARATRANSIT ADVISORY COUNCIL
November 20, 1991

MEMBERS PRESENT: Co-Chairs Patricia MacTaggert and Michael Ehrlichmann, Doris Caranicas, Harlan Dahl, Bonnie Featherstone, Mary Kennedy, Cynthia Mayer, Morgan Grant, Jerry Hayes, Sue Olson, David Jordal, Bernie Skrebes, Sue Warner, Bruce Nawrocki

OTHERS PRESENT: Anne Shotton; Lisa Rotegard; Cynthia Curry, Judy Hollander, Linda Hennessy, Mary O'Hara Anderson, Mary Fitzgerald

Co-Chair MacTaggert called the meeting to order at 9 a.m. at the Metropolitan Transit Commission offices. She noted that the minutes of the October 23 meeting had been distributed and will be placed on the agenda of the next meeting for approval in order to allow members time to review them thoroughly. (Morgan Grant should be noted as present.)

FUNDING SOURCES FOR TRANSPORTATION

Mayer distributed comparison charts of the Metro Mobility and Medical Assistance programs with a few additions to the version seen at the September 25 meeting. Shotton reviewed Exhibit C, Common Carrier Transportation. Lisa Rotegard discussed federal regulations and reimbursement structures for nursing homes. Ehrlichmann commented that there is a great deal of misunderstanding on the part of the legislators about the issue of nursing homes' use of the Metro Mobility program. The question is whether care facilities received state appropriations before Metro Mobility and whether there were budget adjustments for transportation once the program came on line and they began using it instead. In some facilities they received a bonus that went into other programs. Rotegard said half the agencies have a rental allowance but no adjustments were made. Ehrlichmann said that in effect the budget model was developed on the basis of providing transportation and no adjustment was made to reflect that costs moved to the Metro Mobility program. Rotegard said nursing homes would argue they do not have enough money. Ehrlichmann said he does not begrudge them the money they need, but the other programs have trouble getting funding. Those dollars never got shifted to provide the service that Metro Mobility is now providing. Policymakers think RTB can refuse to provide some services. Rotegard said nursing homes are sent a letter directing them to quit using medical assistance if they have transportation benefits in their budgets. MacTaggert said some homes do not have those funds in their rates. The

issue is very complex and the rate system also affects the private-pay person. Ehrlichmann said that since this is an outstanding concern, the historical relationship of transportation reimbursement should be tracked.

Grant said Metro Mobility should be able to tap into those dollars but the people living in rehab centers and nursing homes use Metro Mobility if the facility does not have a fleet large enough to take care of their needs. Perhaps there is a way to identify ridership by the home address. Caranicas said it may be possible that Metro Mobility is the most cost effective way of delivering that service, but it is worth exploring. MacTaggert said those are the kinds of points that should be made in the legislative report. Ehrlichmann said it is appropriate to recognize that revenue was being spent and never was transferred to the people who ended up providing the service. The rides moved but the revenue did not.

Skrebes said that in looking at nursing homes you will find residents go shopping and other places in groups of threes, particularly women. The men only go out to ball games or things of that sort. He asked if a clearer picture can be gotten of the kinds of calls from nursing homes and the associated costs. Curry said there is no break-out of nursing home calls.

Hayes said there are some facilities, such as Courage Center, where people go for out-patient use of the swimming pool or to receive therapy. The difference between a nursing home and a rehabilitation facility has a large gray area.

Shotton distributed and discussed Exhibit D, 1990 Funding Sources for Transportation. MacTaggert said that from information at the last meeting and other meetings we see that other states are getting involved in coordination and consolidation of systems. There is no basic way to do that. It is commonplace to have one agency to serve as the broker and it is not uncommon to use a mix of systems with decentralized dispatching. Some carriers only provide certain kinds of trips. The committee heard that there is a need for service quality and on the local level we must understand the need for change, who needs the service, and ask what needs to be coordinated and how we will get it done. It is necessary to identify the advantages for the community and the agencies involved in developing these models.

DISCUSSION OF METRO AREA COORDINATED/CONSOLIDATED OPTION

Shotton said that in meetings of the technical committee they started by deciding which programs would be involved in a coordinated approach. The legislation that mandated this committee specified DHS and Metro Mobility, which eliminates the Minnesota Department of Transportation

programs. Ehrlichmann said that when the legislation was drawn up it was because RTB saw that there are two programs with similar services but very different terms. The question was why we were not working together. RTB's initiative was in response to legislators' concerns about maximizing efficiency. Shotton said the technical group decided the best place to start was Metro Mobility and Medical Assistance and included common carrier taxi rides. Both systems fund taxi service as special transportation. Some other programs and funding sources were eliminated as areas that might be consolidated and coordinated. There was discussion of Wheels, Inc. providing paratransit service but also reimbursing bus fares. It is difficult to do and they have difficulty with it. There are a lot of people who own cars which would lead to reimbursing mileage. The group also eliminated Title III-funding rides as well as some rides providing for Medical Assistance by small social service agencies. In some cases the clients needed an interpreter rather than other special service. The committee talked about day training and habilitation rides. The legislation last session changed the guidelines and every DAC has the option of choosing its own carrier. It is her understanding that the plans for funding day training in the future will have transportation rolled into about five individualized programs cost. When looking at proposed models, the technical committee eliminated those rides.

Curry said it is clear that there can be no coordination without consolidation or vice versa. In working through the information the staff will attempt coordination first, starting with eligibility and customer service. DHS said that is the area where they are weak. Through Metro Mobility, RTB has a ridership assistance program in place and can coordinate those areas and move into the area of consolidation. She discussed functions that could be consolidated. There are computer service needs that should be reviewed and meshing the computer systems should be discussed. The technical team did not think we had the assets for this consolidated model. On the question of "how?" the group felt there could be a contractual agreement on the first phase. The group had many questions on the service model. In the first phase operations would be done and phase two would be a service and coordination plan. Phases three and four would be implementation of the recommendations coming out of the service plan. This is presented for input from this council.

MacTaggert said she wished to acknowledge the work of the entire work group. While Shotton and Curry are making the presentations, the contributions of others should be noted. Ehrlichmann expressed concern about the phasing-in period being too long. Four years is not acceptable to the Legislature and unless told otherwise, it is not acceptable to him. The obstacles can be overcome. He is concerned that it would take two years

to get to the point of consolidated services. There are other policy makers who will not understand. We need to establish a work program that identifies common objectives and be able to take that to the Legislature that will not take four years to accomplish.

At this point Co-Chair MacTaggert called for a ten-minute recess. When the meeting reconvened, she said the intent of the task force was to have some input from other affected parties. Shotton said there will be representatives from the nursing home association, providers, DACs, and other groups interested but not represented in the work of this group, at the December 18 meeting. There will be a presentation of the consolidation model and they will react. The group will pose questions to them about their policies on transportation. Ehrlichmann asked if, at some point in time, the technical committee will develop a work plan that would include coordination and consolidation and some kind of a policy statement to take back to the Regional Transit Board for adoption and then to the Legislature. The Legislature convenes on February 17 but there will be work sessions held before then. Approval of other organizations will have to be received so everyone can proceed together. He complimented both staffs on how well the work of the council is going. He would like a very specific work plan in January.

MacTaggert said the December 3 meeting will give the council input from others. At the December 18 meeting the council will go over it and incorporate what has been laid out and review funding sources. There is likely to be a need for another meeting early in January to see the staff report. The draft presented to the Legislature will be worked through in early January. After that, there will probably not be additional meetings. She asked that comments be directed to staff. Ehrlichmann said that before the report is submitted to the Legislature there will have to be ample opportunity for input after a draft is developed. RTB is obligated to bring the draft to its Transportation Accessibility Advisory Committee and the senior community. That may be in conjunction with presentation to the Legislature. This will be an important program and one that will not receive unanimous agreement so enough time is needed to allow those who disagree to provide their input. MacTaggert said it is a given that the legislative report will provide advantages and disadvantages. We are trying to meet the January 9 date for the final draft with written comments. It is expecting too much from staff to ask for a written draft on December 18.

Caranicas said the RTB can expect to see something in January. There is no reason RTB would have to take action on anything before that. Ehrlichmann said he would focus on presenting the report to Senator DeCramer's and Representative Kalis' committees. After it is received on January 9th

hearings will have to be held. MacTaggert said this council cannot presume to develop all the answers and she doubts the Legislature expects that.

Skrebes said he has received numerous phone calls from people who want to know how to get snow cleared so they can get to buses. Ehrlichmann said he has talked to the mayors of both cities and wrote a memo to RTB's executive director about calling people together to talk about snow removal at bus stops. The responsibility rests with the cities. In the past the General Assistance Work Program people were sent to do that shoveling. One of the problems is that no one is responsible except possibly the property owner. Neither MTC nor RTB is responsible and no protocol on bus stops was ever established. He suggested that senior having a problem contact municipalities to demand those paths be cleared.

MacTaggert said it is acknowledged that some groups were left out. She asked if anyone sees that as a problem. Grant asked why the Title III programs were excluded. Shotton said those are agencies that have a variety of funding sources, Title III, Medical Assistance, and United Way. They were providing so few rides with such a wide variety of funds into populations that are not necessarily paratransit population that it seemed appropriate to leave that alone. Grant said that when RTB goes through recertification there may be people in that group who are not eligible for Metro Mobility so those trips may increase. Hennessy said the chief barrier in coordinating with Title III is that those programs cannot require a fee for service and cannot refuse people who are unable or unwilling to pay. It does not match with other programs. Curry said they found that many people are falling in the cracks because they are not eligible for Metro Mobility but have specific trips they are making. They do not rely exclusively on Metro Mobility. MacTaggert suggested that a footnote be added explaining the exclusion. Caranicas said the DARTS program operates that way but also has a Metro Mobility program. They have a voluntary fee and Dakota County residents can use the service. Curry said DARTS does not receive Title III funds.

Skrebes raised the insurance requirements. Olson said insurance provisions come into play when volunteers drive their own vehicles. Insurance rates are based on past history. At Red Cross the insurance rates have nothing to do with who drives and whether or not a fare is collected. MacTaggert asked if members want volunteer-driver services added to the program and if there are any other groups that should be included.

Grant asked for a review of the funding sources that are excluded. Shotton said the Minnesota Department of Transportation, Metro Mobility Exurban, Title III and part of common carrier are excluded. Some taxi rides paid for

by counties would be included. MacTaggert asked that an asterisk mark those programs that are included on the funding sources chart.

Olson said people are confused and it would be helpful to have one standardized certification form. Shotton said that was seen as a real advantage. One doctor's certification should be all that is needed and would present less of a burden for providers. In the short term that would be helpful. The final eligibility is something this group cannot do anything about.

MacTaggert said this group agrees coordination of certification and customer service is a good idea. Grant asked what would be done about co-pay. Shotton said Medical Assistance does not have co-pay and under the coordination model they are not talking about dealing with fares. They want to give providers access to information collected for Metro Mobility because they would also be eligible, in many cases, for Medical Assistance. Under federal regulations they are allowed to impose a co-pay although they have not done so. It is based on he cost of service.

MacTaggert said the council does not need to discuss coordination--there seems to be consensus. Consolidation will be discussed.

Caranicas said that starting with scheduling and routing, before Metro Mobility was restructured in 1984 there was one phone number to call at MTC. The problem then was getting into the system. The phone was often busy continuously. The decentralized system solved the problem, but consolidation might recreate the original problem. MacTaggert said that would be an implementation problem. This group cannot get into that level of detail. Curry said there are a lot of questions that have not been worked out yet. In combining the 1.5 million annual trips by Metro Mobility with those delivered by Medical Assistance the staff will have to study efficiency of service. Caranicas said phone access is a manageable issue and it makes a great deal of sense to coordinate scheduling of routing. MacTaggert said the group could address issues of vehicle type, lift equipment, service area, and number of providers and answer the question of whether it is better to centralize or decentralize.

In response to Caranicas' question about present practice, Shotton said the provider submits invoices for each trip on paratransit and payment is made every two weeks. Dahl said most providers try to send invoices in one or two days after the ride. Olson asked for an explanation of the term "per hour" and "per capita." Shotton said "per hour" is the system used in Pennsylvania by both Access and Wheels, where providers have vans dedicated to the program and are paid on an hourly basis. "Per capita" is a contracting arrangement similar to HMOs that provide all the services

needed in a particular month. It moves you away from reviewing each ride. As an agency, DHS is moving toward managed care. MacTaggert said capitation is improved management. You need to determine whether they meet the needs of the population. There are a number of formulas for determining the fee. Shotton said staff has not determined how that should be handled. DHS staff would carve out their part of the population and pay a capitation rate monthly, perhaps into Metro Mobility or a consolidated organization to manage the rides.

MacTaggert said another issue is funding of administrative costs. Curry said there would be no agency between the provider and the client. The agency would be the administrative function for financing. Skrebes used the example of a person on dialysis who must go in for treatment several times a week. It would be more efficient to bill once for all those trips. Shotton said in going to a consolidated model the provider or Metro Mobility would not bill DHS for each trip but would take some risk that what is billed covers the cost of all the trips. MacTaggert said implementation issues would have to be dealt with but that the council should not attempt to do that at the outset. She recommended that members make a list of implementation issues that concern them.

Shotton said the study should involve a consultant who would help put together the best practices for this area, drawing on other cities' models. Staff needs to pick up all the points that need to be addressed in the report. MacTaggert asked how people feel about the Coordination/Consolidation approach. Featherstone said from a policy-maker's standpoint this can be compared to the airport dual-track approach. It seems when talking about coordination you are talking about identifying all the facets and an emphasis on efficiency for the taxpayers and users. We are looking at efficient use of the resources we have and need to make sure we are using them well. In consolidation policy-makers want to know about standardizing forms, equipment and so forth. It should be simplified so agencies providing service, users and the public all understand.

MacTaggert said this group talked about funding resources but human resource issues are also very important. Jordahl said service standards are a bottom-up issue--we need a balance on what is acceptable for users and use of our human resources, i.e., what kind of waiting period is acceptable? Warner said she is not fond of doing one study after another. We have a good idea of what works and do not have the time, but we need to implement changes in coordination and get the ball rolling. Aa year or two down the road we can decide on doing a study on how we can make improvements. MacTaggert said she had not been clear. If the group agrees

to support coordination, "study" might be a misnomer. Warner said the list is a good starting point and you need to make continuous improvements.

Curry said the purpose of the study is to define the feasibility of doing consolidation and coordination of the Metro Mobility program with DHS's Medical Assistance program. The model shows that coordination is feasible, but you cannot do one without the other. We would do coordination while preparing for consolidation. There has to be a determination of the best way to combine the services and answer questions on how to match the programs to be sure we can offer the program in conformance with federal and state regulations. We must have provider service standards. The initial phase is to get through the consolidation. There are so many unanswered questions that staff could not address in six months.

Grant said he shares Warner's point about studying an issue. He would not like to see another study, but would rather draw upon the resources for this committee to develop an implementation plan so it would not cost anything.

Hayes asked if, at some point, this committee would put out a Request for Proposal (RFP) for an organization like Wheels. He asked if that is within the scope of the charge from the Legislature. Curry said that has to come out of this committee's action. MacTaggert said the Legislature may agree to fund it. The consultant would be used because some people will believe the the agencies' perceptions are biased because they are involved in these programs.

Featherstone asked if this group will be talking action on whether to proceed with coordination and take action to recommend coordination or consolidation or on retaining an outside person. MacTaggert said the goal of this group is to make a recommendation to the Legislature and others. It could have several options. This meeting should conclude with a decision on which way to go; that is what they are expecting from this group.

Skrebes said when Metro Mobility was created in 1979 it was used for any purpose of trip. It is time to take a new look and develop a form that will not hurt people but will enhance their transportation needs.

The chair reviewed the agendas of the December 3 and December 18 meetings. The Paratransit Advisory Council will make its recommendations on December 18 and move them forward along with the technical comments. The direction developed at the December 18 meeting must be clear so that staff can write the report.

There being no other business, the meeting was adjourned at 11:30 a.m.

I hereby certify that the foregoing constitutes a true and accurate record of the Paratransit Advisory Council's meeting of August 6, 1990.

Respectfully submitted,

Mary Fitzgerald
Secretary

Approved this _____ day of _____ 1991.

Minutes of the Meeting of the
DEPARTMENT OF HUMAN SERVICES/
REGIONAL TRANSIT BOARD
PARATRANSIT ADVISORY COUNCIL
December 18, 1991

MEMBERS PRESENT: Co-Chairs Patricia MacTaggart and Michael Ehrlichmann, Bernie Skrebes, Jerry Hayes, Harlan Dahl, Sue Warner, David Jordal, Doris Caranicas, Bette Undis, Donna Allen, Morgan Grant, Bruce Nawrocki, Bonnie Featherstone

OTHERS PRESENT: Lisa Rotegard, Mary O'Hara Anderson, Cynthia Curry, Anne Shotton, Chris Gran, Cindy Mayer

Co-Chair MacTaggart called the meeting to order at 9:15 a.m. at the Metro 94 conference room. Minutes of the November 20 meeting had been sent in the mail. The minutes were recommended for approval and were accepted as presented.

The members have received a draft of the report of this committee. Anne Shotton asked that the members make notes on the draft. Additional comments should be sent so they are received by Friday, or no later than Monday, December 23, 1991.

Staff will get a final draft to committee members by January 3, 1992. The committee should get comments back by January 10. The final report will be printed and distributed at the Commissioner and Legislative levels.

This is final meeting unless the committee wishes to meet. The Committee agrees.

David Jordal reported on the meeting December 3. It was attended by the committee and providers of special transportation. No one from the nursing home industry came - maybe because of the weather.

Small providers were most vocal. They've developed niches in Medical Assistance, and are concerned with customers and about their business. Some of their customers are confused; They need special service.

Smaller providers are concerned with customers. They are going to get pushed out by big groups.

David Jordal said that as a large provider, his company is concerned about service. Service delivery is the key. Is an hour wait time acceptable? No. Which level of service is acceptable? Door to door, etc. Pittsburgh has 5 levels of delivery. Routing. Escorts. Education of nursing home staff and clinic workers. Need help to run smoothly. Reimbursement. Based by level of service: Hour; Trip; Customer types; Areas.

Providers are getting pinched now; costs are going up. Reimbursement is going down. Getting pinched, one person sold out.

Patricia MacTaggart - Legislative concerns. Lets put ideas on the table.

Jerry Hayes - I was there at the December 3rd meeting. I was really impressed with the feeling of the providers for their clients. But shoveling walks and dressing clients are too much. There should be some middle ground. The client should take responsibility for being ready to be picked up. It's wonderful to be a Good Samaritan but its too costly.

I empathize with these folks, having been a small businessman, but if we are faced with no service because of lack of funds, something has to give.

Bernie Skrebes - Representing retired persons. We hear complaints that someone is on a vehicle for an hour. Late to work. Maybe fired. On the way home, on a vehicle for one and a half hours. Only 15 minutes from destination. They should route pickups and dropoffs. Lady has called with complaints.

Harlan Dahl - Metro Mobility, if they do try to route, sometimes a real outlying person may be picked up way ahead of time.

Patricia MacTaggart - There must be a complaint or grievance process.

Bette Undis - In some of the models, there is a place for the smaller provider. In the recommendations, is there a place for small providers? Set criteria, set cost and a small provider can meet the criteria. It is to our benefit to use these small providers; big providers may become inefficient.

Patricia MacTaggart - There are providers with a specialty, i.e., interpreters. They have a niche.

Bette Undis - Now some Metro Mobility providers are not being reimbursed for what it costs. I believe in coordination, but have a place for the small provider who can meet criteria for reasonable cost.

<u>STAFF DISTRIBUTED/TIME LINE FOR COORDINATION AND CONSOLIDATION</u>.

Patricia MacTaggart -
Legislation - if legislation; done May 1992.

June,1992 - RTB/DHS develop coordination plan. By January 1, 1993 implement coordination plan.

February 1, 1993 - update legislature.

July 1, 1994 - consolidation implementation.

Money available after May 1993 - then need contracted systems.

Real ridership starts July 1, 1994 - a year later.

Bonnie Featherstone - thinks the timeline is realistic and optimistic.

Jerry Hayes - In coordination phase - certify various clients.

RTB - Coming up rapidly to recertify those eligible for Metro Mobility. That process well ahead of June 1, 1992 and December 1, 1992. This spring talking about recertification.

Cynthia Curry - Certification begins July, 1992 - by end of 1993 it should be completed. There are lots of questions: How to pay for it?

Bette Undis - What about computerization?

Michael Ehrlichmann - The more aggressive timelines, the more we meet the wants of the legislators. Go as quickly as possible.

DISCUSSION OF COMMITTEE RECOMMENDATIONS

Bette Undis - There are several ways. None right or wrong. Brokerage coordination system. Set criteria for costs. Who's eligible? Adequate scheduling. Level of service. Set target populations. Then bid it out. Allow large and small providers to bid on portions. Say 6 populations. Nursing home. Demand response. Bid out by population type. Brokerage controlling. Then consolidation. Control it by a few providers. In consolidation, there are a few big providers, lower cost per trip, less service. You eliminate more people. Bid out by population type.

Patricia MacTaggart - Bette's "coordination" is my "consolidation".

Michael Ehrlichmann - We don't bid, we have a rate.

Do we want brokerage/ more providers/ to bid it out? Or...Is there more money for a larger computer system? Can the present system expand to meet needs.

Michael Ehrlichmann - Recognize that there are economies of scale. Recognize we can implement economies of scale. At the same time, recognize certain missions of medical assistance and Metro Mobility. There are different levels of service for Medical Assistance and Metro Mobility. We are here to judge how that is feasible. Maximize all resources (federal, state, etc.--through economies of scale). Take advantage of the largest market. [Issue

- DAC]

The larger the market available for providers, let's them anticipate purchase of a greater amount of equipment. More vehicles, gas, personnel departments, smaller cost per employee. The more people on one van, the cheaper all the rides are.

The distinction is: How far can we go and still accommodate all the needs. (Some providers will feel they can not compete because of size; some customers won't feel their needs can be met).

Taking advantage of economies of scale.

Bruce Nawrocki - What we need to figure is what the actual service needs will be? What kind of provider can meet these needs? Is that type of provider available? What are the delivery service expectations we have, no matter what mode we have.

Jerry Hayes - Our thrust should be:

Develop an organization to handle transportation of DHS and Metro Mobility. Who is eligible to where, handling, scheduling, etc.

The people of Pennsylvania are only serving part of what we are concerning Medical Assistance. We're looking at a bigger picture.

Patricia MacTaggart - Do we want to do that?

Michael Ehrlichmann - Getting back to Bruce's levels of service; higher for vulnerable people.

Patricia MacTaggart - What is meant by level of service?

Curb - curb
Door - door
Door through door
Site - site
(A person to another person down to a driver dropped someone off at a curb)
Level of spontaneity of the trip. Response time. A week ahead to within an hour on the same day.

Determine if DHS and Metro Mobility have service needs that are distinct. Consolidate to where greatest number of persons can be served with the least number of vehicles and bid it out.

Patricia MacTaggart - What we recommend has to accommodate levels of service - integral parts of. What legal obligations DHS to service; doesn't know what are regulations versus policy now.

Vulnerable adult - exposure to weather - don't want them to

Vulnerable adult - exposure to weather - don't want them to get harmed - concern of driver.

Contracts to reflect that the larger population just needs transportation.

Bonnie Featherstone - Spontaneity is one thing; vulnerable persons - something else. We can't lump all together and be successful.

Michael Ehrlichmann - I agree. Metro Mobility now has 24 hours response time.

Bonnie Featherstone - Doesn't see spontaneity in with vulnerable adult(1) and response time (3).

Harlan Dahl - For Medical Assistance, providers have to have same day delivery, i.e., discharge from hospital. In consolidation model, you can accommodate that.

Doris Caranicas - Any model has to have room for exceptions. Driver knows they have an appointment; wait until he knows they'll be picked up. Knows scheduled, scheduled pick up too, (knowing that he will have to wait.) Can estimate. Allow extra 1/2 hour; it's manageable. An exception you have to allow for.

Regular service - 24 hours. Pick up and drop off. Pretty manageable.

There must be education.

Bonnie Featherstone - Start education to the medical community. Good communication has to occur. If there is a special need, it should be right in the chart.

Bernie Skrebes - Does a provider have a standby? Harlan Dahl- Yes. They have vehicles, but not drivers.

Bruce Nawrocki - There are levels of training for specialized services.

Patricia MacTaggart - An entity may have to provide 24 hour service. A subcontractor may be specialized under that.

Jerry Hayes- Concerning this committee and our charge; First, are we going to have an entity to provide this transportation? Can the committee make recommendations of consolidation and coordination? But can't get to great detail.

Michael Ehrlichmann - Specific recommendations
We need as short a timeline as possible to make a consolidated service.
We need a dispatching system, to put the maximum number of people

on the vehicle, which takes advantage of the economy of scale of competitive bidding.

RECOMMENDATION #1. In as short a time table as possible, a coordination that maximizes resources/services to the degree possible in the largest market using a bidding system:

- That accommodates service level needs,
- That accommodates potentially different reimbursement structures for the subcontractors.

Doris Caranicas - Thinks timetable presented is excellent. Lots of us have lots of ideas about details (same day service is more expensive). Recommendation: same day service only available if essential.

Bonnie Featherstone - Establish a process to obtain efficient service in the most economical way possible.

If the consultant recommends that efficient service is what is required, then we must determine how economically to achieve it.

Recommend to legislature - to find a consultant to do it. If no consultant, must use funding of DHS/Metro Mobility staff.

Michael Ehrlichmann - Recommend a consultant.

Bonnie Featherstone - Question: Do we have an in house staff expert?

Patricia MacTaggart - No.

Michael Ehrlichmann - Have expertise but not funding for staff time. Develop a contract mutually to retain a consultant.

RECOMMENDATION # 2. Fund a consultant to bring together the Department of Human Services (DHS) and Metro Mobility (RTB) to develop an implementation plan that delivers an efficient service in the most effective way.

-consultant to make recommendations on how best to do so;
-Within DHS and RTB, fund resources to work with contracted consultant.

Bonnie Featherstone - What is the ultimate achievement? What is the final entity we're establishing. Services medical need or special needs. Needs to be articulated.

Doris Caranicas - Regional paratransit; it is a generic term.

Bonnie Featherstone - Need to articulate what is it? One term to use henceforth.

becomes servicing agency for DHS.

RECOMMENDATION # 3. RTB becomes the paratransit "entity" in the consolidation model to manage the transportation needs of Medical Assistance transportation and Metro Mobility rides.

Michael Ehrlichmann - What legal needs are there for RTB to legally get dollars?

Morgan Grant - DHS. How do DHS services fit into hub type system? Anoka - paratransit to hub system and transfer. Currently for Medical Assistance trip, no transfer. Would you have to use Metro Mobility system?

Cynthia Curry

1) Need consultant to work these issues out. Determine level of service.
2) Eligibility - Identify Medical Assistance clients based on functional ability?

Donna Allen - Two phased process. Recommends?

Patricia MacTaggart - coordinate who is eligible functionally.

Donna Allen - 19,000 Metro Mobility
- 15,000 DHS - don't know about overlap.

Cynthia Curry- That is why we want coordination. Use that as data gathering. Data is there; cross check Medical Assistance and Metro Mobility.

Donna Allen - Do we have the organization?

Cynthia Curry- We do have the organization to do this, yes.

Michael Ehrlichmann - Need consultant to recognize this.

Patricia MacTaggart - Thought we could do the coordination without consultant.

Bette Undis - Supports brokerage system to determine efficiency and cost effectiveness.

Michael Ehrlichmann - Not sure duty of government to assure survival of small business. Our job is to maximize resources. If bidding, if more rides for less cost.

Recommend: Combine.

Cynthia Curry- RTB is looking at having that done by a rehabilitation agency. The service will be contracted to someone who can do functional eligibility determinations.

Recommend: That DHS/RTB coordinate certification of eligibility.

Morgan Grant - I agree.

Recommend: DHS/RTB coordination of and certification of functional eligibility.

RECOMMENDATION # 4. Immediate coordination of DHS and RTB involving certification of a. functional eligibility and b. complaints and quality issues, to the degree possible. Accommodate the issues of the level of spontaneity (same day service), exceptions and legal issues.

Recommend: Social service agencies continue doing paratransit transportation.

Michael Ehrlichmann - DAC - Rides taken out of market. Providers have felt financial impact of that. Lost profitable part of market. These rides produce a greater profit because they're known.

In draft - groups we were going to exclude. Page 15 last page.
Talked about excluding:
DOT -16b2
Exurban (Sec. 18)
Sec. Title III

Bette Undis - All are cornerstones or legs of the social service funding.

Mary O'Hara Anderson - I recommend under 5,000 rides excluded; all non-profits.

* Recommend: Sec. 18, Sec.16b2, social service - excluded from the process.

Doris Caranicas - Recognize in writing that this type of service exists.

Bette Undis - They want to work with the system.

Donna Allen - These could enhance system. It is public funds. Exclude initially. 16B2 - Strict requirement to coordinate.

Bette Undis - Exclude from reimbursement but recommend coordinate with the system.

RECOMMENDATION # 5. Exclude publicly funded reimbursable trips that are funded by section 18, section 16 (b) 2 and Title III provided by nonprofit social service agencies which furnish less than 5000 trips per year.

are funded by section 18, section 16 (b) 2 and Title III provided by nonprofit social service agencies which furnish less than 5000 trips per year.

DACs - Day services have option- can pay in their per diem. No mandate for Metro Mobility now. They find what is out there and pay for trip. (They went to Metro Mobility. Metro Mobility subsidized them. It was cheaper; now not subsidized, so not cheaper.) Exclude because they do their own coordination for their own reasons.

Morgan Grant - Be as inclusive as possible. If DAC finds it cheaper using Metro Mobility, let them. If cheaper elsewhere, let them.

Cynthia Curry - Putting more costly rides back on MMAC.

Patricia MacTaggart - Ask consultant to look at DAC issue and let us not make a recommendation at this time. As part of consultant contract recommend to legislature to recommend to agencies what to do about DACs.

RECOMMENDATION # 6. Educate the medical, provider, and paratransit consumer community.

Donna Allen - Is consolidation the way to go?

Question: What kind of organization does it take to manage that kind of trip? Should consultant tell us whether consolidation is the way to go? Or is there a better way? Do we have enough background to only consider consolidation?

Sue Warner - My recommendation is to coordinate/consolidate services to the degree possible.

Morgan Grant - Don't use "consolidation", it is a negative term. "Coordination" is a positive term. Maximize what is available to use. Develop language around this. Metro Mobility is $4.5 million in red. It is up for some big changes.

Jerry Hayes - Suggests "Maximization of resources", in same way, Consultant use "feasibility" of maximization of resources.

[See RECOMMENDATION #2 above]

Use a consultant to do a feasibility plan and if feasible than to go develop a program.

Sue Warner - Consultant to come back with her idea of what will work.

Morgan Grant - Consultant to develop an implementation plan

Patricia MacTaggart - Should consultant have timeline?

Bette Undis - Consultant may come with two or three plans.

Patricia MacTaggart - if so, it may be near 1996 before we implement.

Mary O'Hara Anderson - At the conference, several transportation consultants are doing this around the country. There are people ready to do this.

Donna Allen - No one has implemented a program.

Florida has.

Bette Undis - It's failing.

* Recommendation: Timeline as amended.

RECOMMENDATION # 7. Adopt timeline (as amended).

RECOMMENDATION # 8. DHS and RTB write legislation for the implementation of these recommendations. DHS write legislation to move special transportation from the service to the administrative category.

Explanation in body of report to lead up to this.

These recommendations will come out in second draft.