Charting a Course to 2040

SOUTH CAROLINA | MULTIMODAL TRANSPORTATION PLAN

Draft Report

STATE HUMAN SERVICES TRANSPORTATION INFRASTRUCTURE REVIEW

Prepared for:

SCDOT

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1 STUDY BACKGROUND

1.1 Project Purpose and Objectives

The SCDOT sponsored this Human Services Medicaid Infrastructure Review to determine whether or not human service transportation delivery resources are being leveraged and utilized to their fullest and most efficient capacity, improving overall transportation within the state. The SCDOT requested CDM Smith build from the successful momentum of the Statewide Multimodal Transportation Plan, which has been underway for the eighteen months. This study reviewed the existing SC Human Services Transportation infrastructure, with specific attention on the state's Non-Emergency Medical Transportation (NEMT) infrastructure.

A primary goal of the study was to receive input from state departments, offices and public and private agencies in South Carolina that provide transportation or have clients dependent upon public transportation. SCDOT wants to understand the current NEMT program structure and how it coordinates with other departments.

1.2 Background

Medicaid is one of the federal government's largest providers of human services transportation, spending between $2 and $3 billion annually[1] on non-emergency medical transportation. The successful coordination of federally-funded human services transportation services is highly dependent upon the extent to which these resources coordinate with and complement other specialized transit and human service transportation options. Because Medicaid programs are administered by states, which are able to set their own rules and regulations within the Centers for Medicare and Medicaid Services (CMS) framework, coordination of NEMT with transit and other human services transportation is highly dependent on state Medicaid agencies' policies and priorities.

Under the federal Medicaid law, states assume the responsibility of ensuring that Medicaid beneficiaries have access to needed health services. Medicaid beneficiaries utilize NEMT to gain access to nearly all Medicaid-funded services. In many rural areas, beneficiaries may utilize NEMT for long-distance trips to tertiary care facilities. NEMT also serves beneficiaries needing routine, scheduled transit, such as regular visits to adult day centers, day habilitation, or dialysis centers.

[1] Non-Emergency Medicaid Transportation: How to Maximize Safety and Cost Effectiveness Through Better Use of Private For-Hire Vehicle Operators, Paper.

States across the country have developed NEMT programs to serve their state's specific beneficiary needs, within the context of the available provider resources and political landscape. More recently, states have developed and implemented NEMT models specifically to strengthen monitoring and oversight, often in response to increased NEMT utilization and costs or after finding significant fraud and abuse.

Two basic models of health care reform are in existence today, but have fundamentally different approaches. One model empowers consumers to choose from among competitive, organized health plans based on measurable results important to the consumer. The second does not offer such freedom of choice to the consumer and instead relies on a centralized planning model in which government determines the type and scope of available services.

Over the past decade, some states have moved toward centralizing NEMT program administration regionally or statewide, and many have also shifted NEMT program financial risk to contracted vendors in broker-based models. Other states, for political, programmatic, or budgetary reasons, have not centralized and have, instead, delegated administration of Medicaid transportation services to local government authorities.

- Typical human service consumer transportation demand centers on non-emergency medical transportation and work-related transportation.
- Existing NEMT model in SC is the brokerage system.
- The existing SC brokerage model has mechanisms in place – why, where, when trips are made; all complaints are recorded and performance measures are in place. One goal of the brokerage system is visibility at all levels, which was not in place prior to the brokerage model.

1.3 Public Outreach

As mentioned above, one of the primary goals of the study was to receive input from state departments, offices and public and private agencies that provide transportation or have clients dependent upon public transportation. SCDOT recognizes coordination among the multiple organizations is valuable and will continue in the future.

The public outreach process for this study included collecting qualitative data with departmental staff via electronic surveys, personal and phone interviews, as well as working with the SC Interagency Transportation Coordination Council (SCITCC) and the transportation providers, both public and private, across the state.

The Governor established the SCITCC in recognition of the complex governing structures that have arisen over time to meet the needs of various populations for transportation services, which has resulted in a lack of consistency in approaches, an overlap of services in some places, and unconnected services in others. The Council is assigned the responsibility to plan and develop mechanisms for increasing coordination of funding streams and resources at both the state and local levels and enhance coordination between resource agencies in order to maximize the efficient use of public

transportation. The Executive Order establishing the SCITCC calls for representation from the following agencies:

South Carolina Interagency Transportation Coordination Council Members
Lieutenant Governor's Office on Aging
South Carolina Budget and Control Board
South Carolina Commission for Minority Affairs
South Carolina Commission for the Blind
South Carolina Councils of Governments
South Carolina Department of Commerce
South Carolina Department of Disabilities and Special Needs
South Carolina Department of Health and Human Services
South Carolina Department of Mental Health
South Carolina Department of Social Services
South Carolina Department of Employment and Workforce
South Carolina House Education and Public Works Committee
South Carolina Office of Regulatory Staff
South Carolina Office of Veterans Affairs
South Carolina Senate Transportation Committee
South Carolina Vocational Rehabilitation Department
Transportation Association of South Carolina

The CDM Smith team also reviewed applicable background documents and program policies, as research for the study. These documents include:

- US Department of Health & Human Services Strategic Plan and Priorities, 2010-2015
- State Human Service Transportation Coordinating Councils: An Overview and State Profiles, February 2010
- January 2012, State Agency Transportation Services and Coordination Survey
- Building the Fully Coordinated Transportation System, Self-Assessment Tool for States, June 2010
- SCITCC Annual Report, January 2011
- SCITCC Summary of Agency Program Profiles/Information, December 2008
- Temporary Assistance for Needy Families Block Grant State Plan, Federal Fiscal Years 2013-2015
- 2011-12 Lieutenant Governor's Office Accountability Report

- South Carolina Department of Mental Health, Community Mental Health Service Block Grant Application, FY2014-2015
- South Carolina Department of Employment and Workforce, Transparency of Funding Appropriation Report.
- South Carolina Department of Employment and Workforce, Management and Trust Fund Review, FY2013.

1.3.1 Meetings

July 24, 2013

An initial meeting was held on July 24, 2013, with the SCDOT and the Department of Health and Human Services (DHHS). The SCDOT provided an introduction, background, the purpose of this study, and why the timing is right to complete the Human Services Infrastructure Review. DHHS staff gave an overview of the existing brokerage model for Medicaid transportation that is in place today. They also wanted to ensure that the private community transportation providers are contacted and involved with this study.

September 12-13, 2013

The SCITCC held a regular meeting on September 12, 2013. The primary topics discussed at the meeting were the Statewide Multimodal Transportation Plan Update and the introduction of this study focusing on Human Services Infrastructure. In addition, a review of the multiple federal programs supporting transportation was also discussed.

All members of the SCITCC received stakeholder questions in August and September relating specifically to coordination of services. The general questions included:

Stakeholder General Questions
Name, Agency
Contact Information
Does your agency provide NEMT transportation or have clients that use transportation? Describe services/programs.
How has/does the existing brokerage model worked for your agency and for your clients?
Are you familiar with other states using a different model for NEMT services? Discussion of Brokerage Model vs. Consumer Choice Models.
What model do you think is best for the state of South Carolina and for the clients using the transportation options? Why?
How would changes in the NEMT transportation model affect your agency and clients?
How do you envision your agency increasing coordination with public transportation agencies, such as combined trips, funding, scheduling, etc.?
Where do you see NEMT transportation in 5 years, in 10 years?

The agencies were also invited to have one-on-one or group discussions with CDM Smith after the September 12 meeting or on the following day if available. Some SCITCC agencies assisted with outreach and extended the stakeholder survey to their counterpart offices that are located outside the state office. This effort allowed more feedback from multiple areas across the state.

September 2013

A Technical Review Team for this Human Services Medicaid Infrastructure Review was established. SCDOT sent requests to members of the SCITCC to determine interest and Committee member requests.

October 2013

In addition to the above outreach, SCDOT contacted the public transit agencies to participate in the study effort by providing a Survey Monkey link to the questionnaire with the stakeholder questions. The information was sent to the 29 transit agencies in the state. Five transit agencies responded to the survey, with three of the five responding their agency is a NEMT provider. All the agencies supported having a consumer choice model for NEMT transportation and to have increased coordination among the local public transportation providers.

November 2013

A SCITCC Technical Review Team held their initial conference call meeting on November 1, 2013. The primary discussion of the meeting was to review the purpose of the Technical Team and to provide an update on the survey responses to date.

January 2014

The multiple transportation companies who are private providers for Medicaid were contacted via email. The information sent to the providers included an introduction and purpose of the study and a link to Survey Monkey with the stakeholder questions. The deadline for responses was January 24, 2014. The responses to this survey will be compared to results from a *2012 Medicaid Transportation Provider Survey*, shown in **Appendix A**, to determine variances or actions that have changed.

February 2014

The SCITCC held a regular meeting on February 10, 2014. The primary topic for the meeting was a review of the Technical Memorandum 1 (TM1) for this study. Members clarified/discussed agency needs and any updates to the data presented in the report, primarily for financial and trip information. Specifically, funds that are spent annually on transportation should be represented along with the number of one-way trips provided in that year, if available. Agencies agree to send updated data to incorporate into the Final Report. Other topics included an update of the statewide Multimodal Transportation Plan, comments on TM1, and next steps of the study.

May 2014

A SCITCC Technical Review Team held a conference call on May 28, 2014 to discuss TM1 and comments received thus far. One goal of the call was to identify preferred peer states in which the study team would contact for additional information about their program, lessons learned with their infrastructure, and any other facts about coordination of transportation services within those states. In

addition, team members were asked to send any specific questions for the peer state calls that they may have from their agency. The preferred peer states to contact for further information were Georgia and Kentucky.

August/September 2014

A SCITCC Technical Review Team developed a set of questions for the peer state calls with Georgia and Kentucky representatives, which were hosted in August and September 2014. **Appendix B** provides the peer state questionnaire. The SCITCC Technical Review Team conducted the following interviews.

- Leigh Ann Trainer, Section Manager for the Department of Human Services, State of Georgia, August 6, 2014, 10:00a-12:00p.
- David Cassell, Georgia Regional Transportation Authority/Governor's Development Council, September 10, 2014, 11:00a-1:00p.
- James Peoples, GA Department of Community Health, September 18, 2014, 11:00a-1:00p.
- Vickie Bourne, Executive Director; Eric Perez and Jeremy Thompson; Kentucky Transportation Cabinet – September 16, 2014, 10:00a-12:00p.

A summary of the peer state comparison and interviews is discussed later in this report.

1.3.2 Online Survey Results – Private Providers

As discussed earlier in the chapter, one goal of this study was to have a comprehensive outreach process from all state departments with transportation components. One such effort involved the online survey effort to the multiple transportation companies who are private providers for Medicaid transportation. The Department of Health and Human Services and Office of Regulatory Staff provided an extensive database with contact information of over 800 providers for services across the state. Each organization was contacted via email with information, such as an introduction of the study and also the purpose of the study. A link to Survey Monkey with stakeholder questions was included in the email and the deadline for responses was January 24, 2014. The survey questions are listed below.

Private Provider Survey Questions
Name, Agency
Contact Information
Does your organization provide NEMT transportation?
Does your organization provide work-related transportation?
How has the existing NEMT Brokerage Model worked for your organization?
Are you familiar with other states using a different model for NEMT or work-related public transportation services?
Which NEMT/Public Transit model do you think is best for the state of South Carolina and its Agency Consumers?
How would changes in the current NEMT transportation model affect your organization?
How do you envision your organization increasing coordination with other organizations in your region?
Where do you see NEMT and/or work-related transportation in the future?

Fifty survey responses were received from the existing Medicaid providers. Summary responses to the questions are provided below.

Approximately 62 percent of the respondents provide work-related transportation, as shown in **Figure 1-1.** Only 25 percent of the providers were familiar with different models in other states for NEMT transportation services. Those that were familiar with other state models discussed states that use Fee for Service model, not a broker. Others were familiar with a state Department responsible for Medicaid that would work directly with a regional non-profit or with the transportation providers to schedule the trip. Others were familiar with NEMT in North Carolina where the counties were responsible for NEMT trips.

Figure 1-2 illustrates that over 70 percent of the respondents think the Consumer Choice Model is best for the state of South Carolina verses the Brokerage Model. The majority of responses supported the Consumer Choice Model because it would offer consumers a preference in the transportation provider verses being told which transportation company would provider service for their trip.

Other findings from the survey responses were that most respondents stated that individual customer service would improve through the Consumer Choice Model. Thoughts were expressed that if the existing brokerage service continues to be maintained by the cheapest provider for the trip or lowest bid, that there will be a long term effect on the quality of service and the longevity of businesses. Businesses are not able to build a capital replacement plan into the existing negotiated trip and mileage rates. Respondents stated the existing Model has limitations with coordination due to time constraints for travel and wait time frames. Without flexibility, limited coordination can occur and multiple vehicles are likely scheduled in similar service areas, resulting in duplication of service. Some respondents supported the Brokerage Model due to the improved organization of trip assignments, reporting, and potential for reduction in fraud and waste.

In comparison to the *2012 Medicaid Transportation Provider Survey,* common problems were identified as lack of consumer choice of provider, poor communication, and long wait times. Improvements in 2012 included on-time performance, accountability of providers, more organized scheduling, which is similar to responses in the 2014 survey.

Other similar responses between the 2012 and the 2014 survey include:

- low reimbursement rates to transportation providers with increased expectations and mandatory requirements
- communication with Broker management is challenging
- less coordination of trips due to time constraints and inflexibility
- need increased technology for trip scheduling and reporting
- need to set standards for Brokerage Model

Figure 1-1: Does your Organization Provide Work-related Transportation?

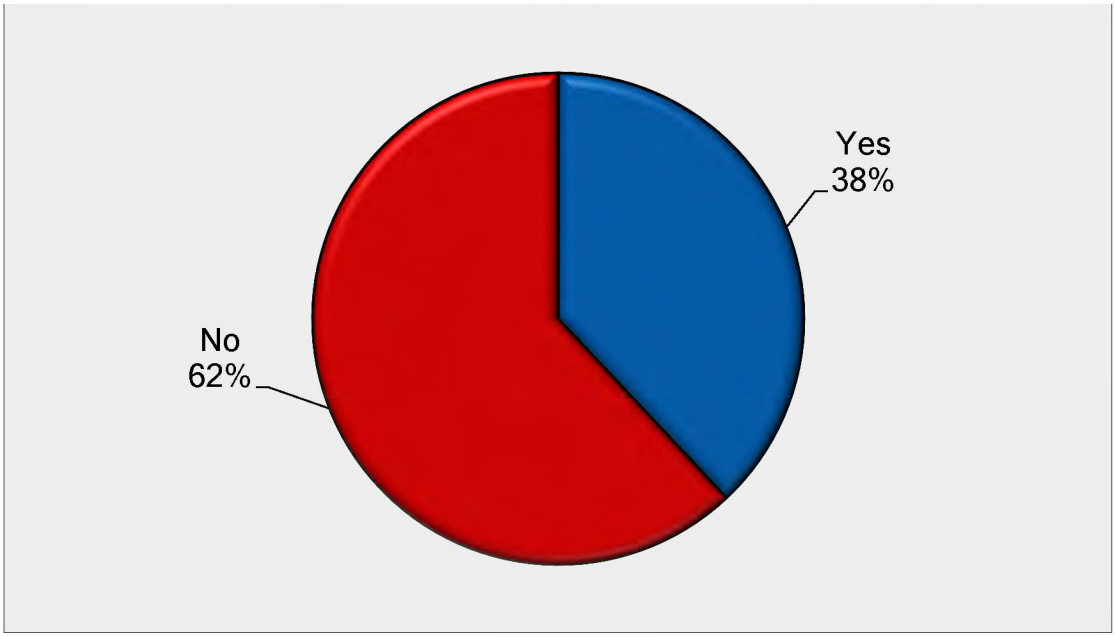
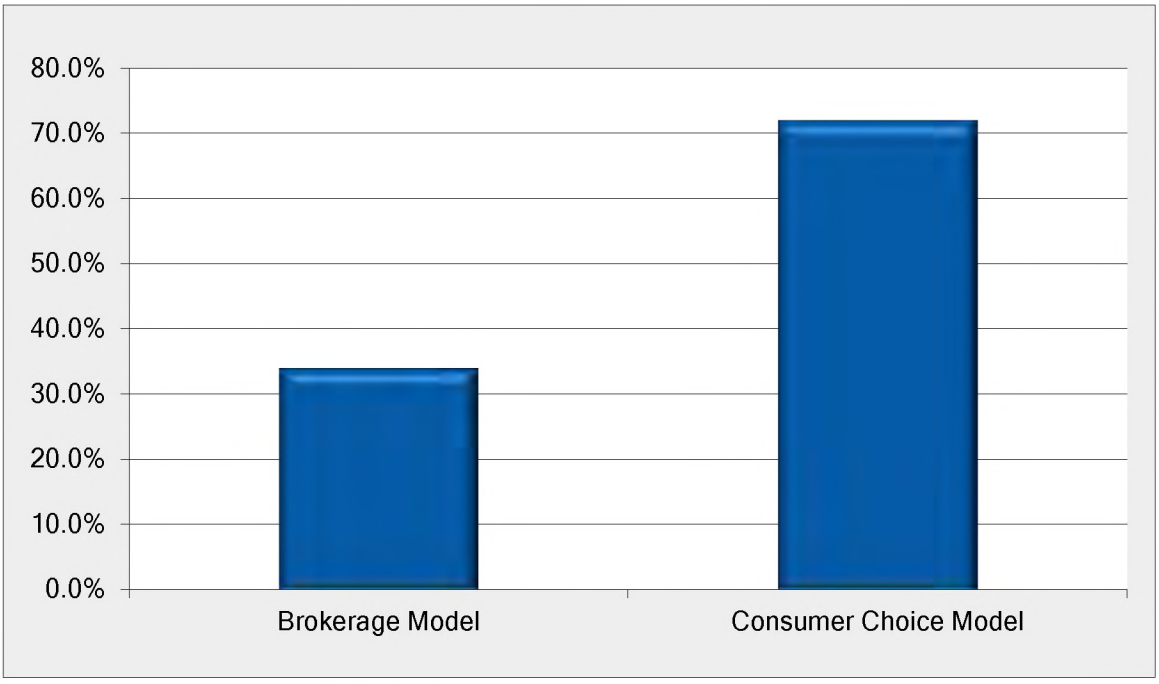


Figure 1-2: Which NEMT/Public Transit Model Do You Think is Best for the State and Its Agency Consumers?



1.4 Report Summary

This Final Report for the Human Services Medicaid Infrastructure Review includes detailed data regarding the South Carolina NEMT program, along with public feedback from agency stakeholders, the community, and local providers, which was used as the basis for developing future options to the NEMT infrastructure in South Carolina. The peer information presents a variety of strategies used in other states for administration of services. These data were used to research alternatives for South Carolina and to identify advantages and disadvantages

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2 STATE DEPARTMENTS WITH TRANSPORTATION COMPONENTS

2.1 State Agencies with Transportation Components

Over a decade ago, the United States General Accounting Office identified over 60 federal programs, most of which are administered by the Departments of Health and Human Services, Labor, Education, and Transportation, which fund a variety of transportation services for the transportation-disadvantaged. Since that time, South Carolina has implemented several mechanisms to review and enhance coordination efforts, including the aforementioned SCITCC. In addition, in 2008, the *South Carolina Mass Transit and Human Service Programs Transportation Study Committee,* the Committee which recommended and launched the SCITCC as it stands today, completed a summary report of state agencies actively involved in providing transportation, contracting transportation, or needing transportation for program consumers. A summary table from that study is shown in **Table 2-1** and continues to be valid today.

Table 2-1: Clients/Consumers Served

Agency	Elderly	Disabilities	TANF	NEMT	Other
Lieutenant Governor's Office on Aging	★				
South Carolina Department of Disabilities and Special Needs		★			
South Carolina Department of Health and Human Services	★	★	★	★	
South Carolina Department of Mental Health	★	★		★	
South Carolina Department of Social Services			★		
South Carolina Department of Transportation	★	★	★		★
South Carolina Vocational Rehabilitation Department		★			

The following text provides detailed agency information regarding transportation, which will be used to analyze potential coordination alternatives for the future.

2.2 South Carolina Department of Health and Human Services - Non-Emergency Medical Transportation Program

The state of South Carolina presents a diverse geographic and demographic environment. The SC Non-Emergency Medical Transportation (NEMT) program must handle services from the urban areas of Columbia, as well as support rural regions, such as the Upper Savannah, in which Medicaid

beneficiaries must travel in some circumstances, over 100 miles in each direction to receive most specialty care.

South Carolina Department of Health and Human Services (DHHS) administers the Medicaid program and is responsible for ensuring the availability of NEMT for Medicaid beneficiaries in the state. The existing DHHS goal for transportation is:

> ***DHHS Goals/Objectives for Transportation:***
>
> *To provide safe reliable transportation to all Medicaid members that need it using the most appropriate and cost effective means delivered by qualified and courteous drivers using safe vehicles and equipment.*

South Carolina uses the brokerage model to assume full responsibility for providing Medicaid NEMT service. This model has been in place for approximately 10 years. The primary reasons for the DHHS to change to the brokerage model a decade ago were due to:

1. Increasing costs in the program, with little or no end to the increasing costs in site. Some years experienced 10 percent or more increase in costs.
2. Lack of accountability of the providers with little oversight was being experienced. Abuses were reported in the system.
3. Level of visibility and how the Medicaid program worked was not clear. One example from the old system was that complaints were not tracked formally and very little data were available. In addition, very little data for tracking and monitoring trips was available.

The current broker, Logisticare, has the following duties: eligibility screening, fielding trip requests with a call center, assigning trips, managing transportation providers, and reporting. The existing contract ended in May 2014. DHHS is currently underway with the procurement process for the next contracted services.

The current DHHS process for managing and oversight of the Medicaid broker is monthly reporting by the broker for each region they have a contract for – trips, miles traveled, on time performance, call center metrics, complaints and denials. The broker is also responsible for Ad hoc requested reports, as requested by DHHS staff. **Appendix C** presents a sample monthly summary report. Monthly operations meetings are held with the broker and DHHS staff. Staff conducts joint field observation site visits to review / inspect transportation providers, along with announced and unannounced visits to the Broker's SC business office / call center. In addition, the South Carolina Department of Health and Environmental Control conduct scheduled site visits to the transportation providers.

Logisitcare, a private for-profit national entity, currently manages transportation services and does not provide transportation themselves. However, as mentioned above, DHHS is currently conducting the procurement process for the next DHHS NEMT provider, which may remain the same or a new company may be named, depending upon the outcome of the process. Across the country, Medicaid NEMT brokers are currently working at local, regional, and statewide levels. In South Carolina, it is at the statewide level. Logisticare has a fee for administration, in addition to the cost of providing transportation. Logisticare is paid a fixed fee every month for NEMT services. Any cost overruns are the broker's responsibility, enabling the DHHS to predict costs with more accuracy. The Broker is responsible for negotiating rates with transportation providers.

The Logisticare contract in SC includes eligibility screening, trip scheduling, and third-party contracting with local transportation companies. Logisticare maintains a pool of NEMT providers and distributes trips according to the least costly, most appropriate mode available. The company has a toll free number for assistance and handles provider reimbursement and quality assurance. The broker is required to have TTY service, as well as language translation services, if needed.

The reservation process generally begins with the member or someone on behalf of the member (health care provider, or care giver) who calls a toll free number to request transportation. The Broker checks:

- Eligibility
- Traveling to a Medicaid covered service
- Has given the three day notice for routine appointments (3 day notice is not required for urgent medical appointments), and
- Determines if special assistance is needed (will also book space for an escort if needed).

Currently, approximately 60 percent of the transportation requests are for 'standing orders,' where the member attends or is treated three to five days per week, such as Adult Day Care, Behavioral Health, or Dialysis. Reservations for these trip types are usually arranged by the treatment facility on behalf of the member. The South Carolina Medicaid coverage area is generally within South Carolina and within 25 miles of the border with other states. As needed, the broker also arranges transportation for services outside the coverage area that may include air fare, meals and overnight accommodations for the member and an escort.

The DHHS has performance measures in place to monitor the brokerage service (see **Table 2-2**). Should the performance measures not be met, then DHHS has a corrective action plan in place, followed by the potential for assessment of liquidated damages. In addition to the performance measures listed below, a well-defined complaint process is in place with detailed reporting requirements to the DHHS monthly of all complaints. Expedited reporting is required for injury or accidents reports.

Table 2-2: Key Performance Measures

DHHS Broker Key Performance Measures – Transportation	
Indicator	**Measure**
A-Leg Pick Up	within 30 minutes of the scheduled pick up time (30 before or 30 after) 90% of the time (daily average)
A-Leg Drop off	up to 45 minutes before the appointment as long as the facility is open 95% of the time (daily average)
B-Leg Pick Up	within 30 minutes of the scheduled pick up time (closed or scheduled pick up) or within one hour of the call to request the return ride – 90% of the time (daily average)
B-Leg Drop Off	within normal ride time – 99% of the time (daily average)
Urgent trips and discharges for hospitals	Pick-Up within 3 hours of the call to request transportation
Ride Time	must be no longer than 1 hour plus normal drive time (includes loading and unloading factor) – 99% of the time (daily average)
Provider No Shows	less than 0.25% (daily average)
Key Performance Measures – Call Center	
Average speed to answer	< 60 seconds average daily
Call abandonment rate	< 5% daily
Time on hold before abandonment	< 90 seconds average daily
Average time on hold for calls placed on hold	<= 3 minutes daily average

Approximately 950,000 persons are enrolled in Medicaid, with almost all members being eligible for transportation benefits if going to a Medicaid covered service. About 7.5 percent of the eligible population uses the transportation benefit. In the last fiscal year, DHHS reported approximately 2M trips were provided annually. Approximately 80 percent of those trips were made by private transportation providers. The agency also has some individual contracts with other agencies that provide transportation for Medicaid clients (some school districts, School for the Deaf and Blind, Lt. Governor's Office - Continuum of Care). Other contracts include partners, such as the Councils on Aging and a few Regional Transportation Authorities (RTAs). Several RTAs have terminated their relationship with the broker and no longer provide transportation for Medicaid beyond their fixed routes. Logisticare also arranges bus tickets for members whenever possible for the fixed route transportation systems.

The Medicaid expenditures for FY2010-2013 are shown in **Table 2-3**. The overall Medicaid budget is approximately $6B annually, with approximately one percent or $60M allocated to the NEMT Broker.

DHHS has other NEMT contracts, which equate to approximately $5M annually that the agency would like to consolidate. DHHS is also reviewing the inclusion of all transportation for Adult Day Care into future contracts. It is currently paid directly to Adult Day Care for any trips less than 15 miles, which are approximately 500,000 one way trips per year.

Table 2-3: Medicaid Expenditures, FY2010-2013

State FY	FY2010	FY2011	FY2012	FY2013
NEMT – Broker	$49,626,932	$55,307,324	$59,916,924	$60,832,300
Total Medicaid Expenditures	$5,290,000,000	$5,880,000,000	$5,260,000,000	$5,940,000,000

To summarize, DHHS expresses interest in reviewing other models; however, other models would need to provide an equal or better level of service just as the existing brokerage does, such as high visibility, reporting, customer services, etc.

2.2.1 Lieutenant Governor's Office on Aging

The Lieutenant Governor's Office on Aging (LGOA) is the designated State Unit on Aging for South Carolina and receives Title III funds from the U.S. Administration on Aging (AoA). The majority of aging services are federally funded through the 1965 Older Americans Act (OAA). This law requires states to establish a comprehensive and coordinated network of services for older Americans at the State and regional levels. The mission of the Lieutenant Governor's Office on Aging is to enhance the quality of life for seniors through advocacy, planning, and development of resources in partnership with Federal, State and local governments, nonprofits, the private sector, and individuals.

The LGOA has designated ten (10) planning and service districts (PSD) to plan and implement aging services by providing financial assistance within the regions to plan, administer, and deliver a wide range of needed services through local providers/contractors. Such efforts should bolster existing services, coordinate short and long-range development efforts, and facilitate creation of new services needed to fill current gaps.

Transportation is a critical service which allows seniors to meet their daily needs, and to achieve the ultimate goal of maintaining independence and remaining safely in their homes. Without adequate transportation seniors eventually have to relocate with family or be institutionalized.

One key strategic goal for the LGOA includes improving transportation services for seniors statewide. Transportation continues to be a major challenge for the aging network in South Carolina. One successful coordination project is the Assisted Rides Volunteer Program (ARP) being offered through the Waccamaw, Santee Lynches and Central Midlands Aging and Disability Resource Centers (ADRC). This program is made available through a partnership with and a grant from the South Carolina Department of Transportation (SCDOT). The ARP provides seniors and their caregivers with needed

critical transportation by matching volunteers with transportation requests. Since July 2013 (through June 2014), the ARP has provided over 7,313 trips totaling 520,014 miles. The Lieutenant Governor's Office will continue working with South Carolina Department of Transportation and all the AAAs/ADRCs to expand this transportation project statewide.

Approximately 5,000 clients use transportation services funded by Aging funds (state and Federal). In terms of service utilization, transportation is the second most utilized service after nutrition. The total Aging funding for transportation is approximately $5M annually.

Local Councils on Aging or Senior Service Agencies provide demand response transportation for elderly persons across the state to/from medical appointments (non-Medicaid), essential shopping, nutrition sites, etc. Typically, local agencies lease vehicles for transportation or contract out the service to other local transportation providers.

2.2.2 South Carolina Department of Disabilities and Special Needs

The South Carolina Department of Disabilities and Special Needs (DDSN) is the state agency that plans, develops, coordinates and funds services for South Carolinians with the severe, lifelong disabilities of:

- mental retardation and related disabilities
- autism
- traumatic brain injury
- spinal cord injury and similar disability

While DDSN provides services that address these specific disabilities, the agency recognizes that their consumers will routinely need services provided by other state agencies - such as education, public health, mental health, housing, transportation, and social services. DDSN works with other state agencies to coordinate, arrange for, and deliver services to eligible persons. DDSN's specialized services supplement and enhance, not replace, services provided by other state agencies.

DDSN is governed by a seven-member Commission appointed by the Governor with the advice and consent of the Senate. A Commission member is appointed from each of the state's six Congressional districts, and one member is appointed from the state at-large. The Commission is the agency's governing body and provides general policy direction and guidance. Appointed by the Commission, the State Director has jurisdiction over the central administrative office located in Columbia, SC, five regional centers and all services provided through contracts with local agencies and service providers.

DDSN provides services to the majority of eligible individuals in their home communities through contracts with local service-provider agencies. Many of these agencies are called Disabilities and Special Needs (DSN) Boards, and they serve every county in South Carolina. Approximately 60-70 transportation providers are contracted in each of the 46 local counties to provide necessary DDSN services. The contracts for service in the local counties have a Request for Proposal procurement process and are typically rebid every five years. Approximately 15,000 persons each day need transportation within the DDSN program.

DDSN also provides 24-hour care for individuals with more complex, severe disabilities in Regional Centers, located in Columbia, Florence, Clinton, Summerville and Hartsville. DDSN directly oversees the operation of these facilities, which are managed by a facility administrator. Approximately 800 consumers have services on the five regional center campuses, using approximately 35 vehicles for transportation. Trip logs are kept with each vehicle at the Regional Centers to monitor consumer usage.

Each local DSN Board serves as the initial entry point for all DDSN clients. The DSN Board, or the Information and Referral System for persons suspected of having a head or spinal cord injury, will first screen applicants to determine if an eligibility packet should be completed and sent to DDSN. At this point, the applicant can choose from a list of qualified service coordination or early intervention providers to assist them in the eligibility determination process.

Once a person becomes eligible for DDSN services, the Service Coordinator determines what level of service coordination the consumer will receive, based upon the assessed needs. As applicable, the Service Coordinator works with the consumer and his/her family and friends to develop a Person-Centered Plan to address the needs identified and to monitor the implementation of the plan. There are approximately 32,000 persons in South Carolina qualified for DDSN services. The Department estimates approximately 95 percent of their consumers are Medicaid clients. A high percentage of the DDSN consumers are unable to ride general public transit service due to the severity of their disability. A flat fee of $1000 per month is allocated to each client, which includes transportation costs. The flat fee is based upon historical data and adjusted as needed each fiscal year.

2.2.3 South Carolina Department of Employment and Workforce

The South Carolina Department of Employment and Workforce (DEW) is responsible for paying unemployment insurance benefits, collecting unemployment taxes, helping people find jobs, matching businesses with qualified candidates, and collecting and disseminating state/federal employment statistics. The main goal of the agency is to match jobseekers with employers quickly, efficiently, and effectively.

DEW, one of 16 cabinet agencies in South Carolina, is a partner in the state's workforce system. This includes SC Works centers, satellite offices and Connection Points in 12 local workforce investment areas, where DEW and its partners provide services to meet the needs of the state's businesses, jobseekers and those looking to further their careers. The majority of DEW's budget is funded through federal sources. The U.S. Department of Labor allocates funds from the Federal Unemployment Tax (FUTA) to the states to pay for administrative and operational costs. Employer-paid state unemployment taxes pay for state unemployment benefits.

SC Works and DEW offer access to a variety of workforce services in all 46 S.C. counties. SC Works Centers include reemployment services for jobseekers, partner services, business services and resource rooms for use when filing for unemployment benefits or searching for work online. DEW provides assessment, counseling and job referrals connecting citizen with employers and upcoming job fairs.

DEW is not directly responsible for transportation services in the South Carolina counties; however, the agency has long-recognized the valuable link of available transportation to sustainable employment. Regional and local offices support and are open to increasing coordination efforts for DEW participants.

In some areas of the state, the SC Works program financially supports mileage reimbursement for job search and training related activities. In communities where public transportation is available, participants use the service to access work related appointments. For example, in the Waccamaw Region, with proof of attendance, participants are reimbursed for mileage, using 65 percent of the current government assessed mileage rate. In addition, Workforce Invest Act participants utilize public transportation in Horry and Georgetown Counties, Coastal RTA, and in Williamsburg counties, participants use Williamsburg County Transit system.

Another unique example of DEW proactive support for moving citizens into employment and training is with the Upstate Workforce Investment Board. The agency received two grants for approximately $7,000 from a local foundation which is used to transport students to/from Adult Ed and Spartanburg Community College. The local organizations, Mission of Grace and Salvation Army, use their vans and WIB pays them for the services. The agency also has a youth program that uses school buses, as it is an in-school youth program. Public transportation in the region has limited service hours and service area, thus creating a challenge for those getting to employment sites outside the service area.

2.2.4 South Carolina Department of Social Services, Division of Family Assistance

The Department of Social Services is one of the largest agencies within the state, with approximately 4,400 employees, and an annual budget over $1.2B. DSS has multiple programs and services designed to provide assistance and protection for citizens in South Carolina. The Division of Family Services is one of the core programs for the department.

Approximately 12,525 annual participants, as of December 31, 2013, are actively enrolled in the DSS program, Temporary Assistance for Needy Families (TANF) or the Family Independence (FI) program. TANF is a time-limited program of two years maximum, with the goal of helping the family achieve self-sufficiency within those two years. Transportation is one of the mandatory requirements of the program. For an individual to remain eligible in the TANF program, case managers must verify participation hours in a countable work activity that meets the criteria of 20 or 30 hour per week average (depending on the circumstances and demographics of the household) each month.

Of the 12,525 TANF participants, approximately 5,816 are child-only participants and not eligible for transportation reimbursement. Of the remaining 6,709 program participants, approximately 5,131

receive a monthly stipend which includes transportation funding. The average transportation amount per person per month included in the stipend is $75. For some rural areas in the state, the amount is higher due to the distance traveled to services. In addition, in the areas where public transit service is available, the agency uses bus passes for transportation. This equates to approximately $385,050 annually used solely for transportation. The Division estimates that approximately 98 percent of the participants are also Medicaid eligible. DSS also serves 97,000 Able-Bodied Adults Without Dependents (ABAWDs) of the Supplemental Nutrition Assistance Program (SNAP) at an annual cost of $300,000.

In the past, DSS used to have a brokerage model in place for services and have considered this option for delivery. However, the primary reason for the existing model in place is the high cost of the brokerage in the past using a cost per trip basis.

2.2.5 South Carolina Department of Transportation, Office of Public Transit

During SFY 2012, 27 public transit operators were supported by funding managed by the SCDOT Office of Public Transit. Among these transit operations were agencies that provided services in small towns, counties, urbanized service areas, and multiple-county regions of the State.

- 7 urbanized transit agencies
- 16 non-urbanized transit agencies
- 4 joint service (urban & non-urbanized) agencies

Currently, general public transit services are available in 40 of the 46 counties in the State. Those counties without established general public transit service were Abbeville, Cherokee, Greenwood, Laurens, Saluda and Union Counties. In 2012, transit agencies employed a total of 875 transit vehicles in delivering a variety of service types to residents and tourist in South Carolina.

During SFY2012 27 general public transit agencies provided 12,679,763 one-way passenger trips, which is a 6.8% increase in transit ridership in comparison to the SFY 2011 ridership level of 11,874,494. The transit agencies operating in urbanized service areas generally have higher ridership than those operating in rural communities. This observation is also evident in the SFY 2012 transit data for South Carolina, as the urban transit providers delivered 9,318,403 passenger trips in comparison to 3,361,360 trips delivered by rural transit agencies. While data is not collected to evaluate direct benefit to transit patrons and impact on the community; the actual services delivered and the reported transit data for SFY 2012 reflect employment connection opportunities for workers, access to medical services for residents, connection to educational facilities for students and access to public services and facilities around South Carolina.

Total public transit revenue for SFY 2012 was $62,882,843. The greater percentage of this total went to urbanized service area agencies, with a total of $35,652,436. The rural agencies had a collective total of $27,230,403 for SFY 2012. There was a small increase in expenditures from SFY 2011 to SFY 2012 of 1.4 percent, and a 7.8 percent increase from SFY 2010 to SFY 2012.

In FY2012, public transit agencies provided approximately 367,500 Medicaid trips out of the 12,679,763 total trips (3%) for the state. Medicaid operating costs were approximately $8,871,392 that year, with approximately 217,800 annual revenue hours and 4,979,000 annual revenue miles reported for Medicaid trips. Public transit agencies reported 141 peak daily vehicles in service across the state for Medicaid on an average day.

Coordination is on the forefront for many transit agencies across the state. The agencies recognize the benefits and cost savings involved with multiple partners. One recent example of moving coordination forward occurred in the Berkeley-Charleston-Dorchester Council of Governments Region. The COG sponsored a Coordination of Human Service Transportation Workshop on June 22, 2012 in Charleston, South Carolina. The purpose of the Workshop was to identify ways to plan and implement effective transportation strategies in order to offer transportation choices and services for improved access to employment, healthcare, and other activities of daily living for the citizens in the area.

2.2.6 Summary

The agencies discussed in the above paragraphs are actively involved with transportation for their consumers and for the general public. These data were used to assist in the analysis of coordination opportunities in the future.

3 PEER REVIEW OF COMPARISON STATES

The purpose of the peer review is to understand the coordination models adopted by other states and compare and contrast these models with South Carolina as future alternatives are developed. The objective within this analysis is to identify strategies, programs and practices that could improve coordination in South Carolina.

There are a variety of existing state-level models in place that can be reviewed and used to develop and build upon South Carolina's current process and mechanism. Specific facets of peer state models are discussed below, and served as points of discussion and comparison, and were considered in the development of future alternatives for South Carolina.

3.1 Florida

One of the hallmarks of the Florida coordination model is formalized coordination structures at both the state and local levels. By legislative statute, Florida created the Commission for the Transportation Disadvantaged (CTD), a public state-level entity which now coordinates much of the funding for the regional human service transportation in Florida. This includes some FL Department of Transportation funding, Medicaid funding, some other state-level human service agency funding, and funding dedicated to the CTD to help sponsor customers whose trips are not subsidized by one of its funding partners. The CTD then contracts directly with the Community Transportation Coordinator (lead coordinating agency) in each region/county.

The Commission consists of seven voting members all appointed by the Governor; five Business Community Members and two members who have a disability and use the Transportation Disadvantaged (TD) System. One of these members must be over 65 years of age. In addition, the Secretary of the Department of Transportation, the Secretary of the Department of Children and Families, the Director of the Agency for Workforce Innovation, the Executive Director of the Department of Veterans' Affairs, the Secretary of the Agency for Health Care Administration, the Director of the Agency for Persons with Disabilities, and a county manager or administrator who is appointed by the Governor, or a senior management level staff of each, serve as ex officio non-voting advisors to the Commission.

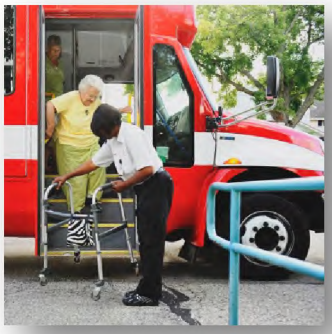
The Commission typically has 15 full-time and 2 part-time staff that provides support and administers the statewide TD Program. The Executive Director provides oversight for all staff and is directly accountable to the Commission.

Florida state law requires transit services to be coordinated at the county level. The Commission directs coordination for the Transportation Disadvantaged and the state uses county or regional transportation coordinators who operate as part of the state's program to provide transportation to

Medicaid clients, either directly or through brokers. Medicaid clients in Florida who need rides to necessary medical services contact the Community Transportation Coordinator (CTC). The CTC then either provides or arranges for the trip and bills the state's fiscal agent. If transportation is not available in a particular area, the client contacts the regional Medicaid office. The CTC or the regional Medicaid office determines eligibility for transportation.

The Local Coordinating Board (LCB) oversees and annually evaluates the CTC, which is approved by the Commission. The LCB is appointed and staffed by one of the 11 Regional Planning Councils (RPC) authorized by Florida Statutes or by a Metropolitan Planning Organization (MPO). The LCBs provide local assistance to the CTCs by identifying local service needs and providing advice and direction to CTCs on the coordination of services. Each LCB is recognized as an advisory body to the CTC in its service area.

Florida's Medicaid transportation program is operated as an entitlement program. The underlying philosophy of the program places an emphasis on service without regard to cost. The transportation program operates as an optional medical service, making it eligible for high federal matching rates. Florida's program is innovative because of the coordinated approach it uses to provide NEMT. Under the statewide mandate, all programs that receive or administer state funds for transportation must participate in the coordinated transportation network.



Florida's statewide model used by regional/local coordinated systems develops a cost and rate pertinent to each supporting agency. The statewide cost allocation model is based on accounting principles used in the Transportation Disadvantaged Program. The method is built upon three years of both historical and projected budget data, and provides fully allocated rates with local ability to adjust rates at specified times. This enables the lead regional coordinating entity or service provider to itemize all of its costs, apportion the costs to each funding sponsor based on historic ridership, and develop a unit cost per each sponsor for invoicing purposes.

A key responsibility of the Commission for the Transportation Disadvantaged is to administer the Transportation Disadvantaged Trust Fund (TDTF) that provides funding to carry out the statutory responsibilities of the Commission. Since 2011, the Department of Highway Safety and Motor Vehicles (DHSMV) is required by law to transfer from the Highway Safety Operating Trust Fund (HSOTF) the sum of $5 million annually to the Transportation Disadvantaged Trust Fund (TDTF) in the Department of Transportation (FDOT). The TDTF revenues support the Commission for the Transportation Disadvantaged in fulfilling its statutory purpose and responsibilities to the transportation disadvantaged.

Other funding revenues for the TDTF are appropriated by the Legislature to the commission and are used to carry out the responsibilities of the commission including its administrative expenses. The largest funding source contributor of the TDTF is the Agency for Health Care Administration (ACHA),

which administers the Medicaid program and contributed $65.9 million to TDTF in FY 2010-11. Motor vehicle registration fees accounts for over $21 million of the annual revenues distributed to the TDTF. These include a $1.50 dedicated fee on initial and renewal registrations on certain private use vehicles, $5.00 from each issuance of a temporary handicapped disabled parking permit, and a $1.00 voluntary contribution on motor vehicle registrations.

FDOT transferred $17.8 million from the State Transportation Trust Fund in FY 10-11 to the TDTF. This includes $11.8 million, or 15% of the public transit block grant funding, which is required under s. 341.052(5), F.S., to be distributed TDTF for transportation disadvantaged service providers. In addition, $6 million is transferred annually as part of the FDOT Adopted Work Program, public transportation operations funding.

The TDTF funds are a critical part of the Florida model as these funds are used to fill local transportation gaps by providing transportation for people who have limited mobility, but do not qualify for transportation services through other funding sources – described as "non-sponsored customers". The TDTF funds are distributed by formula through two grant programs – one for CTCs in the provision of direct transportation services and equipment, and one for local planning agencies for the purpose of transportation disadvantaged planning and for providing staff in support of local Coordinating Boards.

As outlined in the Florida Statutes, the Commission produces an annual performance report that provides an overview of the program, highlights program accomplishments, and summarizes statewide trends. The annual performance report also provides statistical, operational, and financial information on all coordinated transportation services from information gathered from the local CTCs and planning agencies. In addition to capturing ridership data and other service outcomes, the coordinated structure enables the important reporting of unmet transportation needs due to lack of funding, lack of vehicle availability, or other reasons.

3.2 Georgia

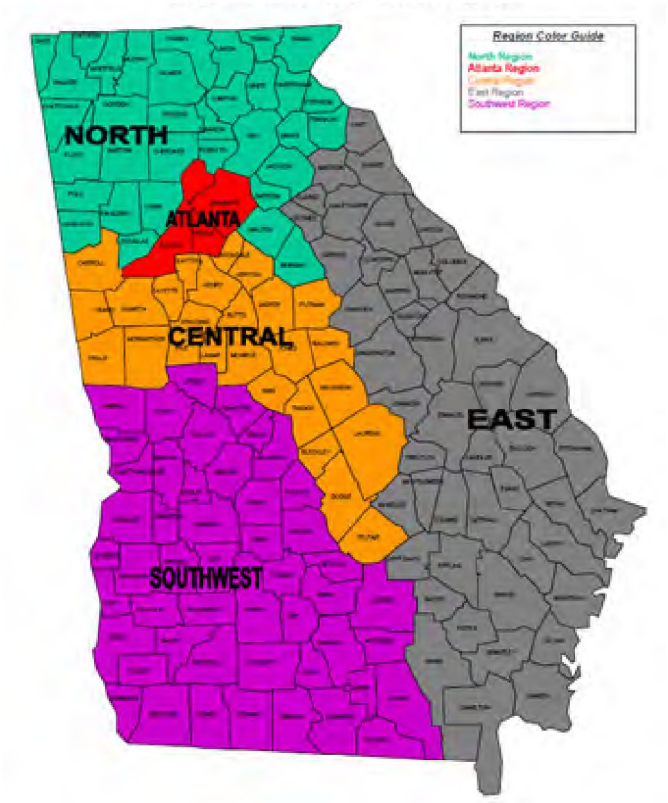
The Georgia Department of Human Services (DHS) administers the Section 5310 Program for the State of Georgia, employing federal and state funding authorized for the implementation of public transportation programs. The DHS Coordinated Transportation System is administered by the Transportation Services Section within the Office of Facilities and Support Services. The system is designed to provide services to DHS and other eligible clients and citizens, and therefore is a human service transportation system. The system provides services to the DHS Division of Aging, Division of Family and Children's Services (DFCS) (Temporary Assistance to Needy Families (TANF)) and the Department of Behavioral Health and Developmental Disabilities (DBHDD) clients. The system also serves clients from the Department of Labor's Vocational Rehabilitative Services.

The state is divided into twelve regions. A Regional Transportation Office (RTO) is staffed in of each of the state's regions. The RTO is the focal point within each region, and is responsible for transportation provider monitoring and compliance. Three Field Operations Coordinators (FOCs) oversee the RTOs. Each FOC is responsible for one of three districts. Each district contains four of the twelve regions.

For NEMT services, the state is divided into five regions as shown in **Figure 3-1**. The Georgia Department of Community Health (DCH) has a contracted broker in each of these regions to administer and provide transportation services to Medicaid members. Brokers are responsible for:

- Recruiting and contracting with transportation providers;
- Administering payments;
- Gatekeeping and verifying need;
- Reserving and assigning trips;
- Assuring quality; and
- Overseeing administration and reporting.

Figure 3-1: Georgia Non-Emergency Transportation Program



The brokers are obtained through a competitive bid process and are paid a capitated rate for each eligible Medicaid member residing in their region(s). Eligible Medicaid members must contact the broker serving their county three days in advance of their appointment to schedule transportation. Urgent care situations can be arranged more quickly. Each broker has a toll free number to schedule transportation.

The coordinated system operates through a series of purchase of service contracts within each region. Providers are a mix of governmental entities, for-profits, and private non-profits. In many regions a lead provider is the prime contractor. A prime contractor, such as a Regional Development Center (RDC), provides overall contract management in coordination with the RTO and subcontracts with additional entities to provide the transportation services.

Each region has a Regional Transportation Coordinating Committee (RTCC). The purpose of the committee is to establish policies and procedures within each region. In addition, the committee is responsible for contractor oversight and approval of new contacts and contractors each year. The Committee is made of regional division and human service provider representation. All committee members have a vested interest in the system and are either provided services by the system or play an active role in the system.

3.3 Kentucky

In Kentucky, a single coordinated Human Service Transportation fund from among several state agencies administers human service programs. The model established a series of transportation Brokers throughout the state, whose job it was to secure the most cost effective transportation delivery for the human service clients of the various programs involved. The first Broker began in 1998 and the program was fully operational across the state in 2004. The Human Services Transportation Delivery (HSTD) program provides non-emergency, non-ambulatory medical transportation services throughout the State. Subregional transportation providers have contracted with the State Office of Transportation Delivery (OTD), which is responsible for coordinating and providing transportation for each of the State's 15 transportation subregions.

Human Service Transportation Delivery geographic regions were established by the Kentucky General Assembly. A Coordinated Transportation Advisory Council is an inter-agency decision-making body, established by KY Statute, open to the public, and has voting members from the Health and Families Cabinet, Workforce Development, and Transportation. The CTAC oversees the progress of human services transportation coordination, program issues, and policy development.

In addition to the CTAC, the Executive Quality Management Council (EQMC) is a formal council among Cabinets that drafts policy for transportation delivery, takes issues to the CTAC and developed the Quality Improvement Plan for the Human Service Transportation Delivery program.

Agreements are in place for the following:

- Annual agreements between Partners and the Transportation Cabinets
- Transportation Cabinet with Finance Cabinet
  - Annual agreements with Transportation Brokers
- Transportation Broker
  - Agreements with subcontractors

The Broker in each region coordinates the planning, rate setting, and transportation delivery for multiple programs. Reimbursements are based upon on number of caseloads. The different funding sources include public transit fares, Workforce Department for the Blind and for Vocational Rehabilitation fees, and Medicaid capitated rates. Subcontractor rates and base cost of trips are established and reviewed by the Transportation Cabinet. The Broker must submit trip data, complaint tracking, phone report, and detailed financial budget to the KY Transportation Cabinet.

3.4 Minnesota

In Minnesota, NEMT is provided through the state's version of Medicaid, Medical Assistance (MA). The most common form of NEMT in Minnesota, in terms of usage, is known as access transportation services (ATS). Though overseen by Minnesota's Department of Human Services (DHS), counties have

the primary responsibility for delivering ATS to MA recipients under the fee-for-service MA program operated by DHS. The manner in which counties provide ATS and manage the program varies depending upon the differences among the counties (e.g., number of MA recipients; available transportation resources; rural v. urban).

Approximately two-thirds of MA recipients in Minnesota are enrolled in managed health care plans (Managed MA) and generally receive NEMT through these plans. Other recipients are covered by a fee-for- service (FFS) system operated by the Minnesota Department of Human Services (DHS). Two categories of NEMT are provided in Minnesota: Access Transportation Services (ATS) and Special Transportation Services (STS). ATS generally involves either curb-to-curb or door-to-door service. Under curb-to-curb service, MA recipients are responsible for getting themselves to the curbside in front of their pick-up site and from the curbside at their drop-off location. With door-to-door service, the driver provides assistance from the door of the pick-up site to the door of the drop-off location. All MA recipients are eligible for ATS.

STS is a more complete transportation service (referred to as door-through-door) and is reserved for those recipients who are, due to cognitive or physical impairment, unable to use ATS because they require more assistance. The ATS portion of NEMT is administered by county human service agencies, while STS is administered at the state level by DHS.

3.5 North Carolina

Coordinated transportation efforts in North Carolina date back to a 1978 Executive Order requiring the coordination of human service transportation throughout the State. Presently there are over 50 coordinated systems operating in the State. Agencies representing the aging population, mentally challenged residents, vocational programs, and city and county programs all work together to provide transportation options that are more cost-effective and efficient than in the past. The state funds NEMT transportation in some regions as an administrative service, and in some regions as a medical service with a 1915 (b) waiver.

The North Carolina Department of Transportation created a block grant program that consolidated community transportation funding and required that each county have in place a coordination plan in order to be eligible for those block grants. Three additional pre-requisites for block grant eligibility include:

- A transportation advisory or governing board must be established representing specific state agencies and/or services
- A lead coordination agency designated, and
- The lead agency must have a Memorandum of Understanding (MOU) with each of the five core agencies, including the Departments of Social Services, Aging, Mental Health, Health, and Vocational Rehabilitation.

The North Carolina statewide cost allocation model is used by regional/local coordinated systems to develop a unit cost and a rate pertinent to each sponsoring agency. In North Carolina, the statewide model is built upon historical data (from an analysis of service) and projected budget data. The end product is a fully allocated rate for demand-response service, with ability at the local level to adjust the rate based upon subsidy considerations. This enables the lead regional coordinating entity or service provider to itemize all of its costs, apportion the costs to each funding sponsor based on historic ridership, and develop a unit cost per each sponsor for invoicing purposes.

3.6 Pennsylvania

Pennsylvania operates an extremely cost-effective program known as the Medical Assistance Transportation Program (MATP). The MATP is a county-based program that uses local transportation resources and direct management at the local level. The state funds its NEMT transportation as an administrative service.

In Philadelphia, the state contracts with a broker that directs clients to the appropriate and least costly transportation mode (i.e., either fixed-route transit or Para transit provided by local subcontractors). Counties may provide services directly, broker services through subcontracts with public or private agencies, or use a combination of methods. Funds can be used to provide transportation through a number of systems, including providing tokens or bus passes, reimbursing eligible clients for fares, coordinating volunteers, entering into contracts with integrated public transit services, providing services directly using county-owned vehicles and staff, and reimbursing clients for private vehicle expenses. The guiding principle for the MATP is the use of the most cost-efficient service available that meets the client's needs.

In Philadelphia, the Pennsylvania Department of Public Welfare has used a broker to provide NEMT services (for recipients in both fee-for-service and managed care arrangements) since 1983. Using all modes of transportation, including transit passes, individual transit tokens, reimbursement for mileage in a car driven by the recipient, and trips provided in a wheelchair van, the broker provides over 2 million trips per year at an administrative cost of approximately $2.5 million. The broker usually costs between 15 and 17 percent of the total operation. Since the state began using brokerages, it has reduced its NEMT costs by one-third.

3.7 Virginia

In Virginia, the Department of Rail and Public Transportation (DRPT) is the lead agency to help guide compliance with the Executive Order 13330 on Human Service Transportation Coordination. The Department is working to meet the federal government's coordination principles in several important ways. DRPT established the Interagency Transportation Coordinating Council in 2003 to promote interagency cooperation at the state level. The goal of the Council is to allow state agencies to actively work together to identify and recommend state policy changes needed to eliminate duplication and to improve transportation coordination and services to key populations. The Interagency Coordinating

Council consists of agencies under the Secretaries of Health and Human Resources and Transportation including DRPT, the Departments for the Aging, Blind and Vision Impaired, Mental Health, Mental Retardation and Substance Abuse Services (DBHDS), Social Services, and Health.

The state of Virginia reports funding NEMT as an administrative service only. Virginia has a statewide capitated broker that provides NEMT for all of the non-managed care Medicaid population. NEMT is included in the Medicaid Managed Care Plan. There is coordination with state transit authorities using transit passes, which are issued by the broker.

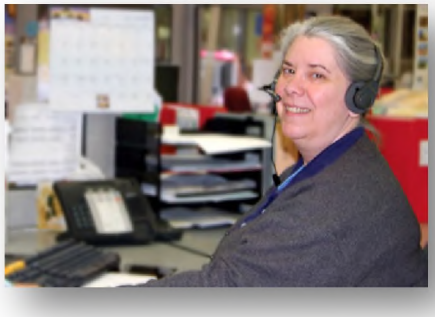
Under the Medicaid Managed Care plan, NEMT is carved in and included in the capitation rate for each health plan. Managed care entities typically subcontract for NEMT services (i.e., out of the five regions, one subcontracts with Logisticare, three subcontract with MTM, and one administers NEMT in-house). A statewide broker, Logisticare, coordinates services for all non-managed care recipients, including fee-for-service and Primary Care Coordinated Network (PCCN) populations.

3.8 Washington

The Washington State transportation brokerage system is a mechanism to share trips among various funders. They arrange for the lowest cost, most appropriate method of transportation, which can include public transit bus passes, gas vouchers, client and volunteer mileage reimbursement, taxi, ferry, commercial bus, and air.

Since 1989, Washington's NEMT services have been managed by transportation brokers for the state's 13 transportation service regions. Washington's Department of Social and Health Services contracts with the transportation brokers, which are selected through a competitive procurement process. The state has opted to fund NEMT transportation statewide using the Deficit Reduction Act option.

In addition to brokering NEMT trips for Medicaid eligible clients, NEMT brokers also can and do contract with other programs to arrange for transportation, such as seniors, veterans, students, and employment transportation. When appropriate, these trips can be shared and costs allocated by trip, miles, service hours and/or a combination of all methods. NEMT brokers or their providers who arrange trips for multiple programs typically assign grouped or shared ride trips only if the assigned group or shared ride trip is more cost effective to the funding source than it would be in comparison to providing separate individual trips, or when it is not possible to provide separate trips.



For NEMT trips, brokers pay transportation provider's based on a pre-negotiated rate, which may include mileage, time, a flat fee, or other factors. The costs are allocated equitably to the clients' specific medical program account codes. There are currently over 90 program account codes that are used to allocate costs for NEMT trips.

When arranging for shared trips, each funder is invoiced for their rider's portion of the trip. These trip costs may include reduced shared ride rates that transportation providers include in their negotiated rates.

The state of Washington has been particularly successful at achieving well-coordinated, cost-efficient NEMT services; however, recently, changes in Medicaid policies have contributed to an increase in service reductions and unmet needs. Dropping reimbursement rates, combined with increased paperwork due to greatly increased federal oversight requirements are resulting in significant service cuts by both non-profit and government operated NEMT providers. These impacts are particularly acute in rural areas, but are starting to affect suburban areas as well.

3.9 Peer State Conference Calls

After the SCITCC members reviewed the information presented in this chapter, the next step for the study included conducting peer state conference calls with two states in which the SCITCC members expressed interest in receiving additional data about a state program. The states selected to contact for additional information were Georgia and Kentucky.

A SCITCC Technical Review Team developed a set of questions for the peer state calls with Georgia and Kentucky representatives, which were hosted in August and September 2014. Interviews were conducted with:

- Leigh Ann Trainer, Section Manager for the Department of Human Services, State of Georgia, August 6, 2014; 10:00a-12:00p.
- David Cassell, Georgia Regional Transportation Authority/Governor's Development Council, September 10, 2014, 11:00a-1:00p.
- James Peoples, GA Department of Community Health, September 18, 2014, 11:00a-1:00p.
- Vickie Bourne, Executive Director; Eric Perez and Jeremy Thompson; Kentucky Transportation Cabinet – September 16, 2014, 10:00a-12:00p.

3.9.1 Georgia Peer Call - Additional Data

Ms. Leigh Ann Trainer was our primary contact for the State of Georgia. She recommended that we contact two other persons, Mr. David Cassell and Mr. James Peoples, because they would have a different perspective of transportation in Georgia, particularly because of the uniqueness of our study with public transit agencies and Medicaid transportation. The summary below provides information from each of the Georgia representatives.

- Georgia initiated a broker system for NEMT in 1999, which has been a cost-saving mechanism for the state.
- Currently the State has two transportation brokers covering five regions. The state coordinates with the brokers to verify services with the providers.

- The state monitors transportation providers to verify if they are supplying proper services and checks driver manifests, logs, sign-in by family members, etc.

Leigh Ann Trainer, Section Manager for the Department of Human Services, State of Georgia

Ms. Trainer has been with the State for many years and coordination needs were identified in the 1990s. The first contract of the Georgia Transportation System Model occurred in 1999. The coordinated service model was pursued to improve and enhance transportation across the state and across the state programs.

DHS partners include Department of Disabilities (DBHDD), Vocational Rehabilitation, Division of Aging, GDOT, and the 159 local Counties. A Memorandum of Understanding exists among the partners, with DHS administering all funds. The FY2013 budget was approximately $28M, with approximately $3M from the FTA 5310 program. Approximately 19,000 consumers are active and approximately 2.4M one-way trips were provided. Twelve Regional Commissions (RC) (similar to Council of Governments in South Carolina) are located across the state with DHS staff in each region. The average cost per trip for FY2013 was $11.36. Administration costs for 29 staff are approximately $1.5M annually.

The DHS organizational structure includes 29 staff in the transportation service section, located across the state. A Mobility Manager, a Contract Manager, and three area Field Operations Coordinators assist with monitoring services. The Field Operations Coordinators are located outside Atlanta and telecommute. They are located in the four different transportation regions outside Atlanta.

DHS has an existing transportation manual for all regions across the state and transportation providers operating the service. The DHS staff, with coordination from the RPC, monitors vehicles, drivers (minimum requirement 21 years, annual mechanic certifications, active driver files, and other mandatory requirements for operating a vehicle.

DHS heavily coordinates with the state DOT through purchase of trips from FTA 5311 providers, FTA 5310 providers, etc. Georgia uses a web-based trip ordering system that works with a multitude of software programs. GDOT uses Route Match software, which is implemented for about half of the transit agencies across the state. Some choose to use other software. The Trip Ordering software was developed in-house for DHS, which began approximately 10 years ago. It began in-house due to limited software options for trip planning 10 years ago. Today, there are multiple companies that perform these functions; however, DHS has invested much time and money to continually upgrade its system. It is an ongoing process for development to meet the capacity requirements of the trip information, added users, and to process quickly for DHS reporting. It has been a learning experience for the Department.

DHS has 25 contracts in place for transportation services currently, with 11 out of the 25 contracts for the Atlanta metro region. The remaining 14 are dispersed across the state. With the existing model, there is not one boiler plate for the 12 regions. The contract is with the RC, who has a Regional Transportation Coordination Council, made of local partners. The RTCC meets each year to review the

needs and decides who will be the subcontractors to provide service. The consumer does not have a choice of providers. The partner agencies order trips for their clients; thus, no central call center. The coordination of services is within the DHS partner agencies. Currently the agency has a very low percentage of complaints for services. The complaints are tracked manually in the different regions and reported appropriately.

Some of the key measures being used today to evaluate the performance of the Georgia DHS transportation program include:

- Cost per trip
- Cost per mile
- Cost per hour
- Cost per client

DHS provides an annual Governor's Report that includes a regional and state summary of the program activities. The agency conducts annual surveys about the transportation services each year to the providers and to the clients. A sample of the survey form for the consumer is shown in **Appendix D**.

Ms. Trainer is familiar with some other peer state costs, such as Florida, Kentucky, and North Carolina. Georgia has very low on-demand trip requests, which allows the agency to keep costs lower than other states that have high on-demand requests. South Carolina has a high on-demand trip request of up to approximately 40 percent of total trips, which increases costs. DHS reports meeting 30 percent of the needs today. The agency is limited because of funding.

In the future, DHS would like to increase coordination with NEMT. Much coordination among the other agencies is in place today, with the potential for NEMT to be coordinated in the future. Medicaid is not included in the existing coordination model because the Department of Community Health (in which Medicaid is housed) prefers the brokerage model, which is working well for them. Mr. James Peoples will provide additional information from the DCH perspective.

David Cassell, Georgia Regional Transportation Authority (GRTA)/Governor's Development Council (GDC)

Mr. Cassell is the Program Manager for GRTA/GDC, whose purpose is an independent reporting entity in the state supporting increased coordination and cost efficiency. The GDC has an Advisory Council made up of the following partners:

- DHS
- Behavioral Health & Disabilities
- Department of Commerce
- Department of Community Health (Medicaid)
- Department of Labor
- Department of Energy
- Department of Transportation

The purpose of the GDC is to assist and advise the Governor on the state's economic development and planning activities. This role includes coordinating the efforts of other state agencies and performing tasks designed to address specific areas of importance to the state's overall economic success. The GDC was created through Senate Bill 90, shown in **Appendix E**, as an amendment to Title 32 of the Official Code of Georgia. The members of the GRTA Board serve as the GDC with a statewide purview whose work is supported by GRTA staff, such as Mr. Cassell who provides administrate support for the agencies. The GDC reports to the Governor's Office of Planning and Budget. The GDC coordinates with the GDOT and DHS departments in an advisory capacity, particularly through the Technical Coordinating Group, under the GDC.

The GDC prepares an annual report for the Governor, which consists of data received from across the state from the DOT, DHS, and DCH. Typically the data is in Excel format with an evaluation of data for annual operating costs, passenger trips, and operational cost per passenger trip. The 2014 annual report is shown in **Appendix F**.

A variety of technology is used across the state for transportation services. The rural public transit providers use RouteMatch through GDOT deployment which began in 2011. DHS uses TRIP$ software, an in-house program, which is described above by Ms. Trainer. The brokers across the state through DCS use proprietary software supplied by the brokers company:

- Logisticare = LogistiCAD, and
- Southeasterntrans = NET InSight

The existing model used in Georgia does not have a consumer choice option for available transportation providers. The NEMT broker assigns the transportation provider. For rural transportation, it will depend upon the provider in the region and what services they provide.

The DHS coordinated model in place today works with many human service programs by coordinating the necessary transportation services. The mobility management function works well by grouping trips, as they are able on a single route, regardless of the funding source. Medicaid has not moved under the DHS umbrella to date. Total Medicaid enrollment was approximately $1.79M in 2013, with a total cost for the program at approximately $9 billion.

Key measures evaluated by the GDC include annual operational costs, cost per passenger trip, cost per vehicle mile, service coverage (% of eligible Georgians with access to rural HS transportation) and extent of coordination (if a rural public transportation provider is used, then the trip is coordinated). The estimated cost per trip is $17.14. The GDC also does a comparison of costs for areas with coordinated trips versus those non-coordinated areas. The agency will maintain annual reporting in the

future; however interest in the GDC participation may diminishes over time, if just an established reporting entity. The GDC may require greater involvement or structure to maintain effectiveness and/or meaning in the future.

Three items the GDC would like to see changed in the future include:

- DHS to use rural transit providers more frequently
- NEMT book more frequently to rural transit providers in a patients area
- Integrate RouteMatch and TRIP$ software for truer picture and better information management.

Lessons learned by the GDC as advice for other states pursuing coordination are to bite off small pieces at a time. States should approach opportunities in a manageable and meaningful way. Measures of effectiveness should be kept to a minimum and be meaningful. The next priority for the GDC is to have increased coordination between DHS and NEMT. The following priority would be to increase coordination of the rural transit providers.

James Peoples, GA Department of Community Health

Mr. Peoples is the Director of Transportation and Special Projects, Division of Medicaid, Department of Community Health. The history of how the state programs were clustered began in the 1990s, when the state brought many agencies together, including Medicaid, under one umbrella. DCH was created in 1999 by the Georgia General Assembly through the transfer of certain functions and duties performed by three state health agencies. Those agencies were the Department of Medical Assistance (now Medicaid and the State Children's Health Insurance Program); the Health Planning Agency and the State Personnel Board (including the Georgia Merit System's health care plan section, now the State Health Benefit Plan).

In 2009, the Healthcare Facility Regulation Division was created at DCH from sections transferred from the former Department of Human Resources' Office of Regulatory Services. Also in 2009, the Office of Health Information Technology and Transparency (now the Health Information Technology Division) was formed at DCH. Today, the Department of Community Health serves as the lead agency for health care planning, purchasing and oversight in Georgia.

DCH is one of Georgia's four health agencies serving the state's growing population of almost 10 million people. Responsible for a $12 billion budget for State Fiscal Year 2014, the department is one of the largest agencies in Georgia state government. Five enterprise offices support the work of the agency's four programs, with more than 600 DCH employees based in Atlanta, Cordele and across the state.

Mr. Peoples manages the transportation programs for DCH. NEMT is administered by a Broker Services program, which began in 1997. The state is divided in to five regions –- North, Atlanta, Central, East and Southwest. DCH contracts with a broker in each of these regions to administer and provide transportation services for eligible Medicaid members. The brokers are responsible for:

- Recruiting and contracting with transportation providers;
- Administering payments;
- Gate keeping and verifying need;
- Reserving and assigning trips;
- Assuring quality; and
- Overseeing administration and reporting.

The brokers are obtained through a competitive bid process, which occurs every five years, and are paid a capitated rate for each eligible Medicaid member residing in their region(s). Eligible Medicaid members must contact the broker serving their county three days in advance of their appointment to schedule transportation. Urgent care situations can be arranged more quickly. Each broker has a toll free number to schedule transportation.

Two brokers are currently active in GA - Logisticare and Southeasterntrans. One broker has two regions and the other has the remaining three regions. The current contracts began in 2012 and will be in place until 2017. DCH will begin the process in 2016. Each offeror may bid on up to three regions to provide service. The selected brokers negotiate rates with transportation providers in each region by trip and/or by distance. There are approximately 1,000 providers currently in Georgia.

DCH requires robust technology and software to be in place for their brokers; however, they do not require specific software – it is up to the broker which software will be used. One existing broker has invested in tablets for each of their subcontracted providers. The tablets are preloaded with the broker software, which allows the provider to input data for each trip instantaneously. That broker has real-time data available at their fingertips, without excess paperwork. DCH does not have access to the software or raw data, but all data is available in the required reporting elements, as indicated in the contract. There are many required data reporting elements, such as utilization, call center holds, etc. Performance standards are set in the contract by DCH. Should the broker not meet the performance standard, DCH will instate liquidated damages to the broker until the performance is improved.

Public transit agencies are used within the brokerage system; however, DCH recognizes the need to use them more. It is more convenient in the urban areas, such as Atlanta or Savannah, to utilize the public transit agencies because more extensive service areas and service hours. Medicaid members also know that by using public transit, they may not get picked up at their door versus having to walk to the bus stop. DCH purchases bus passes, as appropriate for the client. Often, the client has the opportunity to use the pass for multiple trips. For

rural areas, DCH encourages the brokers to use the public transit agencies, but does not mandate them.

The brokers are responsible for vehicle safety, inspections, drug and alcohol testing, and other mandatory requirements in the contract from DCH. DCH staff monitors and audit the broker. As complaints are made, DCH will review and audit more frequently.

DCH transportation element is made up of a lean staff of three persons - the manager and two contract compliance auditors. Staff is tasked with policy development for the division and monitoring the broker's performance. Both existing brokers have huge staff, including call center operations. Due to staff limitations, DCH recognizes they are not as involved with the subcontract providers as they would like to be. The eligibility process is not handled in the DCH Department. The state DHS and the broker are responsible for this function. Residents go to the local county office to complete required paperwork.

DCH provides approximately 300,000 monthly trips or 3.6M trips per year. Approximately 50,000 Medicaid members actively use the transportation services each month. Approximately 60 percent of ridership is the elderly market. As mentioned above, the Medicaid budget is over $9B annually. Approximately $87M is used annually for transportation services.

The legal team at DCH reviews the standards included in the contract between DCH and the brokers. All performance measures are tied to a liquidated damage if not met. The contracts are assessed quarterly.

Items DCH staff would like to see changed in the future include:

- More involvement between DCH staff and transportation providers. Limited staff and resources do not allow much of that today.
- A redesign of the five different regions across Georgia. The existing boundaries do not take into consideration typical travel patterns of Medicaid clients.
- More involvement of public transportation providers as subcontractors for service.
- Develop incentives for transportation providers to improve service, such as on-time performance.

Other changes in the future may be a movement toward a full manage care system for Medicaid members. Approximately 75 percent of the members are currently in that category, with 25 percent as fee based. If full managed care occurs in the future, transportation may also be changed with different oversight.

Lessons learned from the Georgia experience include accountability of the broker with performance measures and liquidated damages and oversight of the services. Good relationships between the brokers and the state must be in place to have a successful program.

3.9.2 Kentucky Peer Call - Additional Data

The second peer state conference call was with:

- Vickie Bourne, Executive Director Kentucky Transportation Cabinet (KTC);
- Eric Perez, Staff Assistant Kentucky Transportation Cabinet, and;
- Jeremy Thompson; Human Service Transportation Branch Manager, Kentucky Transportation Cabinet

Kentucky has in place today a Broker-based Model, risk-based reimbursement for administration and services. The state has 11 regions with not-for-profit brokers operating in all areas. The Office of Transportation Delivery's seven-person staff oversees broker contracts and screens for eligibility. The Office is responsible for seeking grant funds; the oversight and implementation of various statewide public transit grants; and coordinates human service transportation, such as non-emergency medical transportation.

The Human Service Transportation Delivery Branch is responsible for the oversight of the Human Service Transportation Delivery (HSTD) program. The HSTD program consolidates transportation services previously provided by various state governmental agencies. The former transportation delivery process was fragmented, increasingly costly, and vulnerable to fraud and abuse. In addition, transportation services were not easily accessible in some rural areas.

Under the HSTD program, transportation services for the Department for Medicaid Services, Department for the Blind, and the Department of Vocational Rehabilitation are now coordinated by the Kentucky Transportation Cabinet, Office of Transportation Delivery. Funding for these services used to go directly to the counties.

The Office coordinates with other public transportation providers by contracting with the brokers to provide transportation to non-Medicaid individuals with prior authorization. The reimbursement of non-Medicaid riders is a per mileage rate. Kentucky has a successful model for coordination, especially beneficial in transporting from rural areas to medical specialty centers. With the existing Broker Model in place today, individuals (Type 07/08) with disabilities (as determined by state law) have freedom of provider choice. The broker is required to distribute trips fairly for all other trip types.

The Kentucky Transportation Cabinet pays the broker, who pays the subcontractor by a rate established by the Transportation Cabinet. Each broker has a cap payment per member, per month. The subcontractors are paid on a fee for service model.

Approximately $65M annually is spent on NEMT in Kentucky. The average trip cost ranges from $18.00 to $20.00 per trip, and $1.70 per mile. The Kentucky Transportation Cabinet has an administration budget of approximately $440,000 annually, which includes Executive Director, Staff Assistant, Branch Manager, (4) Medicaid Specialists, (2) Internal Policy Analysts, and an administrative specialist. The Analyst and Specialist report to the Brach Manger. The Branch Manager reports to the Staff Assistant

and Executive Director. The Office of Transportation Delivery reports monthly to the Department of Medicaid. The broker reports to the Kentucky Transportation Cabinet and subcontractors invoice and report to the brokers. Regular meetings are held with the brokers and representatives from Medicaid, Vocational Rehabilitation, Department of Blind, and the Kentucky Transportation Cabinet. The Kentucky Transportation Cabinet coordinates with the Department of Transportation because the DOT oversees and manages the NEMT program. Approximately 1M residents are enrolled in Medicaid.

The technology used by the Kentucky Transportation Cabinet is variety of programs. Various reports are received in Excel, Access, and other transportation software. The Cabinet coordinates with a third party contractor to transfer trip data to them, which gives them access to pertinent information, such as vehicle titles, license, etc. Many brokers (who are all currently private, non-profit agencies) use Route Match, Trapeze, or other specialized software. Whichever software used, it must be capable of producing standard reports set by the state. The data from each broker is uploaded to the state to review. The existing standard for a trip has 36 different fields that must be completed for accurate tracking and monitoring by the Kentucky Transportation Cabinet. Monthly reports are generated for the Department of Medicaid Services.

Transportation providers interested in applying for FTA5310 funding must have a coordinated plan in plan for their region that is inclusive of their agency to be eligible for the funds. Trends indicate that most of that funding program is allocated for vehicle replacement, which is one of the greatest needs in Kentucky for all providers.

Current coordination in Kentucky works well with participating partners. For example, Medicaid recipients are not allowed to go to the drug store after a medical appointment; however, the broker coordinates the Medicaid trip with public transportation so the recipient will get their prescriptions. The brokers coordinate as much as possible; however, there are limitations due to time restrictions with Medicaid.

Multiple key performance measures are in place for the Kentucky Transportation Cabinet, particularly for its annual assessments. All subcontracts are reviewed, operating authorities, verifying vehicle insurance, background checks on drivers, vehicle inspections, monthly trip data, financial data, rider surveys conducted, complaints tracking and monitoring, required drug testing, etc.

Items the Kentucky Transportation Cabinet would like to see changed in the future include:

- Discuss the regulation of providers and make it a smooth and easy process to get inside the network.
- Medicaid requires pickup of all recipients that have scheduled a trip; however, there are no penalties or limitations if the Medicaid recipient does a no-show. This unlimited policy is costly

to the subcontractor and the broker. A limitation/stipulation or accountability should be developed for NEMT no-shows.

- Kentucky is currently under the Waiver Plan. Processes may be simpler if Kentucky moved to a State Plan. However, many of the public transit agencies would not be eligible if the state moved to the State Plan.
- Freedom of choice provides good customer service options for residents; however, this option limits coordination with higher expenses for transportation.

Lessons learned from the Kentucky perspective include

- Maintaining good relationships with the brokers, state health service representatives, the legislature, and other program partners.
- Make your staff know well any new Medicaid regulations.
- Do not allow brokers to deny transportation or set subcontractor rates.
- Coordination with the public transit agencies is a major reason the human services transportation model works.

3.10 Summary

The above detailed data regarding the South Carolina NEMT program, along with the public feedback from agency stakeholders, the community, and local providers was used as the basis for developing future options to the NEMT infrastructure in South Carolina. The peer information presented a variety of strategies to review in the alternatives development process. An example of common elements present in the majority of peer states include:

- Legislative or executive orders that mandate coordination efforts.
- State level coordination councils involved in the administration, oversight and/or monitoring of local coordination progress.
- Local level coordination councils involved in the organization, funding and delivery of county-based and/or regional transportation services.
- Several of the public and specialized transportation funds are combined and administered as a single funding source.
- States provide funding for to support local coordination efforts, including staff for coordinating council staff.
- States provide technical support for coordination efforts.

- State level coordination councils are engaged in on-going efforts incorporate Medicaid NEMT resources into the local coordinated transportation system.

The next chapter provides detailed information on alternatives for South Carolina. The data were reviewed by SCDOT, key State Agency Stakeholders, and by the SCITCC for comment. Infrastructure alternatives are presented in the next section and were based upon the extensive feedback received by stakeholders and through conference calls with selected peer states as potential models for South Carolina. Three different future alternatives for South Carolina were explored, which include remaining with the current brokerage system, modifying the existing brokerage, or moving to a competition-based, coordinated infrastructure with consumer choice. The advantages and disadvantages for each alternative are examined.

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4 HUMAN SERVICES INFRASTRUCTURE ALTERNATIVES

As demonstrated within the previous chapter of this report, a variety of models exist across the country today in how NEMT services are administered. Even among states using brokerage models, different frameworks are managed in different areas. To assess future Human Services Infrastructure options for the State of South Carolina, a number of models were reviewed and **four alternatives** were developed for South Carolina to consider.

1. Remain Status Quo – Regional Model
2. Regional Broker – similar to Georgia
3. Regional Broker - similar to Kentucky
4. Statewide Consolidated Contracting Agent

As documented within this report, the state of South Carolina spends approximately $128M annually on public and specialized transportation, as shown in **Table 4-1**. This amount is an estimate because some state agencies presented in Chapter 2 of this report did not report annual transportation costs. The current South Carolina regional broker model for Medicaid offers both opportunities and challenges as the State reviews how they can improve and enhance coordination of all resources.

Table 4-1: Transportation Expenditure for Public and Specialized Transportation

South Carolina	
Annual Transportation Expenditures	**Annual Cost - Estimate**
Medicaid	$60,000,000
Lieutenant Governor's Office on Aging	$5,000,000
Department of Social Services	$300,000
Department of Transportation	$63,000,000
Estimated Cost of SC Transportation	**$128,300,000**

** Note: Estimate due to not all state agencies providing costs.*

4.1 Opportunities

Existing coordination in South Carolina began over 10 years ago and has supported human service coordination among all state agencies. These include:

- Governor-established South Carolina Interagency Transportation Coordination Council (SCITCC).

- Multiple state agencies recognize coordination as an important strategy to improve transportation services.
- Ongoing efforts at the national and state level to support and encourage local participation in federal grant programs.
- Multiple agencies working together to fund, administer and manage federal transportation programs.

4.2 Challenges

Efforts to improve and expand coordination in South Carolina face challenges moving forward. Some of these challenges are a result from the historical state government structure, from state departments that have always conducted business in a certain method and are uncertain about changes to that program, and others result changes in how transportation is provided for South Carolina residents.

- Demographic trends suggest that the demand for transportation services across the State will increase.
- The existing delivery system for transportation services in South Carolina is fragmented, such as Medicaid follows these procedures, Office of Aging uses this method, and DOT follows these regulations. Funding programs further impede coordination with different guidance and restrictions on how funds may be used.
- Fragmented transportation service programs create gaps in service delivery and duplication of services.
- Some existing transportation programs are currently underutilized and could be maximized to provide additional services to meet transportation needs.
- Local governments and non-profit organizations are challenged to meet matching resources requirements for grants.
- Lack of consistent data information across programs and grants.

The opportunities and challenges presented above summarize conditions in South Carolina. These data are also shown in **Table 4-2** as strengths, opportunities, weaknesses, and threats.

Table 4-2: Analysis of South Carolina Strengths, Weaknesses, Opportunities, and Threats

Strengths:	Weaknesses:
▪ Available resources and funding ▪ Committed staff in many State Departments open and will to work together ▪ Existing network of public transit agencies ▪ Recognition that coordination of services results in cost savings for all organizations	▪ Limited regional transportation services network ▪ Fragmented public transit and human services transportation providers; includes funding and service delivery. Some regions are more advanced than other regions ▪ Underutilization of existing fleet for all State programs ▪ Local level challenges with finding local match requirements for grants ▪ Program regulations/requirements for State Departments that present a barrier to coordinated efforts
Opportunities:	**Threats:**
▪ South Carolina Interagency Transportation Coordination Council (SCITCC) ▪ DHS Medicaid broker model	▪ Increasing demand for services ▪ Local funding used across multiple jurisdictions ▪ Coordination champions in different State Department may leave ▪ Lack of coordination requirements and incentives at the state level ▪ Reluctance to reach across all transportation programs ▪ Program and policy barriers for transportation delivery required for several State Departments

4.3 Future Alternative Structures

Knowing our strengths and weaknesses as summarized above and from the information presented in this report, the following alternatives were proposed for South Carolina.

4.3.1 Alternative 1: Remain Status Quo – Do Nothing

This alternative would continue coordination in South Carolina as exists today. Coordination is strong in some regions of the state and non-existent in other areas. The State Departments would continue to look for opportunities for coordination through regional offices and through potential grant opportunities, such as the Housing and Urban Development (HUD) and Federal Transit Administration (FTA) coordinated grants.

Advantages

The SCITCC would continue to function as today and act as a transportation coordination entity for State Departments with a focus on identifying opportunities for policy development and education of coordination. The current mission of the agency would continue with quarterly meetings to report

status updates from different Departments. The Committee would continue to report to the Governor on existing accomplishments and state of coordination across the state. The DOT would remain the lead agency in organizing regularly scheduled meetings.

The SCITCC would continue with ongoing coordination efforts, seeking opportunities for enhanced coordination policy development and monitoring to meet federal grant requirements. This alternative would continue to encourage local, regional, and state level coordination efforts and would have a low impact or no change on funding resources. This alternative is business as usual with little or no resistance from existing partners.

Disadvantages

The Status Quo approach does not support increasing coordination across the State Departments or address the increasing demands for transportation. It does not establish clear expectations for South Carolina Departments for coordination, solely a high level encouragement, which leads to inconsistent level of transportation service statewide. This alternative does not have a strong potential for changing the existing policies and process for delivery of transportation services.

4.3.2 Alternative 2: Regional Broker – Similar to Georgia

This alternative for South Carolina was developed based off similar characteristics that exist within the state of Georgia today and their plans for the future, as noted in their *May 2011 Implementation Plan for Georgia Rural and Human Services Transportation Plan 2.0.*

In South Carolina, a new, lead **Transportation Coordination Department** would be developed to partner with Department of Disabilities and Special Needs, Office of Aging, Vocational Rehabilitation, Department of Transportation, the Department of Health and Human Services, and other agency members of the SCITCC, as appropriate to service delivery.

This alternative focuses on coordination at the state level with a solid vision for transportation coordination and at the local level with incentives for more coordination. This option revolves around a Mobility Manager Framework at the state level to streamline and coordinate policies, procedures, requirements, and reporting across the transportation funding programs.

The concept is for the Transportation Coordination Department (TCD) to function as the facilitator of state level coordination of transportation services by working cooperatively and constructively with each agency to minimize programmatic and organizational obstacles to coordination. The existing SCITCC would serve as the technical committee to assist in the coordination of policies, procedures, requirements, and reporting across the transportation funding programs. The existing SCITCC is comprised of designated key players and senior staff from DOT, DHHS, Aging, Vocational Rehabilitation and other state level agencies that fund transportation services for their clients. The SCITCC is a neutral party and interfaces with a broad range of representative agencies that impact and influence transportation.

Within the TCD, a position should be created for a State Mobility Manager who will function as the lead staff person responsible for facilitating coordination activities at the state level. The State Mobility manager will be housed in the TCD and work as lead staff for the SCITCC. To provide sufficient authority and responsibility to carry out the mission of coordinating transportation service policies and programs at the state level, it is further recommended that the SCITCC and the TCD office be established by executive order or legislative action.

It is the intent that the TCD and SCITCC would hire a qualified professional to serve as the State Mobility Manager as the lead staff dedicated to overseeing the mobility management responsibilities and to work with the members of the SCITCC to refine policies, procedures, requirements and reporting to facilitate transportation coordination at the state level.

The State Mobility Manager is envisioned to serve as the administrative staff for the TCD. The State Mobility Manager will be the point person for planning, implementing, managing and evaluating state-level coordination programs and other TCD initiatives. The State Mobility Manager will be the lead for providing technical assistance to regional mobility managers.

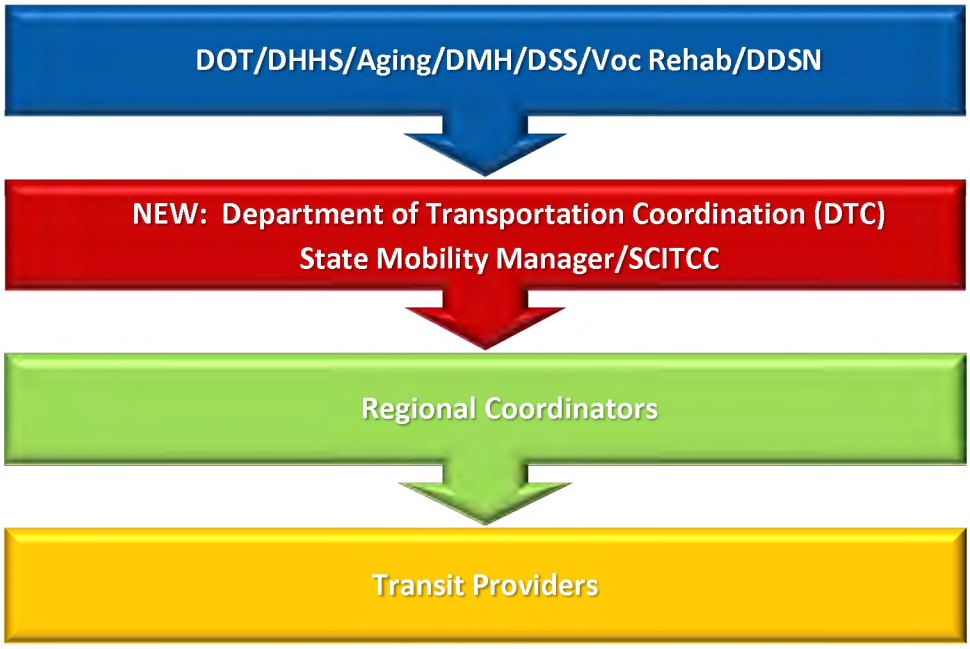
The process for achieving transportation coordination in South Carolina requires commitment at the highest level which must be supported with a series of official actions. Technically, once the State commits to coordinate, the act of coordinating programs and services is largely a matter of making sense out of what is being coordinated today. For this reason, the formation of a State Transportation Coordination Department and designation of a State Mobility Manager are critical to provide the authority, responsibility and process for coordination.

Initial steps to this formation are shown below, along with a proposed organizational chart for the new department in **Once the** state level authorization of the Department of Transportation Coordination is approved, it can immediately serve as the conduit for DOT, Vocational Rehabilitation, Mental Health, Aging, and Social Service programs and funding. The existing DOT, DDSN, and DHHS structures require a longer lead time due to funding in advance based on eligible members and rates. The DTC will need to develop a compatible cost allocation and reimbursement basement for the DHHS program. Until that time, DHHS would continue to work with contract providers.

Figure 4-1.

- The SCITCC recommends the formation of the State Transportation Coordination Department through a memorandum of understanding executed by members of the Committee. Ultimately, the Governor will take action to formally authorize structure of the new Department.
- The SCITCC should assist in the hire and train of a State Mobility Manager.
- The SCITCC should examine and adopt recommendations for streamlining program and reporting requirements, coordinating and delivering transportation services, and collaborating funding programs.
- Once the state level authorization of the Department of Transportation Coordination is approved, it can immediately serve as the conduit for DOT, Vocational Rehabilitation, Mental Health, Aging, and Social Service programs and funding. The existing DOT, DDSN, and DHHS structures require a longer lead time due to funding in advance based on eligible members and rates. The DTC will need to develop a compatible cost allocation and reimbursement basement for the DHHS program. Until that time, DHHS would continue to work with contract providers.

Figure 4-1: Alternative 2: State Level Infrastructure



The long-term goal of this alternative is the have the DTC coordinate funding and administrative services for all transportation programs, including DOT, DDSN, and DHHS. The long-term coordination at the state level should be with the DTC and the creation of the State Mobility Manager, both of which should be a neutral state department with sufficient authority. It is recognized that formation of the DTC, the hiring of a State Mobility Manager, and the reorganization of programs and policies will all take time. The staffing needs of the new department will need to be developed. The reorganization of support staff in partner agencies will need to reviewed and likely moved under the new department to support specific programs. Adequate oversight, management, and administration at the state level will be key to support partner staff at the regional level.

Regional Support for DTC

To support the statewide efforts of the State Mobility Manager and the DTC, a Regional Transportation Coordinator and Regional Coordinating Council (RCC) need to be in place across the state of South Carolina. Currently, several different regions exist for the different state departments, in addition to the 10 Council of Governments across the state. The DTC would need to delineate uniform boundaries for multiple program service areas with consistent boundaries. Once these boundaries are determined, a Regional Coordination Council would be established in each region, consisting of representatives from each of the transportation programs.

The Regional Transportation Coordinator (RTC) would be the lead staff person who provides operational, administrative and financial oversight in mobility management functions. The RTC would be designated by the RCC, in conjunction with the SCITCC and DTC. This RTC would be the focal point of organizing the coordination of service delivery in the region through broker services.

Advantages

The advantages of Alternative 2: Regional Broker is the implementation of increased overall coordination and leads to the ultimate goal of having a new department responsible for all transportation coordination. The process will take time, but will increase coordination among all state agencies involved in transportation delivery.

The SCITCC has a clear role with increasing responsibility for coordination oversight. They would define coordination expectations and outcomes for the State. The SCITCC would examine the coordination barriers in place today and develop policies to maximize coordination while meeting federal and state mandatory requirements. In the long-term, the SCITCC links administrative and management oversight with future funding decisions. They are able to use available funding and potentially leverage additional funding in the future. This Alternative provides clear direction for the SCITCC and for other state departments.

Disadvantages

Alternative 2 provides a short-term and long-term direction for South Carolina. Some disadvantages for the short-term are that departments are likely to be reluctant to permit other departments decision-making authority over funding. The departments will need to develop internal reporting procedures for spending and oversight decisions. Alternative 2 will also require legislative directive to designate roles, responsibilities and authority of the new department and for the SCITCC in overseeing coordination. The formation of a new department, the hiring of a State Mobility Manager, and the reorganization of programs, positions, and policies will take time. Determining the funding resources for the new state position is also a challenge. A portion of the pooled funds from each of the partner agencies would be used for the new State Mobility Manager position.

Strategies Forward

The following strategies are initial steps identified to move coordination to the next level in South Carolina.

- Annual report to Governor for accomplishments and state of coordination.
- Prepare new work plan for SCITCC based on goals.
- Clear direction established for SCITCC.
- Requires legislative directive for new department, roles, and responsibilities.

- SCITCC partner agencies develop MOU for initial regional meetings and for coordination of services with the Office of Aging.
- SCITCC prepare guidelines for funding decisions based on coordination requirements for all programs.

4.3.3 Alternative 3: Regional Broker – Similar to Kentucky

Alternative 3 discusses a regional broker model for South Carolina inspired by the Kentucky coordination efforts developed over the past decades. This alternative has similar end results as in Alternative 2 with a state regulated department guiding coordination efforts.

Alternative 3 introduces a new department, Human Services Transportation Delivery (HSTD), under the auspices of the SCDOT. The HSTD would be responsible for transportation coordination of various state governmental agencies, such as DHHS, DOT, Vocational Rehabilitation, Department of Social Services, and Department of Mental Health. This alternative focuses on coordination at the state level with a solid vision for transportation partnerships designed to enhance the accountability of the four main players in the system - the state, the brokers, the transportation providers, and the riders. To provide sufficient authority and responsibility to carry out the mission of coordinating transportation service policies and programs at the state level, the HSTD would be established by executive order or legislative action.

The existing SCITCC would serve as an independent reporting entity in the state supporting increased coordination and cost efficiency. The existing SCITCC is comprised of designated key players and senior staff from DOT, DHHS, Aging, Vocational Rehabilitation and other state level agencies that fund transportation services for their clients. The SCITCC is a neutral party and interfaces with a broad range of representative agencies that impact and influence transportation. The purpose of SCITCC is to assist and advise the Governor on the state's transportation coordination efforts among state agencies.

The HSTD is envisioned to conduct the planning, implementing, managing and evaluating state-level coordination programs and other initiatives. The process for achieving transportation coordination in South Carolina requires commitment at the highest level which must be supported with a series of official actions. Technically, once the State adopts the new organizational chart with HSTD under the SCDOT purview, HSTD will have authority and responsibility for implementing coordination.

The goal of this alternative is the have the HSTD coordinate funding and administrative services for all transportation programs, including DOT, DDSN, and DHHS. It is recognized that formation of the HSTD and the reorganization of programs and policies will all take time. The staffing needs of the HSTD will need to be developed. The reorganization of support staff in partner agencies will need to reviewed and likely moved under the new department to support specific programs. Adequate oversight,

management, and administration at the state level will be key to support partner staff at the regional level.

Many existing districts and regions exist for the different agency partners in the state. The HSTD will define regional areas across the state where brokers will be responsible for transportation services. The HSTD will develop a compatible cost allocation and minimum rates for brokers to contract with subcontractors. It takes time and patience for the formation of the new HSTD, along with a detailed review for reorganization. The staffing needs of HSTD will need to be developed. The reorganization of support staff in partner agencies will need to reviewed and likely moved under HSTD to support specific programs. Adequate oversight, management, and administration at the state level will be key to support partner staff at the regional level. The Broker in each region will coordinate planning and transportation delivery for the multiple programs.

Advantages

The advantage of Alternative 3: Regional Broker is to increase coordination among all state agencies involved in transportation delivery.

The SCITCC would serve as an independent reporting entity in the state supporting increased coordination and cost efficiency. The agency will assist and advise the Governor on the state's transportation coordination efforts among state agencies. In addition, the SCITCC would develop an annual report, similar to the report shown in Appendix E. Data would be requested from the partner agencies to summarize coordination efforts and complete the report.

The HSTD would have a clear role with increasing responsibility for coordination oversight. They would define coordination expectations and outcomes for the State. They would examine the coordination barriers in place today and develop policies to maximize coordination while meeting federal and state mandatory requirements. The HSTD links administrative and management oversight and transparency with future funding decisions. HSTD may be able to use available funding and potentially leverage additional funding in the future. This Alternative provides clear direction for the SCITCC and for other state departments.

Disadvantages

Alternative 3 provides a clear vision for coordination across the state with a separate department to lead the efforts; however, it takes time to develop. Some departments are likely to be reluctant to permit other departments decision-making authority over funding. Alternative 3 require legislative directive to designate roles, responsibilities and authority of the HSTD. Determining the funding resources for administration of HSTD is also a challenge.

Strategies Forward

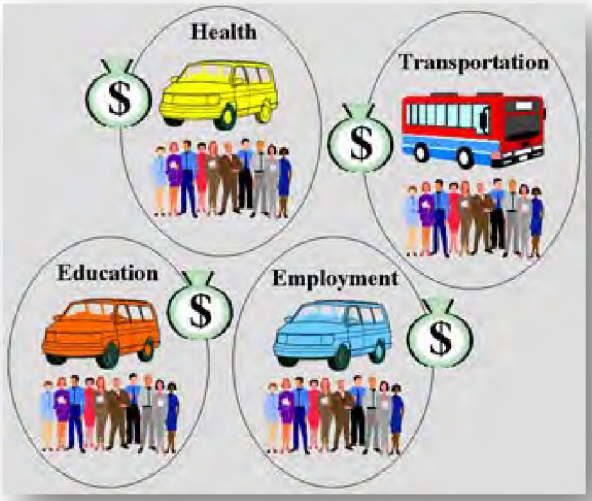
The following strategies are initial steps identified to move coordination to the next level in South Carolina.

- Annual report from SCITCC to Governor for accomplishments and state of coordination.
- Clear direction established for HSTD and SCITCC.
- Requires legislative directive for new department, roles, and responsibilities.
- HSTD prepare guidelines for funding decisions based on coordination requirements for all programs.

4.3.4 Alternative 4: Statewide Consolidated Contracting Agent – Hybrid of Alternative 2 and 3

Alternative 4 is a hybrid with many of the good strategies of alternative 2 and 3. The primary difference is that all transportation for state agencies would be controlled under ONE contracting agent with the state. A **Transportation Coordination Division** would be created under the Department of Transportation. If a state program has transportation needs for their clients, that agency would work directly with the TCD and the contracting agent to supply that transportation, not matter the type of service. The contracting agent would be responsible for establishing the type of transport, contacting providers in the member's area, and transporting to their destination. State departments would have a single point of contact to ensure transportation is provided for their program members. Each state department with needs would coordinate funds to provide the maximum efficiencies in providing services.

Alternative 4 introduces a new division, Transportation Coordination Division (TCD), under the auspices of the SCDOT. The TCD would be responsible for transportation coordination of all state governmental agencies, such as DHHS, DOT, Vocational Rehabilitation, DSS, DSN, Office of Aging, and DMH. This alternative focuses on coordination at the state level with a solid vision for transportation partnerships designed to enhance accountability for all services. To provide sufficient authority and responsibility to carry out the mission of coordinating transportation service policies and programs at the state level, the TCD would be established by executive order or legislative action.



The existing SCITCC would serve as an independent reporting entity in the state supporting increased coordination and cost efficiency. The existing SCITCC is comprised of designated key players and senior staff from DOT, DHHS, Aging, Vocational Rehabilitation and other state level agencies that fund transportation services for their clients. The SCITCC is a neutral party and interfaces with a broad range of representative agencies that impact and influence transportation. The purpose of SCITCC is to assist and advise the Governor on the state's transportation coordination efforts among state agencies.

The TCD is envisioned to conduct the planning, implementing, managing and evaluating state-level coordination programs and other initiatives. The process for achieving transportation coordination in South Carolina requires commitment at the highest level which must be supported with a series of official actions. Technically, once the State adopts the new organizational chart with TCD under the SCDOT purview, TCD will have authority and responsibility for implementing coordination.

The goal of this alternative is the have the TCD coordinate funding and administrative services for all state agencies. It is recognized that formation of the HSTD and the reorganization of programs and policies will all take time. The staffing needs of the TCD will need to be developed. The reorganization of support staff in partner agencies will need to be reviewed. Adequate oversight, management, and administration at the state level is a primary goal for the agency. This organizational structure supports the national efforts for consistent transportation performance measures, asset management, and transparent reporting.

The contracting agent and the TCD will coordinate efforts for developing cost allocation for transportation providers across the state. It takes time and patience for the formation of the new TCD, along with a detailed review for reorganization. The staffing needs of TCD will need to be developed. The reorganization of support staff in partner agencies will also need to be reviewed.

Advantages

The advantage of Alternative 4: Statewide Contracting Agent is to increase coordination among all state agencies involved in transportation delivery.

The SCITCC would serve as an independent reporting entity in the state supporting increased coordination and cost efficiency. The agency will assist and advise the Governor on the state's transportation coordination efforts among state agencies. In addition, the SCITCC would develop an annual report, similar to the report shown in Appendix E. Data would be requested from the partner agencies to summarize coordination efforts and complete the report. This organizational structure supports the national efforts for consistent transportation performance measures, asset management, and transparent reporting.

The TCD would have a clear role with increasing responsibility for coordination oversight. They would define coordination expectations and outcomes for the State. They would examine the coordination barriers in place today and develop policies to maximize coordination while meeting federal and state mandatory requirements. The TCD links administrative and management oversight and transparency with future funding decisions. TCD may be able to use available funding and potentially leverage additional funding in the future. This Alternative provides clear direction for the SCITCC and for other state departments.

Disadvantages

Alternative 4 provides a clear vision for coordination across the state with a separate department to lead the efforts; however, it takes time to develop. Some departments are likely to be reluctant to permit other departments decision-making authority over supply transportation to their program members. Alternative 4 requires legislative directive to designate roles, responsibilities and authority

of the TCD. Determining the funding resources for administration and oversight of TCD is also a challenge.

Strategies Forward

The following strategies are initial steps identified to move coordination to the next level in South Carolina.

- Annual report from SCITCC to Governor for accomplishments and state of coordination.
- Clear direction established for TCD and SCITCC.
- Requires legislative directive for new department, roles, and responsibilities.
- TCD prepare guidelines for contracting agent and determine transportation needs from each state department, along with revenue sources for the services.

4.4 Coordination Strategies

The following coordination strategies support future development of enhanced services for South Carolina. Increasing coordination is the best way to stretch scarce resources and improve mobility for everyone across the state. The strategies include coordination oversight and monitoring, dedicated state funding, incentives, and required planning, technical strategies and assistance, and regional infrastructure.

4.4.1 Program Monitoring

Many states with successful coordination programs provide oversight at the state and regional or local level. This structure provides transparency in the oversight of the coordination framework and establishes common policies and procedures that foster and mandate coordination at all levels. Responsibility for implementation may rest with the local entity, which allows flexibility in the coordination of services. Coordination is continually a work-in-progress.

4.4.2 Dedicated State Funding, Incentives, and Required Planning

Aligning transportation funding resources available through different state and federal departments and programs with coordination goals is one of the most challenging tasks associated with state level coordination. States can only work within federal program requirements. One way some states have helped remove funding barriers is by combining funding across state and federal programs. Other states have established state coordination funds, which are available for planning and implementation. Other states the funding is available for operations only. Examples of dedicated funding sources are in Florida and North Carolina.

4.4.3 Technical Strategies and Assistance

In addition to broad policy-based strategies, there are numerous ways states can support coordination through technical strategies and assistance. Some examples are cost allocation and rate setting models, transit insurance pools, training and technical assistance and coordination resource handbooks, and implementation guides.

4.4.4 Regional Infrastructure

South Carolina has a large number of sparsely populated rural areas. Many states have focused on counties or regional council of governments as the foundation for coordinated systems. These boundaries provide a basis and goal for regionally coordinated services.

4.5 Conclusions and Next Steps

This document provides alternatives for South Carolina with recommended strategies for increased coordination with the intent of formalizing an infrastructure and process to successfully advance enhanced coordination in South Carolina. The goal of any alternative selected, if any, would ultimately be to put the state in a position to provide more trips at the same service quality or better service quality than currently provided to transit customers.

The success of transportation coordination in South Carolina is ultimately dependent upon the commitment of partner agencies at the state-level and local-level to implement this series of strategies that when combined together, serve to address the existing needs. More detailed organizational analysis will be required as the state moves to the next level of coordination. As South Carolina takes the next steps to increase coordination, it is extremely important that all state agency partners are continually engaged to drive and define the process. In order for improved coordination to be a sustainable practice, many key decisions must be made and a clear vision must be established. The SCITCC will review this document, determine a preferred Alternative and make recommendations to move forward.

APPENDIX A: 2012 MEDICAID PROVIDER SURVEY RESULTS

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2012 Medicaid Transportation Provider
Survey Results
December 2012
Kathy Mayfield Smith, MA, MBA
Ana Lòpez – De Fede, PhD
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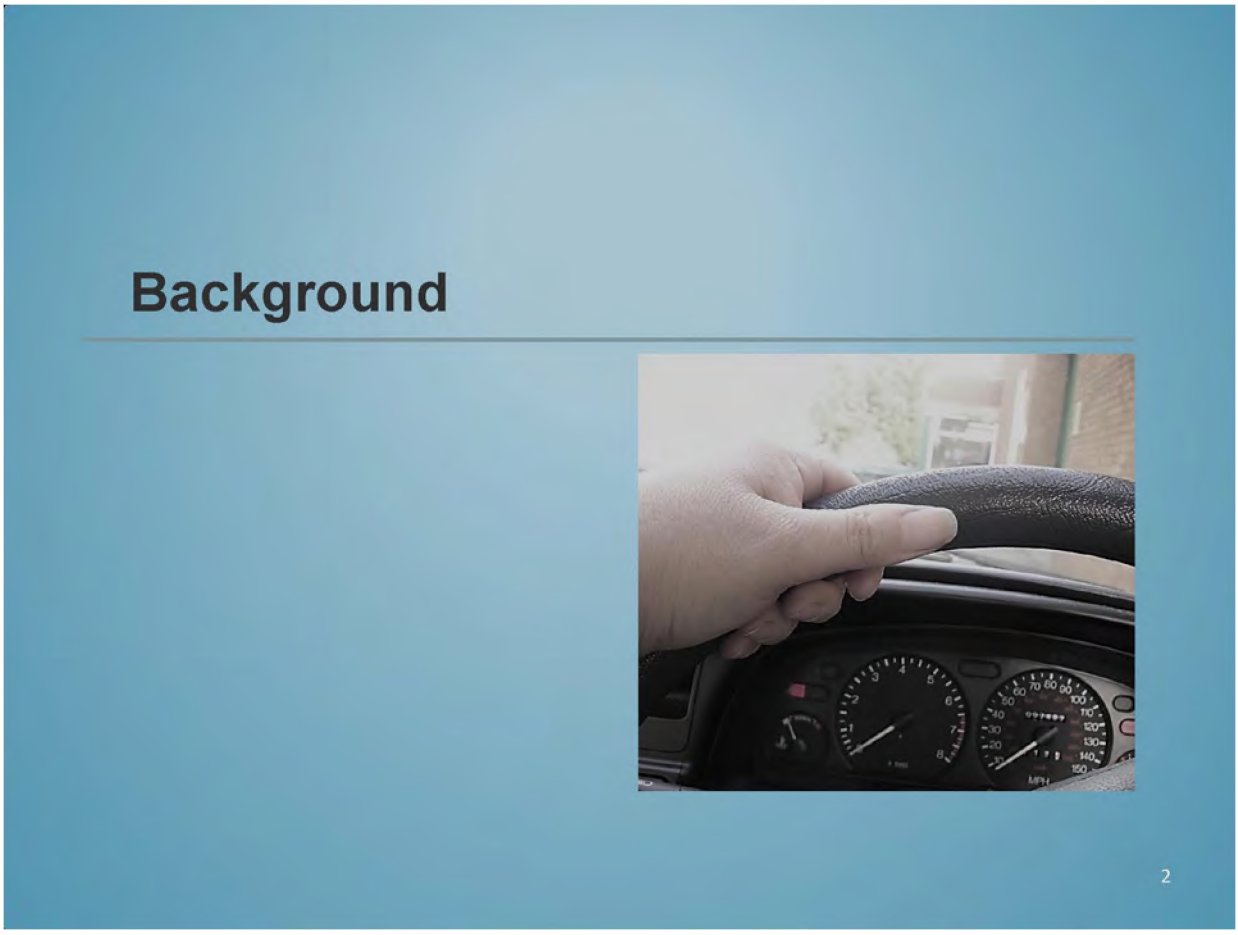
1


Background
2

Objective

- Conduct a survey of SCDHHS Non-Emergency Medical Transportation (NEMT) Providers to:
  - Assess state of NEMT provider network
  - Assess provider experience and satisfaction
  - Gather input and recommendations for improvement

PRMM

3

Methodology

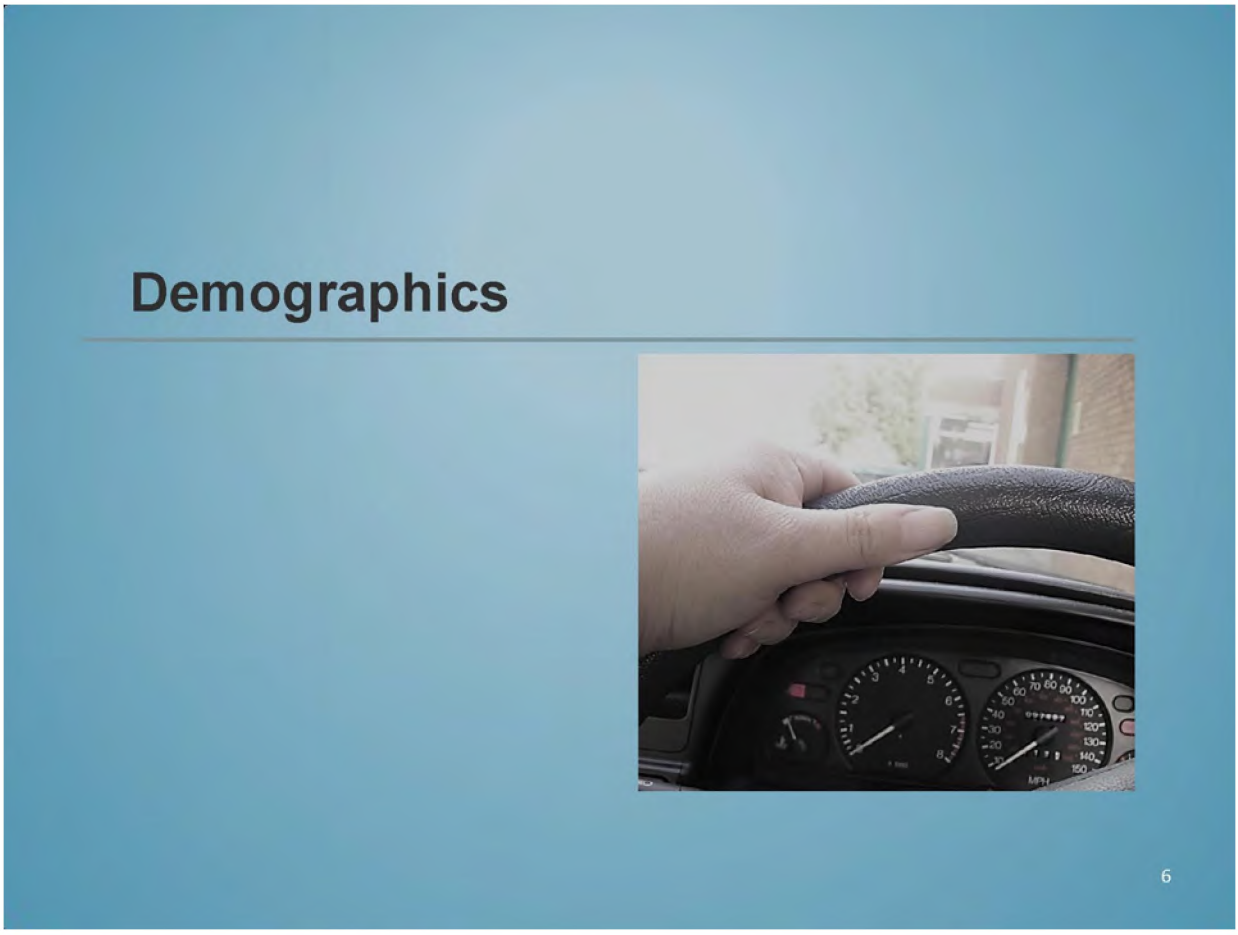
4

Survey and Data Collection

- 21 Question survey
- Combination standard response and open-ended questions
- Population of 151 NEMT providers
    - Mixed method data collection:
        - Mailed letter and survey
        - Telephone follow-up
    - 1-800# for call backs/questions

PRMM

5


Demographics
6

Demographics - Provider

- 95 providers completed surveys for a 63% return rate (95/151)
  - 58% (88) continue to provide NEMT
  - 5% (7) no longer provide NEMT
- Service areas range from single county to entire state
- Provider types
  - For-profits (70%)
  - Non-profits (24%)
  - Regional Transit Authority-RTA (2%)
- Time providing NEMT
  - Most (64%) have provided NEMT for between 1-5 yrs.
  - Average number of years providing transportation is 8
  - Range is 3 months – 40 years
  - Some (6%) have provided for less than 1 year

PRMM

7

Demographics - Fleet

Vehicle Type	# providers with vehicles for Medicaid	Total # of vehicles	Approx. # vehicles for Medicaid NEMT	Range of # of vehicles	Average Age of vehicles	Range of age of vehicles
Sedan, ambulatory	30	127	113	1 - 10	6.6	<1 – 16 years
Van/bus, ambulatory	48	361	315	1 - 35	6.2	<1 – 15 years
Van/bus, wheelchair accessible	46	474	463	1 - 80	6.3	1 – 15 years
Ambulance	25	385	261	1 - 85	6.8	3 – 15 years

- Providers utilize a variety of vehicles
- Most common vehicles are accessible/ambulatory vans
- Average age of vehicles is about 6.5 years (<1 – 16 yrs.)

PRMM 8

Demographics - Fleet

- Ability to replace vehicles in fleet
  - A majority (72%) are able to replace their vehicles
  - For-profit (79%) and RTA (100%) providers are more comfortable in their ability to replace vehicles than non-profit (48%) providers
  - 8% have of all major concerns about ability to maintain safety and reliability
- Criteria used to replace/cycle vehicles

  - Most (90%) providers use general condition of the vehicle
  - Approximately half (54%) use mileage and age (51%) of vehicle

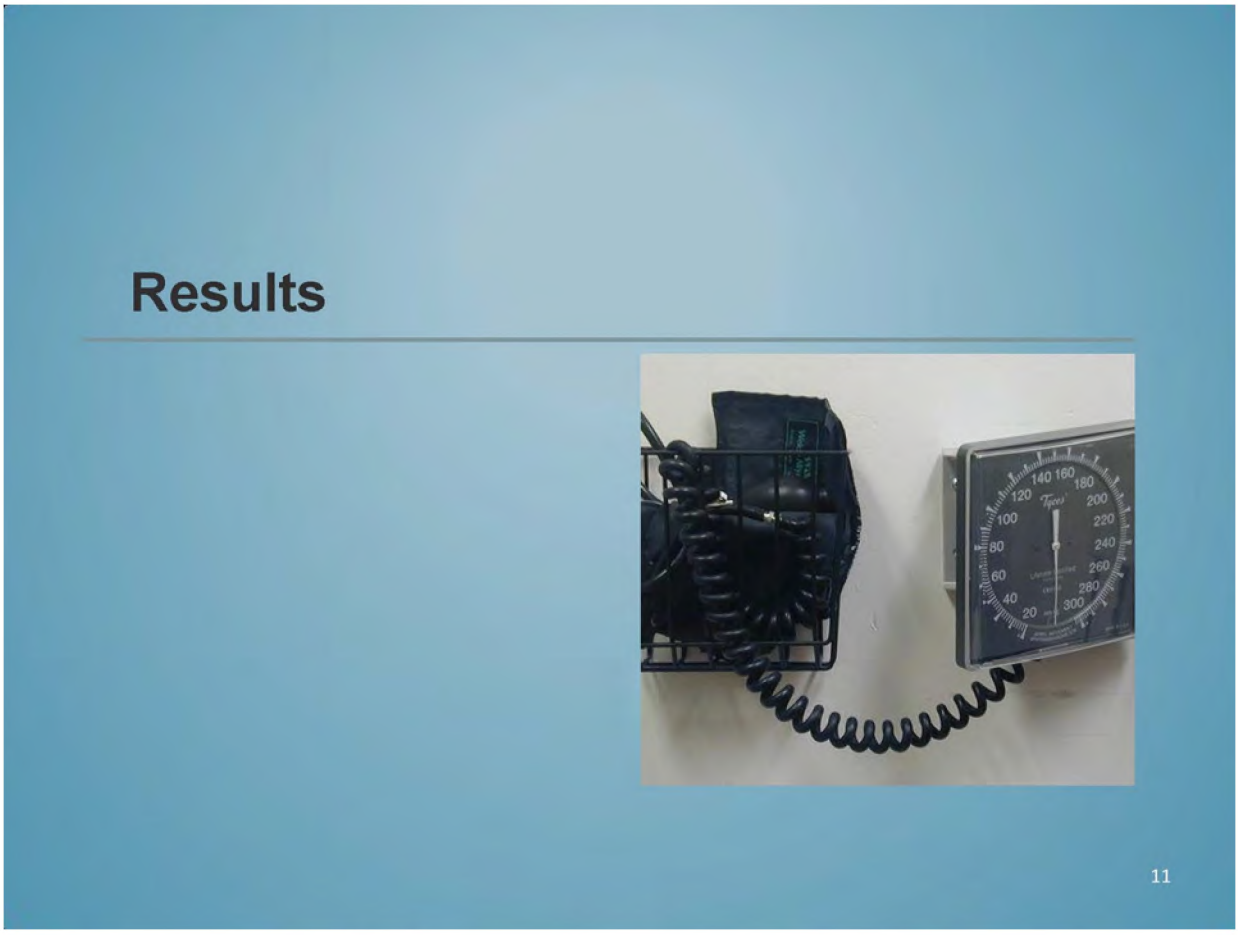
PRMM 9

Demographics - Trips

Number of Trip Made per day	Average	Range
Weekdays	69	0 - 197
Saturday	19	0 - 197
Sunday	2	0 - 60

- Most (69%) providers would prefer to make more trips [For-profits and RTAs (75%); Non-profits (52%)]
- 28% have about the right amount; only 2% want less
- Change in number of trips since February 2012
  - 31% have increased
  - 44% have decreased

PRMM 10


Results
11

Experience and Satisfaction

- With your business/organization
  - Most providers (67%) expect business to expand in next 5 years
  - Feelings about quality of participation in Medicaid NEMT varies with 37% indicating it has remained stable; 33% indicating it has declined and 29% indicating it has improved
  - Single biggest threat to business: low reimbursements and higher operating costs (22), lack of trips (15)
- With Current broker
  - Less than half (39%) believe services for consumers have improved

- Most common problems include: lack of consumer choice of provider (11), poor communication (7), lower availability of providers (7), missed appointments (5), long waits to be picked up, don't schedule trips with less than 3 days notice even if resources available, scheduling problems such as mix-ups and no standing orders (5), and technology problems (use of faxes, phone system complicated for seniors)
- Most common improvements include: On-time performance (7), level of accountability of providers better (4), higher safety standards (3), educating consumers on policy and procedures (2), allows scheduling appointments in advance, more organized (2)

PRMM 12

Experience and Satisfaction
Current broker continued

Almost two-thirds (62%) believe services have not improved for providers

Most Common Positives	Most Common Problems
• Work with provider to deliver quality service (8); e.g., monitoring - broker visits sites and grades providers, more driver training • Get paid on time (3) • Electronic billing and web portal (2) • Ability to get answers quickly (2) • Increased business (2)	• Lower rates (16), but higher expectations (6) and increased costs, i.e., insurance and gas (8) • Reduced or poor communication (9), e.g., slow to return calls, difficult to get management on phone, back & forth confusion • Unprofessional staff (5)- faxed information lost or not entered correctly, wrong phone # or address of consumer, rude • Poor technology (4)- e.g., fax trip schedules rather than online • Less cost effective (7)- don't coordinate rides so provider can transport more than one person to same location, require previously local providers to go outside service area – up to 80 miles for pick-up, out-of-county providers transport to my area when I am available), don't pay for "deadhead" miles • No consumer choice (3) – e.g., previously regular consumers who request my company no longer get assigned • Assignment inequities (3)– appear to assign more trips to "favorite providers," blame computer glitches • Paid less frequently

PRMM 13

Recommendations
Changes to System to allow provider success

Adequate reimbursement	• DHHS should set a standard minimum rate taking into consideration avg. cost of running a vehicle per day; make broker pay fuel reimbursements as promised • Minimize distance traveled out of local area; pay all providers same rate for same level of service • Increase trips; consider costs of operation adjustments (e.g., gas) • Pay for A leg when consumer is "no show" especially on longer distance trip
Improve broker IT/other systems	• Require better IT system • Provide user-friendly website allowing providers to accept/reject trips (to build own manifest) • Better billing system; be able to electronically access pick-up times that broker puts in system
Improve communication between broker and provider/facilities	• More 2-way communication to promotes systematic approach for allocating work flow and volume • Better communication and wider window of times available for provider to call • Better responsiveness to calls/questions • Monitor fax machine; • Have a contract with facilities so they know who to call, etc.
Scheduling and efficiencies of scale	• More flexibility to multi-load, assign multiple trips from same area going in same direction • Better system to schedule and route trips to have volume and make trips more comfortable • Allow providers flexibility in scheduling • Person responsible for scheduling trips should be educated on trip areas and needs of consumers (e.g., high medical need with appropriate provider)

PRMM 14

Recommendations
Swapping Role with Broker (120 responses)

Improve Operational Efficiency (N = 45)

- Scheduling/Coordination of trips (#1 recommendation) - coordinate by zip code, facility and distance to allow multi-loading, book local trips with local providers first, allow 30 day advance scheduling and provider to see; allow scheduling within 3 days if providers can do; get rid of or be flexible with pick-up times
- Administrative - minimize paperwork, more assistance in learning procedures, easier process to get drivers/EMTs approved, consolidate inspections (1 company's busses inspected by 3 agencies last spring); create better billing system, reduce paperwork, problems with fax machine
- Improve/better use of technology – use better technology for scheduling; system to allow providers to select trips 30 days in advance; interactive website so providers can posts trips and pickup trips others cannot service; and re-implement system that allows exchange between providers and transporters
- Education of staff – train on service area (maps/locations in relation to provider and facility), customers' needs; provider capacity/ability; have a route manager trained in efficient route management; train on good customer service (e.g., phone etiquette, rudeness)

PRMM 15

Recommendations
Swapping Role with Broker (120 responses)

Improve Reimbursements/rate (N = 25)
- Timeliness – pay providers weekly
- Competitive rates/cost of operations adjustments –cost of "decent" drivers, increased fuel, insurance
- Rate equity across providers – "favoritism;" distribute trips fairly; equal pay for same trips
- Pay for "no shows" and "deadhead miles" – trips are longer, less multi-loading of riders
- Provide loans/incentives to providers who perform well to help develop

Improve relations/communication with providers (N = 23)
- Build better relationship with providers – consider providers as partners, not "work horses"
- Designate a service representative for providers – increase availability, responsiveness
- Timely notice of procedural changes – communicate between quarterly meetings
- Meet with providers to get input, discuss their needs and know them and their capabilities
- Improve customer service
- Have independent organization address complaints between providers and broker

Customer care (N = 21)
- Allow consumer choice of providers
- Hold consumer accountable for "no shows"
- Verify phone and address of consumer

PRMM

16

Recommendations
Swapping Role with SCDHHS (N = 79)

Changes to Brokerage System

- Eliminate broker and return to DHHS
- Set standards for broker (e.g., timely notification to providers, equal pay for same service, timely reimbursement of providers, extended hours for provider assistance after hours)
- Monitor broker and hold accountable
- Ensure all transportation is under broker system including Councils on Aging
- Hire more field agents to monitor transportation providers behavior and compliance
- Allow DHEC EMS to oversee ambulances
- Revisit report cards – a lot of the information does not reflect provider work
- Permit background check conducted by other state agencies (e.g., DSS child care, foster parents) to be used for transportation

Communication with providers

- Get input from providers – survey is good start, meet with providers (without broker) regularly
- Facilitate meeting of broker and providers to collectively find ways to improve efficiency/quality

PRMM 17

Recommendations
Swapping Role with SCDHHS (N = 79)

Reimbursement rates

- Develop pay for performance incentives with input from providers to support improved quality
- Set minimum rate that supports safe operations – Assist providers to negotiate COL adjustments
- Permit multiple transporters a day for transportation (e.g., parent transports to treatment; facility transports home)

Consumer Care

- Get consumer input and opinions to gather more than just complaints
- Provide a hotline to make transportation more accessible
- Provide a ride reservation and "Where's My Ride?" number that remains the same when brokers change to avoid confusion for consumer

PRMM 18

Recommendations - Swapping Role with a Medicaid provider/facility (N = 66)

Consumer Care

- Communicate with transportation provider to address issues before complaining
- Push for choice of provider
- Ensure broker has updated information on member
- See patients at scheduled time (especially dialysis)
- Nursing/rehabilitation facilities have members ready on time
- Exhibit patience for unforeseen events (e.g., trains)

Operations - cost efficiencies

- Work to schedule more Medicaid patients during same hours
- Schedule of standing orders and notify broker when patient no longer comes to facility
- Train staff on Medicaid transportation procedures and how transportation providers operate

PRMM 19

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Institute for Families in Society | University of South Carolina

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APPENDIX B: PRIVATE PROVIDER SURVEY

SC Human Services Transportation Infrastucture Review - Private Provider

Please provide your input to the following Stakeholder questions by Thursday, November 21, 2013. Responses will be provided to CDM Smith who is lead consultant for this project.

Thank you for your participation!

***1. Organization Name**

***2. Your Name**

***3. Your email address**

***4. Does your organization provide Non Emergency Medical Transportation (NEMT)?**

- ◯ Yes
- ◯ No

If yes, please describe NEMT services provided:

Page 1

SC Human Services Transportation Infrastucture Review - Private Provider

***5. Does your organization provide work-related transportation?**

- ◯ Yes
- ◯ No

If yes, please describe

***6. How has the existing NEMT Brokerage Model worked for your organization?**

SC Human Services Transportation Infrastucture Review - Private Provider

***7. Are you familiar with other states using a different model for NEMT or work-related public transportation services?**

- ◯ Yes
- ◯ No

If yes, please describe

***8. Which NEMT/Public Transit model to you think is best for the state of South Carolina and it's Agency Consumers?**

- ☐ Brokerage Model
- ☐ Consumer Choice Model

Why?

Page 3

SC Human Services Transportation Infrastucture Review - Private Provider

***9. How would changes in the current NEMT transportation model affect your organization?**

10. How do you envision your organization increasing coordination with other organizations in your region?

Page 4

SC Human Services Transportation Infrastucture Review - Private Provider

11. Where do you see NEMT and/or work-related transportation in the future?

☐ 5 years?

☐ 10 years?

Please comment

12. Please provide other comments/questions you might have?

Page 5

APPENDIX C: SAMPLE MONTHLY SUMMARY REPORT

South Carolina Department of Health and Human Services

Broker Performance Report - Region

Transportation Metrics	Performance Goal	January 2013 Final	February 2013 Final	March 2013 Final	SFY 2013 Q3 Totals	SFY 2013 Totals
Unduplicated Beneficiaries		7,152	6,782	6,805		17,508
Total trips provided by type of transportation		43,426	39,384	40,590	123,400	365,335
• Non-Emergency Ambulatory Sedan/Van Trips		31,372	28,117	29,118	88,607	265,195
• Wheelchair Trips		5,526	4,984	5,133	15,653	45,833
• Stretcher Trips		717	607	684	2,008	5,819
• Individual Transportation Gas Trip		5,480	5,404	5,315	16,199	45,771
• Non-Emergency Ambulance ALS		2	4	4	10	35
• Non-Emergency Ambulance BLS		65	66	55	186	426
• Public Transportation Bus Trip		264	192	281	737	2,456
Total Over Night Trips Arranged		24	17	25	66	199
Total Extra Passengers		6,278	5,406	5,500	17,184	53,879
• Number of Pickups On Time (A Leg)		15,916	15,658	16,219	47,793	142,787
• Number of Deliveries On Time (A Leg)		15,682	15,293	15,653	46,628	139,758
• Number of Trips Within Ride Time (All Trips)		39,583	38,260	39,172	117,015	351,855
• Percent of Pickups On Time (A Leg)	>= 90%	81.10%	83.90%	84.60%	83.20%	82.50%
• Percent of Deliveries On Time (A Leg)	>= 95%	80.20%	80.70%	81.90%	80.93%	80.72%
• Percent of Trips Within Ride Time (All Trips)	>= 99%	99.70%	99.60%	99.70%	99.67%	99.50%
Actual number of calls *		110,364	94,504	92,957	297,825	898,162
• Average phone calls daily		5,017	4,725	4,427	4,723	4,827
• Average Answer Speed	< 1:00	00:55	00:41	00:37	00:44	00:57
• Average Talk Time		03:05	03:08	03:09	03:07	03:09
• Average Time On Hold	<= 3:00	01:26	01:30	01:31	01:29	01:34
• Average time on hold before abandonment	< 1:30	01:02	00:55	00:54	00:57	01:06
• Average number of calls abandoned daily		209	145	117	157	205
• Percentage of calls abandoned daily	< 5.0%	4.17%	3.07%	2.64%	3.32%	4.43%
Total number of complaints by type		499	429	645	1,573	4,512
• Provider No-Show		65	57	73	195	554
• Timeliness		221	180	313	714	1,642
• Other Stakeholders		158	142	206	506	1,924
• Call Center Operations		17	26	30	73	136
• Driver Behavior		16	9	13	38	94
• Provider Service Quality		3	7	4	14	41
• Miscellaneous		8	4	3	15	62
• Rider Injury / Incident		11	4	3	18	59
• Provider No-Shows as percentage of total trips	<= 0.25%	0.15%	0.14%	0.18%	0.16%	0.15%
• Complaints as percentage of total trips		1.15%	1.09%	1.59%	1.27%	1.24%
Total number of denials by type		1,012	919	949	2,880	7,952
• Non-Urgent / Under Days of Notice		173	149	185	507	1,515
• Non-Covered Service		158	167	128	453	1,446
• Ineligible For Transport		74	76	73	223	534
• Unable to Confirm Medical Appointment w/ Provider		53	45	44	142	313
• Does Not Meet Transportation Protocols		2	1	1	4	11
• Incomplete Information		441	413	438	1,292	3,291
• Needs Emergency Services		4	3	2	9	13
• Beneficiary Has Medicare Part B or Other Coverage		107	65	78	250	829
• Denials as percentage of total trips		2.33%	2.33%	2.34%	2.33%	2.18%

* Includes calls for Regions 1-3.

Source: Logisticare Monthly Report

APPENDIX D: CUSTOMER SATISFACTION SURVEY FORM

DHS COORDINATED TRANSPORTATION
CUSTOMER SATISFACTION SURVEY (CONSUMER)
Service Provided July 1, 2013 through December 31, 2013

Transportation Provider Name _____

Agency/Program Name _____

The Department of Human Services wishes to know how the DHS coordinated transportation system is working for you as a DHS consumer. Please answer the questions below by circling your response, and return this survey to your Regional Transportation Office.

1.	What is your **overall** satisfaction rating with transportation?	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied
2.	How likely are you to recommend transportation to a friend or relative?	5 Very Likely	4 Somewhat Likely	3 Neither Likely Nor Unlikely	2 Somewhat Unlikely	1 Very Unlikely
3.	How satisfied are you with your driver assisting you on and off the vehicle?	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied

Please rate your level of satisfaction with transportation in the following areas:

4.	**Responsiveness** (Responding to your concerns as it relates to transportation)	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied
5.	**Professionalism** (Maintaining a professional standard and/or character while delivering services)	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied

6.	**Understanding of My Needs** (Providing assistance where needed)	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied
7.	**Safety** (All vehicles are safe while in operation)	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied
8.	**Timeliness** (Transportation is delivered in a prompt and timely fashion)	5 Very Satisfied	4 Somewhat Satisfied	3 Neither Satisfied Nor Dissatisfied	2 Somewhat Dissatisfied	1 Very Dissatisfied

Comments:

_____

_____

_____

_____

(Optional)

Signature of Consumer/Guardian _____

APPENDIX E: SENATE BILL 90

13 LC 39 0359

Senate Bill 90

By: Senators Gooch of the 51st, Miller of the 49th, Mullis of the 53rd, Chance of the 16th, Beach of the 21st and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 32 of the Official Code of Georgia Annotated, relating to highways, bridges, and ferries, so as provide for the periodic submission of certain information by state, regional, and local transportation authorities to the Governor's Development Council; to require the submission of certain information to the Georgia Coordinating Committee for Rural and Human Services Transportation by the Governor's Development Council; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 32 of the Official Code of Georgia Annotated, relating to highways, bridges, and ferries, is amended in Chapter 9, relating to mass transportation, by adding a new Code section to read as follows:

"32-9-11.1.

(a) Beginning July 1, 2013, all state, regional, and local government authorities that provide public mass transportation services shall examine the manner in which transportation services are provided and develop a report of potential public-private partnership alternatives to such services. Such examination shall include but not be limited to:

(1) The means by which the private sector could be utilized to deliver reasonable and responsive service, either wholly or in part, including, but not limited to, the operation of bus or rail services and the maintenance of vehicles;

(2) A review of any impediments which may hinder the implementation of public-private partnerships and steps that can be taken to remove or reduce such impediments, including timetables for implementation;

(3) An evaluation of nonpublic sector transportation providers as potential partners for more cost-effective and cost-efficient service delivery to disabled and aging communities;

S. B. 90
- 1 -

including, but not limited to, private sector, nonprofit, volunteer, and faith based transportation providers;

(4) The means by which services may be provided by nonpublic sector transportation providers while ensuring public accountability and customer satisfaction through the use of internal mechanisms designed to provide input and recommendations from customers;

(5) An analysis of functions which lend themselves to public-private partnerships, including, but not limited to, information technology, planning, financial management activities, fleet management of rolling stock, use of existing procurement contracts to achieve maximum cost efficiencies, internal functions which are essential to service delivery and directly supportive of service delivery, and routine agency functions which at a minimum include routing and scheduling; and

(6) The means of improving customer information and trip planning through the incorporation of mobility management approaches to service delivery through private sector information technology providers. 'Mobility management approaches' means technology based systems designed to inform travelers of all available transportation options within a geographic area, regardless of the provider.

(b) By March 1, 2015, and every other year thereafter, a report of public-private partnership alternatives shall be submitted to the Governor's Development Council. No later than July 1 of each year thereafter, the council shall submit a report to the members of the State Advisory Subcommittee for Rural and Human Services Transportation as required under Code Section 32-12-6, which shall include a summary of the reports submitted on public-private partnership alternatives."

SECTION 2.

Said title is further amended in Chapter 12, relating to the Georgia Coordinating Committee for Rural and Human Services Transportation, by revising Code Section 32-12-6, relating to required reports and recommendations, as follows:

"32-12-6.

No later than July 1 of each year, the Governor's Development Council shall submit the preliminary report of the Georgia Coordinating Committee for Rural and Human Services Transportation and a summary of public-private partnership alternatives reports as described under Code Section 32-9-11.1 to the members of the State Advisory Subcommittee for Rural and Human Services Transportation. Comments and recommendations may be submitted to the Governor's Development Council for a period of 30 days. No later than September 1 of each year, the Governor's Development Council shall submit a final report to the ~~Governor's~~ Office of Planning and Budget for review and consideration. The report shall address each of the specific duties enumerated in Code

Section 32-12-5 and such other subject areas within its purview as the Governor's Development Council shall deem appropriate. Each report shall focus on existing conditions in coordination of rural and human services transportation within the state and shall make specific recommendations for means to improve such current practices. Such recommendations shall address at a minimum both their cost implications and impact on client service. No later than January 15 of each year, the ~~Governor's~~ Office of Planning and Budget shall submit the final report of the Governor's Development Council and any affiliated budget recommendations to the presiding officers of the General Assembly, with copies of said report sent to the chairpersons of the transportation committees, the appropriations committees, and the health and human services committees of each chamber of the General Assembly."

SECTION 3.

All laws and parts of laws in conflict with this Act are repealed.

APPENDIX F: 2014 RURAL AND HUMAN SERVICES TRANSPORTATION FINAL REPORT

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2014 Rural and Human Services Transportation FINAL REPORT

Prepared for The Governor's Office of Planning and Budget

Created by the Governor's Development Council and the Georgia Coordinating Council for Rural and Human Services Transportation

August 2014

Governor's Development Council

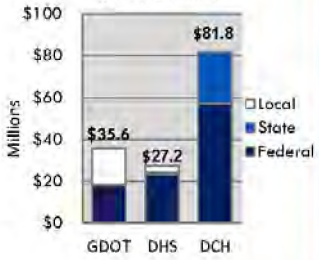
August 2014

RURAL AND HUMAN SERVICES TRANSPORTATION (RHST) 2014 REPORT EXECUTIVE SUMMARY

Background:

- The RHST network provides eligible Georgians access to necessary services (e.g., medical, jobs, training, etc.) in 159 counties and 12 regions
- Total RHST operational costs in FY 2013 were $144.6 million
- GA's RHST network provided 8.2 million trips in FY 2012
- Three agencies administer all RHST funds in GA–GDOT, DHS and DCH ("Big 3")
- 68% of funds are federal, almost all state dollars leverage federal funds
- The number of Georgians who rely upon RHST services is expected to grow 29% faster than the general population
- A 31% increase in funding will be needed by 2030 to satisfy the expected increase in demand

Total Operational Costs
$144.6 million



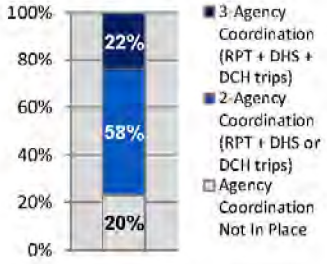
GDC Role:

- In 2010 the General Assembly designated the Governor's Development Council (GDC) with annual RHST reporting requirements in nine reporting areas
- Each year the GDC collaborates with stakeholders and the Advisory Subcommittee to make recommendations that increase coordination and efficiencies; this is the fourth year of reporting
- Data analysis regarding the efficiency and level of service impacts of recommendations is required, and those efforts are underway

Existing Levels of Coordination:

- GDOT's rural public transportation (RPT) systems are the backbone of GA's coordination efforts; this report evaluates the extent to which HST programs coordinate with them
- 114 Counties provide GDOT-funded RPT; considerable coordination (i.e., resource bundling) occurs between the RPT provider and HST programs in these counties

Percentage of the 114 Counties Providing Rural Public Transportation (RPT) that Coordinate with HST Programs (DHS & DCH)



- *3-Agency Coordination* – In 22% of these counties, the Rural Public Transportation (RPT) provider contracts with both DHS and DCH to provide trips, a 2% decrease from last year. Here, all Big 3 RHST agencies are placing trips on a common provider.
- *2-Agency Coordination* – In 58% of these counties, the RPT provider contracts with either DHS or DCH to provide trips, a 5% increase from last year. Often the RPT provider is contracting with DHS.
- *Agency Coordination Not in Place* – In 20% of these counties, the RPT provider does not contract with HST programs, a decrease of 3% from last year. Here, HST programs contract with separate providers.

Consistent with the Governor's Vision

The GDC's coordination effort is consistent with the Governor's vision for a lean and responsive state government, to improve the movement of people, increase access to healthcare throughout the state, and improve intergovernmental cooperation.

Projected Growth in RHST Eligible Populations

RHST populations are expected to grow 29% faster than the general population. To meet this increase in demand RHST funding would have to increase from $144.6 million in 2013 to $187.2 million by 2030.

RHST Mission Statement

Identify methods to increase cost-effectiveness while maintaining or improving level of service

Governor's Development Council
Coordinating Rural and Human Services Transportation in Georgia
2014 RHST Report
Executive Summary

RHST Advisory Subcommittee

Dept. of Transportation
Dept. of Human Services
Dept. of Community Health
Dept. of Behavioral Health & Developmental Disabilities
Dept. of Labor
Dept. of Community Affairs
Dept. of Education

Strategic Focus of 2014 Recommendations

Identify methods to coordinate rural public transportation (RPT) and DHS services in the short term and NET over the long term

Integrate GDOT and DHS technologies

Better understand the efficiency impacts of resource bundling

Contact:
David Cassell
Governor's Development Council
404-463-3007

Key Findings and Recommendations:

Finding: Further coordinating rural public transportation (RPT) and DHS services is the most appropriate short term approach to stretch limited resources:

- DHS trips are typically shorter than NET trips and more often go to common destinations, making them easier to coordinate
- 75% of counties offering RPT service also provide DHS trips demonstrating the benefits and feasibility of coordinating these services
- Non-coordinating RPT systems are interested in coordination opportunities with DHS

Recommendation: Identify methods to further coordinate rural public transportation (RPT) and DHS services in the short term to help stretch limited resources

Finding: Coordinating RPT and NET services can offer efficiency benefits over the long term, but is more challenging than coordinating RPT and DHS services:

- Compared to DHS trips, NET trips are typically longer and more often go to unique destinations, making them more difficult to coordinate
- Given limited service areas, RPT providers can be a less-preferable choice to provide NET trips
- Fewer RPT systems coordinate NET services than they do DHS indicating greater challenges in coordinating RPT and NET services

Recommendation: Identify methods to coordinate RPT and NET services over the long term to increase the opportunity to achieve efficiencies

Finding: Integrating DHS and NET broker technology platforms with GDOT's platform will produce benefits where sufficient coordination exists:

- Without integration, RPT providers coordinating DHS and/or NET service manually transfer data between platforms; automating would reduce costs
- GDOT's technology has been integrated with one of two NET brokers who coordinated services with many of GDOT's RPT providers making integration cost-effective
- Integrating GDOT and DHS platforms is a significant opportunity given how coordinated these services are, but integration should wait until DHS's platform is deployed (expected in 2014)

Recommendation: Integrate GDOT and DHS technology platforms to reduce administrative costs and improve data accuracy once DHS technology is fully deployed

Finding: Better understanding service efficiency and on-time performance impacts of resource bundling could improve the chances of increasing coordination.

- Previous analyses showed a correlation between resource bundling and cost efficiencies; evaluating service efficiency impacts would help determine whether resource bundling is a causative factor in these efficiencies
- Data to conduct this analysis could be drawn from GDOT's newly installed RPT technology once a full set of data is available

Recommendation: To improve the likelihood of increasing coordination, evaluate the service efficiency and on-time performance impacts of resource bundling once sufficient data are available

Report Purpose

The Transportation Investment Act of 2010 calls for the Governor's Development Council (GDC), with assistance from the Georgia Coordinating Committee for Rural and Human Services Transportation (RHST Committee), to provide the Governor's Office of Planning and Budget (OPB) with an annual report identifying methods to increase the coordination of Georgia's rural and human services transportation (RHST) system. The purpose of the legislation and the resulting report is to ensure the most cost-effective delivery of RHST services in Georgia in order to best serve the clients utilizing the system. A draft version of this report is to be provided to the RHST Advisory Subcommittee by July 1st, and a final report is to be provided to OPB no later than September 1st, annually.

The GDC's annual reporting effort is also a critical part of achieving the Governor's Strategic Goals for Georgia. Achieving cost efficiencies in RHST delivery is consistent with Georgia's vision of a lean and responsive state government. Further, the following specific goals can be achieved by this reporting effort:

- Improve the movement of people and goods within the state;
- Leverage public-private partnerships and improve intergovernmental cooperation for successful infrastructure development;
- Increase access to health services throughout the state;
- Improve access to treatment and community options for those with disabilities; and
- Build and maintain a quality state government workforce.[1]

This report satisfies the GDC's legislative requirements by providing an examination of the nine reporting tasks from the Transportation Investment Act that were assigned to the GDC in O.C.G.A. §32-12-5. The table on the following page identifies each task and the chapter in which it is addressed.

[1] Governor's Office of Planning and Budget, *Governor's Strategic Goals for Georgia*, accessed via http://opb.georgia.gov, June 3rd, 2013.

Legislative Task	Primary Locations in Report
O.C.G.A. § 32-12-5(1): **An analysis of all programs administered by participating agencies**, including capital and operating costs, and overlapping or duplication of services among such programs, with emphasis on how to overcome such overlap or duplication.	Appendix B Chapter 6
O.C.G.A. § 32-12-5(2): (An examination of) the **means by which transportation services are coordinated** among state, local, and federal funding source programs.	Chapter 5
O.C.G.A. § 32-12-5(3): (An examination of) the **means by which both capital and operating costs for transportation could be combined or shared** among agencies, including at a minimum shared purchase of vehicles and maintenance of such vehicles.	Chapter 2 Appendix C
O.C.G.A. § 32-12-5(4): An analysis of the **areas which might appropriately be consolidated to lower the costs of program delivery without sacrificing program quality** to clients, including shared use of vehicles for client trips regardless of the funding source for the respective trip.	Chapter 2 Chapter 6
O.C.G.A. § 32-12-5(5): An analysis of **state of the art efforts to coordinate rural and human services transportation elsewhere in the nation**, including at a minimum route scheduling so as to avoid duplicative trips in a given locality.	Chapter 3
O.C.G.A. § 32-12-5(6): A review of any **limitations which may be imposed by various federally funded programs** and how the state can perform within those limitations as it reviews possible sharing opportunities.	See 2013 Report (no new findings in 2014)
O.C.G.A. § 32-12-5(7): An analysis of **how agency programs impact and interact with state, local or regional transportation services** performed on behalf of the general public through state, local or regional transit systems.	Chapter 5
O.C.G.A. § 32-12-5(8): An evaluation of potential **cost-sharing opportunities** available for clients served by committee agencies so as to maximize service delivery efficiencies and to obtain the maximum benefit on their behalf with the limited amount of funds available.	See 2013 Report (no new findings in 2014)
O.C.G.A. § 32-12-5(9): An analysis of possible **methods to reduce costs**, including, but not limited to, greater use of privatization.	Chapter 5

Table of Contents

Chapter 1. Defining RHST Coordination, the Need, and its Benefits

What is RHST?

Rural and Human Service Transportation (RHST) provides Georgians access to necessary transportation services such as medical appointments, senior services, jobs, and education/training throughout Georgia's 159 counties. The RHST system is driven by several federal funding sources which are matched by state and local funds. This system consists of rural public transportation (RPT), DHS transportation, and Medicaid non-emergency transportation (NET) respectively, administered by three state agencies as follows. Table 1.1 shows the number of counties in which each type of service is provided.

Table 1.1: GDOT (RPT), DHS, and DCH (NET) Service Coverage

Type of Transportation	Counties Served[2]
GDOT Rural Public Transportation (RPT)	114
DHS Transportation	159
DCH Medicaid NET Transportation	159

Source: GDOT, DHS, DCH Staff, December 2013-March 2014

Rural public transportation (RPT) is historically funded by FTA Section 5311 as administered by GDOT. Most of the 5311-funded services are county-based, although there are some regional and municipal systems. At the time of this report, there were 70 service providers in 114 counties in Georgia providing 5311-funded RPT. Virtually all of these services in Georgia are demand-responsive (generally requiring call-in reservations 24 to 72 hours in advance). Services are provided by public entities (e.g., counties) and private entities, both non-profit and for-profit contractors. Customers can access rural public transportation with no trip purpose restrictions; they can use these services to go to work, shopping, jobs, recreational activities, and more.

Department of Human Services (DHS) transportation is organized through DHS's 12 regional offices. Funding programs that support client transportation include Title IIIB funding for senior transportation, Temporary Assistance for Needy Families (TANF), and Social Service Block Grants (SSBG). DHS also arranges trips for clients of the Department of Behavioral Health and Developmental Disabilities (DBHDD) under a memorandum of understanding. Eligibility for DHS transportation is generally based on a combination of the individual's disposition (e.g., age, income, presence of disabilities) and an identified lack of transportation. DHS also administers FTA Section 5310 funding which is used to support the operations of senior and disabled transportation operated by private subcontractors.

There are 81 DHS providers in all 159 counties in Georgia. Services are provided by public entities (e.g., counties) and private entities, both non-profit and for-profit contractors, under contract to either the regional DHS office or a coordinating DHS contractor such as a Regional Commission or a Community Service Board. Many of the service contractors who provide RPT service also provide DHS transportation, thereby often coordinating trips of RPT customers and DHS customers.

[2] The number of counties served fluctuates during the year for both GDOT and DHS (e.g., as of the finalization of this report 114 counties had GDOT (RPT) coverage). Each RHST Report provides a snapshot of service and does not reflect these changes in real time. In recognition of this, where RHST Report data is used to identify areas for further analysis, updated data should be collected.

Department of Community Health / Medicaid Non-Emergency Transportation (NET) is a program for Medicaid (low-income) recipients eligible for transportation to covered medical appointments. DCH has organized NET transportation into five regions administered by an NET broker under contract to DCH. There are currently two brokers covering the five regions. Each broker contracts with one or more service providers in each county. NET service providers are public entities (e.g., counties) and private entities, both non-profit and for-profit contractors. In some counties, NET service providers are also providing RPT and/or DHS transportation. There are approximately 194 NET providers statewide serving 159 counties.

Figure 1.1: RHST In Georgia

RPT = Rural Public Transportation
NET = Medicaid Non-Emergency Transportation
DHS = Department of Human Services

What is RHST Coordination?

In the context of RHST, coordination can take on different meanings depending on what is being coordinated. For example, information about available resources can be coordinated into a central repository. Operational policies and practices can be shared among service providers. Service providers can co-procure vehicles, training resources, maintenance, insurance, and fuel. Service providers can utilize each other to serve trips in a more efficient manner. And, if one service provider is under contract to coordinate or provide 5311-funded RPT, DHS transportation and/or NET service (see Figure 1.1), the resulting coordination of trips (i.e., resource bundling) can lead to efficiencies. The primary manner in which trips are coordinated occurs when HST programs place trips on RPT operators. Figure 1.2 on the next page tracks this type of coordination and shows the percentage of the state's 114 counties where RPT operators are present in which there is:

- **3-Agency Coordination:** In 22% of these counties, the Rural Public Transportation (RPT) provider contracts with both DHS and DCH to provide trips. Here, all Big 3 RHST agencies are placing trips on a common provider.
- **2-Agency Coordination**: In 58% of these counties, the RPT provider contracts with either DHS or DCH to provide trips. Often the RPT provider is contracting with DHS.
- **Agency Coordination Not in Place**: In 20% of these counties, the RPT provider does not contract with HST programs. Here, HST programs contract with separate providers.

Compared to FY 2013, a lower percentage of counties (22% in FY 2014 vs. 24% in FY 2013) have 3-county coordination and a higher percentage of counties (58% in FY 2014 vs. 53% in FY 2013) have 2-agency coordination. This means that overall, the percentage of counties with agency coordination increased from 77% in FY 2013 to 80% in FY 2014.

The Need for Coordination

Personal mobility needs in Georgia are changing in response to a growing and diversifying population. RHST populations (low-income, persons with disabilities, aging population, individuals without cars or who choose not to drive) are projected to grow by 31% by 2030, compared to the 24% projected growth rate in the general population over the same period. This higher growth rate is largely due to the fact that the elderly constitute a higher proportion of the RHST population than the general population (e.g., DHS has funds specifically dedicated to elderly transportation). To keep pace with this increase in demand and provide a comparable level of service to today, a 31% increase in funds would be necessary.[3] With the certainty of substantial growth in RHST populations, and no certainty that funds will be available to accommodate this growth, there is a clear need to pursue coordination options that stretch the RHST funding dollar.

Figure 1.2: RPT Coordination with HST Agencies

Percentage of the 114 Counties Providing Rural Public Transportation (RPT) that Coordinate with HST Programs (DHS & DCH)

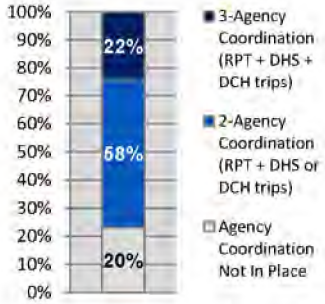
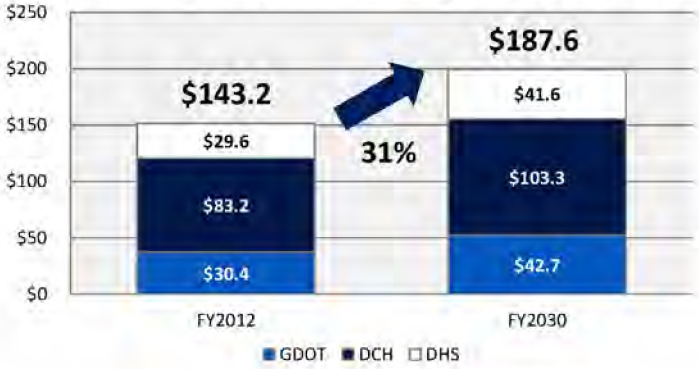


Figure 1.3: Georgia's Projected RHST Funding Needs (in millions) (FY 2030)



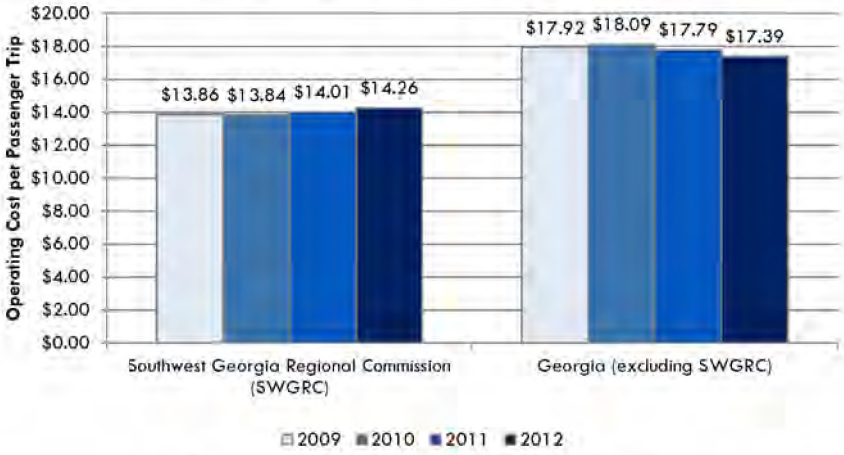
Sources (Funding Amounts): GDOT, DHS, and DCH staff
Coordinated Council on Access and Mobility, Report to the President – Human Services Transportation Coordination
2010 U.S. Census
2000 U.S. Census
U.S. Census Interim State Population Projections

[3] Projected dollars not adjusted for inflation

The Benefits of Coordination

While there are many potential benefits to coordination, this report highlights two that warrant consideration. First, previous reports have shown that the coordination of trips (resource bundling) can create cost efficiencies.
In the 2012 RHST Report, the business case for the resource bundling concept was evaluated by comparing the unit cost per trip in the Southwest Georgia Region Commission (SWGRC) area (where RPT, DHS and NET trips are combined on common providers) to the rest of the state (which exhibits a lower extent of coordination; see Figure 5.1). For the 2014 RHST Report update, FY 2012 statistics have been added to the FY 2009, FY 2010, and FY 2011 figures, and are presented in Figure 1.4. In each fiscal year, the unit costs per trip are lower in the SWGRC than the rest of the state, suggesting that resource bundling could create cost efficiencies.

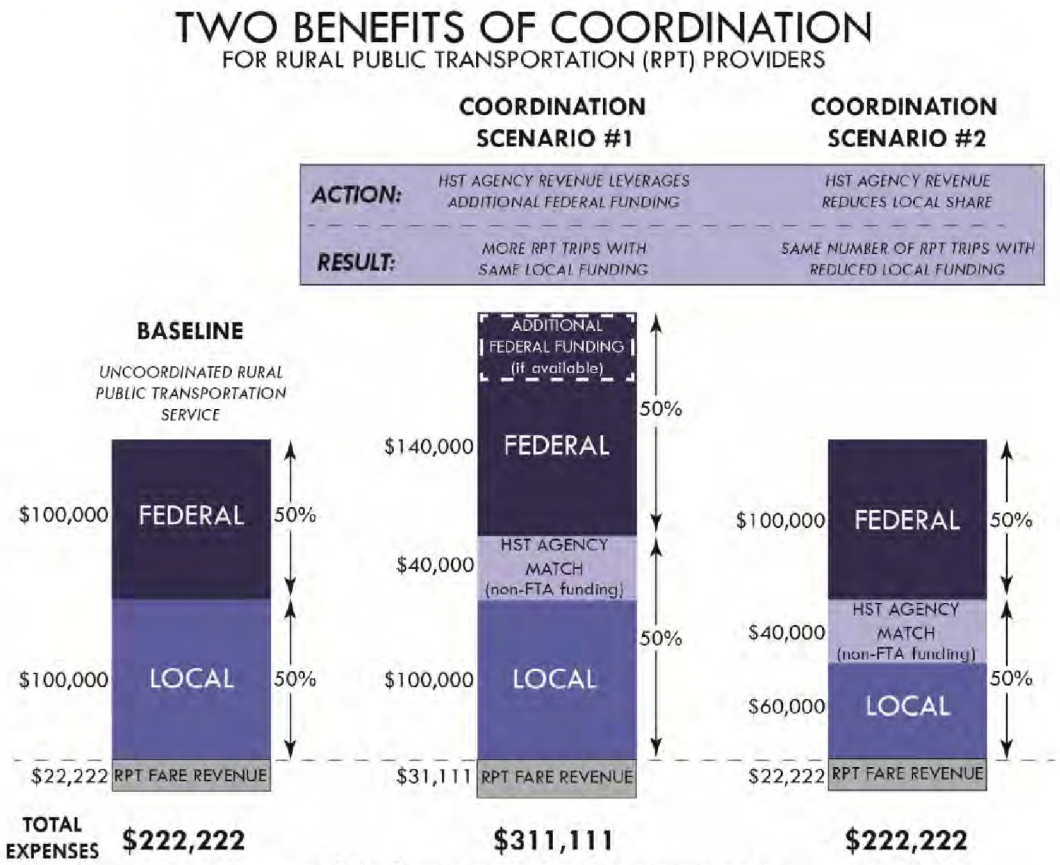
Figure 1.4: Cost per Trip Comparison: Southwest Georgia vs. the Rest of the State



Source: GDOT, DHS, DCH December 2013-March 2014

In addition to increasing the overall cost-effectiveness of service, coordinating trips can also benefit local governments that provide RPT service in their jurisdictions. When local governments providing RPT service contract with HST agencies to provide trips, the revenues received from the HST agency can be used as local match for federal (FTA Section 5311) dollars. When HST revenues are used as local match, one of two scenarios will result. Under the first scenario, the local government providing RPT service can elect to invest the same amount of county dollars as they had prior to coordination. In this scenario, the HST revenues can be used to increase their total local share thereby leveraging more federal 5311 dollars (provided additional 5311 funds are available). Under a second scenario, the local government could elect to reduce the amount of county dollars previously invested and use the HST revenues to partially or fully replace their local match. In this scenario, the same amount of federal 5311 dollars would be leveraged. Hypothetical scenarios demonstrating these two benefits are illustrated in Figure 1.5.

Figure 1.5: Benefits of Coordination – Enhanced Leveraging of Federal 5311 Dollars



Dollar figures are for illustration purposes only.

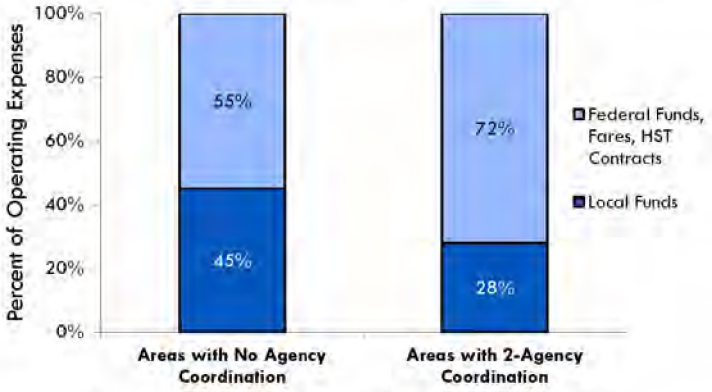
Source: Nelson\Nygaard Consulting Associates

Figure 1.6 shows a real-world example of how coordination scenario 2 from Figure 1.5 is occurring in the Middle Georgia Regional Commission (MGRC) area. In the MGRC area, three counties coordinate their RPT services with an HST agency, in this case, DHS (i.e., the RPT operator also provides trips for DHS). These counties are grouped together and labeled "areas with 2-agency coordination". In these three counties, the percentage of operating expenses paid by local funds is 28%.

Five additional counties in the MGRC area do not coordinate their RPT services with HST agencies. These counties area grouped together and labeled "areas with no agency coordination". In these five counties, the percentage of total operating expenses paid by local funds is higher at 45%.

What Figure 1.6 shows is that local governments sponsoring coordinated systems better leverage federal funds, and therefore, can have the same overall budget as a local government sponsoring a non-coordinated system, but pay less (in terms of local dollars) for it. Furthermore, given that coordinating services can lead to cost efficiencies, it is also likely that the local government sponsoring the coordinated system can provide more trips with the same overall budget as a system that is not coordinating services.

Figure 1.6: Analysis of Leveraging Federal Dollars from the Middle Georgia Regional Commission



Source: Middle Georgia Regional Commission, March 17, 2014

Chapter 2. Status of 2013 Recommendations

A key focus of this year's report is to track the progress of the four recommendations made in the 2013 RHST Report. Table 2.1 below lists each recommendation, its purpose, the progress to implement or evaluate it, and the results.

Table 2.1: Status of 2013 Recommendations

Recommendation	Purpose	Progress to Implement or Evaluate	Results and Next Steps
Evaluate options to provide private sector access to Department of Administrative Services (DOAS) vehicle purchase, maintenance and insurance contracts and fuel cards	Lower capital and operating costs for private sector RHST providers	Expansion requires legislation; to consider expansion, benefits need to be clear Benefits of vehicle purchase and maintenance not clear given existing data State self-insures assets, no contract available to expand Fuel cards could remove taxes, not recommended at this time	**Evaluation Complete** Private sector consortiums represent the best way to reduce unit costs in these areas (see Appendix C for examples)
Evaluate options to increase RHST provider access to surplus capital	Respond to increasing capital costs and needs for all RHST providers	GDOT amended their surplus vehicle policy to allow local governments first right to retain vehicle, can be used for RHST purposes	**Implementation Complete**
Integrate GDOT (RouteMatch) technology with NET brokers technologies first, and DHS after their platform is fully deployed	Reduce administrative costs for providers and increase accuracy of data	RouteMatch 93% integrated with one NET broker, full integration expected Second NET broker lacks sufficient number of potential installations, integration not recommended DHS technology under deployment	**RouteMatch and NET broker implementation complete** **RouteMatch and DHS integration recommended in FY 2015**
Evaluate the service efficiencies of resource bundling and/or conduct site visits to areas without agency coordination	Provide information to evaluate potential to increase the level of resource bundling (trip coordination)	Service efficiency data not ready for analysis in 2014 Surveys conducted in lieu of site visits, (see below for results)	**Service efficiency / on-time performance analysis recommended in FY 2015** **Survey Evaluation Complete - develop recommendations based on findings in 2015 Report**

Surveys in Areas without Agency Coordination

A key finding of the 2013 RHST Report was that detailed information was lacking as to why more RPT service providers do not provide trips for HST agencies (i.e., DHS and the NET brokers on behalf of DCH). This information was considered necessary in order to identify appropriate recommendations to increase coordination.

This resulted in a recommendation to conduct site visits to RPT systems where agency coordination was not in place. During the 2014 reporting year it was determined that a better first step would be to conduct surveys in order to minimize staff resources while still obtaining the necessary information. GDOT together with Nelson\Nygaard staff identified 26 RPT systems lacking agency coordination and began conducting phone interviews in December 2013. The list of 26 RPT systems was narrowed down to 18, as 8 of the RPT systems were found to coordinate with DHS and/or the NET brokers. Each of these 18 RPT systems responded to the survey resulting in 100% RPT response rate. In addition to contacting the RPT provider, both the regional DHS office and the regional NET broker were surveyed in February 2014 to gain additional perspective.

While the purpose of the survey was to determine why these systems did not coordinate with HST agencies, the survey also sought to quantify previously anecdotal findings. For example, several questions were asked about service characteristics (e.g., whether services were run in-house or contracted out, service area, etc.) as previous reports identified that privatized systems and those serving multiple counties are more likely to coordinate. The results of key questions are shown below and are followed by the key takeaways from the overall survey.

A key system characteristic question that was asked was whether services were run in-house (i.e., publicly operated) or contracted out (privatized). Figure 2.1 shows that of the RPT respondents, 94% indicated they directly operated service (run in-house) while 6% indicated they used a contractor to deliver service (contracted out). By comparison, a greater percentage (39%) of the 114 counties with RPT service contract out services (see Table 5.1). One can deduce from this that coordination is more likely with RPT service that is privatized. This makes logical sense given that private service providers who contract with counties to provide RPT service are likely to seek out additional contracting options such as providing DHS or NET trips, and that private providers may also have additional non-public vehicles affording them the capacity to accommodate the additional trips.

Figure 2.1:

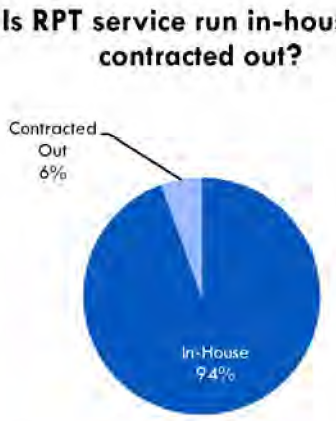


Figure 2.2:

Do you provide trips outside your jurisdiction?

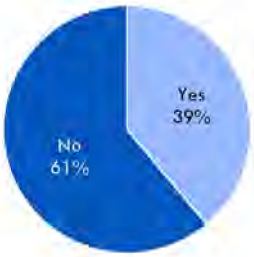
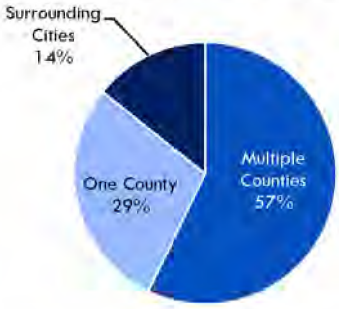


Figure 2.3:

If you provide trips outside of your jurisdiction, what additional areas do you serve?



A second service characteristic that was important to assess was each RPT system's service area. Stakeholder feedback from previous reports indicated that some RPT systems did not leave their county and that this hindered coordination opportunities since many HST trips do. An RPT system that does not leave its service area (frequently a single county) would be especially limited in providing NET trips. The NET brokers have indicated that many trips, particularly those to specialists, travel significant distances. Data collected for this year's report supports this claim as vehicle miles per NET trip were 81% greater than RPT trips and 140% greater than DHS trips.

Figure 2.2 shows that the majority of RPT systems where agency coordination is not in place (61%) do not leave their county/municipality. This potentially supports the notion that service area is a limitation to coordination.

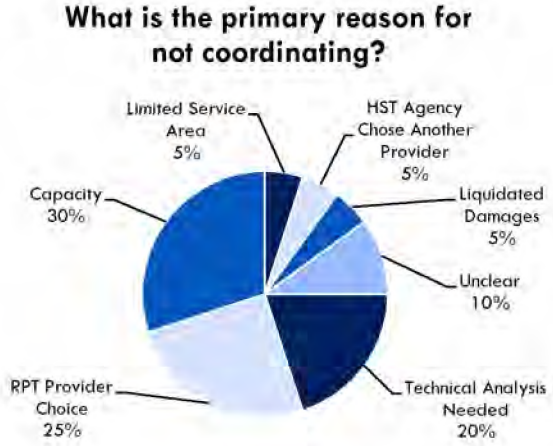
For the 39% of RPT systems that indicated they did leave their service area, each was asked what additional areas were served. Figure 2.3 shows that most, or 57%, served multiple counties, while 29% served one county and 14% served surrounding cities. The fact that most RPT systems that leave their county serve multiple surrounding counties may suggest that service area is not a major factor that prevents coordination. However, feedback from HST agencies suggested that some RPT providers serving multiple surrounding counties may provide trips to select facilities at select times of the day. This may be occurring where RPT customers have recurring appointments at facilities outside of the city or county sponsoring the RPT service. Thus, while Figure 2.3 suggests that multiple counties are served, it is possible only limited destinations are served.

RPT systems were also asked to provide the primary reason why coordination is not occurring. These responses are summarized in Figure 2.4. Since two of the 18 RPT systems provided two different reasons each (one for not coordinating with NET and a second for not coordinating with DHS) the responses heard are typically referred to as a percentage of total responses rather than a percentage of systems responding.

Three reasons explain 75% of all responses. System capacity was cited most often as 30% of responses indicated that more vehicles would be needed to take on HST trips. RPT provider choice was cited 25% of the time. In most cases this response was indicated by an HST agency that attempted to contract with the RPT provider but was unsuccessful for reasons that could not be determined. Where RPT provider choice arose as the primary reason, the RPT system often did not provide an answer to this question. Technical analysis was indicated 20% of the time. This refers to the need to evaluate how additional trips from HST agencies would impact the performance (e.g., on-time performance, total trip times, etc.) of the trips the RPT provider was already providing.

Four additional reasons were heard. 10% of responses were unclear, in this case the RPT system did not answer the question nor did an HST agency, or conflicting answers were provided. Liquidated damages were cited once by an RPT system that was concerned over the potential to pay penalties where performance guarantees (e.g., on-time performance) required by the NET broker were not met. In another case, an RPT system indicated that they wanted to contract with an HST agency but that agency chose a different provider for unknown reasons. Finally, one response indicated that the limited service area of the RPT provider prevented an HST agency from considering entering into contract negotiations. While limited service area was only cited once as the primary problem, caution should be taken to assume it is not a factor that prevents coordination. Recall that most of the primary reasons provided below are from RPT systems, not HST agencies, and only HST agencies provided this as a limitation to coordination.

Figure 2.4:



Key Takeaways - Surveys in Areas without Agency Coordination

After a thorough survey of all 18 RPT systems where agency coordination is not in place and obtaining feedback from DHS and the NET brokers, the following key takeaways were found:

- **Coordinating NET trips on RPT systems appears more challenging than coordinating DHS trips:**
    - Quantitative evidence shows that NET trips are longer than RPT and DHS trips. Vehicle miles per NET trip (a proxy for average trip length) are 81% greater than RPT trips and 140% greater than DHS trips. Longer trips tie up an already limited vehicle fleet preventing more trips from being provided near the system's core service area.
    - Unique destinations are more common with NET than DHS trips. NET trips go to any of a number of medical providers while DHS trips more often have common destinations and times, such as trips to senior centers. Trips with increasingly common destinations and/or times are easier to coordinate on RPT systems.
    - Some RPT systems do not leave their jurisdiction (typically a county) or visit only limited destinations in adjoining counties. Figure 2.2 shows that 61% of the surveyed RPT systems do not leave their jurisdiction. Of the 39% that do, Figure 2.3 shows some only visit select surrounding cities. Where multiple jurisdictions are served, HST agencies have suggested trips are provided to select destinations. This limits the percentage of NET trips that can be assigned to an RPT system and splitting off only a small number of trips is often not cost-effective for NET brokers.

- **Focusing on methods to coordinate DHS and RPT services is more appropriate in the short term:**
    - Given that they are shorter than NET trips and more often go to common destinations, DHS trips are easier to coordinate with RPT trips. Evidence of this can be found in the extent of coordination statewide. Of the 114 counties with RPT service in FY 2014, 75% currently provide DHS trips compared to 27% that provide NET trips.
    - Sixteen of the 18 RPT systems surveyed indicated a desire to have follow-up conversations about coordinating services with DHS.

- **Privatization of RPT services may increase opportunities to coordinate services:**
    - The RPT systems surveyed showed significantly lower levels of privatization than exists statewide where most RPT systems are coordinating services. 6% of the surveyed systems privatize their service whereas 39% of RPT services are privatized statewide.
    - Private sector providers may be better positioned to address coordination limitations identified in the survey. Figure 2.4 identified capacity as the primary reason why RPT systems do not coordinate. Private providers often purchase vehicles and use them to provide coordinated RHST services. Private providers also have no specific jurisdiction, which increases opportunities to cross jurisdictional lines and serve larger areas, a coordination barrier identified by HST agencies.

Chapter 3. RHST Technology Deployment and Integration

The 2013 RHST Report recommended pursuing the integration between technologies used by RHST agencies in order to save time and effort at the provider level, and increase the overall accuracy of information. Below is a brief description of each technology platform and an update on efforts to deploy and integrate them (also shown in Table 3.1).

RouteMatch

GDOT began deploying RouteMatch scheduling software early in 2011 at all RPT providers in the state and deployment is now 100% complete. RouteMatch software is used by these providers to record and track clients and trip eligibility for various programs, to book and schedule trips, to optimize vehicle schedules, and to generate required reports and invoices.

TRIP$

DHS's software program, TRIP$, is designed to support DHS coordinated transportation networks by supporting client and trip eligibility determination, trip booking, trip confirmation, and invoicing functions. Trip requests are entered into TRIP$ and provided to service contractors who then schedule service delivery. Unlike RouteMatch, TRIP$ does not provide automated scheduling functionality. DHS TRIP$ software is deployed in 30% of counties statewide as of the writing of this report and is expected to be fully deployed during the third quarter of 2014. GDOT and DHS have indicated a desire to integrate TRIP$ and RouteMatch once TRIP$ is fully deployed. Integration between TRIP$ and RouteMatch will create benefits given that 75% of GDOT 5311 RPT service providers also operate DHS services.

LogistiCAD and NET InSight

DCH's two NET brokers, LogistiCare and Southeastrans, each use proprietary software to receive trip requests from NET eligible customers, track clients and book trips with contracted NET service providers, and to generate program reports. Much like TRIP$, neither broker software package includes automated scheduling capabilities. GDOT directed RouteMatch to integrate NET broker information into the RouteMatch scheduling software. For Southeastrans, only three providers also operate RPT services (one of Southeastrans' two NET regions is Atlanta which has no RPT providers) and thus, the cost of integration does not appear to be justified at this time. LogistiCare, however, contracts with 27 RPT systems and both parties have undertaken efforts to integrate their software. As of the writing of this report, integration has been achieved in 25 of the 27 RPT systems that LogistiCare contracts with and full integration is expected.

Table 3.1: RHST Technology Deployment in Georgia

	RouteMatch GDOT 5311 Rural Transit	TRIP$ DHS Coordinated Transportation System	LogistiCAD (DCH – Medicaid)	NET InSight / Mobile (DCH – Medicaid)
Services Supported	Supports GDOT rural public transportation providers (RPT's) by booking and scheduling trips, creating driver manifests, and generating reports	Supports DHS providers by creating lists of eligible customers requesting trips	Supports DCH Medicaid NET brokerages managed by LogistiCare in three DCH Regions (East, Central, Southwest)	Supports DCH Medicaid NET brokerages managed by Southeastrans in two (2) DCH Regions (North, Atlanta)
Percentage of RHST Trips Supported (as of March 2014)	100% of RPT trips 73% of DHS trips	30% of DHS trips	64% of NET trips	36% of NET trips
Percentage of Total RHST Trips Supported via RHST Technology (as of March 2014)	**91%***			
Integration Status with GDOT's RouteMatch Technology (as of March 2014)	N/A	**0% Integration** TRIP$ to be integrated with RouteMatch after it is fully deployed - integration expected to begin in FY 2015	**93% Integration** Full integration expected during FY 2015	**0% integration** Number of RPT's also providing trips for Southeastrans too low to justify integration at this time

** Trip total from FY 2012 – calculation includes all GDOT and NET trips and 73% of DHS trips.*

Chapter 4. Performance Management Dashboard

A key component of the annual RHST report is to understand the effectiveness of the RHST network, the level of service (LOS) provided, and the extent of coordination statewide. The performance dashboard in Table 4.1 on the following page addresses each of these areas.

Table 4.1 shows that operational costs and trips have both increased from last year's report. Operational costs increased by $1.4 million, or 1% to a total of $144.6 million for FY 2013. This increase is driven by a $5 million increase in GDOT's FTA funds. In contrast, both DHS and DCH funds decreased slightly. Total trips have increased by nearly 400,000 from FY 2011 to FY 2012, an increase of 5%. The majority of this increase (315,000 trips) comes from the Medicaid NET program which has seen a steady rise in eligible members from FY 2011 through FY 2012; this is due to the lasting impacts of the economic downturn. GDOT's 5311 systems also increased the number of trips provided by 45,000, DHS provided an additional 38,000.

The operational cost-per-passenger-trip data show a positive trend from FY 2011 to FY 2012, decreasing from $17.34 to $17.14, or approximately 1%. While both GDOT and DHS cost-per-passenger-trip increased slightly in FY 2012, the NET program reduced costs while increasing trips by 315,000 resulting in a reduction in the overall cost-per-passenger-trip metric. This is due to the nature of DCH's NET contracts which locks in a total capitated payment amount over a given time period. Since Medicaid-eligible populations increased during this timeframe but not at an amount that requires a change to the total payment, an increase was seen in the number of trips without a commensurate increase in costs.

Both GDOT and DHS have seen an increase in service coverage since FY 2010. GDOT has netted seven new systems resulting in a 3% increase in the number of Georgians with access to rural public transportation services. Similarly, DHS has increased the number of counties where services are provided resulting in a 4% increase in services and 100% service coverage. Much of the DHS increase has come in the northeast corner of the state where local interest in participation has increased. Notably no data is provided for the NET system; this is because federal mandates require that NET be provided statewide, resulting in a 100% coverage for this RHST program.

Table 4.1 also shows the percentage of counties where 5311 rural public transportation (RPT) services are available and the RPT operator is providing trips for DHS, the NET broker, or both; this measure is referred to as the extent of coordination (also referred to as resource bundling). The table shows that the extent of coordination has increased from 77% in FY 2013 to 80% in FY 2014. This positive change is due to eight counties (in DHS Regions two, five, and nine) changing from no coordination in FY 2013 to 2-agency coordination in FY 2014. Of these eight, all but one county is now coordinating RPT with DHS; the one other county coordinates RPT with NET. Additionally, one county changed from no coordination in FY 2013 to 3-agency coordination in FY 2014.

Table 4.1: 2014 RHST Performance Dashboard

Performance Measure	Description	Baseline		Update		Trend	Analysis
		Value	Year[4]	Value	Year[4]		
Trips, Cost and Service Efficiency							
Operational Costs (millions)	Annual RHST operational costs[5]	$143.2	FY 2012	**$144.6**	FY 2013	↑	$5 million increase in FTA programs offset decreases seen in NET and DHS services
Total Passenger Trips	Total number of passengers (counted each time they board a vehicle)	7,838,137	FY 2011	**8,236,784**	FY 2012	↑	Increase largely from NET (315,000 additional trips) Slight increases in GDOT and DHS programs
Operational Cost per Passenger Trip ($/trip)	Total annual operational cost divided by total annual passenger trips	$17.34	FY 2011	**$17.14**	FY 2012	↓	9% efficiency increase in NET offset slight increases in GDOT and DHS programs
Level of Service and Coordination							
Service Coverage	Percentage of eligible Georgians with access to RHST services[6]	GDOT 69%	FY 2010	**GDOT 72%**	FY 2014	↑	Net gain of 7 counties due to increased local interest
		DHS 96%	FY 2010	**DHS 100%**	FY 2014	↑	Increased participation (local interest) in Northeast Georgia region
Extent of Coordination	Percentage of counties where 5311 rural public transportation is offered in which the 5311 operator provides trips for DHS, DCH or both	77%	FY 2013	**80%**	FY 2014	↑	Increased coordination due to eight counties changing from no coordination to 2-agency coordination and one county changing from no coordination to 3-agency coordination

[4] The State FY's begins on July 1st and end on June 30th.
[5] State administrative costs are not included.
[6] DCH data is not reported because federal law requires 100% coverage.

Chapter 5. Current State of Coordination

This chapter provides an overview of the state of coordination by first assessing HST agency use of rural and urban transportation systems and the extent to which the private sector is utilized in the provision of services. After establishing the current state of coordination in Georgia, federal policies and local initiatives impacting the RHST landscape are discussed. At a federal level, select budget cuts and the implementation of the most recent federal transportation law, MAP-21 have the potential to impact funding levels. At the local level, the development of the Atlanta Regional Commission's (ARC) "One-Click" program will improve RHST clients' understanding of and access to transportation options.

HST and Public Transportation Coordination

This section evaluates the level of coordination among HST agencies (i.e., DHS and DCH via its NET brokers) and public transportation providers. Two perspectives are provided: HST agency use of rural public transportation providers, and HST agency use of urban, fixed route public transportation providers.

The coordination of rural public transportation (RPT), DHS transportation and Medicaid NET occurs when DHS or the regional NET broker places trips (via contract) on the RPT provider in that area (i.e., resource bundling). Figure 5.1 shows the extent to which this happens, as follows:

- The light blue counties offer RPT service, but the RPT operator does not provide trips for DHS nor the NET broker. In these areas, agency coordination is not in place.
- In medium blue counties, the RPT operator also provides transportation to DHS or the NET broker but not both; this is referred to as two-agency coordination.
- In the dark blue counties the RPT operator provides trips for DHS and the NET broker; this is referred to as three-agency coordination.
- The white counties have no RPT services, either because the county is not eligible for rural public transportation or because the county is not currently participating in the program.[7]
- The outlined counties contain at least one urban public transportation system. Refer to Figure 5.2 for an assessment of HST coordination with these systems.

Figure 5.1 shows that in FY 2014 rural public transportation (RPT) is provided in 114 of Georgia's 159 counties. RPT service providers are also providing either DHS or NET trips (2-agency coordination) in 66 (or 58%) of those 114 counties. RPT service providers are providing both DHS and NET trips (3-agency coordination) in another 25 (or 22%) of those 114 counties. Overall, some level of coordination is occurring in 91 (or 80%) of the 114 counties in which RPT services are provided.[8] Coordination is not in place in 23 of the 114 counties (or 20%) meaning that rural public transportation operators exist in these counties but do not provide trips for DHS or the NET broker.

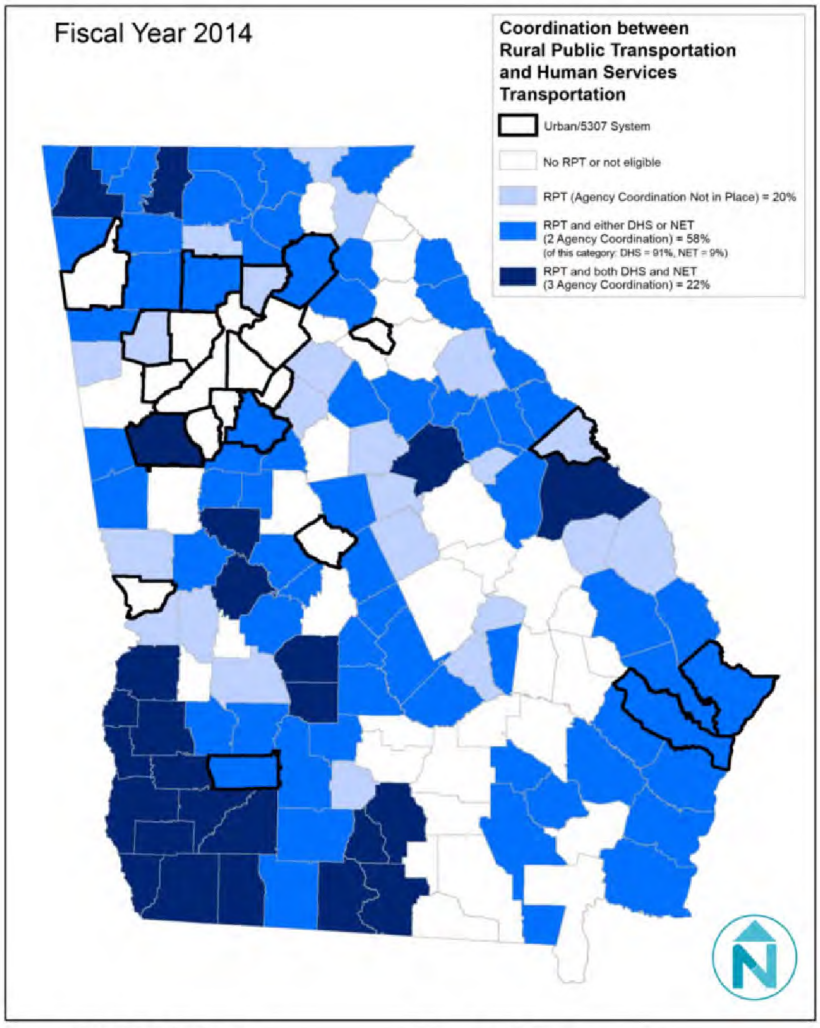
[7] Counties in white have no RPT services but all have DHS service and NET service available.
[8] Notably, in 91% of the 60 counties where 2-agency coordination exists, RPT operators are providing trips for DHS. This supports previous anecdotal report findings that DHS typically contracts with RPT providers.

Compared to FY 2013, the total level of coordination has increased from 77% to 80%; however, the level of 3-agency coordination has shifted from 24% in FY 2013 to 22% in FY 2014. The major shift from 3-agency coordination to 2-agency coordination occurred in 5 counties in the Southwest Georgia Regional Commission (SWGRC), where one of the RPT and DHS contractors ceased to provide NET trips. This shift also caused part of the increased percentage of 2-agency coordination (56% in FY 2013 to 58% in FY 2014) because these five counties switched from 3-agency coordination to 2-agency coordination. Additionally, eight counties changed from having no agency coordination in place in FY 2013 to having 2-agency coordination (either DHS or NET) in FY 2014. These counties include Banks, Dodge, Greene, Jackson, Limpkin, Montgomery, Morgan, and Tattnall. Moreover, one county (Walker County) jumped from no coordination in FY 2013 to 3-agency coordination in FY 2014.

Due to the reasons presented above the percentage of counties in which the RPT provider is coordinating with DHS and/or the NET broker (2 or 3-agency coordination) has increased from 77% in FY 2013 to 80% in FY 2014.[9] The 20% of counties that provide RPT separately represent the most immediate opportunity to improve the extent of coordination in Georgia.

[9] Data challenges may also be influencing the increase in coordination from FY 2013 to FY 2014. While conducting surveys in areas where agency coordination was not in place it was found that some of the systems identified in FY 2013 as lacking agency coordination were coordinated. Likely the extent of coordination in FY 2013 was higher than 77%.

Figure 5.1: Coordination between RPT and HST



Source: GDOT, DHS, DCH Staff
January 2014 - March 2014

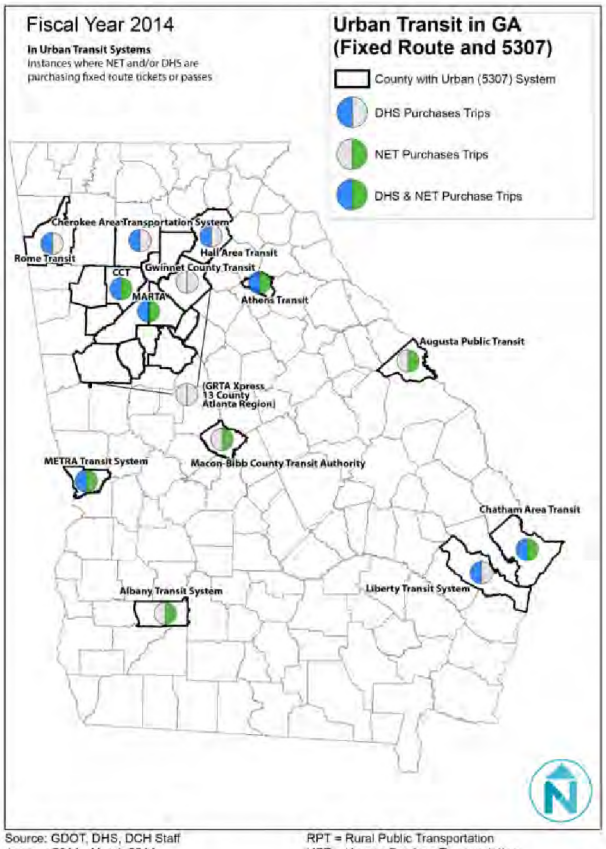
RPT = Rural Public Transportation
HST = Human Services Transportation
(HST includes Department of Human Services [DHS] and Medicaid Non-Emergency Transportation [NET])

HST agency use of urban, fixed route providers is also important to assess, both because the fixed route provider represents the least cost means to transport an HST client and that stakeholders have requested additional information about how HST agencies use such providers.

As shown in Figure 5.2, there are 23 counties in the state that have fixed route transit systems that are also funded through FTA 5307 grants. Of these 23 counties, in Athens, Chatham, Cobb, Columbus, Fulton, and DeKalb Counties DHS and NET brokers are both purchasing trips from the urban transit systems. In Cherokee, Hall, Liberty, and Floyd Counties, DHS only is purchasing trips from the urban transit system. In Dougherty, Richmond, and Bibb Counties, only the NET broker is purchasing trips from the urban transit system. The GRTA *Xpress* urban system (which covers a 13 county area) and Gwinnett County Transit are the only urban transit systems not used by DHS nor the NET broker.

This marks the first year of collecting fixed route public transportation usage and the GDC will make efforts to improve data collection during the 2015 reporting year. Two improvements will be targeted. The first is to obtain the number of trips by fixed route system, and the second is to understand why some HST agencies are not using specific fixed route systems.

Figure 5.2: Urban Transit in GA



Source: GDOT, DHS, DCH Staff
January 2014 - March 2014

RPT = Rural Public Transportation
HST = Human Services Transportation
(HST includes Department of Human Services [DHS] and Medicaid Non-Emergency Transportation [NET])

Privatization

This RHST legislation requires the GDC to evaluate greater use of the private sector as it represents a potential method to reduce service costs. This section addresses the current state of privatization, and compares the level of privatization in FY 2014 to FY 2013.

Table 5.1 shows that as was the case in previous RHST reports, this year's findings show that Georgia's RHST network is largely privatized; in fact, RHST is more privatized in FY 2014 than FY 2013. The percentage of private DHS providers has increased from 40% in FY 2013 to 66% in FY 2014. The major change from public to private providers occurred in DHS Region 2 Georgia Mountains. Within the last fiscal year, ten counties in the Georgia Mountains region changed from public operators to a private operator. The percentage of private GDOT providers has stayed relatively the same from FY 2013 to FY 2014 (40% vs. 39%, respectively). Similarly, the percentage of DCH NET providers has stayed the same during this period (96% in FY 2013 vs. 95% in FY 2014).

Table 5.1: RHST Privatization in Georgia FY 2014

Big 3 RHST Agencies	Percentage of Private Entities	Percentage of Public Entities
GDOT	39%	61%
DHS Transportation	66%	34%
DCH NET	95%	5%

Source: GDOT, DHS, DCH Staff, January 2014-March 2014

Impact of Federal Landscape Changes on RHST Funding in Georgia

There were two major changes since the previous report that impact RHST coordination efforts in Georgia: budget cuts to select RHST programs, and the implementation of MAP-21 provisions.

Budget Cuts to Select RHST Programs

When Congress was unable to meet the requirements of the Budget Control Act of 2011, automatic across-the-board cuts of eight percent (8%) were made in all non-defense Federal programs. Some RHST funding programs, such as the Transportation Trust Fund programs (the source of funding for the Section FTA Section 5311 and Section 5307 programs) and Medicaid, were excluded from these automatic cuts, others were not. For example, the Older Americans Act program and other U.S. Department of Health and Human Services (DHHS) programs were affected. Thus, while GDOT and DCH funding is unlikely to decrease from these budget cuts, some DHS funding sources are likely to experience reductions over the short-term.

Implementation of MAP-21 Provisions

Moving Ahead for Progress in the 21st Century Act (P.L. 112-141) is a two-year, comprehensive highway and transit re-authorization bill. Known as "MAP-21", provisions impacting RHST in Georgia include: (1) the merger of the FTA 5316 (JARC) funding program with the FTA 5307 (urban) and 5311 (rural) public transit funding programs; (2) the merger of the FTA 5317 (New Freedom) funding program with the FTA 5310 funding program; and (3) the addition of a new program, the Appalachian Region Program.

- Projects previously funded under the FTA 5316 (JARC) funding program are now specifically allowable under both the Urban Formula Program (Section 5307) and the Rural Formula Program (Section 5311). According to FTA, Congress did not merge the two programs to reduce overall investment; presumably, each formula program was increased to enable programming of new JARC-type projects and/or continuation of existing JARC projects without compromise to existing uses of formula funds. To determine the impact of this action in Georgia, a comparative assessment of funds made available in nonurbanized areas was made (Table 5.2). The apportionment data support the claim that while the programs were combined, there was no reduction in funding. Looking only at Section 5311 and JARC data, Georgia received 11.6% more rural funding through MAP-21 in FY 2013 than under SAFETEA-LU in FY 2012.
- Projects previously funded under the FTA 5317 (New Freedom) funding program are now specifically allowable under the Section 5310 program, which is administered by DHS under an agreement with GDOT. However, no additional funding that otherwise would have gone into the 5317 pot of funding was added to the 5310 funding.
- A new funding program, the Appalachian Region Program has been established. This program will provide annual apportionments in both FY 2013 and FY 2014 to fund transportation projects in thirty-six (36) counties in northern Georgia (Figure 5.3). This increases the available FTA rural funding by 2.9%. With all rural FTA funding sources considered, the FY 2013 apportionment was 14.5% higher than in FY 2012 (as shown in Table 5.2).

Figure 5.3: Appalachian Region Program Designated Areas

Table 5.2: Increase in FTA RPT Funding (FY 2012 to FY 2013)

FTA RPT Funding Program	Percent Increase from SAFETEA-LU (FY 2012) to MAP-21 (FY 2013)
Section 5311 (including JARC)	11.6%
Appalachian Region Program	2.9%
Total Change in Rural Funding	**14.5%**

Source: FTA Apportionment tables; FY 2012 and FY 2013

Atlanta Regional Commission (ARC) Veterans Transportation and Community Living Initiative (VTCLI) "One-Click" Project

The Regional Mobility Management One-Click System (RMM OCS) for the Atlanta region, funded via the Veterans Transportation and Community Living Initiative (VTCLI) grant of the Federal Transit Administration (FTA), will be a robust information and referral system that will connect people, including RHST clients, with information related to nearly all modes of transportation (e.g., fixed route urban, rural and human services) in the Atlanta region through a public website (i.e. one-click).

The project is separated into two phases. In Phase 1, a user will be able to determine what travel options are available to them by answering a series of questions related to trip time, origin, destination and eligibility. Users can then attempt to book a trip by contacting the provider they choose to use and/or are eligible to use. Phase 2 of the project will help users reserve and pay for the demand-response options directly through the One-Click website, noting that the website will have to route the user to outside vendors in instances where ARC does not provide the service that is requested.

The project has been developed as a partnership between six pilot sites to develop and test the software and public website. These pilot sites include the Veterans Affairs Medical Center of Atlanta, ARC Agewise Connection, Atlanta Regional Workforce Board, RideSmart Carpool/Vanpool, Cobb Community Transit, Disability Link, and Goodwill Industries. The One-Click project will be supplemented with an implementation project to pinpoint how the One-Click website will increase reach to new partners beyond the initial six pilot sites.

Based on current planning, the pilot sites will test the application in summer 2014, and the site should go live in fall 2014. ARC will be employing a train-the-trainer model to train professionals at community service agencies on using the One-Click system. Agencies that serve the project's target populations such as older adults, persons with disabilities, low-income persons, and veterans will have an opportunity to receive training on how to train end users to access the One-Click at home and use it as a professional tool to help their clients locate transportation options.

Chapter 6. 2014 Recommendations

The preceding chapters have introduced a number of findings and recommendations. In this chapter, these findings and recommendations are grouped into key areas representing the major themes that arose throughout the 2014 reporting year. Each grouping starts with a key finding and the details that led to it, and identifies a recommendation to be pursued. Implementing these recommendations will be the primary scope of work for the 2015 reporting year.

Finding: Further coordinating rural public transportation (RPT) and DHS services is the most appropriate short-term approach to stretch limited resources:

- Compared to NET trips, DHS trips are typically shorter and more often go to common destinations, making them easier to coordinate.
- 75% of counties offering RPT service also provide DHS trips; these successful partnerships demonstrate both the feasibility and benefits of coordinating these services.
- Sixteen of the 18 non-coordinating RPT systems surveyed indicated interest in discussing opportunities to coordinate services with DHS.

Recommendation: Identify methods to further coordinate rural public transportation (RPT) and DHS services in the short term to help stretch limited resources.

Finding: Coordinating RPT and NET services can offer efficiency benefits over the long term, but is more challenging than coordinating RPT and DHS services:

- Compared to DHS trips, NET trips are typically longer and more often go to unique destinations, making them more difficult to coordinate.
- Survey data indicates many RPT providers offer limited service or no service to surrounding counties, making them a less-preferable choice to provide NET trips.
- 27% of counties offering RPT service also provide NET trips while 75% provide trips for DHS, suggesting there are greater challenges coordinating RPT and NET services.

Recommendation: Identify methods to coordinate RPT and NET services over the long term to increase the opportunity to achieve efficiencies.

Finding: Integrating DHS and NET broker technology platforms with GDOT's platform will produce benefits where sufficient coordination exists:

- Without integration, RPT providers coordinating service with DHS and/or NET brokers manually transfer data between platforms; automating data transfer would reduce costs and increase data accuracy.
- GDOT's technology has been integrated with one of two NET brokers who coordinated services with many of GDOT's RPT providers, making integration cost-effective.
- Integrating GDOT and DHS platforms is a significant opportunity since 75% of counties offering RPT service coordinate services with DHS.
- Integration between GDOT and DHS should wait until DHS's platform is fully deployed, which is expected in 2014.

Recommendation: Integrate GDOT and DHS technology platforms to reduce administrative costs and improve data accuracy once DHS technology is fully deployed.

Finding: Better understanding service efficiency and on-time performance impacts of resource bundling could improve the chances of increasing coordination:

- Previous analyses showed a correlation between resource bundling and cost efficiencies but could not identify resource bundling as the causative factor.
- Evaluating service efficiency impacts would help determine whether resource bundling is a causative factor in cost efficiencies, potentially improving the case for further coordination.
- Data to conduct this analysis could be drawn from GDOT's newly installed RPT technology, once a full set of data is available.

Recommendation: To improve the likelihood of increasing coordination, evaluate the service efficiency and on-time performance impacts of resource bundling once sufficient data are available.

Appendix A: RHST Committee Enabling Legislation

Chapter 12 of Title 32

32-12-1.

The General Assembly finds that there exist a number of programs designed to provide rural and human services transportation and that frequently these services are provided over large geographic areas through various funding sources which are frequently targeted to narrowly defined client bases. The sheer number of such programs lends itself to a need for coordination among the programs and agencies which implement them so as to best assist economies in purchasing equipment and operating these many programs, to better serve the taxpayers of the state in ensuring the most cost effective delivery of these services, and to best serve the clients utilizing the transportation services provided through these programs.

32-12-2.

There is created the Georgia Coordinating Committee for Rural and Human Services Transportation of the Governor's Development Council.

32-12-3.

The Georgia Coordinating Committee for Rural and Human Services Transportation and its advisory subcommittees shall meet not less often than quarterly. Administrative expenses of the committee shall be borne by the Governor's Development Council. The members of the committee shall receive no extra compensation or reimbursement of expenses from the state for their services as members of the committee.

32-12-4.

The Georgia Coordinating Committee for Rural and Human Services Transportation shall establish the State Advisory Subcommittee for Rural and Human Services Transportation which shall consist of the State School Superintendent and the commissioners of the Department of Transportation, Department of Human Services, Department of Behavioral Health and Developmental Disabilities, Department of Community Health, Department of Labor, the Governor's Development Council, and the Department of Community Affairs or their respective designees. The commissioner of transportation or his or her designee shall serve as chairperson of the State Advisory Subcommittee for Rural and Human Services Transportation. The Georgia Coordinating Committee for Rural and Human Services Transportation may also establish such additional advisory subcommittees as it deems appropriate to fulfill its mission which shall consist of a representative of each metropolitan planning organization and representatives from each regional commission in this state and may include other local government representatives; private and public sector transportation providers, both for profit and nonprofit; voluntary transportation programs representatives; public transit system representatives, both rural and urban; and representatives of the clients served by the various programs administered by the agencies represented on the State Advisory Subcommittee for Rural and Human Services Transportation. Members of advisory committees shall be responsible for their own expenses and shall

receive no compensation or reimbursement of expenses from the Georgia Coordinating Committee for Rural and Human Services Transportation, the State Advisory Subcommittee for Rural and Human Services Transportation, or the state for their services as members of an advisory committee.

32-12-5.

The Georgia Coordinating Committee for Rural and Human Services Transportation shall examine the manner in which transportation services are provided by the participating agencies represented on the committee. Such examination shall include but not be limited to:

(1) An analysis of all programs administered by participating agencies, including capital and operating costs, and overlapping or duplication of services among such programs, with emphasis on how to overcome such overlapping or duplication;

(2) The means by which transportation services are coordinated among state, local, and federal funding source programs;

(3) The means by which both capital and operating costs for transportation could be combined or shared among agencies, including at a minimum shared purchase of vehicles and maintenance of such vehicles;

(4) An analysis of those areas which might appropriately be consolidated to lower the costs of program delivery without sacrificing program quality to clients, including shared use of vehicles for client trips regardless of the funding source which pays for their trips;

(5) An analysis of state of the art efforts to coordinate rural and human services transportation elsewhere in the nation, including at a minimum route scheduling so as to avoid duplicative trips in a given locality;

(6) A review of any limitations which may be imposed by various federally funded programs and how the state can manage within those limitations as it reviews possible sharing opportunities;

(7) An analysis of how agency programs interact with and impact state, local, or regional transportation services performed on behalf of the general public through state, local, or regional transit systems;

(8) An evaluation of potential cost sharing opportunities available for clients served by committee agencies so as to maximize service delivery efficiencies and to obtain the maximum benefit on their behalf with the limited amount of funds available; and

(9) An analysis of possible methods to reduce costs, including, but not limited to, greater use of privatization.

32-12-6.

No later than July 1 of each year, the Governor's Development Council shall submit the preliminary report of the Georgia Coordinating Committee for Rural and Human Services Transportation to the members of the State Advisory Subcommittee for Rural and Human Services Transportation. Comments and recommendations may be submitted to

the Governor's Development Council for a period of 30 days. No later than September 1 of each year, the Governor's Development Council shall submit a final report to the Governor's Office of Planning and Budget for review and consideration. The report shall address each of the specific duties enumerated in Code Section 32-12-5 and such other subject areas within its purview as the Governor's Development Council shall deem appropriate. Each report shall focus on existing conditions in coordination of rural and human services transportation within the state and shall make specific recommendations for means to improve such current practices. Such recommendations shall address at a minimum both their cost implications and impact on client service. No later than January 15 of each year, the Governor's Office of Planning and Budget shall submit the final report of the Governor's Development Council and any affiliated budget recommendations to the presiding officers of the General Assembly, with copies of said report sent to the chairpersons of the transportation committees, the appropriations committees, and the health and human services committees of each chamber of the General Assembly.

Appendix B: FY 2013 Detailed Program Costs

Agency	Funding Program	Operations				State Administration	Capital				Totals			
		Federal	State	Local	Total	State	Federal	State	Local	Total	Federal	State	Local	Total
DCH	**Medicaid NET Totals**	$57,259,719	$24,539,880	$0	$81,799,599	$152,979	N/A				$57,259,719	$24,692,859	$0	$81,952,578
GDOT	FTA 5311	$13,398,571	$0	$13,398,615	$26,797,186	$694,147	$4,893,990	$611,749	$611,749	$6,117,488	$18,292,561	$611,749	$14,010,364	$32,914,674
	FTA 5316	$2,561,869	$0	$2,280,745	$4,842,614		$1,150,325	$26,250	$128,012	$1,304,587	$3,712,194	$26,250	$2,408,757	$6,147,201
	FTA 5317	$2,201,962	$0	$1,755,119	$3,957,081		$764,818	$0	$76,202	$841,020	$2,966,780	$0	$1,831,321	$4,798,101
	GDOT Totals	$18,162,402	$0	$17,434,479	$35,596,881	$694,147	$6,809,133	$637,999	$815,963	$8,263,095	**$24,971,535**	**$637,999**	**$18,250,442**	**$43,859,976**
DHS	DBHDD (SSBG)	$7,767,057	$0	$2,636,567	$10,403,624	$1,933,603	N/A				N/A			
	TANF	$5,956,681	$0	$0	$5,956,681									
	FTA 5310	$3,558,784	$0	$0	$3,558,784									
	Revenue Contracts (County and DOT)	$1,882,760	$730,427	$0	$2,613,187									
	SSBG (Div of Aging)	$2,471,045	$96,323	$0	$2,567,368									
	Title IIIB (Div of Aging)	$1,122,418	$137,031	$68,966	$1,379,315									
	GVRA (Voc Rehab)	$422,004	$0	$0	$422,004									
	Aging State (includes CBS)	$0	$0	$332,261	$332,261									
	DHS Totals	$23,230,749	$963,781	$3,037,794	$27,233,224	**$1,933,603**					**$23,230,749**	**$2,898,284**	**$3,037,794**	**$29,166,827**
GDC	**FTA 5307 Totals**	$0	$0	$0	$0	**$118,248**	$0	$0	$0	$0	$0	$23,650	$0	$118,248
	Total	$98,652,870	$25,504,561	$20,472,273	$144,629,704	**$2,898,977**	**$6,809,133**	**$637,999**	**$815,963**	**$8,263,095**	**$105,462,003**	**$28,252,791**	**$21,268,236**	**$155,097,629**

Appendix C: Examples of Shared Approaches to Procuring Insurance and Maintenance via Consortiums

One of the GDC's required reporting areas is to evaluate opportunities to combine or share capital and operating costs for items such as vehicle purchase, maintenance and insurance. In Chapter 2 of this report it was determined that the best opportunity to do so in Georgia is for the private sector to pursue bulk purchasing opportunities in these areas (e.g. consortiums). The examples below represent best practices around the country to pool resources in the purchase of maintenance and insurance.

Vehicle Maintenance, DARTS in Dakota County, Minnesota

The Dakota Area Resources and Transportation Services (DARTS) in Dakota County, Minnesota operates 37 vehicles, providing coordinated (i.e., client mixing) demand-responsive service to Metro Mobility customers; ADA trips in Dakota County; senior residents of Dakota County; and clients of other human service agencies that purchase service through DARTS. Because these trips are coordinated, productivity and hence cost efficiency is improved, and the sponsor's funds purchase more trips than if separate fleets were used. [10]

DARTS established a Vehicle Maintenance Services (VMS) subsidiary that maintains vehicles for 80-90 organizations. VMS provides services for organizations located in the Twin Cities region that operate specialized vehicles for transit-dependent riders. These organizations have limited or no on-site resources for vehicle maintenance; by utilizing DARTS VMS they decrease their vehicle operating costs, reduce vehicle downtime, and improve vehicle safety for their riders. Vehicles in the VMS program are also safer and inspection-ready, which increases the quality of the transportation services that the organizations provide.[11]

Shared Insurance, ACCT in Washington State

The Agency Council on Coordinated Transportation (ACCT) is a partnership of members from the legislature, state agencies, transportation providers, and consumer advocates. ACCT's mission is to direct and promote activities that efficiently use all available state and community resources for special needs transportation across the state of Washington.

ACCT's vision is to remove transportation as a barrier to participation in community activities. One barrier identified was the lack of insurance and/or high insurance premiums faced by nonprofit corporations.

As a result, the ACCT Council supported Senate Bill 5869 which successfully passed and allows nonprofit corporations to form a self-insurance risk pool with other nonprofit corporations or a local government

[10] RLS and Associates, Minnesota Coordination Action Plan, March 2006
[11] http://www.darts1.org/transportation/vehicle-maintenance-services

entity for property or liability risk. The Non-Profit Insurance Program (NPIP) was formed in August 2004 and administers a Joint Insurance Purchasing Program wherein members pool their losses and claims. NPIP members also jointly purchase insurance, administrative and other services through the program including claims adjustment, risk management consulting, and loss prevention. The primary benefits to nonprofit organizations participating in the insurance pool are lower insurance premiums, stable access to the insurance market, and increased availability of risk management and loss prevention services.[12]

Shared Insurance, WSTIP in Washington State

On January 1, 1989, eight public transit systems united to form a self-funded liability-only pool, the Washington State Transit Insurance Pool (WSTIP). The initial combined contribution was $1,204,205. At the outset, the WSTIP offered $10 million in limits per occurrence on a first dollar basis with a $250,000 self-insured layer. Members were assessed based on their exposure of miles and boardings. The actuarial expected losses were $460,000 and the administrative expenses were $168,500.

WSTIP's membership has increased to 18 public transit organizations, and three associate members. The current annual budget is approximately $7.6 million. WSTIP provides auto liability, general liability, public officials (errors and omissions), all risk property, crime, boiler, and machinery. Members may select deductibles from $0 to $10,000. WSTIP provides optional auto physical damage up to $500,000 (actual cash value) and uninsured motorist/under-insured motorist coverage up to $60,000/occurrence. The current loss fund is actuarially set at $3,550,000 and the administrative expenses are $1,350,000. Current member equity is in excess of $7.2 million. WSTIP is accredited by the Association of Governmental Risk Pools.[13]

Shared Insurance, Western Iowa

In response to increasing insurance rates, a group of transit systems in Western Iowa banded together to obtain fleet insurance through an insurance consortium. A total of 300-500 vehicles were insured through the consortium. The consortium's success is attributed to the perseverance of an independent insurance broker who negotiated with a variety of insurance companies on behalf of the transit system consortium.[14]

[12] RLS and Associates, Minnesota Coordination Action Plan, March 2006
[13] RLS and Associates, Minnesota Coordination Action Plan, March 2006
[14] RLS and Associates, Minnesota Coordination Action Plan, March 2006