Transportation Health Care Roundtable
Tuesday, October 25, 2022, 1:30pm to 4:00pm
Rocky Gap Resort
Flintstone, Maryland

Agenda

A. 1:30pm - Registration

B. 1:45pm – Welcome, Introductions & Review of Roundtable #1

1) Welcome & Introductions
2) Overview from Roundtable #1

C. 2:15pm – Presentations
1) Wendolyn McKenzie
2) Jackie Crabtree

D. 2:30pm – Focus Areas and Whiteboard Exercise
1) Coordination
2) Industry Characteristics
3) Unique Patient Characteristics

E. 3:45pm – Next Steps
Homework
1) Policy Development
2) Recommendations
3) Resource Identification
4) Sustainability

F. 4:00pm – Adjourn

Next Meeting: Thursday, November 17, 2022 – Maryland Department of Agriculture, 50 Harry S. Truman Parkway, Annapolis, MD

Roundtable I Meeting Notes
September 29, 2022

Notes begin at 20:00 minutes in the meeting on Slide 9. For previous comments refer to PowerPoint notes slides:

John D- The dialysis system has exploded, especially in the last 7 years. With improved technology, dialysis patients are living longer, which a good thing but does create a greater burden on the system. As more dialysis centers continue to crop up, the primary focus for Tam is providing the Transit systems assistance to address the need. While the need can vary based on the number of centers available, at least 50% is focused on on-demand, curb to curb service. In 2021, TAM's effort focused on assisting this need by working with the centers. In 2021, there was budget language in MDOT to study NEMT and there was a study completed. In summary, the study indicates a great need with little. SB 838 by TAM. To increase the STAP funding. The fund is available across the state. Funding has been flat for the past 2 decades. Beginning in 2025, the funding would increase. Tam also focuses that our transits need resources including drivers. He noted much could be done in coordination.

Noelle- There was a discussion about HB1243, Noelle and John H gave testimony. Noelle pointed out there was a case management component which was very good since it allowed the case managers to participate.

John Hartline- John gave a little background on HB 1243. At the RMC summit, a year ago, he advocated for NEMT funding and he met with Seth Howard who inquired about this topic. Working with Delegate Howard's office by providing bullet points, the bill was submitted to benefit all 5 TCC. The main problem was that the bill was not supported by any Democrats. The bill was a great idea for rural health and through additional discussion, the urban partners became interested. The Bill included a provision that Governor provided contingency money of $1 million to be distributed to the 5 TCC. Unfortunately, the bill failed

Sara- Sara provided a broad description of her office. There are 50 Rural offices of Health in the country. There are 18 offices in Maryland. The ACA made healthcare available across the US. The Act influenced the state to adopt the Total Cost of Care model program. This approach helped transition the industry from volume based to value-based healthcare. In this regard both rural areas and Baltimore City are very similar when in this context. They see some funding for Medicare in SB295. Our "All payer model" is unique throughout the country. We have a hospital global rate system and we focus on preventative care. This could include non-emergency. The HSCRC is focused on keeping people out of the hospital and allows a higher quality of life to keep people out of hospitals. It is now growing in the primary care program. The more we

treat people out of hospital, the better for the patient as well as the healthcare system. Some programs that support TCC includes the Maryland Heartcare program to help people for transportation. But there are gaps, still. We have a variety of ways to address including our local Health depart transportation program. But we need to break down the silos.

Usually, peoples with disabilities have services but dental services are not available. This is a tragedy. Sara responded the approach should be "Non-emergency Health medications for opioid use. There was a discussion of the Western Maryland program about their Tooth Fairy program.

It was noted that some people view Oral health differently than medical health. There is a fear of the procedures. It is important to equalize oral health with health care. Delegate Robyn Lewis entered a link in the chat about HB 6 that passed that expand access for dental coverage for all adults in Medicaid. We hope will address the unmet need.

Our MDOT MTA OLTS is very active serving our transportation representatives. Tanya stated they manage all of the formula funds for the State. Section 5310 is administered by OLTS mostly to non-profits and they also support the LOTS for operating and Capital funds. IIJA (Infrastructure Investment Jobs Act) is a very large potential funding source. The IIJA initiated a larger pot of money of formula funds and MDOT MTA OLTS is restructuring the methodology for distribution. All LOTS will be able to review the formulas. There is also Section 5310 funding and Nancy Huggins is the OLTS expert. Tanya also mentioned discretionary funds that are available. For example, there was a grant that was delivered today, called Strengthening Mobility and Revolutionizing Transportation (SMART) Grants Program. This is a planning grant, and the grant can be used a support a system integration component.

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**After the Roundtable, Tanya forwarded on the SMART grant and noted the following portions of the application can be used for increasing Equity and Access specifically to:*

1. ***Get reduced-fare transit to people who need it by streamlining income-based transit fare programs by integrating back-end databases with other social service programs.***
2. ***Improve infrastructure for all by using technology to assess infrastructure that supports mobility, including sidewalks, bus shelters, bike lanes, and curb cuts.***
3. ***Improve equity with the integration of climate, public health, and socioeconomic data into transportation operations.***
4. ***Improve responsiveness, flexibility, and efficiency of paratransit services with booking, scheduling, and routing systems.***
5. ***Enhance transportation for passengers in wheelchairs by integrating an automated wheelchair securement system into transit, paratransit, or local mobility vehicles.***

Tanya noted that many of these grants have no or little matches. This is a direct and efficient way to fund the LOTS.

Nancy Huggins- The Section 5310 grant is now available to non-profits and throughout the state except for Montgomery and Prince George. There was a meeting at the TAM conference on this grant. A recording of the meeting is available on the TAM website. This grant permits funding for both operating and capital funding. There is a 50% match and 20% for capital funding. The application can be found on the TAM site and available for non-profits.

Senior Rides is another program that Nancy discussed and manages. It is available to fund rides for seniors and will include all types of services (shopping, friends, as well as medical). This grant is Statewide including Montgomery and Prince Georges (unlike the 5310). The round will open in January. There was a discussion about the current low funding level and there is a strong effort to increase funding. John noted that the Senior Rides program increased funding is a TAM priority because it is such a very small amount and it generally relies on volunteers and the program is very efficient.

Another area for discussion is the NEMT Medicaid program. It was pointed out that many consider NEMT funding is for Medicaid only. There are only 4 transit systems in Maryland that use the Medicaid transportation funding in Maryland. The rest are not connected to a Transit but operate under non-profits. It was pointed out that most NEMT is through these other programs not just Medicaid. IN summary, NEMT is a combination that include a public area, for profit area, nonprofit area and private (family) area.

To put in context, Tanya told a story of a 17 year old girl whose mother had a massive stroke. She was just above the poverty line and was not eligible for Medicaid. Suddenly, there was no one who could take her to the follow up appointments and she had to rely on a 17 year old child. Even the MTA bus system was challenging due to physical disabilities and ailments. The line item is very small and most of us must still rely on family. But can someone do if they have no family who can drive them?

There was a question about volunteers. Nancy commented that she must develop a report each yar to the Legislation. Some questions were asked such as “How many miles have been used by Senior Rides do we have?” Note: After the meeting Nancy provided a summary of the rides which is attached to this report. They are transporting more people. Many of the Senior Rides program had to transition due to COVID to call people and deliver food.

From Nancy Huggins (after the meeting)

The following information is from a DRAFT report to the Governor on the FY2022 Senior Rides Program.

FY2022 Senior Rides Report (excerpts)

	FY2022
One-Way Trips	32,854
Senior-Ride Miles	323,584
Senior-Ride Hours	27,113

The grantees (8 in FY22) provided transportation and/or services for 1,765 individual seniors during FY2022. These were seniors with needs for access to medical appointments, trips for shopping and/or religious services, frail or vision-impaired seniors who need an escort to travel, and seniors with needs for ongoing therapy or medical treatment. Many of these seniors are not able to rely on family, friends, or neighbors for their rides. The SRP provides an alternative transporation service that allows the participating seniors to access needed services and to remain connected to their communities.

In FY2022, the grantee began seeing an uptick in service by providing more trips, traveled more miles and accumulated more hours as compared to FY2021. Also, in FY2022, there were 1,765 seniors transported: 191 more than FY2021. This is due to the increases of services following the height of the COVID-19 Pandemic. Several agencies that had switched from driving seniors to delivering food and supplies to those seniors in FY2020 and FY2021 continued the practice into FY2022, along with transporting passengers.

Sharon from PIC- works with keeping people engaged. Transportation is a high demand to the doctor, grocery store and hairstylist. Covid was a huge setback. Many volunteers had to stop due to health. The office stopped driving for 2-week s and they also set up rules to safety (masks, keep windows down, etc.) They get phone call saying this is their only opportunity for transportation. They don't have a close-knit family or anybody to help them. Appointments and outpatient services require that someone needs to be there all the time for the care and drive them home. This is very hard for someone. There was question about pay. PIC offers gas reimbursement but many will turn it down. When the gas prices went up, they went to the county to get more funding. Sharon noted that 98% of their volunteers will reject the payment. There are some programs that have paid drivers, but the bulk are voluntary. There is quite a bit for training, is the car in good shape, sexual harassment, etc. There was a question clarifying the number of senior ridership and drivers.

There was a question when the Senior Rides program seen an increase. In 2014 and it has not raised for %. The legislation allowed up to 500,000 but the program is funded less than $300,000.

Would anyone want to comment on the bridging the gaps. There was a discussion of Veteran transportation. They have been concerned about health transportation and they have asked us to include transportation. When we began W2W, we were getting requests for veteran calls. J. Hartline described how he received a call from a veteran who had a brain operation scheduled in Walter Reed but he had no transportation. When he completed their forms, the patient was able to drive but, a few years later, he was not. When he requested the VA provide transportation, they pointed out that he completed the form stating he did not need the transportation and if he needs to change that, he will have re-fill the forms and wait until they are approved (=/- 90-120 days). They have the money but it takes a lot of time to qualify.
There is a particular insanity that there is a medical operation that is very expensive but the operation must stop because of the cost of transportation. It was pointed out that paratransit serves mostly dialysis but it is supposed to help many others.

PIC reached out to dialysis centers about transportation to see if they would be interested in some type of financial arrangement to provide transportation. Sometimes it is a need for coordination or even intervention. They were not amendable

There was a discussion about the VA transportation service in Cambridge. They will only drop off patients on Route 50 and they will not go to the door. They will not leave Route 50. There needs to be something that make sure the patient is at their house to their door. They will just leave them on the side of the road.

Sara mentioned this is connected to work force development.

It was pointed out that dialysis centers are not willing to coordinate to support transportation for their patients. This is something that should be evaluated and particularly for dialysis, this is a life and death. For the non-profits and transportation, they have no money, no drivers, and this is an emergency. There was a brief discussion that matching hospitals with patients is very helpful to coordinate transportation. Specifically, Wheels to Wellness in Southern Maryland works with local hospitals to match the patients. Noelle described the program further. The case managers are interested in the program to help people.

There was an interest in increasing the technology. Opening the dialysis center may help this. It seems we have the tools but we need to keep up with one shared solution rather than county to county. This may help with coordinating different types of rides. However, there was a comment that local agencies are supportive due to HPPA

requirements. For example, the W2W program needed to sign MOU's and BAAs with each hospital. Must keep patient information separate from the transportation information so that we can know the patient needs with the rides. As we move towards more urban areas, this may be very challenging if dealing with multiple hospitals.

If there is dialysis center, they need to be pulled in into the strategy. There needs to be buy in through technology and the State is working towards more social determinants of health and Crisp is getting pulled into this.

Tanya mentioned there discretionary spending. SMART is a potential grant to provide support. This is a planning grant and may be a great tool. Must be a government entity or transit authority. Partnerships are a great opportunity.

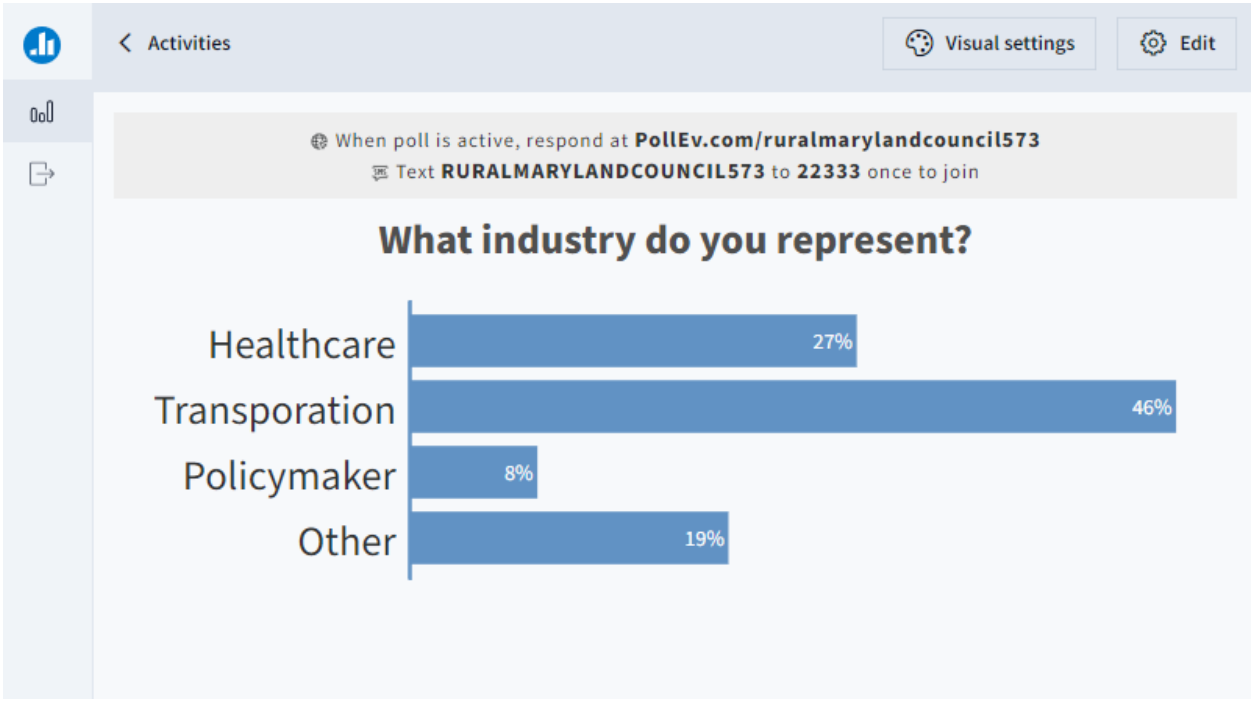
Question From Ms. Valentine. Are there any transportation programs? In Washington County, the CAC completes a program. But the current program cannot extend to the major regional areas. Nancy commented there are no programs in Washington County for outside of region program. There was an opportunity to apply for the Senior Rides program opened in January. The 5310 program is open now.

Dr Lorena de Leon-MPC works in the western part of the state and she described that most of their patients have transportation issues and they don't qualify. It is a nightmare to coordinate transportation across the state. They spend countless hours to download forms and many times they will hear stories of patients who are left on the curb. s. They are looking for to consider opportunities to use technology to centralize resources. Tripspark with is used by MDPT to coordinate with Medicaid. She works with four medical facilities. Anything

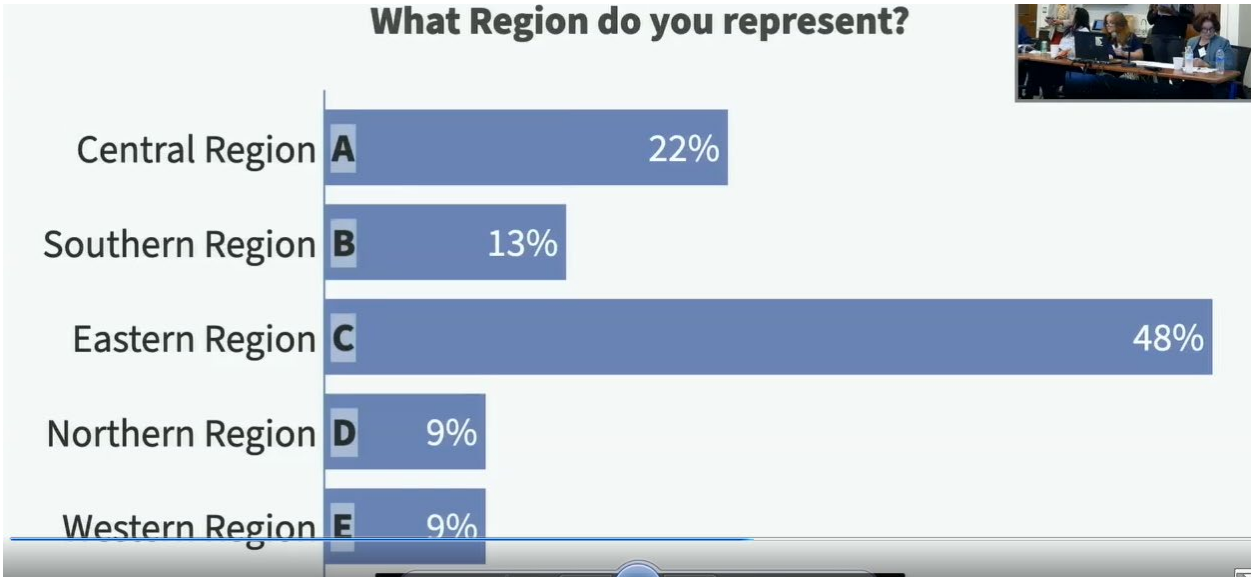
Lunch.

Vignette with Erin Farley

Poll Question 1:

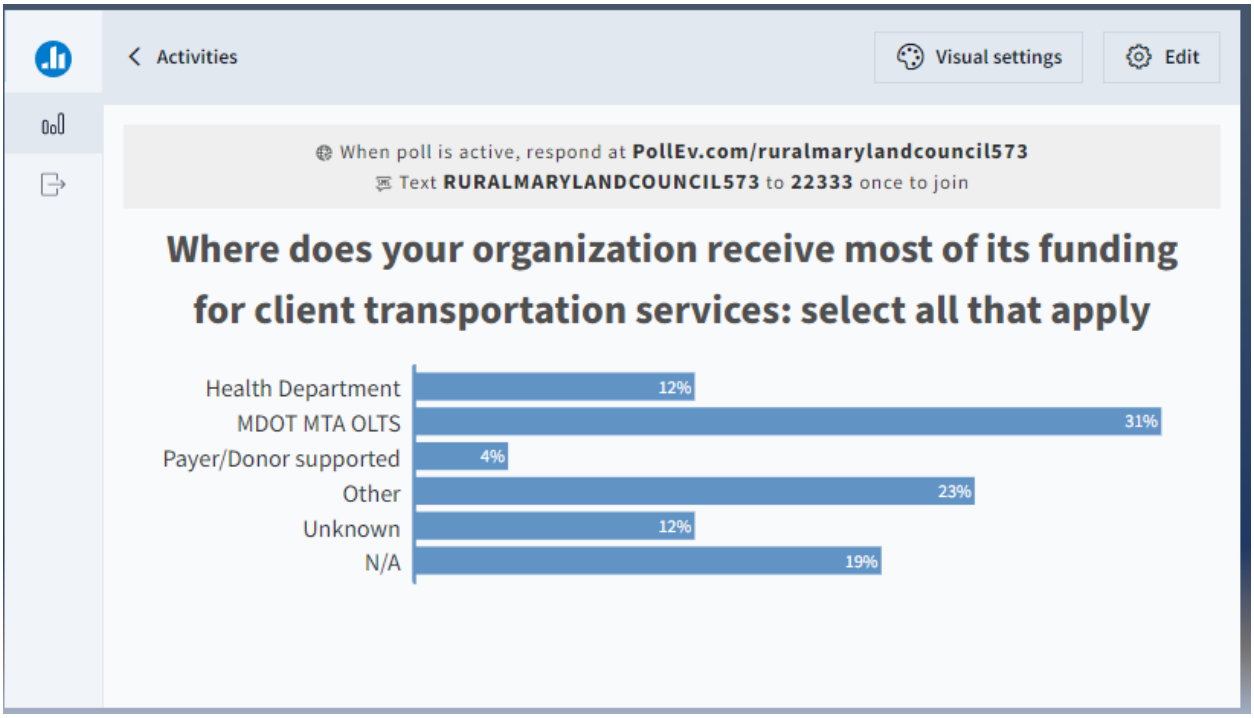


Strong transportation representation. 27% healthcare and 19% other. 8% policymaker.



Eastern Region had the strongest response at almost half of the responses followed by central and southern.

Poll Question 2:



It was noted this is a multiple type of response.

Yolanda's observations:

- There was about 80% who are receiving funding for transportation service.
- About 1/3 of the funding is from MDOT. The second largest group was "other"
- Only 12% of the participants received funding from the Health Department. The smallest group was payor/donor supported
- Almost ¼ of the group indicated they get their funding from other sources" If it is not health department or MDOT MTA, does anyone know where they get this funding?

(For percentage breakdown details, refer to the slides. The following is a summary of the discussion and notes should be reviewed together with the slides) The meeting returned back to reviewing the survey results. The survey was released in early to mid-July and we received over 300 responses.

Demographics:
Land use: Rural was about 2/3 and clearly the largest group; suburban was almost a third and urban was about 7%. This is a good mix maybe heavy on rural.

Region: Based on MDOT map. There is an emphasis on rural areas which patterns the land use. The Eastern shore was the largest region represented.
Organization classification: Government represented almost half with non-profits representing about 44% There was some interest from private sector but remained at less than 10%Of the government group, almost half were local representatives with about 1/3 was State government.

How do you define NEMT: There was a clear tier level.
What non-emergency was available: The largest group was "I don't know" which seems that we need to work on defining the service.
What is your community's most urgent need? Although there is less understanding of the services, there is a better understanding of what are the needs.
Problem with current services: demand exceeds service, and funding. Patient non-compliance was not seen as a problem.

It was noted that the demand exceeds services is connected to funding. It was also pointed out that we were asked to identify what was the greatest problem.

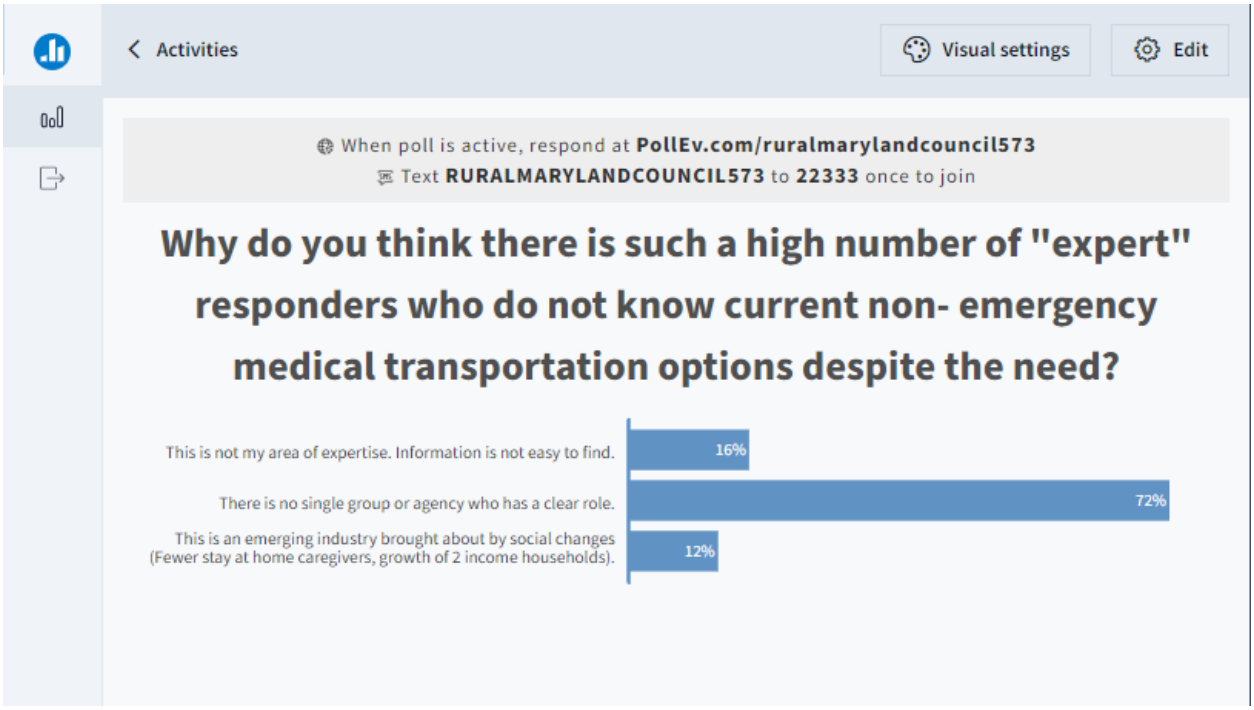
Demand could also include available appointment times.

Who is eligible? It was noted that the most needy may be identified

Who should be considered for providing NEMT? By far, non-profits were identified as the preferred group. This was preferred over other groups. Then Government and then hospitals.

Comments: Alex Handy of Upper shore Transit. Met with local hospitals suggested they promote ride to contact DCT or Queen Annes and put in their advertisement "If you need a ride". This seems logical but they did not get far.

It was noted that rural was the largest followed by suburban area.



One of the primary problems is that there is not clear group or leader.

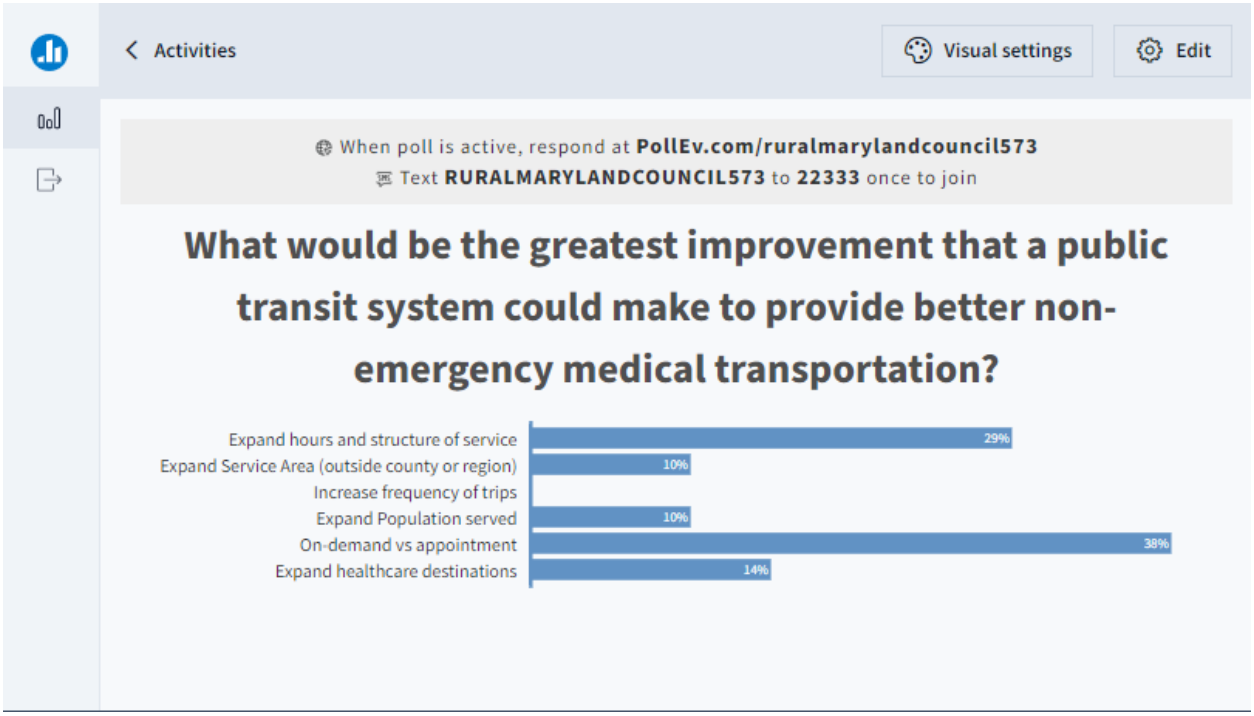
Comments: (Sara) There was a brief discussion on how all of the programs "braid together". We also braid organization together too (non-profit, hospital, non-profits). This is such a big part of life (transportation) There needs to be some parameters set to establish who does what and when. And there needs to be some mapping of that. Who does what best and how do we pull it all together. Hopefully, this roundtable and this group will help.

(Noelle) There are a lot of experts at the table and we end up thinking someone else is doing this or is responsible. Maybe Medicaid, etc. There is a belief that "someone" is doing this but we don't know if they really are

(Dr. Lorena Del Leon) commented that in other states, the managed care organizations can better control the funding or can direct it to other entities. In Maryland it is based on the County and this creates a challenge.

John H- In Southern Maryland and on the Eastern Shore, the healthcare system requires transportation out of the region to a specialist. There really is no one who needs long range transportation. This point was re-affirmed by Dr DeLeon who works in a large managed care program. She noted this is common and they recently had a similar situation. One community member had surgery in PG and needed follow up care in Baltimore. It was ridiculous to find transportation since it took three weeks to

coordinate and they paid out of pocket. So, it's just not the knowledge of what is available but the capacity of the area resources to find the transportation.



Expand hours and provide on-demand services. No one selected frequency of trips. (Yolanda) It is not a matter of number of hours but it is a matter of targeted trips. There was a question on what on-demand service is.

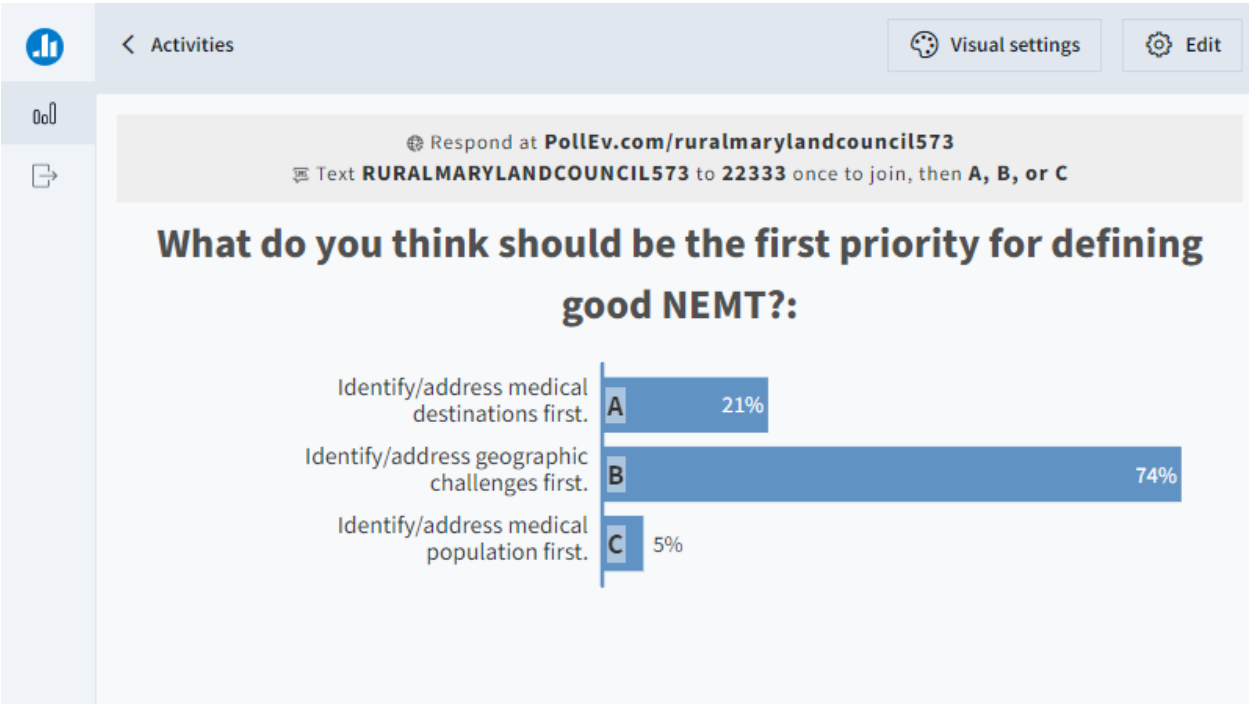
Suzanne from Cecil County– Described on-demand verse others. On demand is more similar to an uber or lyft but it is operated by a public transit system. Her demand response program is on ADA/paratransit and she relies on using "deviated routes" system instead. This allows her the ability to deny trips. For example, right now, she has only 3 drivers so if you have a trip and call at the last minute, you may not get a ride because there is no one available. She participated in an on-demand pilot project that was funded through IMI to assist citizens who were on active recovery and it was very successful. Very dynamic She discussed you can create zones where the trips occur so you do not duplicate services where you have a robust transit service. It also helps with the last mile and connections.

Chris (Carroll)- Public school system may be another example to consider. The sub system has changed to be more open. Previously you would get phone calls early in the morning. They switched to a model that any area that you can sub in and you can pick out a month worth of work. Might a model to take from public school to

Dr Lorena del Leon- They are working on a blueprint around this with a multi-modal company that can use the MTA platform and that can also include uber or lyft. This will allow a lot of options since you can have a centralized platform that can do multi model and that can help with full ambulance transport to ambulatory patients. Having that option helps.

Yolanda commented on W2W. She noted that uber and lyft are not available. This was affirmed by Dr Del Leon. She is building a business case with them to bring them to the table. Suzanne form Cecil affirmed this was their problem

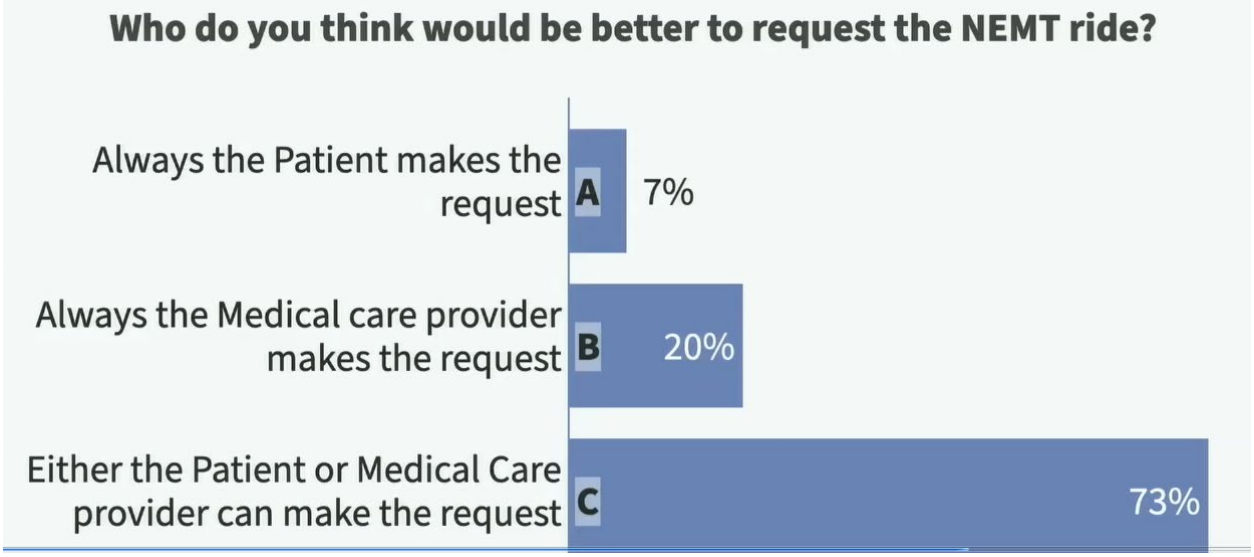
Sharon mentioned that elderly may not understand the technology. One patient discussed her son set up a n uber ride. She was willing to take a cab. Also, many uber and lyft may not have the wheelchair capacity. Dr del Leon commented that Lyft was trying to become wheelchair accessible. But having a centralize d platform was very helpful.



Overwhelmingly, address the geographic challenges first was preferred. There was a question about the descriptions. Medical destinations would prioritize hospitals and medical centers for service; geographic rural/urban deserts challenges are to prioritize the areas where patients are not served because there is no service and the third is to target specific patients with chronic diseases such as dialysis patients to provide them

with transportation. It was noted that the more rural have a high geographic issue. Further, there is no "one size fits all"

Dr. Valentine-Western Maryland has several areas



There was a discussion that "always" is very hardline. You want the responsible party to be the one who makes the appointment (mom, dad, etc.) because you may not have any kind of negative thing you can give….. It's easier to find the pattern if it is one person being responsible. When asked, Keith Adkins noted that the survey results offered "no big surprises". Keith commented that sometimes they will get a request from the Health Department to pick someone up. They will go out pick up the patient only to find out they did not need the ride and that "they told them at the Health Department" and that information does not get communicated back. The DCS would then be stuck with the cost of the pick-up include in gas, wear and tear and driver time. If they had the software program that shared, they could collect that information they could keep track of the no shows and who is mismanaging the appointments. Keeping up with the addresses was also very difficult because people will move or change their phone number and they won't update the transportation provider at DCS. They currently do not have a dispatcher to make reminder calls to patients of their upcoming rides. They complete over 2,000 trips a month that would be difficult to keep up. It was noted that sometime

Darlene Valene-

John Hartline- W2W studied what was done by Mike Pennington. That is why we have the care coordinators to call the day before. Our no show is about 2-4 % because there was a focus by the care coordinator/doctor and a patient. If the patient would not come out, the driver would go to the door. At that stage, the driver would be responsible for collecting the patient.

Chris- We are going to be an iterative process anyway do we need to hire specialize driver to take the harder patients. If we complete this type of work at the State, that free up time for others.

Tanya -There is a need for a joint effort by both healthcare and transportation providers and do we have the capacity to keep this long term.

Darlene- they have their own patients. There will always be a high number of no shows.

Sharon- PIC asks patients to give a 5-day notice and the driver will call and introduced themselves to the patient. They have a low no show rate. The collaborative approach is huge. There is no way a dispatcher will call all the patients. The population is challenging and may be difficult due to their physical ailments. "How do you feed an elephant" one bite at a time. There is no one simple thing to do this.

There is a need to recognize there is no "one size fits all"

Sara- When appointment made in the medical clinics, there should be a conversation for expectations. Where do you get those expectations? Hopefully that will impact no show and build value.

A level of coordination puts scheduling as a gatekeeper with people who have skin in the game (budget). It becomes incumbent on them to use their resources well which will affect their service if not coordinated. As transit, we should be able to rely on information so that we can tell you when we can and can't complete a ride. The gatekeeper can manage it at granular patient level and maybe the organization and the State provides the overarching controls and sets up that coordination infrastructure and charges that with working with the providers and we don't lose the piece to get the patients to the need. This is very important in the more rural areas such as Eastern shore "to get the patients over the bridge".

Scott Warner- Question 5 was difficult. Concerned that the burden would fall on the Transit system. What is the healthcare system going to do? They tried this before. They came to the table because 30% failed to show up.

John- Many times, he hears that the health care industry will "dump" patients on the transit system. These are people. There is very little concern from the healthcare

industry to provide. Medicaid will send them to the transit system. More money is good but if the structure is not addressed, the system will continue to have the same inefficiencies that we have now. As the population ages, it will continue to be difficult to provide. Covid upended a lot of thigs for example, NEMT, is making transits to keep their head above water. This is a partnership with both sides to come to the table.

John H- We allocate funding/miles at the hospitals. We tell them a certain number of miles each month. They have a limited number of miles.

Darlene Valentine- works in medical field and wanted to comment on the relationship. For example, the medical team should work with the patient to outreach worker who works with transit and healthcare to make sure it works. They have outreach workers who reinforces the need that it is important to their appointments.

Dr del Leon – The transit system does the best they can and this is about coordination. This starts with the funding and the distribution and make sure the person in the middle gets their help

Nancy reinforced that coordination is the highest score item.

Elizabeth Beck- could not unmute her sound.

Several emphasized the need for partnership.

Could the healthcare be part of the funding of the solution.

Noelle- There is a total cost of care which they pay but the actual driving patients is not their area.

Suzanne (Cecil)- It's not just healthcare it is workforce, etc. Until everyone had transportation it would be a barrier.

Lenny (Dorchester) Maybe look into mobile integrated health to visit homes. Doing house calls may be good. He is in EMT.

There was a discussion about patients who do not need an ambulance but they need to get an appointment. They are also susceptible to scammers because they are simply lonely. There was a discussion about the types of ambulance patients. Tier I- patient needs immediate help at medical center (lights flashing, etc.) Tier II- patients needs some help at the medical center (no lights flashing) Tier III- patient does not need immediate help and that could have been an appointment Tier IV- patient is just lonely.

Noelle- patients who don't pay the ambulance, it comes out the hospital budget which affects their other projects. It was noted that one local EMT station 80% are not for emergencies.

It was also noted that we know who the "frequent flyers" are

ALTARUM
HEALTHCARE VALUE HUB

Hospital Rate Setting: How it Works in Maryland

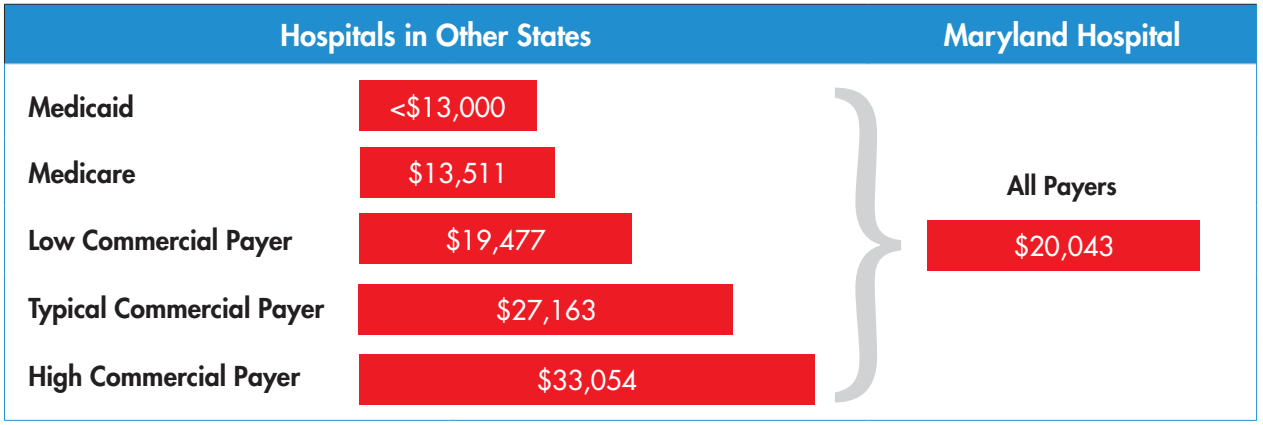
Two Ways to Pay Hospitals

In most states, hospitals negotiate rates with each payer separately. The result: A hospital is paid different rates for the same services, depending on the payer.

How is Maryland Different?

Hospital rate setting is a system in which an authority, usually a state agency, establishes uniform rates for hospital services for multiple payers. Maryland sets uniform rates for hospital services, so all payers pay about the same rate at a given hospital. This all-payer system requires a federal waiver so the state's rate setting agency can replace Medicare's payment rules with its own.

Example: Hospital Payment for Major Joint Replacement



Sources: Analysis of 2013 Medicare and commercial hospital payments by CBO (Tables 2 and 5): https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf. *Maryland estimate is the ratio of MD payments to US average from CMS Inpatient Charge Data FY 2014 (found here:* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2014.html*)*

Evolution of Maryland's Waiver Program

In 1977, Maryland received its first federal waiver, which allowed the state to replace Medicare rates with all-payer rates. The system worked well in terms of keeping per-admission spending growth low, but the number of admissions grew. In 2008, the state piloted a global budget system in 10 hopsitals to reduce unnecessary admissions and pay for value. Each hospital received a fixed global budget covering all outpatient and inpatient services.

In 2014, a new waiver was enacted statewide. Each hospital receives a global budget based on revenue from the previous year (base year). The hospital's global budget is adjusted annually based on cost inflation, demographic changes and performance on specific quality measures.

Previous Hospital Payment Model (1977-2013)

Total Admissions/ Services X **Rate paid per case** = **Hospital Revenue**

- Incentivized volume over value
- Revenue unknown at beginning of year
- More admissions/ services equaled more revenue

New Hospital Payment Model (2014-Today)

Hospital Revenue for Base Year X **Updates for population changes, value, cost inflation** = **Global Budget (allowed revenue for next year)**

- Incentivizes value and population health
- Revenue known at beginning of year
- More admissions doesn't equal more revenue

More information can be found at *www.HealthcareValueHub.org/Hospital-Rate-Setting*

VERMONT ELDERS & PERSONS WITH DISABILITIES PROGRAM MANUAL & BACKGROUND CHECK POLICY

Vermont Agency of Transportation
Policy, Planning, and Intermodal Development Division

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CONTENTS

1. ELDERS & PERSONS WITH DISABILITIES TRANSPORTATION PROGRAM

Vermont's Elders and Persons with Disabilities (E&D) Transportation Program continues to play an important role filling gaps in existing transportation services for older adults age 60 and above and individuals with disabilities. Vermont's public transit providers serve as regional transportation brokers and work with human service agency partners to coordinate E&D trips together with Non-Emergency Medical Transportation (NEMT) provided through Medicaid, contracted service with community organizations and institutions, and transportation for the general public. This coordinated transportation approach extends the impact of available E&D funding, as the regional brokers utilize multiple funding sources and fill capacity on vehicles to the maximum extent possible.

1.1. Public Policy

It is the goal of the State of Vermont to fulfill, insofar as is feasible, the public transportation needs of older adults and persons with disabilities. State law—24 V.S.A. § 5083 (a) (1)—states the primary goal for public transit is providing "basic mobility for transit-dependent persons."[1] The Vermont Agency of Transportation (AOT) uses funding from the Federal Transit Agency (FTA) 49 U.S.C. §5310 program to partially meet this goal. That separate program is a formula allocation program, based on census counts of older adults and persons with disabilities in each state. Federal funds must be partially matched by non-Federal contributions. AOT awards the population-based §5310 formula grants to organizations that purchase vehicles whose principal use is to meet unmet transportation needs of older adults and persons with disabilities.[2]

Because Vermont has a small population, the §5310 formula allocation is insufficient for meeting the special transportation needs of older adults and persons with disabilities for whom mass transportation services are unavailable, insufficient, or inappropriate. To increase services, enhance efficiency, and be more effective, Vermont also administers this program, a supplementary transportation program for older adults and persons with disabilities (E&D Transportation), as an integral component of its public transportation program.

The §5310 formula allocation program buys vehicles. The primary use of those vehicles is to meet the unmet transportation needs of older adults and persons with disabilities. The E&D Transportation program, on the other hand, pays for some rides (purchase of transportation services, rather than purchase of vehicles) for older adults and persons with disabilities. The E&D Transportation program coordinates funding from several Federal, State, and local sources—including non-governmental sources—to make public transportation accessible, safe, responsive, reliable, convenient, and affordable for as many persons as possible. Additionally, Section 3006(b) of the 2015 FAST Act created a discretionary pilot program for innovative coordinated access and mobility and examples of traditional

[1] *Transit dependent person as used in this context* means either a person who is unable to drive either because of age or disability or legal status, or not having have access to a car because of income.

[2] For additional information, refer to the FTA's Enhanced Mobility of Seniors & Individuals with Disabilities- Section 5310 webpage https://www.transit.dot.gov/funding/grants/enhanced-mobility-seniors-individuals-disabilities-section-5310.

and non-traditional activities funded under these funds.[3] Eligible projects include both traditional capital investment and nontraditional investment beyond the Americans with Disabilities Act (ADA) complementary paratransit services.

1.2. Eligible Grant Applicants

In each public transportation region of Vermont, AOT designates a single public transit provider as the administrative entity to submit an annual grant application for funds for E&D Transportation. This allows maximum coordination and efficiency among all stakeholders within each planning region of Vermont. Although Federal regulations allow for all non-profits to apply for and receive funding, to advance the goal of a fully coordinated public transportation system, AOT will accept only a single integrated grant application to fund public transportation from each region. Stakeholders interested in partnering with the regional provider in their area should contact the administrative entity responsible for the delivery of E&D services. The one exception to those eligible is the Vermont Association for the Blind and Visually Impaired. Given the unique services they provide, AOT will accept one statewide application from them.

AOT accepts grant applications only if they show that other regional partners and stakeholders worked with the designated public transit provider in preparing the application (i.e. through letters of support, letters specifying match commitment from E&D Partners, meeting minutes that demonstrate that E&D Partners have reviewed and contributed to the grant application, etc.). The application must also demonstrate that efforts are ongoing to coordinate public transportation among regional partners and stakeholders. Regional Planning Commissions (RPCs), human service agencies that operate within a region, municipalities, community organizations, passengers, and the public at large should be invited to participate in public transportation planning and coordination that leads to applying for grants. The designated regional administrative entity may subcontract with other organizations to purchase some or all E&D Transportation services, rather than provide services directly. The decision of how to provide services is based on coordinated regional planning among stakeholders and varies by region. Subcontractors of E&D services will be required to establish a Title VI program if it is determined they fall under the definition of federal subrecipient[4].

1.3. Submitting Grant Applications

Designated public transit grantees submit integrated public transportation grant applications in the required format. All components of the application—including Committee approvals, required certifications and assurances, service descriptions, and a budget—must be submitted to AOT by the published filing date. AOT will not approve incomplete or late applications. AOT will provide technical assistance in preparing grant applications on request.

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[3] 49 U.S.C. Section 5310 / FAST Act Section 3006. Additional information on nontraditional investments can be found https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/funding/grants/37971/5310-enhanced-mobility-seniors-and-individuals-disabilities-fact-sheet.pdf.

[4] 2 CFR § 200.330 - Subrecipient and contractor determinations. https://www.govregs.com/regulations/title2_chapterII_part200_subpartD_subjgrp33_section200.330

1.4. Review and Approval of Grant Applications

A committee consisting of all staff in the AOT Public Transit Section will review all applications and local agreements for funding for the E&D Program and shall develop recommendations for approval and funding. The recommendations shall be submitted to the Secretary of the Agency of Transportation (AOT) for approval. The Secretary retains sole authority to approve applications and may revise the committee's recommendations at their discretion. After individual grant applications are approved by the Secretary, they are consolidated and submitted to FTA by AOT as a statewide grant application. AOT through the Secretary, coordinates all Federal grant activity with FTA. FTA reviews all statewide applications and approves Federal funding.

Upon approval of the statewide grant application by FTA, AOT and each grantee execute an individual grant agreement (contract). Individual grant agreements specify the terms and conditions under which public transit will operate in each region.

1.5. Regional E&D Advisory Committees

E&D Partners and relevant stakeholders are organized into Regional E&D Advisory Committees (Committees). Each public transit region must designate its own Committee. Regional Planning Commissions (RPCs) shall organize and facilitate Committees. In some cases, two RPCs may share responsibilities for a Committee if the transit district area covers more than one RPC region. Committees may be subcommittees of Transportation Advisory Committees that also deal with other transportation issues, or they may be separate committees. Annually, AOT shall include expectations and guidelines for Regional E&D Advisory Committees within the Transportation Planning Initiative (TPI) Work Program Guidance issued to RPCs and the Metropolitan Planning Organization (MPO). Tailored guidelines will be distributed to each Committee by its parent RPC or MPO. Additionally, the annual Guidance will be referenced in the annual Transit Provider contracts with AOT.

Committees may incorporate preexisting groups that previously participated in public transit and human service transportation planning. Committees may include representatives of:

- involved public transit providers,
- area agencies on aging,
- adult day services,
- community mental health centers/designated agencies,
- community action agencies,
- all Agency of Human Services (AHS) Field Services Directors in each planning region,
- consumer representatives,
- statewide advocacy groups,
- local human service agencies,
- and other concerned parties.

Committees shall meet regularly, or at least quarterly, to receive subcommittee reports and discuss the status of the integrated program. Meetings shall include reviews of current service levels, service quality concerns, budget balances, funding issues, and matters that will improve services to consumers. Reviews of current service levels shall include verifying that services are the most cost effective and appropriate to meeting consumer needs and use only authorized and appropriate modes.

After an organizational meeting of the entire Committee, subcommittees or task forces may be created to deal with issues, such as funding, service quality, changes in transportation needs, etc. HSAs (Human Service Agencies) should participate in these meetings and monitor the financial status of their projects. More details are included in the Reports section toward the end of this manual.

Each Committee shall develop:

- An annual regional service plan that shall define roles for each participating partner. The transportation needs of each partner and the region will be specified in the regional service plan.
- An annual work program of tasks to be accomplished by the Committee during the year, per the TPI Guidance.

Grant applications will describe how each proposed project contributes to the goals of the regional service plan. A financial plan that allocates available funding shall be part of grant applications. The grant applications will also explain efforts made to obtain funding from other sources. Local agreements among regional partners shall be included with the grant application. AOT will review these local agreements and may request clarification, but AOT is not a partner to local agreements. AOT shall make staff available to provide technical assistance at Committee meetings. If issues or concerns cannot be addressed before submitting grant applications, AOT will help craft suitable solutions that avoid interruption of services.

2. E&D TRANSPORTATION SERVICES

E&D Transportation is an integral part of transportation for the general public. To preserve resources and benefit as many persons as possible, passengers are to be encouraged to use the least costly transportation mode that meets their needs. In most cases, the lowest-cost mode is fixed-route buses that follow a regular schedule of stops at designated locations. In cases where fixed-route public transit is unsuitable for the needs of the consumer, demand response door-to-door service may be possible, if funding and other resources are available. The budget designated for E&D Transportation will be specified, within the overall §5311 general rural public transportation program budget.

2.1. Demand Response Service

Most often, demand response service is used by those who are 60 or older or who have an Americans with Disabilities Act (ADA) defined disability that interferes with one or more major life functions. Demand response service requires reservations at least twenty-four hours in advance. Except for extraordinary requirements—such as trips for large groups—no more than forty-eight hours advance notice shall be required.

Demand response service may be supplied by volunteer drivers who use their own vehicles, vehicles owned by the public transit system and driven by employees, or, if necessary, taxis. Whenever possible and appropriate to meeting the needs of passengers, more than one passenger should ride in each vehicle to reduce per-trip costs.

Authorized Mode of Transportation

The appropriate mode of transportation is determined as part of an intake process when a passenger requests demand response service. Each passenger's need is periodically reevaluated. Local agreements between public transit providers and affected human service agencies may specify procedures for

periodically reevaluating the type of transportation appropriate to passengers with special needs. Both human service agencies and public transit providers should provide information to assure that reevaluations are in the best interest of each passenger and resulting recommendations are appropriate for passenger needs.

E&D Transportation must be safe and must accommodate passenger assistive mobility aids; such as wheelchairs—if those mobility aids meet the approved ADA definition[5] and can be accommodated on the vehicle (e.g., they fit on the lift or ramp and in the securement area). Agencies may only decline to transport a wheelchair occupant if doing so would be inconsistent with "legitimate safety requirements," as discussed below. A vehicle that complies with the base Part 38 specifications will be able to accommodate, at a minimum, all occupied wheelchairs weighing up to 600 pounds and measuring 30 inches in width and 48 inches in length (formerly known as a "common wheelchair"). Vehicles that exceed the minimum Part 38 specifications (e.g., those that have lifts with design loads of 800 pounds and securement areas larger than 30 x 48 inches) will accommodate larger, heavier devices.

Non-accessible vehicles may be used for passengers who do not require special accommodation, but accessible vehicles must be available when needed. Buses, mini-buses, private automobiles, taxis, and vans are acceptable. New vehicles acquired with Federal or State funding to transport passengers in public service must be fully accessible.

Rider Assistance

Drivers will provide door to door assistance to older adults and persons with disabilities who require such aid). Drivers must successfully complete instruction in passenger assistance and be currently certified to provide such assistance by the public transit provider before transporting passengers who may require assistance.

For passengers who need help, the driver will assist the passenger from the outside door of the pick-up location to the outside door of the drop-off location. (Insurance and vehicle security concerns preclude drivers from entering buildings with passengers. Passengers who need assistance inside a building must arrange for an aide. Providing aides is not the responsibility of public transit providers; however, they shall work with HSAs as needed.)

A passenger may be accompanied by an aide or attendant if such assistance is needed. The aide's assistance may be needed on or off the vehicle. The aide or attendant is considered part of the E&D Transportation program whose sole purpose is to assist the eligible passenger. Therefore, the aide or attendant is not charged a fare, but is considered necessary so the eligible passenger can use transportation services. Passengers who need the assistance of an aide or attendant must inform the dispatcher or their human service agency when they schedule a trip, so appropriate seating arrangements may be made.

[5] Section 37.3 of the DOT regulations implementing the Americans with Disabilities Act of 1990 (ADA) (49 CFR Parts 27, 37, and 38) defines a "wheelchair" as a mobility aid belonging to any class of three- or more-wheeled devices, usable indoors, designed or modified for and used by individuals with mobility impairments, whether operated manually or powered. For more information see:
https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/Final_FTA_ADA_Circular_C_4710.1.pdf

Vehicle Capacity
It is desirable that vehicles operate at capacity when possible. However, the primary responsibility of transit providers is to ensure that each passenger receives safe, comfortable, and timely transportation. The timing of appointments or the length of trip may require that vehicles operate at less than full capacity. The collective professional judgments of public transit providers and human service agencies will determine appropriate dispatching, scheduling, and seating arrangements on a case-by-case basis. These arrangements will consider the functional abilities of passengers, which may change over time.

In limited cases, if there are empty seats in a special needs vehicle that can be used safely by other passengers, without compromising service quality, the unused capacity may be offered to those with schedules and destinations that are a good fit. In all cases, unused capacity is determined not only by the availability of empty seats, but also by the ability of the driver to assure that every passenger aboard will receive a safe, comfortable ride that meets or exceeds all quality expectations. Arrangements to include members of the public on demand response vehicles that carry special needs passengers must be evaluated by trained HSA staff on a case-by-case basis. General public passengers will be accommodated on a space available basis.

General Public Passengers
General public passengers must pay the fully allocated cost of their rides, as specified in public transit providers' published fares. No passenger will pay more than the fully allocated cost of their ride. In most cases, special needs passengers who are referred by a human service agency that has a local service agreement with the public transit provider giving the ride do not pay cash fares. The cost of their transportation is paid under the terms of the local agreement. Aides approved by the referring human service agency also do not pay cash fares for their rides. However, travelers without an official role in assisting special needs passengers are considered general public passengers who must either pay the fully allocated cash fare or make other acceptable arrangements to pay for their rides on special needs vehicles. This is true for any public passenger who accompanies a special needs passenger as a social companion, rather than as an aide.

Health, safety, behavioral, or confidentiality concerns may preclude transporting special needs passengers with public passengers on the same vehicle. Public transit providers and human service agencies shall cooperate to determine the transportation suitable for each special needs client. In no event shall passenger health, safety, well-being, or the confidential nature of passenger medical records be compromised for any passenger. Passenger welfare is the primary consideration in determining the appropriate mix of passengers on a vehicle.

2.2. Service Quality

Driver Licensure and Screening
Drivers must be properly licensed in Vermont to operate vehicles used in any public transportation program funded via AOT. Only drivers with a history of safe driving are acceptable and Department of Motor Vehicle (DMV) checks are required before hiring. Drivers who use their own vehicles must present evidence of adequate insurance. All active paid drivers, dispatchers, and mechanics must be included in a pool of safety-sensitive persons who are subject to periodic screening for drug and alcohol use in accordance with FTA rules. Public transit providers may adopt their own written rules for drug and alcohol abuse if all FTA standards are met at a minimum.

Background Checks
In accordance with Federal mandate (CFR455.436), background checks must be performed on all employees, all volunteer drivers, taxi company employees, and all other subcontractor staff – both administrative and direct service providers. Additional information can be found in Section 2.5: Background Checks below.

Trainings
Drivers and dispatchers must be trained in the special needs of passengers who are elderly or who have disabilities, including those disabilities that may not be immediately apparent. Training shall include confidentiality rules that apply to passengers' medical and personal information. Recurring training must be provided for Passenger Assistance Safety and Sensitivity (PASS) to all van/bus and volunteer drivers. Van/bus drivers must also maintain certifications in defensive driving such as Smith System. All van/bus and volunteer drivers must be educated in the company's accident/incident reporting policy. They are required to report all accidents/incidents from the scene and fill out a company incident form and police report if applicable. Transit providers shall enlist the assistance of local human service providers and advocacy organizations in delivering additional annual trainings including including assisting individuals with dementia and Alzheimer's.

Scheduling
Public transit dispatchers shall cooperate closely with Human Service Agencies (HSAs) and shall become familiar with the individual needs of passengers who regularly use demand response services. To the extent possible, public transit providers shall comply with scheduling and transportation requests of HSAs. Local agreements (contracts) between HSAs and transit providers will spell out arrangements for resolving disputes over specific transportation arrangements. Except for special circumstances, such as trips for large groups, public transit providers shall require no more than 48 business hours advance notice to schedule E&D transportation. Usually 24 business hours prior notice is the minimum requirement. Public transit providers and human service agencies shall notify passengers of the requirements for advance notice, including cancellations and schedule changes. Passengers will also be informed of the public transit provider's policy on trips cancelled without notice and other expectations of passengers.

Health and Safety
Public transit providers shall assure that all vehicles are properly equipped to meet or exceed health and safety requirements. Vehicles must be inspected and maintained at least to manufacturer's specifications. Vehicles must be properly equipped and maintained in accordance with laws governing the operation of motor vehicles in the State of Vermont. Any vehicle problems must be corrected promptly. No vehicle with uncorrected problems that may pose health or safety dangers may be used in public transportation.

Grievance Procedures
Each public transit provider must have a documented system in place to receive and record allegations of inappropriate behavior by its employees or volunteers, investigate incidents, and rectify problems. Similar reporting must be available for safety concerns and other issues, such as service that is not timely.

Each public transit provider shall have clearly written grievance procedures available to both the public and HSAs. These procedures are required under Title VI to be posted on their website, buses and

offices.

These procedures shall include notifying passengers of their right to file complaints and the progressive steps to take if a grievant believes an issue is unresolved. Procedures shall specify actions the grievant must take and what responses the grievant may expect. Time limits for filing grievances and responding to grievances shall be included. Grievance procedures must be approved by AOT and must include contact information for passengers who want to submit disputes directly to AOT.

Documentation Requirements
All State of Vermont contracted entities are required to keep records for 7 years. All records must be available at any time for review by Federal or State authorized staff, including all audio and video recordings. These records must be available for review as requested by VTrans staff. This requirement also applies to all subcontracted drivers. These records may be kept in electronic form if they are still readily obtainable upon request.

Trip Manifest Requirements
All trip manifests must be retained, and they must include:

- Full date of trip
- Driver's full name/signature
- Miles traveled (odometer readings)
- Member's full name
- Pick-up and drop-off locations
- Pick-up and drop-off times (actual)
- The time the driver starts and stops billing

2.3. Eligible Costs and Cost Matching

Both capital and non-capital costs are eligible for reimbursement[6].No cost that is unallowable for Federal reimbursement, as specified in FTA and OMB circulars, is an allowable expense. Only categories of expense that are in the budget of an approved grant application will be approved for reimbursement. If an approved budget must be either increased or decreased, the amended budget must be approved by AOT before it takes effect. This includes transfers of funds between grantees by mutual agreement. To avoid delays in reimbursement caused by the need to amend a grant agreement, applicants are urged to develop budgets with care. The total award amount of a grant agreement is a ceiling that may not be exceeded. If a grantee incurs costs that exceed the MLA, those costs are not reimbursable by AOT.

Grantees must match Federal grant funds from non-Federal sources. Administrative and preventive maintenance expenses (including volunteer driver reimbursement) require a 20% match (80% Federal grant funds and 20% from other sources). Operating expenses—which AOT defines as fuel, driver wages, dispatcher wages, and the fringe benefit expenses associated with those wages—are subject to a 50% match. Because of the higher match requirement for operating costs, Vermont annually appropriates

[6] Vehicle acquisitions are not included in this E&D Transportation program manual. Separate applications, with different guidelines, are required to procure vehicles.

State funds that may be used to meet some Federal match requirements. The annual amount appropriated from State funds is not guaranteed. Human service agencies will not be required to provide more than 20% match to support their requested E&D transportation services.

Public transit providers may use hours of service by volunteer drivers, including time spent driving and wait time, as non-cash match. Hours of service are defined by agreements between volunteers and the agency to which they donate their time. In some cases, agencies may allow waiting time, as well as driving time, to be considered an hour of service, if waiting time is a normal consequence of a trip. The volunteers must be part of a pool administered by grantees (designated regional public transit providers) or by local human service agencies under the terms of a local agreement. AOT allows only the hours of volunteer drivers to be used as match. The hours of other volunteers are ineligible for use as match. Public transit providers reimburse drivers for documented mileage at no more than the published standard Federal reimbursement rate. Public transit providers and human service agencies must record volunteer drivers' hours with at least the same degree of care used to track hours of paid hourly employees. These time records must be available for audit and review in the same manner as other accounting records. The agency to which the hours are donated must have a system to assure that no volunteer hour of service is used as non-cash match more than once. Public transit providers may claim those hours as local match for this E&D Transportation project. (AOT does not allow using non-cash match on other projects.) Each hour is valued at the Vermont minimum wage rate in effect at the time of service. No other non-cash match may be used without prior written permission of AOT.

HSAs may enter into local service agreements directly with public transit providers. These contracts may either call for a cash payment for each ride or a payment for specified services over a period. AOT shall review these contracts to assure they comply with FTA and State rules for transportation grants. AOT is not party to these local agreements. If these contracts call for HSAs to pay transit providers cash in return for transporting HSA clients, that cash is not considered revenue from fares. Therefore, it may be used as local match applied to their local agreement for services. This exception applies only to contracts between providers and HSAs.

Other payments for transportation are classified as fare revenue. FTA rules require fare revenue to be subtracted from expenses before claiming reimbursement. Fare revenue may not be used as cash match on the project that earned it. After the expenses are reduced by the amount of fare revenue, the cash may be used as the provider sees fit, including as match for a different Federal project.

Grant applicants must certify that they have or will have sufficient match for Federal grant funds. If a grantee does not provide sufficient match, unmatched Federal funds must be returned.

If unspent funds remain in a region, AOT will attempt to reallocate funds to regions with funding shortfalls. To qualify, recipient public transit provider(s) must document that services that were provided to eligible riders were not reimbursed. There is no assurance that funds will be available for such transfers. All recipients of E&D funding are strongly urged to closely monitor expenditures and stay within budget.

An effective way to enhance E&D Transportation is to share resources. When resource sharing meets the needs of all passengers, passengers whose rides are paid for with other funds—such as Medicaid—can ride on vehicles purchased with §5310 funds and share other E&D Transportation resources, such as centralized scheduling and dispatching. When each funding source contributes its fair share of fully allocated costs, resources are used more efficiently, thereby reducing the cost of each ride.

Eligible trip types include:

- Critical Care Non-Medicaid – Transportation to kidney dialysis and cancer treatment appointments.
- Non-Medicaid Medical needs – All trips to non-emergency medical appointments, except Critical Care Non-Medicaid as defined above.
- Senior Meals Programs – Trips to local congregate meal programs or group settings for seniors at a meal site approved by the local AAA as outlined by the Older Americans Act.
- Adult Day Services – Services include professional nursing services, respite, personal care, therapeutic activities, nutritious meals, and support and education to families and caregivers in a community-based, non-residential day center
- Shopping – Trips to local grocery store and/or pharmacy.
- Vocational – Trips to paid employment, interviews or training programs
- Social/Personal – For socialization and/or personal trips. Trips could include: exercise programs at local senior centers, church, personal trips (such as hair appointment or visiting a family member).
- Wellness – Trips to providers of wellness programs such as nutrition, smoking cessation, pre-diabetes, chronic pain management

Effective July 1, 2018 and thereafter, Subrecipient, or any subcontractor, must do the following:

1. Use to collect, report, dispatch and generate electronic billing information from the Dispatching and Scheduling Software (reports shall match AOT billing to be considered eligible reimbursement as outlined in Attachment B – Payment Provisions, D. 49 U.S.C. § 5311 Elders & Persons with Disabilities Program and included in this Grant Agreement); and
2. Create and maintain a volunteer program, with the assistance of Subrecipient's E&D Advisory Committee and AOT, on a GSA reimbursement with the use of the volunteer's own vehicles by June 30, 2018.

Effective July 1, 2009 and thereafter, excursion trips are not eligible. Subrecipients should follow FTA Charter Regulations (www.fta.gov).

In addition, the Subrecipient will work collaboratively with AOT, Agency of Human Services, its Regional E&D Advisory Committee, and the other public transit Agencies to promote coordination in order to reduce expenditures, improve or increase service, and use resources more efficiently.

2.4. Reports

Uniform statewide reporting is needed to properly evaluate this program and ensure that services for older adults and persons with disabilities are preserved and will improve over time. Detailed reports will form the basis of discussions among stakeholders at mandatory Regional E&D Advisory Committee meetings to determine budget allocations and service levels are proper. It is the intent of both AHS and AOT that E&D Transportation service levels, in combination with §5310 vehicle procurements, are greater than or equal to similar transportation services provided to older adults and persons with disabilities during State Fiscal Year 2018. To this end, an amount designated for the E&D Transportation program will be separately identified within the §5311 overall rural general public transportation budget. The designated E&D budget within the state and within each region shall not be reduced to provide additional transportation to the general public.

Regional E&D Advisory Committee meetings will review budgets and expenditures to assure that budgets are properly managed to continue throughout the grant year. If an Regional E&D Advisory Committee foresees a budgetary shortfall, it will institute measures to determine the greatest need for remaining funds and will reallocate funds as necessary to have the smallest possible negative impact on E&D Transportation services.
Reports from public transit providers to AOT are specified in grant agreements. The specifications include the statewide format of reports. Public transit providers send service indicator statistics to AOT monthly with invoices. Reports by public transit providers to AOT include unduplicated counts of older adults and persons with disabilities served, unduplicated counts of older adults and persons with disabilities who use the E&D program to go to and from kidney dialysis treatments, the number of one-way trips by service category, mode, and costs. Cost data should include the quantity and unit (i.e., hours, miles, etc.)

AOT will compile and summarize the statistics into annual reports and will disseminate these to each member of the Public Transit Advisory Council (PTAC), to each grantee in the E&D program, to the Vermont Center for Independent Living, to the Vermont Coalition for Disability Rights, and to the Community of Vermont Elders. . Reports shall include unduplicated counts of older adults and persons with disabilities served, unduplicated counts of older adults and persons with disabilities who use the E&D program to go to and from kidney dialysis treatments, the number of one-way trips by category, and costs by transportation mode.

Any additional reports needed by HSAs are specified in local agreements between HSAs and public transit providers. Annually, AOT will summarize ridership and other statistics in reports for the General Assembly and Governor. These statistics are among the data considered when periodic management reviews and other studies develop plans for public transit improvements, including the E&D Transportation program. AOT will evaluate e the effectiveness of the E&D Transportation program in meeting the transportation needs of older adults and persons with disabilities and the impact of the E&D program on general public transportation in Vermont. Written E&D analysis will be included in the annual Route Performance Report and presented to the PTAC at the March quarterly meeting for comment. The report will also be made available to the general public on an annual basis on the AOT website.

2.5. Background Checks

In accordance with Federal mandate (42 CFR § 455.436 - Federal database checks.) background checks must be performed on all applicants, employees, volunteer drivers, taxi company employees, and all other subcontractor staff – both administrative and direct service providers. These screenings will determine if the individual has a substantiated finding of abuse, neglect or exploitation of a vulnerable adult or child. Screenings shall also be completed for criminal records that suggest passenger abuse, neglect or exploitation may be a potential problem. No person with a substantiated finding of abuse, neglect, or exploitation of a vulnerable adult or child shall be employed or used as a volunteer by a public transit provider. The safety, security, and well-being of passengers shall determine if an employee or volunteer may participate in any AOT-supported public transportation program.

In summary, applicants must clear all background checks prior to initial hire with the databases listed below, and these must also be rechecked annually unless otherwise noted. If an annual record check

reveals deficiencies the employee, volunteer, taxi or subcontractor must be removed from providing E&D transportation services.

- National Criminal Information Center (NCIC)
- Vermont Criminal Information Center (VCIC)
- Child Abuse Registry
- Adult Abuse Registry
- Department of Motor Vehicles (DMV)
- Office of Inspector General – List of Excluded Individuals/Entities (LEIE) https://oig.hhs.gov/exclusions/index.asp

Additional details on background checks can be found in the four subsections below.

National Criminal Information Center (NCIC) & Vermont Criminal Information Center (VCIC)

Individuals must not have a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving violation of a position of trust, including, but not limited to:

- Abuse, neglect, or exploitation
- Simple or Aggravated assault
- Aggravated sexual assault Stalking and Aggravated stalking
- Arson Assault and robbery
- Assault upon law enforcement
- Cruelty to children
- Domestic assault Extortion
- Embezzlement
- Hate motivated crime
- Kidnapping
- Lewd and lascivious conduct
- Manslaughter
- Murder
- Recklessly endangering another
- Sexual assault

Adult Abuse Registry & Child Abuse Registry

Individuals must not have a substantiated finding of abuse, neglect, or exploitation of a child or vulnerable adult.

Department of Motor Vehicles (DMV)

If a DMV check reveals any violation, Transit Providers must request a variance from VTrans for approval if the services of this driver are still desired. Non-restricted convictions or motor vehicle violations such as a speeding ticket may be allowed depending upon the situation.

Office of Inspector General (OIG)/LEIE

This list includes the names of individuals who have been convicted of illegal activity

regarding fraud or abuse. The search function for this list can be found at both http://exclusions.oig.hhs.gov/ and http://sam.gov. If an OIG check reveals any violation, Transit provider must request a variance from VTrans prior to approval, if such is requested.

Transit providers must also maintain records of all completed background checks on all subcontractor staff who provided E&D transportation services.

3. USEFUL ABBREVIATIONS AND DEFINITIONS

The transportation options in Vermont communities are likely to include some of the services listed below. Keep in mind that names of these services may vary depending on location.

3.1. Abbreviations

AOT Vermont Agency of Transportation
AHS Vermont Agency of Human Services
COA Council on Aging
E&D Elders and Persons with Disabilities Program
FTA Federal Transit Administration
NEMT Non-Emergency Medical Transportation
RPC Regional Planning Commission

3.2. Definitions

Demand Response- Sometimes called Dial-a-Ride, demand response transports multiple passengers who are picked up from different entry points and dropped off at separate destinations. This service often requires reservations to be made at least 24–48 hours in advance.

E&D Grant- Transportation providers working with human service agencies apply to VTrans annually for grant funds to cover operating costs associated with providing transportation to elders and person with disabilities. The grant application process begins in March, culminating in a Grant Agreement between VTrans and the transportation provider for a fiscal year that begins on July 1. The grant reimburses for 80% of actual operating costs, with the remaining 20% either coming from human service partners or in-kind. Local Agreements are entered into between the transportation provider and human service agencies to detail the scope of transportation services to be provided as well as other details including how the required 20% local match will be met.

E&D Partner- A formal member of the E&D Committee. Partners will vary regionally, but typically include the following organizations: Transit Provider, Regional Planning Commission, Adult Day and Senior Center, Agency of Aging, Hospital and/or Healthcare groups, and municipalities. Local agreements are entered into between the transportation providers and partners receiving transportation services to detail the scope of transportation services to be provided. Partners whose clients receive transportation services funded through the E&D Program contribute towards the required 20% local match, either via cash or in-kind.

E&D Stakeholder-Either an "ad-hoc" or a formal member of the E&D Committee. Will vary by region. Could include Regional Planning Commissions, human service agencies that operate within a region, municipalities, community organizations, passengers, and the public at large. Stakeholders should be invited to participate in public transportation planning and coordination that leads to applying for grants.

Federal Transit Administration (FTA)- A component of the U.S. Department of Transportation that regulates and helps fund public transportation. FTA provides financial assistance for capital and operating costs and also sponsors research, training, technical assistance and demonstration programs.

Human Service Agency- A government or not-for-profit organization that provides services for essential needs such as medical care, income support, housing, education, training, and public health, typically for people requiring help due to age, disability, low income or similar reasons.

Human Service Transportation- Transportation provided by or on behalf of a human service agency to bring people participating in the agency's programs or services to those programs or services.

Local Match- The state or local funds required by the Federal government to complement Federal funds for a project. For example, in the case of public transportation, the Federal government may provide 80 percent of the necessary funds for the purchase of a vehicle if the state and transit provider matches 20 percent. A match may also be required by states in funding projects which are a joint state and local effort.

Medicaid Non-Emergency Medical Transportation (NEMT)- NEMT is available to persons with Medicaid to travel to and from medical services. Eligibility criteria and types of destinations vary from state to state.

Public transit/fixed route transportation- Public transit agencies provide fixed route service by bus along established routes with set schedules and no reservations required. Limited fixed route services may be available through other community agencies, such as trips to and from a Center for Independent Living or a senior center.

Paratransit- Must be offered by public transit agencies to individuals who are not able to use fixed route service. This is a requirement of the Americans with Disabilities Act (ADA). Paratransit is a complement to public transit, so must operate within ¾ of a mile of the fixed route and is available during the same hours as the fixed route service. Paratransit is a door-to-door service. A personal care attendant can travel with the passenger at no cost. To qualify for paratransit, riders need to meet specific eligibility requirements established under ADA.

Section 5310- Authorized under 49 USC Section 5310, a Federal program administered by USDOT to provide small buses and vans to eligible agencies which provide transportation services to elderly and disabled persons.

Shared Ride Services (also known as Transportation Network Companies or TNCs)- Include Uber and Lyft and connect private pay passengers with drivers who provide transportation in their own vehicles. These services do not typically offer wheelchair accessible vehicles or rider assistance. Passengers connect with drivers via websites or mobile apps on a smartphone and also pay for the services through a personal account on their phone. A growing number of communities offer access to shared ride services to older adults and people with disabilities through a scheduling phone line which may be operated by a nonprofit organization.

Subcontractor- A legal entity to who a contractor sublets part of the work.

Subrecipient- An organization who received a grant or loan of federal funds from a non-federal organization such as the State of Vermont. Subrecipients are also referred to as grant recipients or grantees. [7]

Taxi Services- Taxis are licensed vehicles that offer on-demand services to passengers. Trips usually can be scheduled in advance or on the spot, and fares are charged per mile or per minute. Many communities require taxi companies to have accessible vehicles in their fleets. Some community agencies offer taxi vouchers to older adults and people with disabilities who meet certain eligibility criteria.

Transportation Voucher Program- Voucher programs provide fare assistance or free rides to low-income older adults and people with disabilities who meet the program's eligibility criteria. Eligible riders usually receive vouchers for specific types of transportation. Voucher programs may offer rides only to certain destinations, such as medical appointments.

Travel Training- Public transit agencies and local aging and disability organizations provide free instruction to help new riders learn to travel safely on public transit. Travel training may be provided by professionals or peers who are experienced users of public transit. The training generally includes classroom instruction plus a group trip on transit.

Volunteer Driver- Services provided by volunteer drivers who use their own vehicles, donate their time to transport riders, and receive reimbursement for mileage at the federal rate.

Volunteer Transportation Programs- May be offered by local nonprofit and faith-based organizations. Drivers provide rides in their own cars or agency-owned vehicles for passengers to reach medical appointments or other important destinations. Rides are generally pre-arranged. Volunteer transportation programs may also offer door-to-door or door-through-door assistance. Some programs require riders to pay a small fee while others offer free rides.

[7] The Federal Uniform Guidance specifies that a subaward is for the purpose of carrying out a portion of a Federal award and creates a Federal assistance relationship with the subrecipient. See § 200.92 Subaward for additional information.