

Expanding Specialized Transportation: New Opportunities under the Affordable Care Act

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The Affordable Care Act (ACA) provides new but limited opportunities to promote or fund specialized transportation services for older people and adults with disabilities. This paper explains how states can use these largely untapped options to expand services for targeted low-income populations with mobility needs. It also presents two case studies illustrating how the Atlanta region and the state of Connecticut are making this work.

Many states are taking advantage of new options within the Affordable Care Act (ACA) to improve access to care for the chronically ill and to promote community living for older adults and adults with physical disabilities. However, relatively few states are expanding transportation services through these new initiatives for low-income people with mobility limitations. This paper explores the ACA options that could expand specialized transportation for Medicaid and Medicare beneficiaries, and for people who are dually eligible for both forms of coverage. It also provides state examples and two case studies to illustrate how these options can work.

Growing Need for Specialized Transportation

Transportation is vital to helping people with mobility limitations live as independently as possible. Many older people and adults with physical disabilities need specialized transportation—such as door-to-door paratransit or escorts into doctors' offices—that can be provided upon request by van, small bus, or taxi. Specialized transportation is especially critical for high-risk, low-income

populations who do not drive and have difficulty taking public transportation because of disability, age-related conditions, or income constraints.

In a given year, about 3.6 million Americans miss at least one medical trip for lack of transportation; this population is disproportionately female, older, poorer, and has a higher rate of multiple conditions.¹ Many people ages 70 and older will outlive their driving years; on average, men for 7 years and women for 10 years.²

Without transportation, the ability to live in one's home and community is compromised. Also, improving access to care for transportation-disadvantaged populations can reduce national health care costs, possibly offsetting the increase in transportation costs.³

Specialized transportation can help states and communities achieve the ACA's goals. Transportation is an important element for states balancing their Medicaid programs toward home- and community-based services (HCBS); enabling people to access preventative care; improving health outcomes; and avoiding unnecessary hospital readmissions.

Medicaid Options for Expanding Specialized Transportation

Medicaid covers transportation to and from medical appointments as a *mandatory* benefit for a beneficiary who has no other means of accessing necessary medical services. The least costly mode of transportation that is appropriate for the physical condition of the consumer must be used. Medicaid also covers emergency medical transportation, such as an ambulance.

State Medicaid programs also can choose to cover nonmedical, community transportation. Most of this funding is provided under Medicaid waivers that allow states to provide HCBS to beneficiaries rather than requiring services to be provided in institutions such as nursing homes.

In 2010, 28 states had Medicaid HCBS 1915(c) waivers that provided optional transportation services to 65,542 older adults or adults with physical disabilities at a cost of nearly \$62 million⁴ (see table 1). Transportation under these waivers can be limited by geographic area and targeted disability group, and the scope, enrollment, and amount of trips can be capped.

States can cover nonmedical, community transportation as an optional Medicaid home and community service in the following

Box 1
ACA Initiatives to Expand Medicaid Nonmedical, Community Transportation

- ✓ Money Follows the Person
- ✓ Community First Choice
- ✓ Balancing Incentive Program
- ✓ Section 1915(i) State Option

ACA initiatives (see box 1). This paper describes these initiatives and explains how they can support new transportation benefits to targeted low-income populations with mobility needs (see table 2).⁵



Money Follows the Person (MFP)

MFP is a grant program for states to shift Medicaid funds toward more HCBS and to identify and transition Medicaid beneficiaries who are living in an institution and want to return to the community. A total of 44 states plus the District of Columbia receive an enhanced federal match for the services provided to Medicaid participants for the first 12 months after the beneficiary's transition back into the community.

More than 40,000 people have moved from institutions to the community under this program.⁶ MFP was established before the ACA, but the ACA extended the program through 2016 and made some programmatic revisions, bringing the total funding for MFP to \$4 billion.

MFP participants from 16 states—out of 25 that provided service expenditure data—utilized transportation during 2012.⁷ When MFP participants receive transportation, the state receives the enhanced federal Medicaid matching rates under the MFP demonstration.

About 1,700 participants (13 percent of 12,839 MFP participants from the 25 grantees with data available for analysis) used the transportation benefit during 2012.⁸ The MFP program is slated to end in 2016, but states awarded grants in 2016 can use their unused funds until 2020.

Table 1
Medicaid 1915(c) Waiver Expenditures on Community, Nonmedical Transportation for
Older Adults and Adults with Physical Disabilities: FY 2010

State	Waiver	Transportation Participants	Transportation Expenditures
AK	Older Alaskans	808	\$1,726,128
AK	Adult Disabled	646	\$2,252,571
CA	MSSP	3,026	\$1,048,447
CO	Elderly, Blind, Disabled	2,309	\$5,910,937
CT	Elderly	212	\$40,162
IA	Physical Disabilities	103	\$103,071
IA	Elderly	1,599	\$1,078,060
ID	PCS for Aged and Disabled	1,069	\$239,418
IL	Disabled	43	\$27,379
IL	Elderly	1,974	\$2,731,374
IN	Aged and Disabled	1	\$2,481
MA	Frail Elders	921	\$289,677
ME	Aged/Disabled	46	\$10,762
MI	Elderly and Disabled	2,109	\$694,984
MN	Elderly	170	\$53,043
MN	Disabled	4,832	\$5,219,009
MN	Community Alternative Care	18	\$14,572
MS	Elderly and Disabled	472	\$517,372
MT	Elderly/Physically Disabled	881	\$305,051
ND	HCBS	24	\$15,065
NE	Aged and Disabled	623	\$412,678
NJ	Global Options LTC	13	\$13,205
NM	Mi Via Nursing Facility	306	\$314,100
NY	Aged and Disabled	1,323	\$3,186,543
OH	Passport	10,782	\$10,837,778
OR	Aging & Disabled	15,283	\$3,611,650
PA	Elderly	2,457	\$2,113,922
PA	Independence	1,803	\$1,865,405
SC	Community Choices	1,757	\$3,717,908
UT	Elderly	2,682	\$3,163,611
UT	New Choices	258	\$148,457
WA	COPES Aged/Disabled	196	\$2,683,646
WI	Community Options Program (Aged/Disabled)	2,012	\$2,908,691
WV	Aged/Disabled	4,550	\$4,583,739
WY	Elderly/Disabled	234	\$45,122
Total		65,542	\$61,886,018

Source: Analysis of 2010 Medicaid 372 waiver reports by the University of California, San Francisco, for the AARP Public Policy Institute.

Table 2
Programs within the Affordable Care Act That Could Promote Transportation

Program	Purpose	Total Funding	Enhanced Medicaid Federal Match	State Participation in Program	Timing	States That Provide Transportation through This Option
Money Follows the Person (MFP)	To provide transition funding for Medicaid beneficiaries leaving institutions for community settings and to fund initiatives that improve the balance of funding for HCBS	\$2.25 billion appropriated by the ACA through FY 2016, totaling \$4 billion	For first 12 months after a Medicaid beneficiary goes back into the community; and federal matching available for a wide range of balancing activities, such as nursing home diversion and staff; leverage for other ACA tasks	44 states + DC: AL, AR, CA, CO, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV	FY 2008–FY 2020	MFP participants in 16 states (out of the 25 states that submitted services data) utilized transportation during calendar year 2012
Community First Choice	To enhance HCBS attendant services and supports under a Medicaid state plan option	Estimates of \$1.585–\$3.7 billion, depending on the # of states and people receiving services under this option	Funds HCBS attendant services and supports at 6 percentage points enhanced federal Medicaid match	4 states: CA, MD, MT, OR	It is not time limited	2 states: MT & OR*
Balancing Incentive Program	To encourage states to balance their Medicaid spending on LTSS toward HCBS	Up to \$3 billion in competitive grants	2–5% federal matching increase (depending on state Medicaid characteristics) to raise HCBS spending by October 2015	21 states: AR, CT, GA, IA, IL, IN, KY, LA, MA, MD, ME, MO, MS, NE, NH, NJ, NV, NY, OH, PA, TX	October 2011–October 2015	1 state: CT is known*

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Table 2 (continued)

Program	Purpose	Total Funding	Enhanced Medicaid Federal Match	State Participation in Program	Timing	States That Provide Transportation through This Option
Section 1915(i) State Option	To provide HCBS under a Medicaid state plan to individuals whose income does not exceed 300% of SSI. Can place limits on the type, amount, duration, population, and scope of services, but services must be offered statewide	No enhanced funds, but it allows states to offer these limited HCBS without Medicaid waivers	None	12 states + DC: CA, CO, CT, FL, IA, ID, IN, LA, MT, NV, OR, WI (several are for people with mental illness)	It is not time limited	1 state: CT is known*
State Demonstration to Integrate Care for Dual Eligible Individuals	To provide better coordinated care for people with Medicare and Medicaid	No set amount	CMS will share Medicare savings with each state in this financial alignment demo	12 states: CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, WA—with signed MOUs	No published end date	CA and MA are known*
Community-based Care Transitions Program	To test models for improving care transitions from hospitals to other settings and reducing readmissions for high-risk Medicare beneficiaries	Up to \$500 million	Community-based organizations paid one rate per eligible discharge for a 180-day period per beneficiary	102 sites	2011–2015	Only some sites provide transportation, such as the Atlanta Regional Commission

ACA = Affordable Care Act

CMS = Centers for Medicare & Medicaid Services

HCBS = Home- and Community-Based Services

LTSS = Long-Term Services and Supports

MOUs = Memorandums of Understanding

SSI = Supplemental Security Income

*At the time of publication, these were the identified states. More states could likely take up these options in the future.



Community First Choice (CFC)

CFC gives states the option to add a new Medicaid benefit that allows consumers to direct much of their own care by choosing service providers and timing of care to meet individual preferences. States receive an enhanced federal match of 6 percentage points for the provision of such “participant-directed” services and supports to eligible Medicaid recipients. This option is not time limited.

As of July 2014, four states—California, Maryland, Montana, and Oregon—had received approval from the federal government for CFC. Of these states, only Montana and Oregon specifically provide Community Transportation as a CFC permissible service. Montana will provide mileage reimbursement for travel in conjunction with medical escort, and community inclusion service transportation approved in the person-centered plan is reimbursable. Oregon already had the benefit in place and was able to continue the benefit in the CFC waiver (see box 2).⁹



Balancing Incentive Program

The Balancing Incentive Program is a grant initiative designed to encourage states to balance their Medicaid spending toward HCBS. This program is for states that rely predominantly on nursing homes and other institutions for Medicaid beneficiaries with long-term care needs. To receive funding, the state must have spent less than 50 percent of its total Medicaid long-term care dollars on noninstitutional services in FY 2009. States, in turn, must agree to make structural changes and meet a target spending commitment toward HCBS by the end of the balancing incentive period, October 1, 2015. As of October 2014, 21 states had received these grants.¹⁰

An official with the Centers for Medicare & Medicaid Services (CMS) said that she did not know of any states that are using Balancing Incentive Program grants to fund community transportation.¹¹ However, at least one state is using these funds for strategic planning that includes transportation (see Connecticut case study).

Box 2

Oregon: Community First Choice Covers Community Transportation

According to Oregon’s Medicaid state plan,

Community Transportation is provided to eligible individual[s] to gain access to community-based state plan and waiver services, activities, and resources. Trips are related to recipient service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified in the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individuals; [and] 2) compensate the service provider to travel to or from the service provider’s home.

Section 1915(i) State Option

This ACA option allows states to provide Medicaid-funded HCBS to individuals whose income does not exceed 300 percent of Supplemental Security Income (SSI).¹² This 1915(i) state option is similar to the 1915(c) waivers described above in that the state can limit the type, amount, duration, population, and scope of services.

However, unlike the 1915(c) waivers, services must be offered statewide and enrollment cannot be capped. States do not receive enhanced federal matching funds, but this option allows them to offer these limited HCBS without Medicaid waivers. The advantage of the 1915(i) option is that an individual need not meet the more stringent institutional level of care requirements to qualify for HCBS.

Twelve states plus the District of Columbia—California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Louisiana, Montana, Nevada, Oregon, and Wisconsin—had 1915(i) state plan amendments as of August 2014.¹³ There is no time limit to this option. Of these states, only one known state—Connecticut—specifies community transportation for older adults or adults with physical disabilities¹⁴ (see box 3). Several of the state 1915(i) options are only for people with mental illness.

Like other new ACA initiatives, the 1915(i) option is very limited. This option is targeted toward specific and small populations. However, it could potentially reach those who are most in need of transportation to help them avoid institutions and remain in the community.

Box 3

Connecticut: Medicaid 1915(i) Covers Community Transportation for Older Adults

Connecticut's 1915(i) state option is for Medicaid recipients who are 65 years of age or older and require assistance with one or two critical needs, such as bathing, dressing, toileting, eating, transferring, meal preparation, and medication administration. People who have more than two critical needs are served under a Medicaid HCBS 1915(c) waiver. In 2014, the 1915(i) program served 550 clients.¹⁵

Transportation services in the Connecticut state option provide access to social services, community services, and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization. This service is offered in addition to medical transportation under the state plan and does not replace it. Taxis, buses, volunteers, or other individuals or organizations can provide transportation when necessary to provide access to needed community-based services or community activities as specified in an individual's plan of care. To receive reimbursement, commercial transportation providers must meet all applicable state and federal permit and licensure requirements, as well as vehicle registration and Medicaid program enrollment requirements.¹⁶

Unfortunately, this service is underutilized. The state has had trouble securing transportation providers because of the low reimbursement rates. Aides sometimes drive their clients, but the state does not pay an additional fee to reimburse them. Home care agencies, however, sometimes pay their aides for this service.¹⁷

Demonstrations for Dual Eligible Individuals That Could Expand Specialized Transportation

In 2011, roughly 10.2 million people were dually eligible for Medicare and Medicaid services; of this total, 7.4 million were eligible for both Medicare and full Medicaid benefits, commonly referred to as full-benefit duals.¹⁸ These “dual eligibles” are typically poorer and sicker than other Medicare beneficiaries, use more health care services, and therefore have much higher health care costs. Dual eligibles often struggle to navigate a complicated system of providers.

Established by the ACA, the CMS Medicare-Medicaid Coordination Office is providing financial incentives for states to coordinate care for the dual eligibles who may need acute, chronic, or long-term care for physical and mental health conditions.

As of September 2014, 12 states—California, Colorado, Illinois,

Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia, and Washington—had signed memoranda of understanding¹⁹ on services for dual eligibles. Most are testing risk-based, capitated, managed care models where health plans receive a per member, per month fee.

CMS does not require that the states expand transportation in these demonstrations beyond what is currently covered in the Medicaid program.²⁰ However, some states are doing this²¹ (see box 4).

In addition to expanded transportation benefits, another advantage of the dual demonstrations is the emphasis on care coordinators who can help ensure access to transportation as well as schedule trips for treatment and follow-up. At the time of publication, these programs were in the early stages of implementation, making it too early to assess the impact of these transportation benefits.

Box 4

State Examples of Dual Eligible Demonstrations with Nonmedical Transportation Benefits

California

The state’s three-way contract is the most direct in requiring participating plans to offer an expanded transportation benefit. Plans have to offer up to 30 one-way nonmedical trips per year to individuals in the demonstration.²² This benefit is in addition to what is available under the MediCal (state Medicaid) program.²³

Massachusetts

The state provides enhanced supplemental services in the demonstration, including nonmedical transportation. The contract explains that the plans must offer “nonmedical transportation services within the community to enable the enrollee to access community services, activities, and resources in order to foster the enrollee’s independence and integration and full participation in his/her community.”²⁴ This transportation benefit is a “new community-based services” benefit. Plans are required to offer this package of benefits, but the beneficiaries’ receipt of these services is dependent on demonstration of need in the assessment and care plan.²⁵

Medicare Options That Could Incentivize Specialized Transportation

The ACA created a number of programs designed to improve care for Medicare beneficiaries with chronic conditions that could expand access to transportation. Medicare covers ambulance trips but only if the patient is either bed-bound or has a medical condition that requires it.²⁶ Unlike Medicaid, Medicare does not cover nonemergency medical transportation or community transportation.

About 5 percent of people with the highest health care needs account for nearly half of health care spending in the United States.²⁷ Older adults and people with chronic conditions make up a disproportionate part of this highest needs group. In addition, billions of dollars are spent on avoidable hospital readmissions each year. People who use many different health care providers to treat multiple conditions often experience duplication and fragmentation of services.

Although the ACA does not pay for specialized transportation for Medicare clients, it does provide monetary incentives aimed at reducing hospital admissions, improving care, and containing costs for vulnerable, high-cost Medicare populations. The following programs offer opportunities to increase transportation services for certain Medicare populations that have lacked access to these services.



Care Transition and Coordinated Care Programs

The ACA has several initiatives to improve care transitions when patients move between one care setting or provider to another. Smooth care

transitions are essential for ensuring that people receive good care when they move, for example, from hospital to home. Another major reason for focusing on better care transitions is to prevent costly hospital admissions and readmissions, particularly for people who are at high risk and who often have multiple chronic conditions. The health care system has been focused on acute medical care, but there is now recognition that critical elements for improved care transitions should include nonmedical services such as family caregiver supports and transportation.²⁸

The Partnership for Patients, Community-based Care Transitions Program (CCTP), Hospital Readmissions Reduction Program, and Accountable Care Organizations (ACOs) are initiatives committed to improving care transitions. The Partnership for Patients initiative aims to prevent hospital-acquired conditions and improve transitions from one care setting to another by reducing readmissions. Twenty-six hospital engagement networks are partnering with nearly 3,700 hospitals that are working with health care providers and facilities to identify promising practices and solutions.

Within the umbrella of the Partnership for Patients, CCTP tests models for improving care transitions and reducing hospital readmissions for high-risk Medicare beneficiaries. CCTP works in sync with the Hospital Readmissions Reduction Program, which penalizes and reduces payments to hospitals for excessive readmissions.

Implemented in 2011, 102 sites are participating in the CCTP.²⁹ The CCTP awardees receive a 2-year agreement that may be renewed for 5 years based on successful outcomes of a 20 percent, 30-day readmission reduction.³⁰ Total funding for CCTP is \$500 million.

The focus is on community-based organizations working collaboratively with hospitals to manage Medicare beneficiaries' transitions and to improve their quality of care. Only some sites provide transportation. The following Atlanta case study is an example of a site that provides supplemental transportation.

The ACA is encouraging doctors, hospitals, and other providers to join together voluntarily as ACOs to provide coordinated care to their Medicare patients. The goal is to ensure that patients, especially those with chronic conditions, receive high-quality care while avoiding unnecessary services and preventing medical errors. Successful ACOs receive some of the savings achieved from the Medicare program.

Case Studies

The following two case studies illustrate how a region and a state have leveraged a variety of ACA grants, state money, and other federal funding to maximize limited funds. They provide insight into the types of transportation being used and the consumers receiving the services.

The case studies also illustrate how both Atlanta and Connecticut have relied upon partnerships to serve more people with mobility needs in their own homes and communities. Both currently are working on efforts to map transportation services within their regions and to better understand gaps in these services.



**Atlanta Regional
Commission**

Atlanta Regional Commission (ARC) is the regional planning and intergovernmental coordination agency for the 10-county area in and around Atlanta, Georgia. It serves as an Aging and Disability Resource Center that

Box 5

Atlanta Initiatives to Expand Transportation

- ✓ Community-based Care Transitions Program
- ✓ Money Follows the Person
- ✓ Regional One-Click System

provides information, referral, and counseling for long-term care services. ARC also administers Older Americans Act services such as meals and transportation throughout the region.

ARC has two ACA initiatives—Community-based Care Transitions Program (CCTP) and Money Follows the Person (MFP)—that are helping older adults and adults with disabilities transition into the community. Also, ARC received funding from the Veterans Transportation and Community Living Initiative grant (which was not part of the ACA) to help launch a One-Click System, so participants in the above two programs—and others such as people with disabilities, low-income workers, older adults, and veterans—can access transportation. The One-Click System is an Internet system that can connect riders to transportation.

Community-based Care Transitions Program (CCTP)

To reduce hospital readmissions, ARC received a CCTP award 2 years ago to coach Medicare beneficiaries who were recently discharged from hospitals. ARC partnered with Emory University Hospital, Gwinnett Medical Center, Piedmont Hospital, Southern Regional Medical Center, WellStar Cobb Hospital, and WellStar Kennestone Hospital to reduce 30-day avoidable hospital readmissions. Their “coaches” visit patients at home within 3 days of discharge and follow up by telephone

over 30 days. Coaches help with medication and symptom management and follow-up visits. As needed, they also provide a short-term supportive services package that can include:

- 14 home-delivered meals;
- transportation: two round trips for medical appointments, including dialysis; and
- up to 6 hours of homemaker services.³¹

As of April 2014, ARC had coached roughly 6,000 patients in their homes. They found that 20 percent of them could benefit from supportive services that include transportation.³² These supportive services were necessary because of poor medication management and lack of follow-up with physicians and community supports.³³

ARC uses transportation providers with Older Americans Act contracts in most counties. ARC coaches can authorize transportation services. Counties then bill ARC for the rides. ARC pays the transportation providers their negotiated rate under the Older Americans Act services contract. However, some counties give patients \$200 vouchers to use for any type of transportation. Administrators note that patients can usually receive more than the two round trips with the \$200 vouchers.³⁴

ARC received the initial 2-year agreement, and it has been renewed for another year. This contract can be renewed for 2 additional years for a total of 5 years based on successful outcomes of a 20 percent, 30-day readmission reduction.³⁵

Money Follows the Person

Georgia has had an MFP program for many years, but ARC has administered this program in the Atlanta region for only the past 2 years. The goal was

for ARC to transition 29 people from institutional settings such as nursing homes to the community each year. ARC exceeded that goal with 48 transitions in FY 2013 and 32 in FY 2014.³⁶

To be eligible, participants must have been nursing home residents for at least 90 consecutive days, and their care must be covered by Medicaid. Although MFP participants have different disabilities and needs, many participants in the Atlanta region are younger adults with physical disabilities who do not have a circle of support. MFP participants are generally more isolated and have higher levels of need. ARC has two full-time equivalent transition coordinators for the MFP program and two options counselors who work with MFP participants and others.³⁷

MFP funds cover transition costs for 1 year after the participant moves back into the community. As part of these funds, each participant has a \$500 transportation budget to use during the year. The program director has found that this \$500 allocation is usually quickly used right after the transition because Medicaid eligibility takes 30–60 days to switch from institutional to HCBS waiver coverage. During this 1- to 2-month period, participants usually spend their transportation benefits on transportation to doctors' appointments, from nursing homes to new homes, to the Social Security office, and sometimes to government agencies to receive identification in order to move into apartments. To maximize the tight \$500 budget, transition coordinators try to schedule several trips back-to-back rather than schedule multiple round trips.³⁸

ARC contracts with a variety of transportation providers, but most MFP participants need paratransit or specialized transportation, especially if they are in wheelchairs or use medical equipment. Because the MFP funds can be used for only 1 year, coordinators try

to find participants affordable housing that is located on or near transit or within paratransit service areas.

Medicaid in Georgia covers medical transportation for eligible participants, but it does not cover optional nonmedical transportation. Therefore, ARC has found that it is important to work with the Centers for Independent Living that conduct travel training on how to take public transportation and connect participants to the One-Click System.

Regional One-Click System

ARC is creating a new regional One-Click system that will allow people easier access to an array of transportation services through the Internet. Consumers can also call agencies' call centers, which will utilize the new system as well.

ARC is partnering with Atlanta Regional Workforce Board, RideSmart/Georgia Commute Options Carpool/Vanpool, Cobb Community Transit, Department of Veterans' Affairs, Disability Link, and Goodwill Industries (for job training) to develop the software and launch the website to help older adults, adults with disabilities, and their families access mobility options. This system will help inform them of the different mobility options, including public transit; community-based services from senior centers, volunteer drivers, and vouchers; commuter services; and nonemergency medical transportation. The system allows users to pinpoint the best option for planning trips based on time and costs.

The software will also enable ARC to have a better understanding of the existing types of transportation needs. With this information, ARC will be able to make more efficient use of transportation resources in the Atlanta region by facilitating regional scheduling, booking, payment, and dispatching of vehicles.



Connecticut

Connecticut is in the beginning stages of reforming transportation services for people with disabilities. The state is working on this issue primarily through its Medicaid “balancing” planning process.

The governor and General Assembly are committed to expanding long-term care options and helping the nursing home industry diversify. In January 2013, the state published an initial 3-year plan for 2013–2015 to balance its Medicaid long-term care services toward HCBS.³⁹ To support these balancing efforts, the state has optimized federal funding opportunities under the MFP program and Balancing Incentive Program. The MFP program has supported both strategic planning and efforts to transition people from institutions into the community. The Balancing Incentive Program brought in \$72.8 million in funding through September 2015, which will be used for implementation efforts. The governor provided an additional \$30 million in state funding.

Strategic Plan

The state’s 2013–2015 strategic plan establishes a framework for changing the design of HCBS, housing and transportation, workforce development, discharges from institutions to community, and nursing homes. The

Box 6

Connecticut Initiatives to Expand Transportation

- ✓ Strategic Plan
- ✓ Money Follows the Person
- ✓ Balancing Incentive Program

plan is based on a partnership with local communities and stakeholders.

The strategic plan acknowledges that transportation is central to helping Medicaid consumers successfully remain in or return to the community. However, the report notes that transportation is “one of the greater unmet needs in communities, [and] it is frequently not accessible or affordable.”⁴⁰ Among the metrics suggested for improving transportation options for Medicaid consumers living in the community are:

- increasing the number of Medicaid HCBS 1915(c) waivers with nonmedical transportation as a service option; and
- increasing the numbers of community transportation coalitions and alternative transportation options through the use of Zipcars and school buses.

Currently, Connecticut is working on a second strategic plan to balance Medicaid at a town level through 2025 by focusing on mapping and projecting housing and transportation needs of people who need long-term care.⁴¹

Money Follows the Person

In addition to supporting the planning efforts, this program has helped from January 2008 through June 2014 more than 2,100 people in the state move from institutions into the community, where they receive Medicaid long-term care; 988 of the transitions were older adults.⁴² The state received approval from the CMS in April 2014 to add mobility management training for its MFP participants who transition out of institutions and into communities. Mobility managers will train them on how to ride the bus.⁴³ Transportation, however, must be a service that is documented as needed in a participant’s care plan.⁴⁴

MFP participants are also eligible to receive transportation services. Although Medicaid can use a variety of transportation providers, ranging from taxis to stretcher vans, the type of transportation usually depends on the town where the participant lives. For example, in some towns, it is difficult to hire a taxi.

Conclusion

Without transportation, it is difficult for people with long-term care needs to “age-in-community,” which is what most people want to do.

The primary method for states to expand community, nonmedical transportation for low-income people with mobility limitations is through Medicaid waivers. However, states can expand Medicaid community transportation benefits to targeted and limited populations through the ACA. Although Medicare does not pay for community transportation or medical trips, except ambulances, the ACA provides opportunities to improve care for Medicare beneficiaries with chronic conditions, which could lead to better access to transportation.

This paper sheds light on the opportunities to expand transportation and tap new funds within the ACA options and demonstrations. Although new funding for transportation in the ACA is restricted and often targeted to specific low-income populations with mobility needs, these new programs could add to a “broad tapestry of funding sources” available to states.⁴⁵ States and regions will need to leverage multiple sources of funding and partnerships with other agencies, as well as transit and health care communities, to tackle the increasing unmet needs for transportation.

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Endnotes

¹ Wallace, R. et al. *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*. Transportation Research Record: *Journal of the Transportation Research Board*, No. 1924. Transportation Research Board of the National Academies, Washington, DC, 2005, pp. 76–84.

² Foley, D., Heimovitz, H., Guralnik, J., and Brock, D. “Driving Life Expectancy of Persons Aged 70 Years and Older in the United States.” *American Journal of Public Health*, August 2002, 92(8).

³ Wallace et al., 2005.

⁴ Analysis of 2010 Medicaid 372 waiver reports by the University of California, San Francisco, for the AARP Public Policy Institute.

⁵ The ACA gives states the option to expand Medicaid eligibility to adults under age 65 with incomes up to 138 percent of the federal poverty level. The indirect effect could be to provide transportation services to younger adults with physical disabilities and midlife adults who need long-term care and do not meet strict state eligibility standards under the traditional Medicaid program. Given the great uncertainty about which states will implement Medicaid expansion and how they will structure the benefits, Medicaid expansion under the ACA is not included in the scope of this paper.

⁶ Morris et al. *Money Follows the Person Demonstration: Overview of State Grantee Progress, July to December 2013*. September 11, 2014.

⁷ Irvin et al. *Money Follows the Person 2012 Annual Evaluation Report*. October 15, 2013.

⁸ *Ibid.*

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⁹ Phone communication with Jane-ellen Weidanz at the Oregon Department of Human Services and the author on April 28, 2014.

¹⁰ Medicaid.gov. Accessed on October 13, 2014, at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html>.

¹¹ Phone communication with Effie George at CMS and the author on January 31, 2014.

¹² The 1915(i) option was originally passed as part of the Deficit Reduction Act of 2005. The ACA, however, modified the rules of the 1915(i) option.

¹³ Kaiser Family Foundation. Accessed on October 13, 2014, at <http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/>.

¹⁴ Email communication about the 1915(i) option with Bethany Lilly of the Bazelon Center and the author on February 25, 2014.

¹⁵ Phone communication with Kathy Bruni, Connecticut Department of Social Services, and the author on May 22, 2014.

¹⁶ 1915(i) State Plan Home and Community-Based Services State Plan Services. Accessed at <http://www.ct.gov/dss/lib/dss/pdfs/SPA12001.pdf>.

¹⁷ Phone communication with Kathy Bruni.

¹⁸ Medicare-Medicaid Coordination Office. *Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006–2011*. February 2013.

¹⁹ Centers for Medicare & Medicaid Services. Accessed on October 13, 2014, at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ApprovedDemonstrationsSignedMOUs.html>.

²⁰ Email communication with Tim Engelhardt of CMS and the author on July 24, 2014.

²¹ Email communication with Fay Gordon, National Senior Citizens Law Center, and the author on February 6, 2014.

²² Contract between U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with California Department of Health Care Services, p. 188.

²³ Analysis from the National Senior Citizens Law Center conducted for the AARP Public Policy Institute. February 6, 2014.

²⁴ Contract between U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with The Commonwealth of Massachusetts and Commonwealth Care Alliance, Inc., Fallon Community Health Plan, Network Health, LLC, issued on July 11, 2013.

²⁵ Analysis from the National Senior Citizens Law Center conducted for the AARP Public Policy Institute. February 6, 2014.

²⁶ Commerce Clearing House Medicare Explained 2012, Health Law Professional Series: 355 Ambulance Services (Chicago, IL, Wolters Kluwer Law & Business, Commerce Clearing House 2012).

²⁷ Stanton, M. *The High Concentration of U.S. Health Care Expenditures*, Research in Action, Issue 19. June 2006. Agency for Healthcare Research and Quality, Rockville, MD. Accessed at <http://archive.ahrq.gov/research/findings/factsheets/costs/expriach/index.html>.

²⁸ Rooney, M. and A. I. Arbage. “Changing the Culture of Practice to Support Care Transitions—Why Now?” *Generations*. Winter 2012–13, 36(4), pp. 63–70.

²⁹ Centers for Medicare & Medicaid Services. Accessed on October 13, 2014, at <http://innovation.cms.gov/initiatives/CCTP/index.html>.

³⁰ Golden, R. and G. Shier. “Innovating for Improved Care Transitions: The CCTP Program and Beyond.” *Generations*. Winter 2012–13, 36(4), pp. 91–93.

³¹ Atlanta Community-based Care Transitions Program flyer. Accessed at <http://innovation.cms.gov/Files/x/Community-based-Care-Transitions-Program-Selectee-Atlanta-Regional.pdf>.

³² Bloomberg et al. “Integrating Care Transitions into the Aging Services Network,” *Generations*. Winter 2012–13, 36(4), pp. 28–33.

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³³ Atlanta Community-based Care Transitions Program flyer.

³⁴ Interview with Kathryn Lawler, Cynthia Burke, and Mary Blumberg with the Atlanta Regional Commission on April 25, 2014.

³⁵ Golden, R. and G. Shier, 2012.

³⁶ Interview with Andrew Parker, Aging and Disability Resource Connection, Atlanta Regional Commission, on May 15, 2014.

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ State of Connecticut, Department of Social Services. "Strategic Rebalancing Plan: A Plan to Rebalance Long Term Services and Supports, 2013–2015." January 29, 2013. Accessed at [http://www.ct.gov/dss/lib/dss/pdfs/frontpage/strategic_rebalancing_plan__1_29_13_final2_\(2\).pdf](http://www.ct.gov/dss/lib/dss/pdfs/frontpage/strategic_rebalancing_plan__1_29_13_final2_(2).pdf).

⁴⁰ *Ibid.*

⁴¹ Interview with Dawn Lambert, project director of Money Follows the Person, and the author on April 11, 2014.

⁴² Email communication with Dawn Lambert and the author on July 22, 2014.

⁴³ Interview with Dawn Lambert on April 11, 2014.

⁴⁴ *Ibid.*

⁴⁵ Lynott, J., et al. *Weaving It Together: A Tapestry of Transportation Funding for Older Adults*. AARP Public Policy Institute: Washington, DC. April 2013.

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