

**2004-17
December 2004**

The Impact of Federal Programs on Transportation for Older Adults

by

**David Koffman
David Raphael*
Richard Weiner**

**Nelson\Nygaard Consulting Associates
San Francisco, California**

***Medical Transportation Consulting
Portland, Oregon**

Audrey Straight, Project Manager,
AARP Public Policy Institute

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This paper represents part of that effort.

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Foreword

Transportation provides the physical connection to the goods, services, and social opportunities that are necessary to a good quality of life for individuals of all ages. The primary mode of transportation in the United States is the car, and the federal government invests significant resources in the roads, highways, and bridges that support movement of people and goods by car.

However, as individuals age they are increasingly likely to face challenges to driving that accompany age-related changes in functional ability. In order to maintain their quality of life, these individuals need alternatives to driving that ensure continued mobility in their communities. As the baby boom generation ages, an increasing number of individuals will face the need for such transportation options.

A number of federal programs and activities have been created and undertaken to meet this need for diverse transportation options. They include public transportation (urban and rural) and human services specialized transportation. The AARP Public Policy Institute asked Nelson Nygaard Consulting Associates, a transportation consulting firm, to provide information about these programs, including their limitations, and to suggest policy options for addressing these limitations. The report is designed to aid policymakers as they make decisions affecting the federal government's role in ensuring that older adults are able to sustain mobility as they age.

AARP's Public Policy Institute conducts both qualitative and quantitative research in its effort to better understand older consumers' views of their transportation needs, preferences, and activity. Reports available from AARP relevant to transportation issues and options include *Coordinated Transportation Systems* (2000) and *Understanding Senior Transportation: Report and Analysis of a Survey of Consumers Age 50+* (2002).

AARP hopes that *The Impact of Federal Programs on Transportation for Older Adults* will contribute to meeting the transportation needs of an aging society.

Audrey Straight, J.D.
Senior Policy Advisor
AARP Public Policy Institute

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1. Executive Summary

Background

The ability to travel within communities is essential to maintaining independence, health, and social connections. Most Americans, including most older Americans, rely on the private automobile for this purpose. However, as individuals age, many of them have to rely increasingly on other means of getting around in their communities. These alternative means include rides with family, friends, and neighbors; public transportation; and transportation provided in connection with services from community agencies and the healthcare system. These transportation alternatives are also important to everyone who does not drive because of personal preference, culture, or limited income.

A number of trends are likely to make it even more important to plan for the transportation needs of older persons who do not drive. People are driving later in life than they used to, and they also are living longer. Other trends with implications for transportation options include the rapid growth in the older population, the increasing numbers of older people living in suburban areas with limited transportation alternatives, the entry into older age groups of a generation with little experience using public transportation, and the increasing cultural diversity in the older population. Depending on how these trends develop, the number of older nondrivers is projected to increase by 15 percent to 52 percent of the older population between 2000 and 2020. These increases may strain community-based services for the elderly and people with disabilities, as well as the medical transportation system. Increasing reliance on noninstitutional care and outpatient medical treatment may intensify these strains.

The federal government plays an important role in addressing these concerns through a wide variety of programs and policies.¹

Purpose

The purpose of this report is to review federal transportation programs and policies that have a major component impacting the mobility of older persons. The report also addresses the limitations of the programs, options for enhancing them and filling gaps, and their ability to meet future needs.

Methodology

The analysis relies on information in published reports, reports posted on agency Web sites, data provided in interviews and in a policy roundtable teleconference with federal and state officials, and tabulations of survey data collected by federal agencies and available to the public. In some cases where national data could not be located, information from individual states and localities has been used for the sake of illustration.

¹ It should be noted that the research for this report took place prior to the publication in August, 2004 of the Government Accountability Office report "Transportation-Disadvantaged Seniors: Efforts to Enhance Senior Mobility Could Benefit from Additional Guidance and Information." (GAO-04-971). That report provides additional information on the transportation needs of and resources available to older persons.

Findings: Summary and Impact of Federal Efforts

The federal government directly affects the mobility of older persons through a number of different activities in two federal departments, the U.S. Department of Transportation (DOT) and the U.S. Department of Health and Human Services (HHS).

DOT programs with the greatest relevance for transportation of older adults include Formula Grants for the Elderly and Persons with Disabilities (section 5310), Formula Grants for Other Than Urbanized Areas (section 5311), Urbanized Area Formula (UAF) Grants (section 5307), and Capital Investment Grants (section 5309). The DOT also oversees implementation of the transportation-related requirements of the Americans with Disabilities Act (ADA), under which public transportation must accommodate persons with disabilities. Specific ADA requirements include providing accessible fixed-route buses as well as paratransit for persons with disabilities who cannot use accessible buses. In addition, the DOT has supported other initiatives, including older driver research and the development of strategies for meeting the transportation needs of older individuals.

1. Formula Grants for the Elderly and Persons with Disabilities (Section 5310) and Formula Grants for Other Than Urbanized Areas (Section 5311): The DOT's Federal Transit Administration (FTA) makes grants to states to support specialized transportation for the elderly and people with disabilities, and for public transportation service in rural areas. The states have considerable latitude in how they administer these programs. There are very few national data about their effect on ridership or riders.

Section 5310 grants are used mainly for capital costs, such as buying vehicles, although the grants can also be used to contract for services. Under section 5310, the FTA provided \$90 million in grants in fiscal year 2003, principally to help some 3,700 nonprofit organizations purchase vehicles and equipment. State officials report that demand for these funds greatly exceeds their availability. States can supplement 5310 grants with other federal surface transportation program funds. For example, in fiscal year 2001 the states used flexible funding provisions in federal transportation legislation to transfer an additional \$102 million from other federal transportation funds (mainly for street and highway improvements) into section 5310 programs.

Section 5311 provides support for capital and operating costs to public and private nonprofit organizations serving the general public in rural communities (defined as communities of 50,000 or fewer outside of urbanized areas). The program provided \$225 million in operating and capital assistance in fiscal year 2002. About a third of the riders of rural public transportation systems are age 60 or older. The section 5311 program has enabled a major expansion of public transportation service in rural areas. Even so, in a recent national transportation survey, 74 percent of households with householders age 65 and older living in rural areas stated that they had no public transportation available.

2. Urbanized Area Formula Grants (Section 5307) and Capital Investment Grants (Section 5309): The FTA supports public transportation in urban areas with grants for public

transportation² authorized by UAF Grants (section 5307) and Capital Investment Grants (section 5309). These grants finance all forms of public transportation, including paratransit for persons with disabilities (ADA paratransit). Appropriations for sections 5307 and 5309 have increased from \$2.8 billion in 1991 (\$3.7 billion in 2002 dollars) to \$6.1 billion in 2002. States are allowed to transfer federal highway funds to public transportation funds and have used this flexibility to add \$6.5 billion to public transportation since 1992. From 1991 to 2000, the number of public transportation agencies (or transit agencies) eligible for participation in these two programs has grown from 390 to 430, and the number of public transportation trips has risen from 7.7 billion to 8.7 billion.

Nationally, some 3.2 million people age 65 and older ride public transportation in metropolitan areas, accounting for 10 percent of all public transportation trips. Federal law requires that urban public transportation operators receiving federal assistance offer a reduced fare of no more than half the peak-hour fare to riders age 65 and older during off-peak hours. Many provide this discount all the time. Public transportation in urban areas provides more rides for older individuals than any other federal program.

3. Impact of Americans with Disabilities Act Paratransit Requirements: The ADA has required public transportation operators to make many changes to improve public transportation for persons with disabilities that also benefit older persons. Wherever there is fixed-route bus transportation, the ADA has required public transportation operators to provide demand-responsive paratransit service for people who cannot use accessible fixed-route public transportation service owing to a disability. Public transportation operators have approximately tripled the amount of paratransit service they provide since the ADA was passed. These service increases and operations improvements have benefited many older adults with physical or mental disabilities that prevent them from using conventional public transportation.

However, no funding has been provided explicitly to help public transportation providers implement the ADA rules. Costs associated with implementing the strict requirements of the ADA give public transportation operators strong incentives to cut back on or avoid any aspect of service not specifically required. The ADA also does not assist persons with disabilities in those suburbs, smaller metropolitan areas, and rural areas without public transportation.

4. Other Department of Transportation Initiatives Related to Transportation of Older Adults: In 2004, the DOT released a comprehensive report on transportation of older adults, *Safe Mobility for a Maturing Society: Challenges and Opportunities*. The report sets forth a vision, and recommendations for achieving that vision, of “a transportation system that offers safe mobility to all people and allows older persons to remain independent and to age in place.” The findings of the report are now guiding the DOT’s activities related to improving transportation for older persons.

² The term “public transportation” will be used throughout this paper to describe transportation provided by public transit authorities. Historically these transportation services have been called “mass transit,” but with the growing interest in serving a wider range of riders than commuters with a variety of services other than large fixed-route buses, the preferred nomenclature is “public transportation.”

Although there is currently no separate and distinct program or funding for older drivers safety research, the Federal Highway Administration (FHWA) and the National Highway Traffic Safety Administration are pursuing research to help people keep driving safely into their older years and to improve the safety of vehicle occupants and pedestrians. For example, in 2003 the Centers for Disease Control and Prevention (CDC) and the FHWA awarded the Seniors' Institute for Transportation and Communications at the University of Florida a \$1.6 million grant to establish the National Older Drivers Research Center. The center's goals are to develop a system

- for identifying elderly drivers who are at risk for unsafe driving;
- for providing referrals to appropriate professionals (e.g., ophthalmologists, physical therapists) who address skills associated with driving; and
- for providing training and assistive devices that may enable safe driving.

Following are the HHS programs with the greatest relevance for transportation of older persons.

1. Older Americans Act Supportive Services: The Older Americans Act (OAA) supports social and health services for an estimated 7 million older persons and their caregivers each year. These services are provided through a network of state units on aging, more than 650 local area agencies on aging (AAAs), and more than 225 tribes and Native American organizations, under the oversight of the Administration on Aging (AoA) in HHS. Although no funding is specifically designated for transportation, funding can be used for transportation under some sections of the OAA. While the extent of OAA transportation services is limited, their impact is great because they target older individuals at risk of losing their independence. OAA programs play a key role in helping older persons travel to various home- and community-based services (HCBS) in coordination with Medicaid waiver programs designed to promote alternatives to institutional care. Unfortunately, resources available under the OAA for transportation and other services have barely kept pace with inflation and have not kept pace with the growing size of the older population.

2. Medical Transportation—Medicaid: The Medicaid state-federal program, administered at the federal level by the Centers for Medicare and Medicaid Services (CMS) in HHS, provides health care coverage, including transportation to medical appointments, to some 42 million low-income and disabled Americans. These recipients include about 4.6 million people age 65 or older, or about 13 percent of all Americans age 65 or older. Medicaid's assurance of access to services has been important for its beneficiaries, because inability to reach health care services is of particular concern for low-income, disabled, and older persons served by the Medicaid program. Medicaid spends an estimated \$1.8 billion annually to provide about 110 million nonemergency trips to and from medical care, or about \$16 per trip. Federal law permits, and the states have taken, many different approaches to the Medicaid access requirement. They range from comprehensive, coordinated programs designed to make it as easy as possible for individuals to reach covered services to reliance on existing public and private services with minimal state assistance.

A growing part of the Medicaid program consists of Medicaid waivers that enable states to offer Medicaid Home and Community-Based Services (HCBS) programs to individuals considered nursing-home eligible. Under these programs, states enable older and disabled individuals to

receive services in their homes and communities, rather than in nursing facilities and other institutions. Two-thirds of the states include transportation in their HCBS programs, providing trips for essential trips such as going grocery shopping. The need for nonmedical transportation for those in the HCBS and other programs is likely to increase in response to the demand for noninstitutional long-term care options.

3. Medical Transportation—Medicare: The Medicare program for older individuals and people with disabilities also covers some transportation costs. Payment is available only for ambulance trips. These trips are very expensive; the 6.2 million trips provided in a year cost about \$2.1 billion, or an average of \$330 per trip. As many as half of the ambulance trips provided are nonemergency trips that, according to Medicare regulations, can be provided only to bedridden patients. It is possible that many of these trips could be provided less expensively on less specialized community transportation systems. There is also concern that many people who need frequent trips for life-sustaining treatments such as dialysis and cancer therapy have difficulty obtaining treatment because of a lack of appropriate medical transportation.

Appendix A provides a list of acronyms used in this paper; Appendix B provides a summary table of the various DOT and HHS programs.

Policy Implications

The findings of this review of the impact of federal programs on the mobility of older persons suggest a variety of options for strengthening existing programs that are currently providing important transportation resources.

- **Increasing Investment in Formula Grants and Loans for Special Needs of Elderly Individuals and Individuals with Disabilities, and for Other Than Urbanized Areas:** One of the most immediate needs is to increase public investment in the sections 5310 and 5311 programs and to allow use of 5310 funds for operating expenses. Increased funding for both capital and operational expenses could help create and expand services to fill the gaps left by public transportation and ADA paratransit. Funding in the section 5310 program is presently sufficient for little more than replacing existing vehicles, allowing local grantees to make only limited use of the flexible funding that has already been added to the program. Flexibility allows money to be transferred into programs, but it also allows transfers out of the same programs. In light of current state fiscal challenges, it is particularly important that federal transportation programs focusing on special needs or rural populations be fully funded and protected from use for activities not targeted to those goals.

Rural areas may not see the explosive growth in the elderly population expected in suburban areas, but large numbers of older individuals will continue to live in rural areas where public transportation services (and ADA paratransit) are often completely lacking. Since older residents of rural areas tend to be poorer than their urban and suburban counterparts, enhancing programs such as the section 5311 program will be important to reaching the millions of persons, old and young, living in rural areas currently unserved by public transportation.

- **Increasing Investment in Urbanized Area Formula Grants and Capital Investment Grants:** Expanding public transportation service in the suburbs and the fringes of metropolitan areas could benefit the increasing numbers of elderly people who live in those areas. In addition, more public transportation services that address the needs and travel patterns of older adults could benefit those older people who do not qualify for ADA paratransit but lack access to a personal vehicle or have had to stop or limit driving.

Ensuring that public transportation operators have the resources they need to continue providing ADA paratransit could benefit older people as well as younger people with disabilities. Older individuals who cannot use ADA paratransit as it is currently designed will need innovative public transportation services that provide more personal assistance, can be used without needing to reserve individual trips, and extend to areas where ADA paratransit is not available. It will also be important for the FTA to develop consistent ADA eligibility screening methods that satisfy public transportation operators' need to contain costs without unfairly screening out or deterring senior applicants.

The Transportation Equity Act for the 21st Century (TEA-21) created a firewall between the Highway Trust Fund and the General Fund that prevents unused appropriations from falling into the General Fund. It also provided for minimum guarantees of federal distributions from the Highway Trust Fund to the states. These policies create an important incentive for states to invest in public transportation because of the certainty of stable funding.

- **Supporting Older Driver Research:** Encouraging and enabling older adults to continue driving safely is as critical as developing better alternatives to driving. Continued research on vehicle and roadway design, as well as driver education and testing, can enhance driver safety. As the body of knowledge increases, it will be necessary to invest in promoting nationwide adoption of improved practices and designs.
- **Enhancing Transportation as a Supportive Service under the Older Americans Act:** Strengthening transportation and caregiver support within OAA-funded programs would be especially useful, because these programs are key providers of services that help older individuals to live in their communities rather than in institutions. Steps that allow coordinated use of existing resources by public transportation operators and community organizations in providing these services could be effective in expanding both the quantity and quality of services.
- **Promoting Medicaid Nonmedical Transportation as a Component of Home- and Community-based Care:** Promoting nonmedical transportation as a component of home- and community-based care could benefit older individuals and, in part, satisfy the continuing demand for noninstitutional approaches to long-term care. Federal mandates or incentives to include nonmedical transportation in states' HCBS programs implemented under Medicaid waivers could help ensure access to home- and community-based care. Measures that could improve the mobility of low-income older adults include incentives or requirements for all state Medicaid programs to offer comprehensive and coordinated transportation programs, especially for those without other alternatives.

- **Expanding Medicare Coverage of Medically Necessary Transportation:** The limits on transportation coverage in Medicare are likely to be a growing concern as more older people need transportation to treatments that they cannot reach by existing public transportation services and cannot afford to purchase privately. Measures to help Medicare beneficiaries could include providing support (such as information about transporting frail individuals or per-mile cost reimbursement) for caregivers who provide rides to medical appointments, and expanding options to bring people to life-sustaining but nonemergency treatment, possibly using community providers.
- **Promoting Research on Nonemergency Medical Transportation:** In many cases existing programs—including urban and rural public transportation, ADA paratransit, Medicaid, Medicare, and community-based aging programs—do a poor job of serving people who need nonemergency transportation for urgent care, such as dialysis and cancer therapy. Research is needed to better understand the gaps left by these programs in order to craft realistic policy and solutions.

Four areas fall outside of existing programs historically associated with transportation for older persons and are areas for potential policy development.

- **Promoting Coordination of Federally Funded Programs:** Expanded coordination could improve both the quantity and quality of human services transportation. Numerous provisions in federal programs encourage this coordination, including flexibility in the section 5310 program, the cost-sharing provisions in OAA-funded transportation, and waivers in Medicaid for nonmedical transportation. Because of the pivotal role of the states in implementing these programs, further progress in promoting coordination will most likely require action at the state level with technical assistance from the federal government. States that have taken full advantage of the existing federal flexibility in the surface transportation program, and that promote coordination in their own legislation and policies, have been able to create a high degree of coordination. Given the flexibility that already exists in the federal programs, the most useful additional steps toward coordination at the federal level would be expanded funding in the sections 5310 and 5311 programs and in OAA, with meaningful financial incentives to states for coordination.
- **Need for Supplemental Transportation:** Since ADA paratransit has proven extremely expensive for public transportation operators to provide, added services for older people are likely to take other forms. They may be provided by local jurisdictions and nonprofit organizations and may make use of volunteers. Public investment to develop these programs could be helpful, as would measures that make it easier for people to volunteer their time, such as providing tax incentives to companies to allow employees to volunteer for a certain number of hours monthly or annually. Another option for increasing supplemental transportation would be to increase public support for caregivers, for instance by disseminating information about the special transportation needs of fragile individuals and individuals with disabilities. Financial assistance in the form of stipends

or mileage reimbursements could help caregivers assist family and friends with transportation and might lead to increased supplemental transportation.

- **Livable Communities through Neighborhood Design and Land-use Planning:** Federal efforts to promote smart growth and livable communities have been limited to relatively small-scale grant programs, awards, and information dissemination. Future efforts to promote pedestrian and public transportation access to neighborhood goods and services could benefit the mobility and independence of older people. The potential payoff of these efforts would be much enhanced by a program of research to understand how different designs work for older persons, especially those with limited mobility.
- **Cultural Diversity:** The increasingly diverse character of the older population will require more effort to understand how the needs of minority elders differ from those of other older people. Useful efforts may take the form of staff training, minority outreach involving community organizations that serve specific linguistic and ethnic minorities, and research into differences in travel patterns.
- **Research:** Encouraging and empowering older adults to continue driving safely later in life is critical in a society where community mobility depends so heavily on driving. Continued research on vehicle and roadway design, as well as driver education and testing, can contribute to enhancing driver safety. As the body of knowledge increases, it will be necessary to invest in promoting nationwide adoption of improved practices and designs.

Research is also needed to support improving and expanding transportation options for the increasing number of older individuals who either cannot or choose not to drive. This research could, for example, help determine how to encourage the use of existing public transportation or identify the gaps left by programs currently providing nonemergency medical transportation. Policymakers could benefit from this research in their effort to craft successful policy and solutions.

2. Introduction and Overview

Background

As individuals age, they face unique challenges in getting around in their communities. Helping older adults maintain this essential mobility has long been a concern of public policy, a concern that has heightened with the aging of the baby boom generation. Not only is the size of the older population expected to grow rapidly, the most rapid growth is expected to occur in the oldest age groups, which have the most severe mobility problems. Further, much of the growth will occur in geographic areas that are poorly served by public transportation.

Even in places where public transportation service is good, older individuals increasingly have little familiarity with public transportation and a confirmed reliance on personal automobiles as the most convenient mode of travel. As a result, there are likely to be large numbers of older adults who find themselves unable to travel by their accustomed methods, and for whom alternative means of travel are either unfamiliar or unavailable.

Purpose

The purpose of this report is to review those federal transportation programs and policies that have a major component impacting the mobility of older persons. The report also addresses the limitations of the programs, options for enhancing them and filling gaps, and their ability to meet future needs.

Methodology

The analysis relies on information in published reports, reports posted on agency Web sites, data provided in interviews and in a policy roundtable teleconference with federal and state officials, and tabulations of survey data collected by federal agencies and available to the public. In some cases where national data could not be located, information from individual states and localities has been used for the sake of illustration.

Population Trends

For the next 10 years, the most dramatic growth in the older population will occur within the oldest group, those age 85 and older (table 1). This is also the group that tends to have the greatest need for alternatives to driving. Beginning in 2010, the size of the 65–74 age group will begin to skyrocket as the first wave of baby boomers turns 65. This trend may not have an immediate dramatic impact on the need for alternative modes of transportation, because more individuals are continuing to drive into their older years. However, continued high growth in the 85+ group and accelerating growth in the 75–84 group will place strains on the system.

Table 1. Projected Growth in the Older Population
(Thousands)

	2000	2010	Increase from 2000	2020	Increase from 2010
65–74	18,188	20,954	15%	31,462	50%
75–84	12,335	12,975	5%	15,508	20%
85+	4,312	5,786	34%	6,763	17%
Total 65+	34,835	39,715	14%	53,733	35%

Source: U.S. Bureau of the Census (2000b)

Decentralization

Increasingly, older individuals live outside of central cities, where high population density has supported public transportation services and where these services are traditionally concentrated. From 1990 to 2000 the senior population (age 65 and older) in metropolitan areas but outside of central cities (that is, in suburbs) grew by 27 percent, while the growth rate of seniors was essentially unchanged in central cities and outside of metropolitan areas (table 2). For the group that has the greatest need for alternative transportation (those 85+), the trend is even more pronounced.

Table 2. Senior Population Growth in and out of Metropolitan Areas
(Thousands)

	In Central Cities		In Metropolitan Areas Outside Central Cities		Outside Metropolitan Areas	
	65 +	85+	65+	85+	65+	85+
1990	9,647	1,026	13,357	1,207	8,238	847
2000	9,856	1,282	17,002	1,936	8,134	1,022
Percent Change	<1%	25%	27%	60%	-1%	21%

Sources: U.S. Bureau of the Census (2000a)

Analysis of the 2000 census shows that even within suburban areas, high growth in the older population is concentrated in newer suburbs and fringe areas that may have little public transportation, while more established suburbs with better service are experiencing slow or no growth in their older populations (Frey 2003). For example, a detailed analysis of the San Francisco Bay area showed that between 2000 and 2025, 65 percent of the growth in the population age 65 and older will occur in places that now have no or only basic access to services by public transportation (Nelson\Nygaard 2002a).

Government and Transportation

The Federal Role

The federal government plays an important role in addressing concerns about the mobility of older persons through a great variety of programs and policies. This report explores those federal transportation programs and policies that have a major component impacting the mobility of

older individuals as they begin to face difficulties in driving and require alternative means of transportation.³ These programs and policies include

- Formula Grants and Loans for Special Needs of Elderly Individuals and Individuals with Disabilities (49 USC 5310), and the Formula Grants for Other Than Urbanized Areas (49 USC 5311) . Both programs are administered by state departments of transportation.
- Urbanized Area Formula (UAF) Grants (49 USC 5307) / Capital Investment Grants (49 USC Section 5309), administered by the Federal Transit Administration (FTA). These grants fund the urban public transportation systems.
- Activities in support of the implementation of the transportation provisions of the Americans with Disabilities Act (ADA).
- Research and related activities to help older adults drive safely as long as possible, sponsored by the Federal Highway Administration (FHWA), the National Highway Traffic Safety Administration (NHTSA), and other agencies.
- Transportation included within other supportive services provided under the Older Americans Act (OAA).
- Medical transportation paid for under Medicaid, as well as nonmedical transportation included within Medicaid’s Home and Community-Based Services (HCBS) waiver program.
- Medical transportation covered by Medicare.

The State Role

Although this paper focuses on federal involvement in the mobility of older persons, the states also play a critical role in delivering services to older adults. The only federal transportation program that specifically targets older people is administered through the states, as are the federal programs for rural public transportation and supportive services under the OAA. Medicaid is a federal-state partnership in which state decisions result in widely varying provisions for transportation. States’ contributions to public and specialized transportation assistance have increased dramatically over the last decade. According to the American Association of State Highway and Transportation Officials (AASHTO), state aid to public transportation totaled approximately \$6 billion in fiscal year 1999, some 20 percent more than federal public transportation expenditures at that time (AASHTO 2001). Of this amount, the AASHTO survey reports that states spent almost \$100 million annually on specialized transportation services for elderly and disabled persons, and an additional \$147 million on discounted public transportation fares for senior and disabled riders.

Appendix A provides a list of acronyms used in this paper; Appendix B provides a summary table of the various DOT and HHS programs.

³ It should be noted that the research for this report took place prior to the publication in August, 2004 of the US Government Accountability Office report “Transportation-Disadvantaged Seniors: Efforts to Enhance Senior Mobility Could Benefit from Additional Guidance and Information.” (GAO-04-971). That report provides additional information on the transportation needs of and resources available to older persons.

3. Findings: Formula Grants and Loans for Special Needs of Elderly Individuals and Individuals with Disabilities (Section 5310), and for Other Than Urbanized Areas (Section 5311)

The FTA oversees two funding programs administered by state departments of transportation. These are the section 5310 elderly and disabled program and the section 5311 rural program. Because of their similarities, and because they frequently work together, they are treated together here.

Section 5310: Formula Grants for Special Needs of Elderly Individuals and Individuals with Disabilities

Program Description

The FTA's program to support specialized transportation for the elderly and individuals with disabilities is known as the section 5310 program. The states administer the program and provide capital assistance to nonprofits and government agencies to purchase vehicles and contract for transportation services. Each state determines specific program eligibility criteria, since neither "elderly" nor "disabled" is defined in the statute or by the FTA. Few states have eligibility criteria that limit use of 5310-funded vehicles to particular categories of riders because most states prefer to combine 5310 funding with other programs (such as OAA funding for supportive services, which include transportation). However, where section 5310 funds are used to supplement spending for public transportation services to individuals with disabilities, eligibility is determined according to local rules governing access to ADA paratransit services.⁴

The FTA requires each state to ensure that local grant applicants and activities are eligible and in compliance with federal requirements. In addition, the state program must provide for maximum feasible coordination of transportation services assisted under section 5310 with transportation services assisted by other federal sources (FTA Circular C9070.1E).

Until 1991, funding was provided only to nonprofit applicants. The 1991 Intermodal Surface Transportation Efficiency Act (ISTEA) opened eligibility to public agencies that operate where no nonprofit is available and to public agencies that coordinate specialized transportation. Allowable uses of 5310 funds by local groups include the purchase of vehicles and related capital equipment. The definition of capital expenses was also amended to allow for the "acquisition of transportation services under a contract, lease, or other arrangement." This provision allows local recipients (such as aging agencies) to purchase services from existing public transportation agencies, rather than requiring them to purchase their own vehicles. As of 2000, approximately 12 percent of local grant recipients were public agencies [such as area

⁴ Because age alone is not a factor in determining ADA eligibility, this practice could theoretically result in section 5310 funds being used for services that exclude some target populations. However, because the largest instances of using these funds for ADA-related projects involve funds that have been transferred into the section 5310 program (see following section on "Flexible Funding"), the practical effect may be a net increase in service to the target populations.

agencies on aging (AAAs)], and about five percent of program funds in fewer than a dozen states were being used to purchase services (FTA 2000b).

Funding

Program Funding: Section 5310 funding for elderly and disabled transportation has risen substantially since the program's inception, growing from \$22 million in fiscal year 1976 (\$62.7 million in 2002 dollars) to approximately \$90 million in fiscal year 2003 (FTA 2003).

Nevertheless, individual state shares remain small in many instances. Twelve states receive less than \$500,000 each under current funding levels. Under amendments adopted in 1998, section 5310 is guaranteed 2.4 percent of all FTA formula grant funds. Funds are allocated to each state on the basis of the state's share of the national elderly and disabled population. States then pass through these funds to eligible local agencies. By statute, these federal funds can pay up to 80 percent of the cost of approved capital projects, with a 20 percent match required from local or state sources. If the project is to meet ADA requirements, section 5310 funds can be used to pay up to 90 percent of the costs of vehicles and related equipment. More than \$1.2 billion in federal funds has been obligated under section 5310 since it was enacted in 1975.

Flexible Funding: Under the "flexible funding" provisions of the Transportation Equity Act for the 21st Century (TEA-21), funds from certain federal highway programs can be transferred to FTA-administered public transportation programs, including section 5310. In addition, the law provides for the transfer of funds between section 5310 and other state-administered FTA programs. The level of net transfers into the section 5310 program has grown sharply in the last few years, rising from \$1.2 million in 1991 to nearly \$102 million in 2001. These transfers were more than the actual appropriations that year, which totaled \$77 million (FTA 2002). By far the largest use of this transfer authority occurred in California, where more than \$40 million in federal highway funding was transferred to a single agency, Access Services, Inc., the paratransit service provider in Los Angeles, to help pay for ADA paratransit.

Services and Accomplishments

FTA officials believe that the program has helped many older adults and persons with disabilities with mobility in their communities and with maintaining independence. However, the section 5310 program is state administered, and FTA collects no data about the actual services provided by grantees.

Approximately 3,700 nonprofit and public agencies receive 5310 assistance (FTA 2000b). Nationwide surveys conducted by the Community Transportation Association of America (CTAA) in 1989, 1994, and 1999 indicate that the number of nonprofit agencies has remained constant. Although all communities are eligible to receive funding, more than 65 percent of the 5310-funded agencies were in rural and small urban areas. CTAA also found that funding recipients were evenly split between groups serving the elderly and people with disabilities, with each receiving roughly 45 percent of 5310 funds. The remaining 10 percent of the funds went to general-purpose agencies. Between fiscal years 1992 and 2001, more than 18,000 vehicles were purchased with 5310 funds. Seventy-one percent of the vans and buses were accessible (i.e., equipped with lifts for wheelchair users) (FTA 2002).

Section 5311: Formula Grants for Other Than Urbanized Areas

Rural mobility has long been of critical importance to older persons because a disproportionate share of them live in nonmetropolitan areas that, historically, have not been well served by conventional public transportation. In 2000, people age 60 and older made up 19 percent of the population in nonmetropolitan areas, compared with 16 percent in metropolitan areas (U.S. Bureau of the Census 2000a).

The original federal transit legislation in the 1960s established the Urban Mass Transportation Administration (UMTA). Public transportation was viewed then essentially as an urban amenity, and all federal assistance was directed to a few of America's major cities. When the section 147 rural transit demonstration program was created in 1974 (P.L. 93-87), it was placed under the FHWA. It was not until 1978, almost 15 years after the passage of the original transit legislation, that the Surface Transportation Assistance Act (P.L. 95-599) established the section 18 rural transit program. In 1992, the ISTEA changed the name of UMTA to the FTA, in recognition that public transportation was important to everyone, including the residents of small towns and rural America.

Program Description

The FTA's rural public transportation assistance initiative today is known as the section 5311 program or Formula Grants for Other Than Urbanized Areas (49 USC 5311). It is a federally funded, state-administered grant program for all communities of 50,000 or fewer outside of existing urbanized areas. States can use these funds to make grants to local recipients in rural areas to provide public transportation. Eligible recipients include state agencies, local public entities, tribal governments, nonprofit organizations, and public transportation operators. Federally funded public transportation services under section 5311 must be available to all community residents and may not be restricted to specific demographic groups. Grants can be used to cover up to 80 percent of the cost of vehicles and other capital equipment, to pay up to 50 percent of the operating cost of a rural public transportation system, and to cover up to 80 percent of certain administrative expenses. States may use up to 15 percent of their 5311 allocations for administrative purposes.

Funding

Program Funding: The rural public transportation program has grown from \$76 million in fiscal year 1979 (\$165 million in 2002 dollars) to \$230 million in 2002 (FTA 2003). Section 5311 funding dramatically increased with the passage of TEA-21 in 1998. Rural public transportation authorizations under TEA-21 grew from \$134 million in fiscal year 1998 (\$145 million in 2003 dollars) to \$240 million in 2003, an 80 percent increase over the six-year period. This increase parallels increases in overall public transportation grant funding, because section 5311 program funding is set at 6.37 percent of total formula public transportation funding. Each state's 5311 allocation is based on its share of the nation's nonurbanized population. For fiscal year 2002, state allocations ranged from \$440,000 in Rhode Island to \$13.8 million in Texas.

Flexible Funding: Flexible fund transfers have not been used as much for section 5311 as for the section 5310 program. In fiscal year 2001, \$29 million was transferred into the section 5311 program, mostly from federal highway funds.

Services and Accomplishments

Prior to 1978, very few smaller rural communities had access to local public transportation. The section 5311 program was established in hopes of addressing this problem and reducing the mobility gap in rural America. As the program is state administered, the FTA does not collect data from grantees as it does for the major public transportation funding recipients. However, survey data show that between 1993 and 1998, the number of 5311 grant recipients increased from 1,147 to 1,215, and the number of trips provided by these systems increased by 62 percent (CTAA and Institute for Economic and Social Measurement 2001). The 5311 recipients, mostly public and nonprofit agencies, provide public transportation services in more than 1,300 rural counties. Tribal entities made up 3 percent of the funded recipients in 1993, but dropped to 2 percent by 1998. As 5311 funding has increased substantially over the past four years, it is likely that there are even more and larger rural public transportation providers operating today, although no more recent figures are available.

Rural public transportation services are of particular importance to older residents. For many older individuals, these public transportation services provide vital links to medical care and other essential services. Persons age 60 and older account for nearly one-third of rural riders—far more than their 19 percent share of the rural population.

Rural public transportation was available in 61 percent of counties with some nonurban population in 1998 (FTA 2002), up very slightly from 59 percent in 1993 (CTAA 1994). From the point of view of individual older persons living in rural areas, the situation may be worse. The 2001 *American Housing Survey*, which tabulates data for households with a householder age 65 and older, found that 74 percent of households in rural areas had no public transportation available (U.S. Bureau of the Census 2002).

Interaction of Sections 5310 and 5311 with Local, State, and Other Federal Programs

The sections 5310 and 5311 programs are deeply entwined with state and local public transportation efforts. Due to limited funding and 5310 and 5311 statutory requirements for local matching funds, agencies have had to be resourceful and flexible in combining program funds. Many states offer dedicated funds to local agencies to cover all or some of the required match. To pay for drivers and other operating costs of vehicles purchased with section 5310 funds, many programs use other state-administered federal assistance, such as OAA funds and, in rural areas, section 5311 funds. The administrative flexibility that has been added to section 5310 in recent years has made it easier for states to integrate this federal assistance into overall community transportation plans. Oregon's DOT, for instance, has developed a consolidated application process so that local communities can simultaneously apply for a combination of blended state public transportation, section 5310, and section 5311 assistance. In general, the section 5310 "purchase of service" provisions encourage existing public transportation agencies to offer services to older individuals in the community, while increased involvement by local public transportation systems in the 5310 program enhances state coordination efforts.

Across the United States, the 5310 and 5311 programs depend heavily on state and local funding. A 1994 national study of section 5310 grantees found that FTA-funded vehicles represented less than half of the total fleet operated by these nonprofit agencies, reflecting the agencies'

dependence on a variety of funding sources (CTAA 1994). Section 5311 funds make up less than 20 percent of the average rural agency's operating budget (CTAA 2001). Funding from state and local governments was the largest single source of operating funds for rural public transportation providers. Although 5311 programs may charge fares to their general public passengers, they typically do not charge fares directly to clients of human services agencies, which contract with the 5311 programs to provide transport for their clients. Revenues from human service programs for transportation of their clients about equaled the level of section 5311 funds received. The major sources of that human services funding were Medicaid (\$53 million), the OAA (\$41 million), Temporary Assistance for Needy Families (\$12 million), and Head Start (\$5 million).

Issues and Options

Funding Benchmarks: TEA-21 authorized section 5310 funding for 2003 at an all-time high of nearly \$91 million. Elderly and disabled transportation assistance is guaranteed 2.4 percent of FTA's formula grant funds, which is the equivalent of 1 percent of the FTA's annual budget. However, each year's appropriation has provided only about 69 percent of the funding needed to replace existing 5310 vehicles that are at the end of their theoretical five-year useful life (FTA 2000b); this leaves meager funds for expanding the 5310-funded fleet. (In actuality, many vehicles are much older than five years before replacement.)

State officials confirm that the demand for 5310 vehicles and funding exceeds available resources. DOT officials in Washington, for example, report that requests for 5310 assistance have been running about twice the amount of funds available (Kirkemo 2002). In California, requests exceeded funding by 42 percent in fiscal year 2002 and by 64 percent in 2001; a decreasing number of agencies have been applying for funding there owing to the increasingly competitive nature of the program (Jacobs 2002).

National transportation associations, such as CTAA and the American Public Transportation Association of America, estimate that double or even triple overall FTA funding is needed to meet the current and future demand. Under the current formula for determining the allocation of formula grant funds among the different formula grant programs, section 5310 funding will rise to as much as \$210 million by fiscal year 2009 only if FTA's budget increases to \$21 billion over the next four years.

In the case of the section 5311 program, rural public transportation advocates have long believed that rural America's share of federal public transportation assistance is inadequate, because rural public transportation's 3.5 percent of FTA formula funding is far less than the 20 percent of the population living outside of metropolitan areas. Rural public transportation advocates have calculated that small towns and rural areas received \$1.94 in FTA assistance for each resident in fiscal year 1995, compared with \$35.69 per capita in our largest urban areas (CTAA 1995). In congressional testimony, rural advocates indicated that lack of transportation is a major problem for rural elderly in reaching medical, nutritional, and other essential services (U.S. Senate Special Committee on Aging 2001).

Flexibility in the Use of Funds: Reports from states that have implemented some of the flexibility provisions added to the section 5310 program in 1991 indicate that these provisions

have been very effective in expanding transportation services to the elderly and improving coordination between state and federal public transportation efforts. However, only a few states so far have taken advantage of the purchase-of-services provisions that were added in 1991. Part of the problem is the limited funding noted above. An Oregon DOT official explained that most of the state's 5310 allocation was committed to replacing vehicles, so not much funding was available to purchase transportation services for older people (Dickey 2002).

Separating Elderly and Disabled Components: One proposed option is to separate transportation for the elderly from transportation targeted to programs for persons with disabilities. Some advocates question whether one program, section 5310, can effectively address the diverse transportation needs of the two distinct groups. Others argue that separating the dual components of the existing program would only weaken the constituencies seeking additional resources for special needs transportation.

Merging Section 5310 and 5311 Programs: Another option is to combine FTA's section 5310 and 5311 programs into a single, state-administered grant assistance program. Merging the programs could simplify the application process for some applicants and could simplify administration and budgeting for state agencies and FTA. However, a merger could also result in reduced ability to target funds to the very different purposes of the two programs—meeting general public transportation needs in small towns and rural areas for section 5311, and meeting special needs of older and disabled persons, regardless of community size, for section 5310.

4. Findings: Urbanized Area Formula Grants (Section 5307) and Capital Investment Grants (Section 5309)

Background

The UAF Grants (49 USC 5307) and the Capital Investment Grants (49 USC 5309) programs, administered by FTA, provide assistance for urban public transportation only. The programs are not restricted to services for any categorical demographic group. However, funds may be used to help public transportation agencies serve the needs of person with disabilities, many of whom are elderly. Moreover, in places where public transportation is available, it is an option for older individuals who are limiting or stopping driving.

Program Description

The federal government has provided assistance for urban transit since 1964, when the Urban Mass Transportation Act established the Urban Mass Transportation Administration, now the FTA. Initially only capital funding was available. In 1974, the National Mass Transportation Assistance Act established a formula grant program that could be used for the capital and operating costs of urban public transportation. In 1991, the ISTEA increased funding authorizations and provided for flexible funding under which certain federal highway funds could be used for either public transportation or highway projects. In 1998, TEA-21 increased public transportation authorizations significantly and provided limited guarantees of funding.

The principal federal funding programs for urban public transportation are the UAF program (49 USC 5307) and Capital Investment Grants (49 USC 5309). The programs are commonly referred to as the section 5307 and the section 5309 programs. Section 5307 funds are distributed by a formula based on the population of each urbanized area and the amount of service provided. In urbanized areas with a population of 200,000 or more, UAF funds may be used only for capital purposes, although some preventive maintenance and ADA paratransit costs can be counted as “capital.”

In small urbanized areas with populations below 200,000, the funds can be used for both capital and operating expenses. Public transportation agencies must offer a reduced fare to elderly and disabled riders during off-peak hours (49 USC 5307(d)(1)(D)). The reduced fare must be no more than half of the peak-hour fare. Many public transportation systems voluntarily extend this reduced fare to all times of day, and many charge much less than half.

Section 5309 grants are available for building or extending fixed-guideway systems (such as light rail and rapid rail), modernizing existing fixed-guideway systems, and major bus-related construction projects and equipment purchases. Except for fixed-guideway modernization, these funds are distributed based on congressional appropriation each year, a process known as earmarking. Capital assistance funding under both section 5307 and section 5309 requires a local/state match of 20 percent, while operating assistance funding requires a local/state match of 50 percent.

Funding Amounts

Appropriations: Federal appropriations for urban public transportation capital costs and operations under the sections 5309 and 5307 programs has increased from \$2.8 billion in 1991 to \$6.1 billion in 2002 (FTA 2003). Although overall funding has more than doubled, the amount used for operating costs, as opposed to capital costs, has increased much less, from \$822 million in 1991 to \$984 million in 2000, of which \$611 million consisted of capital funds that were applied to operations (FTA 2000a).

Flexible Funding: As noted, ISTEA and TEA-21 include provisions for flexible funding. These provisions allow state and local governments the option of using some FHWA funds for public transportation projects under all formula grant programs (including 5307 and 5309) and vice versa. In practice almost all of the transfers have been from highway funds to public transportation funds. These transfers have provided approximately an additional \$6.5 billion for urban public transportation service since 1992, of which \$1.3 billion was transferred in fiscal year 2001 (FTA 2002).

Services and Accomplishments

Federal urban public transportation assistance supports bus, streetcar, rapid rail, and commuter rail service, as well as demand-responsive paratransit, general-public dial-a-ride, and vanpool service, operated by more than 430 public agencies. In 2000 these agencies provided 8.7 billion passenger trips (FTA 2000a). Ridership has grown slowly since 1991, when some 390 agencies provided 7.7 billion trips.

Public transportation serves many older adults. In October 2003, for example, one out of eight individuals 65 and older (more than 3 million people) within metropolitan areas used public transportation (Bureau of Transportation Statistics 2003).

Federal requirements for accessibility for people with disabilities have also produced improvements that benefit older adults. The ADA, in addition to requiring paratransit services that complement fixed routes (see below), has required accessibility improvements for conventional public transportation services. Accessibility features that help older adults with functional impairments include kneeling buses, signage with larger letters, requirements for calling out stops, and elevators and other improvements at key rail stations. As of 2000, 54,585 out of 65,324 buses (84 percent) used in federally assisted urban public transportation had ADA lifts or ramps and were presumably in compliance with other ADA accessibility requirements as well (FTA 2000a). Also in 2000, 1,165 out of 2,641 rail stations (44 percent) were in compliance with ADA accessibility standards. Public transportation agencies were required to make accessible all “key” stations not requiring “extraordinarily expensive” modifications by 1993. All key stations must be made accessible by 2020 (49 CFR 37.47).

Interaction with State and Local Programs

All of the federal transit programs have requirements for state or local matching funds. Even more important, public transportation systems need to use nonfederal sources to pay most of the costs of operating the equipment they buy with federal funds. As a result, states and localities with funding programs for public transportation are better able to take advantage of the federal public transportation program. In 2000, state and local sources accounted for 61 percent of

operating funds and 49 percent of capital funds used by public transportation operators receiving federal assistance (FTA 2000a); the actual state and local share of capital funds far exceeds the matching requirements for the federal capital grant programs. States also have responsibility for distributing formula funds to small urbanized areas (population less than 200,000) and play a role in the administration of flexible funds that have been transferred to public transportation uses. As a result, usage of flexible funding has varied greatly from state to state. Further discussion of flexible funding issues is provided in the sections on federal transportation grants programs.

Issues and Options

Availability of Service: After decades of public support, public transportation service is now available, even if limited in amount, in most major metropolitan areas, including their suburbs. But outside of metropolitan areas and in many smaller metropolitan areas, public transportation service is still quite limited or unavailable. The urban focus of public transportation expenditures contributes to many older individuals being underserved: While more than three-quarters of operating expenditures and vehicle revenue hours are in urbanized areas (as shown in table 3), only half of the people age 65 and older live in urbanized areas of 1,000,000 or more population.

**Table 3. Measures of Public Transportation Service
By Size of Urbanized Area (Fiscal Year 2000)⁵**

Size of Urbanized Area (Population per square mile)	Share of vehicle revenue hours (%)	Share of operating expenses (%)
Large area (more than 1,000,000)	76.9	86.4
Medium (200,000 – 999,999)	16.1	9.9
Small (Less than 200,000)	7.0	3.7

Source: Federal Transit Administration, 2000a

Limitations in the availability of public transportation service affect older adults along with the rest of the population. As shown in table 4, households with a householder 65 and older outside metropolitan areas—i.e., rural areas—are significantly more likely to have no public transportation than are households 65 and older in either suburbs or central cities. According to a national survey of older people, 53 percent of people age 50 and older live more than half a mile from public transportation (Ritter, Straight, and Evans 2002).

⁵ An urbanized area is an incorporated area with a population of 50,000 or more that is designated as such by the U.S. Department of Commerce, Bureau of the Census.

Table 4. Occupied Units with Householder Age 65 and Older with No Public Transportation Available

Size of Metropolitan Area	Percent	Number
Central cities (in metropolitan statistical areas--MSAs)	18	1,076,000
Suburbs (in MSAs)	46	4,802,000
Outside MSAs	74	3,962,000

Source: U.S. Bureau of the Census (2002)

Ability to Use Conventional Public Transportation: Aside from availability, the key issue that determines whether public transportation service can improve the mobility of older people is their ability to use it. More than three-quarters (78.7 percent) of all nonpublic transportation users age 69 and older say they are not limited from using public transportation by an impairment or health problem (Burkhardt et al. 2002).

However, the ability to drive may correlate with the ability to use public transportation. As table 5 shows, more than half (55 percent) of those who never drive owing to an impairment or health problem also do not use public transportation for the same reasons. As might be expected, the highest levels of public transportation use among nondrivers occur among those who are healthy and unimpaired.

Table 5. Driving and Ability to Use Public Transportation (Survey Respondents Age 69 and Older)

	Drive (%)		Never Drive (%)	
	At least Occasionally	Seldom	Due to an impairment or health problem	Not due to an impairment or health problem
Use public transportation without difficulty	11.6	14.3	9.1	31.7
Use public transportation with difficulty	0.3	2.0	3.2	4.1
Don't use public transportation but not limited by impairment or health problem	85.8	66.3	32.5	47.9
Don't use public transportation because limited by impairment or health problem	2.4	17.5	55.2	16.2

Source: Original tabulation by Nelson/Nygaard from the Second Supplement on Aging II (excludes respondents with no public transportation system available). (National Center for Health Statistics, 1994)

Note: Due to rounding, percentages in some columns do not add to exactly 100%.

These results suggest that a substantial percentage of older people who never drive can use public transportation. However, the results also highlight the importance of providing alternatives to conventional public transportation that are easier to use for older adults who no longer drive, as well as the importance of public transportation operators making their services as senior-friendly as possible.

Other national survey results shed light on the specific difficulties that older people face when using public transportation. As shown in table 6, the most prominent problems among nondriving older adults are accessibility, difficulty boarding, concern about crime, limited destinations, and transfers.

Table 6. Problems Using Public Transportation

Problem	Percentage of Respondents Age 75+ Citing Each Item as a Large Problem		
	Drivers	Nondrivers	Total
Destinations are limited		*	21
Accessibility	17	27	17
Concern about crime	12	23	13
Time it takes		*	13
Difficulty boarding	7	27	11
Transfers are difficult	15	20	11
Condition of stations and vehicles		*	8
Getting a seat	5	14	6
Getting information	5	12	6
Cost		*	6

*No significant difference between drivers and nondrivers.
Source: Ritter, Straight, and Evans (2002).

Funding: Increasing overall public transportation funding could improve public transportation for older individuals. However, the ability of such increases to help older people depends on how the funds are used. Older individuals have significantly different travel patterns than younger adults. For example, national survey data show that older people travel mostly between 9:00 a.m. and 4:00 p.m., make shorter trips on average than other people (7.46 miles compared to 9.33 miles), and make far fewer work and school trips (Oak Ridge National Laboratory 2001). Improvements to off-peak local services and improvements that address the difficulties that make it hard for older people to use public transportation would be of greater benefit to older persons than improvements to peak period, commute-oriented services. Each local public transportation agency would need to investigate the travel patterns and preferences of older riders in its area to target improvements to benefit them. For minority elders who are still employed, a continuing concern is transportation from central cities to jobs in the suburbs (Aging Transportation Policy Roundtable 2002).

5. Impact of Americans with Disabilities Act Paratransit Requirements

Background

In addition to conventional public transportation services, public transportation agencies provide specialized paratransit services for people with disabilities. Public agencies that provide fixed-route public transportation services are required by the ADA (P.L. 101-336, 42 USC 12101) to provide paratransit for people who cannot use accessible fixed-route services due to a disability. The ADA and its implementing regulations (49 CFR 37 et seq.) set forth a variety of accessibility requirements for fixed-route public transportation service. They also require that all public transportation agencies provide complementary paratransit service that is comparable to fixed-route service. “Comparability” is defined by the regulations in terms of six criteria: service area, hours, fares, next-day advance reservations, response time, and prohibitions against capacity constraints or prioritizing based on trip purpose. The ADA is a civil rights law, and although it requires public transportation agencies to maintain certain levels of paratransit service, neither the act nor any other federal program provides funding specifically for this purpose. In fiscal year 2001, FTA urban public transportation grantees reported spending about \$1.4 billion in operating expenses on ADA-related demand-responsive transportation, about 6 percent of the grantees’ \$21.6 billion in total operating expenses that year (FTA 2001). Note that these figures exclude capital costs, costs incurred by rural public transportation operators, and costs incurred by public transportation operators that do not receive federal funding.

The Impact of Americans with Disabilities Act Paratransit on Older Individuals

Total Service Levels: Urban public transportation grantees may provide paratransit (also known as demand-responsive) trips to passengers who are not eligible under the ADA, and must provide paratransit to those who are eligible. In 1991, federal urban public transportation grantees reported providing 42 million demand-responsive passenger trips, including ADA paratransit, dial-a-ride, and human services agency trips provided by urban public transportation (FTA 2001). According to an estimate by FTA staff, ADA-related paratransit services accounted for about 16 million of these trips (Weiner 1998). In 2001, the FTA urban public transportation grantees reported 77 million demand-responsive rides, of which almost 48 million were ADA-related. The balance of the 77 million rides were either trips on general public dial-a-ride (a form of demand-responsive service), trips by older individuals or people with disabilities who were not ADA eligible, or trips on services that exceeded ADA requirements in some way. Clearly the ADA paratransit requirements resulted in a major expansion of paratransit services within public transportation service areas.

Use by Older People: No national data are available on use of ADA paratransit services by older people. However, local data suggest that ADA paratransit has benefited older people. In the San Francisco Bay area, for example, 73 percent of those registered for ADA paratransit at 16 public transportation operators are at least 65 years old, and 58 percent are at least 75 years old (Nelson\Nygaard 2002a). In Broward County, Florida, persons age 65 and older constitute 16 percent of the population and account for 82 percent of the ADA paratransit registrants (Busada

2002). Almost half (46 percent) of the registrants are more than 85 years of age. However, it is likely that older paratransit registrants ride less frequently than younger ones. For example, at the Santa Clara Valley Transportation Authority people over 60 years of age comprised 71 percent of ADA paratransit clientele but took 58 percent of ADA paratransit trips provided in fiscal year 2000. Individuals age 70 and older accounted for 58 percent of clients and 45 percent of trips (Nelson\Nygaard 2002a).

Senior Market Penetration: These examples also provide some insight into the issue of ADA paratransit market penetration for older persons. The Broward County figures show that 7.8 percent of the county population age 65 and older is registered with the paratransit program. In the San Francisco Bay area, 9.5 percent of the 65 and older population is registered for ADA paratransit. One indicator of the size of the market for ADA paratransit is found in national survey data that indicate that 13 percent of people age 69 and older who have public transportation available to them are limited in using it by an impairment or health condition (National Center for Health Statistics 1994). The Broward County and San Francisco Bay area data suggest a good degree of market penetration nationally.

Comparison to Pre-Americans with Disabilities Act Services: As noted before, public transportation agency paratransit services sometimes replaced services operated by other agencies. No national data about this phenomenon exist, but some local examples are instructive. In Oakland, California, and nearby communities, state funding that had gone to 10 city-operated programs that served older individuals and people with disabilities was diverted to two public transportation agencies to pay for ADA paratransit (Crain & Associates 1992a). Some of the city-operated programs had age as the only standard for eligibility, while the ADA service eligibility depends strictly on having a disability that prevents use of public transportation. In Reno, Nevada, a pre-ADA paratransit system operated by a nonprofit organization was originally open to anyone age 60 or older, and no fare was charged. When the system was replaced with ADA paratransit from the public transportation agency, ADA eligibility and fares were implemented, thereby excluding many of those who had been eligible on the basis of age (Crain & Associates 1992b).

ADA paratransit in many respects has been superior to services that were replaced. For instance, in the Oakland example, the city-operated services allowed for very limited amounts of travel, particularly between cities. By comparison, the ADA paratransit allows for unlimited amounts of travel with no restrictions on travel between cities. Rosenbloom (1993) notes that most pre-ADA paratransit systems rarely served more than 20 percent of those eligible for service, had serious capacity constraints, and required users to call far in advance for service. By comparison, ADA paratransit systems are required to serve all eligible riders, are forbidden to have capacity constraints, and must accept reservations up to the close of regular business hours the day before a rider wishes to travel.

Issues and Options

Funding: Since ADA did not provide new funding for implementing paratransit services, the money to pay for them must come predominantly from sources that would otherwise be used for conventional public transportation or non-ADA special services. Public transportation agencies need additional funding to pay for the cost of compliance.

Eligibility: Eligibility for ADA paratransit is based entirely on an individual's functional ability to use an accessible fixed-route public transportation system, and not on any medical diagnosis or disability. Age alone is not a basis for eligibility. ADA sets minimum criteria for ADA paratransit eligibility, but leaves it up to public transportation agencies to design a process for judging eligibility based on these criteria. Some use a paper application process that essentially lets applicants "self-certify" as qualified, while others require applicants to appear in person for rigorous functional assessments. Less rigorous certification methods may result in some people receiving service who are not eligible under the minimum ADA criterion, but there is no hard evidence about the extent of such outcomes.

On the other hand, many public transportation agencies have adopted stringent ADA paratransit eligibility certification procedures in order to contain costs and slow dramatic increases in ridership. For example, in Las Vegas the paratransit registration base of 17,000 was almost halved within one year of the implementation of new certification procedures (Weiner 1998). It is not known how many of those previously registered suffered a reduction in mobility as a result.

Currently, public transportation systems in Pittsburgh, Los Angeles, Salt Lake City, Chicago, and the state of New Jersey (among others) require all applicants for ADA paratransit eligibility to appear in person for an interview or a functional test (Nelson\Nygaard, 2002b). These procedures may deter some people who may not view themselves as disabled, or those for whom the process is too burdensome, from applying for paratransit by these procedures. Further investigation is needed to determine the mobility impacts of more rigorous ADA eligibility processes, including whether they prevent eligible people of any age from receiving paratransit service.

Limitations of Americans with Disabilities Act Paratransit Service: ADA paratransit service has many limitations that can make use difficult or impossible for some older individuals. Indeed, the ADA regulations acknowledge that "ADA complementary paratransit is not intended to be a comprehensive system of transportation for people with disabilities." The regulations note that "the ADA is a civil rights statute, not a transportation or social service program statute," and include a comment that "the ADA is intended simply to provide to individuals with disabilities the same mass transportation opportunities everyone else gets, whether they be good, bad, or mediocre" (*Federal Register*, September 6, 1991, p. 45601). Service limitations built into the regulations that may have a disparate impact on older persons include the following:

- **Service Area:** ADA paratransit is required only in areas immediately surrounding public transportation routes. As a result, paratransit service may not be available in precisely those areas where alternatives to driving do not exist or are very limited. As noted above, public transportation routes are particularly limited or nonexistent in suburban and rural areas, where the greatest proportion of the older population resides.
- **Transfers:** ADA permits public transportation agencies to require some paratransit riders to make transfers between paratransit vehicles and fixed-route buses or rail lines for portions of their trips. Where neighboring jurisdictions have different public transportation operators, it is common to require a transfer between the paratransit services of the two operators.

- **“Curb-to-curb” Service:** Operators have a choice of providing “door-to-door” service, in which drivers help riders between the vehicle and the door of their residence or destination, or “curb-to-curb” service, in which this type of assistance is not provided (49 CFR 37.129). For frail older individuals or those subject to confusion, curb-to-curb service could effectively preclude use of paratransit.
- **Subscription Service:** ADA paratransit systems may accept subscriptions (also known as standing orders), but they are not required to do so (49 CFR 37.133). Some public transportation operators see subscription as a technique that allows for scheduling efficiency, but others see it as a nonrequired service that leads to higher demand. The ADA regulations generally limit subscriptions to 50 percent of the service provided at any time of day. For individuals who have limited English, difficulty hearing, or are subject to confusion, having to call on a daily or weekly basis to request trips to nutrition sites or other regular activities could be overly burdensome.

Public transportation systems can exceed the ADA requirements, and many do. However, the expense of meeting the ADA minimum requirements creates a strong incentive for public transportation systems to cut back on any aspect of service that is not actually required for compliance. For example, public transportation systems in Dallas, Tulsa, Los Angeles, and Washington, D.C., have policies of providing only curb-to-curb service (National Transit Institute 2002). Pierce Transit in Tacoma, Washington, cut back its paratransit service area in response to rapidly growing ridership (Nelson\Nygaard 1998). Paratransit operators in Santa Barbara and Marin County, California, provide very limited subscription service. Whether these changes have a unique impact on older individuals as compared to younger individuals has not been measured.

In summary, the ADA appears to have vastly improved paratransit service for a large number of older individuals who can work within its limitations and who live in areas with public transportation service. However, some older people have probably been left behind. This group includes those who live outside of public transportation service areas and those who require a higher level of assistance than provided by some ADA paratransit systems. Targeting a portion of funding for public transportation to improving paratransit services so they do meet more needs could benefit older people and other people with disabilities.

6. Other Federal Initiatives Related to Transportation of Older Adults

This paper is principally concerned with programs that provide mobility options for older adults who no longer drive. For the majority of older adults, however, driving and getting rides in a personal vehicle are the primary modes of transportation. According to the 1995 Nationwide Personal Transportation Survey, persons age 65 and older used personal vehicles for about 90 percent of their local travel (Oak Ridge National Laboratory 2001). For older adults who can drive, as for others in our society, a personal vehicle provides a high degree of mobility and independence. Recognizing this, the DOT has pursued initiatives intended to improve safety and preserve the mobility afforded by personal vehicles for older adults. Related research is being pursued by the National Institute on Aging and the CDC (U.S. DOT 1997). This section briefly summarizes these efforts.

In 2004, the DOT released a comprehensive report on transportation of older adults, *Safe Mobility for a Maturing Society: Challenges and Opportunities*. This report sets forth a vision, and recommendations for achieving that vision, of “a transportation system that offers safe mobility to all people and allows older persons to remain independent and to age in place.” The findings of the report are now guiding the DOT’s activities related to improving transportation for older persons. At the same time, the FTA and the Administration on Aging (AoA) have entered into a memorandum of understanding to undertake cooperative efforts to enhance the community mobility of older individuals.

Although there has never been a separate and distinct program to address safety issues of older drivers, NHTSA has long supported efforts to identify challenges and opportunities to improve older driver and pedestrian safety. In 1988, the NHTSA established a *Traffic Safety Plan for Older Persons*. Since then NHTSA has pursued an active program of research to identify avenues for improving the safety of older drivers, vehicle occupants, and pedestrians. NHTSA research has focused on issues such as identifying factors that increase crash risk for older drivers, improved practices in testing and assessing the performance of older drivers, and ways to help older drivers maintain safe driving skills and safely transition to alternative modes. In its 2002 Notice of Vehicle Safety Rulemaking Priorities (Docket NHTSA-2002-12391-2), NHTSA identified concern for special populations, including older persons, as one of its priorities.

The Federal Highway Administration (FHWA) has also addressed safety issues for older drivers. In 1989, FHWA initiated a High Priority Area within its Human Factors Safety Research program to address problems faced by older road users. Research under this program resulted in an *Older Driver Highway Design Handbook*, published by FHWA in 1998. In 2001 FHWA published an updated version of this handbook, *Highway Design Handbook for Older Drivers and Pedestrians* (FHWA-RD-01-103), and a companion volume, *Guidelines and Recommendations to Accommodate Older Drivers and Pedestrians* (FHWA-RD-01-051). In 2003, the CDC and FHWA awarded the Seniors’ Institute for Transportation and Communications at the University of Florida a \$1.6 million grant to establish the National Older

Drivers Research Center, which will develop a system for identifying elderly drivers who are at risk for unsafe driving, providing referrals to appropriate professionals (e.g., ophthalmologists, physical therapists) who address skills associated with driving, providing training and assistive devices that may enable safe driving, and conducting and promoting research on older driver issues.

7. Older Americans Act Supportive Services

Background

The OAA (P.L. 89-73) was signed into law in 1965 amid growing concern over older individuals' access to health care and their general well-being. The OAA established the federal AoA and charged the agency with advocating on behalf of Americans 60 or older (now estimated at 46 million individuals) and implementing a range of assistance programs aimed at older persons, especially those at risk of losing their independence. That at-risk group has been identified by AoA as including older individuals who are

- age 85 or older;
- living alone without access to a caregiver;
- low income;
- members of minority groups;
- persons with disabilities; and
- victims of abuse, neglect, or exploitation (AoA 2002a).

Federal funds are distributed to states on the basis of the state's share of the U.S. population age 60 and above.

The OAA delivers social and health services to an estimated 7 million older persons and their caregivers each year (AoA 2002c) through the network of state units on aging, more than 650 local AAAs and more than 225 tribes and Native American organizations. In fiscal year 2003, AoA's budget totaled approximately \$1.36 billion, making it the third largest federal assistance effort serving older individuals, after Social Security and Medicare (AoA 2002b).

The Role of Transportation in the Older Americans Act

Transportation is a major service under the OAA, providing needed access to nutrition and other services funded by the AoA, as well as to medical and other essential services required by an aging population (42 USC Chapter 35, Subchapter III, Part B, § 3030d(a)(2)). No funding is specifically designated for transportation. However, funding can be used for transportation under Title III (State and Community Programs) and Title VI (Grants to American Indian Tribes) of the OAA.

Program Description

Title III State and Community Programs: AoA awards funds under Title III of the OAA to the 57 state units on aging to plan, develop, and coordinate systems of in-home and community-based services. These programs include supportive services, congregate and home-delivered meals, in-home services for frail elderly (Title III-D), and disease prevention and health promotion services. Transportation is one of the supportive services that can be funded under Title III-B and is the second largest service element (after congregate and home-delivered meals) funded under Title III.

OAA expenditures for transportation (including assisted transportation) increased by approximately 8 percent, from \$63 million in fiscal year 1996 to \$68 million in fiscal year 2000. These funds helped pay for nearly 40 million rides in fiscal year 1996 and 43 million rides in fiscal year 2000. The OAA funds spent in fiscal year 2000 on transportation were matched by \$107 million in state and local funds (AoA 2002c), making the total reported cost of the trips provided \$176 million, or about \$4.11 per trip.

Much of the transportation available under the OAA is specialized; it is designed to ensure that older individuals can get to meals, nutrition, and other program services offered by AAAs, and to medical and other outside community services. Dependence on these services is highest in rural areas, where roughly one out of four program participants received transportation assistance, compared with an estimated one out of eight in urban areas (CTAA 1992b).

Some information about the impact of these services on senior mobility is available from AoA's Performance Outcomes Measures project (AoA 2002d). Surveys by state units on aging and AAAs in eight states showed high levels of satisfaction by riders: 82 percent of respondents rated AoA-sponsored transportation services very good or better, and 90 percent reported that they felt safe and that the drivers were always polite. For one-fifth of respondents, the AoA-funded program was nearly their exclusive means of transportation. Sixty percent of the riders reported an increase in travel and social activities since beginning to use AoA-funded transportation services.

Title III-funded programs are often coordinated with services, including transportation, provided under Medicaid HCBS waivers (AoA 2002g). According to a 1994 AoA report, almost half of state aging agencies administered Medicaid HCBS waivers. (See discussion of these programs under "Nonmedical Transportation" in the section about Medicaid.)

Title VI Access Services to Indian Tribes: Native American nutrition and other programs are funded under Title VI of the OAA. Grants are made directly to tribal and other Native American organizations representing American Indians, Alaska Natives, and Native Hawaiians. In fiscal year 2002, almost \$26 million were expended for all services under this title of the act (AoA 2002b). Assisted transportation is one of the important access services available to tribal elders. Agency reports show that roughly 700,000 Title VI-funded trips were provided each year between fiscal year 1991 and fiscal year 1995 (AoA 2002e). However, AoA officials are unable to say how much is spent on transportation services under Title VI programs.

Interaction with Local and State Programs

Funding under the OAA is often blended with other state and federal public transportation programs to enhance services to older individuals. In fact, legislative language in TEA-21 requires recipients of OAA and other human service programs to coordinate their transportation programs (FTA Circular 9070.1,E Chapter I). For example, OAA funds are used as a required local match for the sections 5310 and 5311 programs. In 1985, Congress amended the section 5311 program specifically to allow rural public transportation agencies to apply revenue from contracts for service with local AAAs toward these matching requirements (P.L. 99-190, 49 USC 5311(g)(1)). Moreover, it is not uncommon for AAAs to use the more flexible funding under the OAA to pay drivers and operate vehicles purchased with section 5310 capital assistance.

Issues and Options

Charging Fares: Over the years, one of the identified barriers to fully coordinating senior transportation services was the legislative prohibition against charging fees for services provided with OAA funds. Since most public transportation services charge a fare, this restriction made it difficult for community groups to pool funds in order to provide a comprehensive range of public transportation services. OAA-funded programs commonly request donations instead of charging fares. However, the OAA Amendments of 2000 (P.L. 105-501) included new “cost-sharing” language that will permit agencies to charge fares under certain circumstances for transportation services funded in part with Title III funds.

Static Funding: Spending on transportation under the OAA has changed little in 10 years. Total funding for Title III-B, the main source of funding that can be used for transportation, increased from \$306 million in 1994 to \$357 million in 2002 (AoA 2002f), about 17 percent, less than the rate of inflation in the same period. Actual spending on transportation appears to have been relatively constant at about \$69 million per year, based on AoA budget figures and a 1992 analysis by CTAA (1992a). At the same time, the population most in need of AoA services, those age 85 and older, has grown by about 40 percent, suggesting a substantial decline in capacity to provide services.

Status of Transportation within the Older Americans Act: Transportation has evolved into a major service program under the OAA. In addition to providing access to other AoA-funded services, it is increasingly recognized as an important element in helping older adults maintain their independence and participate in community life. However, because there is no separate title or designated funding levels established for these mobility services, transportation assistance is treated as an ancillary service and is entirely optional under the OAA.

8. Medical Transportation: Medicaid

Background

Both of the two large federal health insurance programs, Medicaid and Medicare, pay for some transportation. The transportation provisions under the two programs are quite different, but both have significant impact on older adults. Although Medicaid and Medicare are separate programs, there is an overlap between them. Medicaid covers about 42 million people, of whom 4.6 million are age 65 or older and therefore also eligible for Medicare. Medicaid covers some 13 percent of the population in the 65+ age group. Medicare covers 34.4 million adults age 65 or older, nearly the entire population in this age group, plus some 6 million people with disabilities or with permanent kidney failure (CMS 2002a).

Medicaid is a jointly financed and administered federal/state partnership to provide health care coverage for low-income and disabled individuals. It is administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), an agency within the U.S. Department of Health and Human Services (HHS). The federal government covers a minimum of 50 percent of Medicaid's healthcare costs in each state program. To make the program affordable in poorer states, the federal share increases up to about 75 percent in states with the lowest per-capita incomes (Social Security Act, section 1905(b)).

Types of Transportation Provided under Medicaid

Medical Transportation: Transportation to medical services was not included in the original legislation creating Medicaid in 1965 (Title XIX of the Social Security Act, P.L. 89-97). The Medicaid transportation program that exists today is the result of a succession of federal court decisions and administrative rulings mandating that states guarantee recipients access to covered medical services. Today, federal Medicaid regulations require all states to "ensure necessary transportation for recipients to and from providers" and pay the cost of that transportation (42 CFR 431.53 and 42 CFR 440.170(a)). These regulations establish so-called "access rights." Medicaid is the only federal program that mandates funding for medical transportation services. This assurance recognizes that Medicaid's guarantee of medical benefits requires that recipients can actually get to those services. Medicaid covers transportation for both emergencies (as does Medicare) and routine or nonemergency treatment. The following analysis is limited to nonemergency transportation.

Except for the common federal requirement to ensure access to basic medical services, states design their own Medicaid transportation packages. As a result, there are essentially 50 state programs, each with unique eligibility standards and service levels. For instance, some states simply offer gasoline vouchers or mileage reimbursement to recipients, their families, or neighbors. Others provide a full range of paid medical transport services, including accessible vans, taxis, medical coaches, and public transportation passes.

The most common approach is for states to contract locally with individual public transportation providers and pay for Medicaid trips on a fee-for-service basis. A number of states are centralizing their transportation operations, using brokers and other benefit managers, in order to better control services and costs. The Seniors' Resource Center Inc. (SRC) in Denver, Colorado, is one example of this centralization. SRC is paid a capitated rate to provide Medicaid transportation, but it has brokerage contracts with 15 to 20 service providers and is generally able to make up for long and expensive trips with more numerous short trips. CTAA (2001) has documented best practices in Medicaid nonemergency transportation management implemented by 15 states. Where medical care is provided through health maintenance organizations (HMOs), which now enroll more than 50 percent of the Medicaid population nationally, transportation can be part of the managed care package provided by the HMO or the state can continue to provide transportation using more traditional arrangements.

Nonmedical Transportation: Medicaid permits states to offer a range of nonmedical services designed to assist low-income older and disabled individuals to receive care in their homes and communities, rather than in nursing facilities and other institutions (section 1915(c) of the Social Security Act). Known as the HCBS waiver program, this initiative grew out of efforts to deal with skyrocketing long-term institutional care costs in the Medicaid program. Nonmedical transportation is one of the services authorized under the HCBS program because individual mobility is recognized as an essential element in maintaining independence. Under these HCBS waivers, individualized plans are approved for travel to groceries, pharmacies, and other destinations that could not be authorized under traditional Medicaid provisions. Nonmedical transportation can also include travel for therapy and other treatment not allowed under Medicaid's medical transport program, or providing access to friends, churches, and social activities.

Transportation is not automatically included under state HCBS benefit packages. As of June 2000, one-third of the state HCBS plans did not include transportation services. For nonmedical travel to be covered, it must be specifically identified as one of the services to be included in a state's proposed HCBS plan.

The Impact of Medicaid on the Mobility of Older Adults

Medical Transportation: Medicaid nonemergency transportation represents the largest state and federal investment in human service transportation. It dwarfs social service transportation efforts (such as transportation provided by aging agencies). A recent survey of state Medicaid programs estimates that roughly 110 million nonemergency medical trips are provided annually at a cumulative cost of about \$1.8 billion to ensure that recipients get to doctors and medical services (CTAA 2001). In fiscal year 1999, transportation represented about 1 percent of the Medicaid budget. The cost of the overall Medicaid program (including presumably the transportation component) is expected to more than double by 2010 (HCFA 2000).

There are some important gaps in knowledge about the use of medical transportation by older Medicaid recipients and whether they have unmet transportation needs. Federal administrators do not track data on the age of Medicaid transportation users. Many community-dwelling older individuals have reduced driving capacities and reduced ability to use public transportation and may need more medical transportation services than younger Medicaid recipients. In addition,

many older Medicaid enrollees reside in nursing homes and other long-term care facilities, and are thus less likely to make extensive use of medical transportation services. This area requires further research.

Nonmedical Transportation: Very few data are available about the size of the HCBS nonmedical transportation program nationally. More than \$24 billion was spent on all home and community-based services in fiscal year 2002, representing approximately 10.2 percent of all Medicaid expenditures (Burwell, 2004). But CMS has made no attempt to identify levels of transportation funding under these state-sponsored initiatives. Some information is available about in two states. Oregon operates two waiver programs, one for older and physically disabled individuals and the other for people with developmental disabilities. Nonmedical transportation for both programs totaled \$1.2 million in 1999, or 10 percent of the state's total Medicaid transportation expenditures (Raphael 2000a). In Colorado, which has 10 active waiver programs underway, the \$1.5 million spent on nonmedical transportation represents 15 percent of the state's total Medicaid transportation budget (Raphael 2000b).

Interaction with Local and State Programs

For much of Medicaid's history, state agencies relied on a largely exclusive medical transport system. Taxis and medical vans, known as "ambulettes" in some states, were the providers of choice. Public and community transportation agencies were not heavily involved in the transportation of Medicaid recipients. Over the past two decades, however, the network of medical transportation providers has become much more diversified. Many local human services agencies have begun working closely with the Medicaid program (CTAA 1998).

The integration of Medicaid and other transportation has been particularly significant in rural areas, where access to conventional public transportation is often limited or nonexistent. Medicaid reimbursements have enabled many community transportation agencies to combine multiple transportation subsidies to support a broad range of mobility services for older persons and other residents. For example, a regional community action agency in Maine, which also serves as the area agency on aging, is able to blend Medicaid, federal aging, and federal public transportation funding. The agency brings Medicaid recipients to medical appointments in vans purchased with section 5310 assistance and operated by drivers paid with OAA funds (Garber 2002a). Variations on this model can be found throughout the country. Another example of important tie-ins between Medicaid and senior programs can be found in Washington, where three of the nine regional transportation brokerage agencies serving the state's Medicaid program are Councils on Aging (Department of Social and Health Services undated a).

In the case of HCBS nonmedical transportation, the structure of the program and the diverse nature of the trips provided create significant opportunities to integrate its operation with other transportation services targeted at older individuals. For example, Oregon has begun looking for ways to integrate the HCBS transportation program into a "family" of mobility services. The Oregon program is based on a partnership between local public transportation agencies and the Department of Human Services. Federal Medicaid funds are usually matched with state general funds, but for these programs the match consists of local funds provided by public transportation agencies to pay for the transportation services. Clients use the public transportation services to meet their basic needs, including grocery shopping, social outings, and hair care. Because some

localities might have difficulty finding the required matching funds (Parker 2002), the state allows the public transportation agencies to use state public transportation funds for their local match (Palmateer 2001).

Issues and Options

Coping with Rising Costs: Rising state Medicaid costs, coupled with declining revenues, have contributed to a \$40 billion deficit in the budgets of more than 40 states (National Governors Association 2002). The state deficits have created pressure to cut back on state outlays, including Medicaid, with medical transportation for older individuals and others, along with access to health care, potentially affected. For example, in 2002 cuts in Medicaid transportation of between 3 and 10 percent were proposed in a number of states—including Colorado, Maine, Missouri, and Virginia—and were considered in others (Garber 2002b; Griswold 2002; Yaeger 2002).

In contrast, in Washington, which was trying to close a \$1 billion budget deficit, Medicaid officials decided not to include transportation among their deficit reduction measures; believing that the adverse effect on recipients' access to basic medical services outweighed the potential savings (Porter 2002).

Uneven Implementation: As noted earlier, there are essentially 50 state Medicaid transportation programs operating today. This flexibility allows states to adapt their medical transportation services to local and regional variations and needs. However, available data suggest that the current structure also permits huge differences in the levels and types of transportation services available to Medicaid recipients and the resources expended to ensure mandated access to health care services. States spend an average of \$46 for each Medicaid recipient annually for nonemergency medical transportation. However, six states spent more than \$80 per capita on transportation, while 17 states spent less than \$20 per Medicaid recipient during a 12-month period (CTAA 2001). More aggressive federal monitoring might offer greater assurance that minimum access standards are being met.

Home- and Community-Based Services and the *Olmstead* Decision: In June 1999, the U.S. Supreme Court ruled that it was a violation of the ADA for states to provide services in institutions when disabled individuals could be served more appropriately in community-based settings (*Olmstead vs. L.C.*, 119 S. Ct. 2176, 1999). This landmark ruling—calling for the integration of services within local communities—may have a major impact on the services available to older Americans, 41.9 percent of whom have some disability (U.S. Bureau of the Census 2000a). However, the ruling does not create an entitlement or call for a fundamental alteration of public programs; it applies only if the provision of community services represents a reasonable accommodation.

To better understand the effects of the *Olmstead* decision on individual states, the National Conference of State Legislatures (NCSL) conducted a survey of all 50 states (NCSL 2001). The survey found that most states cited the lack of affordable and accessible housing and transportation as major barriers to serving more people in the community. Many state plans identified improving the transportation components of their HCBS program as a critical need for addressing the civil rights issues raised by the *Olmstead* decision. In fact, almost 20 years after

states were authorized to develop flexible Medicaid assistance programs, 15 states still do not include nonmedical transportation services for older persons in their HCBS programs. Federal mandates or incentives to include nonmedical transportation in state HCBS programs could help ensure access to community-based services that support independent living.

Improved Management and Coordination: Virtually every study of state Medicaid transportation programs has documented that effective management—including the coordination of existing transportation providers and use of transportation brokers—has multiple benefits, such as improving the utilization of primary care and preventive services, reducing unnecessary emergency room services, and increasing overall access to care. For the most part, the quality of service has increased while the average cost per trip has been reduced by these management practices. In Washington, for example, which has operated medical transportation brokerage systems for more than 15 years, the number of trips provided to Medicaid recipients has gone up 40-fold since 1985 (from roughly 50,000 trips to more than 2 million), while the average cost per trip has been cut almost in half (\$33.75 in 1985 to \$17.31 in 2000) (Department of Social and Health Services undated b). State Medicaid officials claim that both the quality and efficiency of transportation services increased while costs declined (Center for Health Care Strategies 1998). Similar improvements have been noted in Portland, Oregon; Philadelphia, Pennsylvania; Arkansas, Kentucky, Oklahoma, and other jurisdictions that have begun to manage and coordinate their medical transportation services. Oregon officials credit the Medicaid nonemergency medical transportation brokerage program in the Portland region with improving service delivery and quality through improved management methods and quality control (Palmateer 1998).

Administration of Nonmedical Transportation: Administrative flexibility could also benefit older individuals and others who use HCBS nonmedical transportation. Differences in how states administer and pay for medical and non-medical transportation appear to create confusion and obstacles for Medicaid recipients who often rely on both types of services. For instance, older beneficiaries may be required to call separate providers, depending upon trip purposes. Similarly, some providers choose not to participate in the HCBS nonmedical program because of cumbersome rules and lower reimbursement rates (Garber 2002b). The Oregon case illustrates particular flexibility in funding for HCBS transportation. Oregon's requirement that local communities provide the funds needed for the state's Medicaid match avoids any impact on the state general fund. Then, to help remove local funding problems as a barrier to participation, the state has allowed localities to use state public transportation funds for the local match.

9. Medical Transportation: Medicare

Background

Medicare provides health coverage to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. As an insurance program, Medicare provides a much more limited set of benefits than Medicaid, which is a low-income assistance program. Two kinds of Medicare coverage are available. Part A Hospital Insurance covers hospital services and some nursing facility care. Part B Supplemental Medical Insurance helps pay for physician services, outpatient services, and other costs. Transportation is covered under Part B and is limited to payment for transportation by ambulance. Both emergency and nonemergency transports can be covered, but only by ambulance, and only when transport by any other means would be harmful to the patient's health. To qualify for nonemergency ambulance transport, the recipient must be bedridden.

A number of the Medicare managed care plans offer additional transportation services that are not covered by traditional Medicare. However, the extent of this practice is unclear because there are no aggregated data.

Medicare Transportation Costs and Trips: Although most older individuals participate in Medicare, information is not available on how many receive transportation benefits. Transportation costs are not broken out and reported separately by CMS. A study by the General Accounting Office (GAO) found that Medicare is spending about \$2.1 billion annually for 6.2 million ambulance trips and fewer than 1,000 air trips annually (GAO 2000). The GAO study found that half of the ambulance trips are nonemergency trips. Because services are restricted to professionally staffed and medically equipped ambulances, the average cost per trip under Medicare is more than \$330.

Issues and Options

Access to Care: Narrow Medicare transportation coverage may leave some people without critical access to care. Of particular concern are trips for "life-sustaining" treatments such as dialysis and cancer therapy. These are urgent trips but they do not meet Medicare criteria for ambulance travel. Public transportation paratransit service may not be feasible or available for these trips if travel to a specialized facility outside of a public transportation operator's local jurisdiction is required. Even within their jurisdictional service areas, paratransit services are often poorly equipped to handle trips for frail patients returning from dialysis and cancer therapy. If the only alternative is to hire private transportation, then the expense of frequent travel to treatment could be a substantial burden for an individual. Hospital discharges are another group of trips for which existing options may be inadequate or unavailable, yet which may not qualify for travel by ambulance under Medicare rules. Research is needed to identify the types and numbers of trips for which better arrangements are needed.

Permitting the use of vehicles other than ambulances for nonemergency but medically necessary trips might reduce per-trip costs. The GAO report describes how elderly Medicare beneficiaries

in rural areas may call 911 for transportation because they have no other options. If some of these trips were carried by community providers, access to care might improve and costs might be reduced.

Many Medicare beneficiaries depend on family members and friends for transportation to doctors and medical appointments. However, these caregivers are not necessarily trained to transport frail passengers regularly and safely, and they often do not have access to information resources, financial assistance, or technical support (Aging Transportation Policy Roundtable 2002). Enhanced assistance to caregivers would improve access to care and reduce caregiver stress. It was in recognition of just these types of issues that Congress created the National Family Caregivers Support Program in the 2000 amendments to the OAA.

The Program of All-inclusive Care for the Elderly Identified as a Model: The Program of All-inclusive Care for the Elderly (PACE) features a comprehensive service delivery system with integrated Medicaid and Medicare financing. The benefit package includes all Medicare and Medicaid services plus additional services, as determined by an interdisciplinary care team. For more than 20 years, PACE has automatically included transportation as a support and preventive service for all older Medicaid enrollees and included transportation as an optional service for Medicare participants (CMS 2002b). PACE demonstrates the feasibility of including transportation in any comprehensive medical care program and might serve as a model for including medical transport coverage as an option under Medicare.

10. Livable Communities

In the past few years, various programs within the DOT have promoted the concept of livable communities. The term “livable communities” is connected to concepts variously titled “smart growth,” “new urbanism,” “new community design,” or “neotraditional design.” Common emphases of these concepts are improving pedestrian access and providing a range of services within walking distance. Several programs under TEA-21, such as the Transportation and Community and System Preservation Pilot Program and the Smart Growth Initiative, are used to fund transportation investments to support such initiatives. An FTA Livable Communities Initiative (FTA 1999) promotes community planning and transit-oriented development concepts.

Livable communities may provide a range of benefits to older adults, including greater ability to get around on foot for those who no longer drive; better access to goods and services thanks to high-density, mixed-use development; greater independence; safer travel environment for both drivers and pedestrians; and reduced social isolation (Frank and Engelke 2000; Harris 2002; Leyden 2002). Howe (2001) provides a useful compendium of smart-growth measures that help create “aging-sensitive communities.” However, older individuals who still drive could be disadvantaged by design aspects of livable communities that emphasize pedestrian over automobile access, particularly if planners do not incorporate road design details that support safe driving.

The federal role with respect to building livable communities is limited because of the local nature of decision-making and implementation. The federal government, however, can promote components of livable communities and provide tools for assessing the impact of federal programs and investment on how communities meet the needs of residents.

11. Can Existing Programs Meet Projected Needs?

The preceding review identifies existing programs that partially address senior transportation needs. Various trends that are now apparent are likely to exacerbate these needs and create new ones. This section provides an overview of these trends, as well as trends that may at least partially reduce the need for alternatives to driving.

Background

Trends That May Increase Demand for Transportation Options: The single trend that will place the greatest demand on programs that support alternatives to driving will be the growth in the older population, especially in the oldest age groups. Additional factors that are likely to increase needs include (1) decentralization of population within metropolitan areas; (2) increasing reliance on noninstitutional care and outpatient treatment as an alternative to nursing homes and hospital care; and (3) economic and social trends that reduce the ability of family, neighbors, and volunteer-based community services to provide transportation. In addition, cultural diversity will increase the need for programs that address cultural and linguistic barriers.

Trends That May Reduce Demand: Trends that may at least partially reduce the demand for transportation services include (1) an increased rate of driving among older adults, (2) increasing incomes that may enable more older adults to provide for their own alternatives to driving, and (3) improvement in the health of older individuals.

Noninstitutional and Outpatient Care

The current trend in public policy and preferences of older persons is to favor programs that enable older individuals to continue living in their homes or in community-based settings rather than in institutional settings. Reliance on community-based care will increase the demand for specialized transportation to help frail older individuals travel to and from day treatment facilities, essential shopping, and other services. Similarly, the trend in medicine toward outpatient care and early hospital release may result in more older people needing nonemergency medical transportation when they cannot drive. The extent of these impacts remains to be quantified.

Availability of Volunteer and Caregiver Transportation

Much recent discussion about meeting the mobility needs of older people has focused on so-called supplemental transportation, including volunteer-based programs (Beverly Foundation 2001). Yet, in discussions, program administrators frequently mention increasing difficulty in recruiting volunteers. Volunteer drivers express problems with the time demands of providing transportation, liability concerns, and regulatory requirements such as drug testing. In addition, in the policy roundtable teleconference conducted for this research, participants noted an increase in requests for assistance from caregivers who need help with transportation. Current research is inconclusive on the degree to which volunteers will be available in the future.

Cultural Diversity

Immigration and other factors are resulting in increasing cultural diversity. The U.S. Census projects that between 2000 and 2020, while the total population age 65 and older will increase by 54 percent, the Hispanic elderly population by 147 percent, the African American elderly population by 80 percent, and the Asian elderly population by 164 percent (U.S. Bureau of the Census 2000b). Differences in family structure, expectations about the roles of caregivers and public programs, driving patterns, and linguistic issues may all require changes to programs to respond to the needs of these groups. Elders from cultural minorities who have been in the United States a long time and those who are recent arrivals may have different needs and require different approaches. For many minority elders who need to continue working, lack of transportation is a barrier to reaching jobs in suburban areas. Only limited transportation assistance is available under the Community Service Employment program (Title V of the OAA).

Possible changes to respond to increasing cultural diversity may include more involvement of community groups that serve specific ethnic and linguistic minorities and greater efforts to make programs usable by non-English speakers. For example, recently in Portland, Oregon, limited state senior and disabled transportation assistance was allocated for the first time to neighborhood groups representing cultural minorities in an effort to overcome language and other barriers to accessing mobility services and navigating the public transportation system (Wells 2002).

Increased Rates of Driving

A trend that may reduce the need for additional transportation options is the growing rate of persons age 85 and older who drive. National statistics show a long-term increase in the number of people who continue to drive into their later years. Between 1983 and 1996, the percentage of individuals age 85 and older who were driving rose from 48 percent to 72 percent among men and from 12 percent to 29 percent among women (Burkhardt et al. 1998). Similar increases occurred in younger age groups within the older population. While this trend poses challenges in the design and operation of streets and highways and in the design of automobiles, it may reduce the need to provide alternatives.

However, despite higher driving rates, increases in longevity mean that large numbers of older adults will require alternative means of transportation for substantial periods toward the ends of their lives. Recent research shows that, subsequent to driving cessation, men will have about six years of dependency on alternative sources of transportation, and women will have about 10 years of dependency (Foley 2002).

The future impact of these trends depends on whether the age of driving cessation is advancing faster or more slowly than longevity is increasing. In other words, will rates of driving in older age groups continue to increase? Figure 1 shows projections of the total number of nondrivers, using two assumptions about future driving rates:

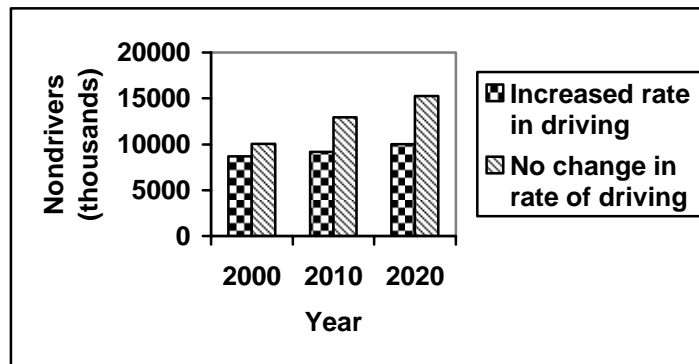
1. No further increase in driving rates. This means that, as each age cohort advances, its driving rate will fall to the current rate of people in the older age group. For example, people who are

now in the 50 to 54 age group in 20 years will drive at the same rate as people now in the 70 to 74 age group. Clearly, this is the most conservative assumption.

2. Increase in driving rates based on current cohort driving rates. As each age cohort advances, its driving rate is set halfway between its current driving rate and the driving rate of people now in the older age group. This assumes that half of the current decline of driving as age increases is due to age-related factors and half is due to social and cultural factors connected to when each cohort came of age. This is a fairly aggressive assumption, but it comes close to matching the increases in driving that have been observed in the past.

Even with the more aggressive assumptions about increased driving rates, the number of older nondrivers will increase by 15 percent over the next 20 years. If the driving rate levels off at current levels, then the number of older nondrivers would increase by 52 percent.

Figure 1. Projected Number of Older Nondrivers (Age 65+)
(Thousands)



Source: Projected from 1995 Nationwide Personal Transportation Survey (FHWA 1995)

Incomes and Health

Changes in incomes and health, both of which may affect whether individuals drive, may also affect the transportation needs of older adults. Evidence about trends in these factors is inconclusive. Over the past 20 years, the financial condition of older people has, on average, improved (Federal Interagency Forum on Aging-Related Statistics 2000). However, there is no assurance that these trends will continue. Siegel (1996) notes that projections showing increases in future economic well-being of older adults are based on rather optimistic assumptions about trends in per-capita incomes. Changes in pensions, Social Security benefits, labor force participation, and the performance of private investments could easily result in dramatic changes in future economic resources of older people and their need for publicly subsidized alternatives to driving.

There are also conflicting trends regarding health and disability. For example, data from the National Long-Term Care Survey (National Center for Health Statistics, 1994) show that the percentage of chronically disabled adults age 70 and older declined from 24 percent to 21

percent between 1982 and 1994. At the same time, the percentage of older adults with various chronic health conditions such as arthritis, cancer, hypertension, and heart disease increased. These trends may allow greater numbers of older adults to continue driving and to use conventional public transportation. However, they could also produce greater numbers of very old individuals living at home and requiring assistance to travel.

12. Conclusions and Policy Implications

This paper has identified numerous issues regarding the impact of federal programs on the mobility of older people, as well as a variety of options for strengthening the programs. This section brings together the most important of these issues and options and draws conclusions about policy changes that could help improve the mobility of older people. Policy options for promoting mobility and safety for older adults include the following.

- **Increasing Investment in Formula Grants and Loans for Special Needs of Elderly Individuals and Individuals with Disabilities, and for Other Than Urbanized Areas:** One of the most immediate needs is to increase public investment in the section 5310 and 5311 programs and to allow use of 5310 funds for operating expenses. Increased funding for both capital and operational expenses could help create and expand services to fill the gaps left by public transportation and ADA paratransit. Funding in the section 5310 program is presently sufficient for little more than replacing existing vehicles, allowing local grantees to make only limited use of the flexible funding that has already been added to the program. Flexibility allows money to be transferred into programs, but it also allows transfers out of the same programs. In light of current state fiscal challenges, it is particularly important that federal transportation programs with social goals be fully funded and protected from use for activities not targeted at those goals.

Rural areas may not see the explosive growth in the elderly population expected in suburban areas, but large numbers of older individuals will continue to live in rural areas where public transportation services (and ADA paratransit) are often completely lacking. Because older residents of rural areas tend to be poorer than their urban and suburban counterparts, enhancing programs such as the section 5311 program will be important for reaching the millions of persons, old and young, living in rural areas currently unserved by public transportation.

- **Increasing Investment in Urbanized Area Formula Grants and Capital Investment Grants:** Expanding public transportation service in the suburbs and the fringes of metropolitan areas could benefit the increasing numbers of elderly who live in those areas. In addition, more public transportation services that address the needs and travel patterns of older adults could benefit older people who do not qualify for ADA paratransit but lack access to a personal vehicle or have had to stop or limit driving.

Ensuring that public transportation operators have the resources to continue providing ADA paratransit could benefit older people as well as people with disabilities. Older individuals who cannot use ADA paratransit as it is currently designed will need innovative public transportation services that provide more personal assistance, can be used without requiring reservations for individual trips, and extend to areas where ADA paratransit is not available. It will also be important for the FTA to develop consistent ADA eligibility screening methods that satisfy public transportation operators' need to contain costs without unfairly screening out or deterring senior applicants.

TEA-21 created a firewall between the Highway Trust Fund and the General Fund that prevents unused appropriations from falling into the General Fund. It also provided for minimum guarantees of federal distributions from the Highway Trust Fund to the state. These policies create an important incentive for states to invest in public transportation because of the certainty of stable funding.

- **Supporting Older Driver Research:** Encouraging and enabling older adults to continue driving safely later in life is as critical as developing better alternatives to driving. Continued research on vehicle and roadway design, as well as driver education and testing, can enhance driver safety. As the body of knowledge increases, it will be necessary to invest in promoting nationwide adoption of improved practices and designs.
- **Enhancing Transportation as a Supportive Service under the Older Americans Act:** Strengthening transportation and caregiver support within OAA-funded programs would be especially useful, because these programs are key providers of services that help older individuals live in their communities rather than in institutions. Steps that allow coordinated use of existing resources by public transportation operators and community organizations in providing these services could be effective in expanding both the quantity and quality of services.
- **Promoting Medicaid Nonmedical Transportation as a Component of Home- and Community-based Services:** Promoting nonmedical transportation as a component of HCBS could benefit older individuals and, in part, satisfy the continuing demand for noninstitutional approaches to long-term care. Federal mandates or incentives to include nonmedical transportation in states' HCBS programs implemented under Medicaid waivers could help ensure access to home- and community-based care. Measures that could improve the mobility of low-income older adults include incentives or requirements for all state Medicaid programs to offer comprehensive and coordinated transportation programs, especially for those without other alternatives.
- **Expanding Medicare Coverage of Medically Necessary Transportation:** The limits on transportation coverage in Medicare are likely to be a growing concern. More older people need transportation to treatments that they cannot reach by existing services and that it is prohibitively expensive to purchase privately. Measures to help Medicare beneficiaries could include providing support (such as information about transporting frail individuals or per-mile cost reimbursement) for caregivers who provide rides to medical appointments, and expanding options to bring people to life-sustaining but nonemergency treatment, possibly using community providers.
- **Promoting Research on Nonemergency Medical Transportation:** In many cases existing programs—including urban and rural public transportation, ADA paratransit, Medicaid, Medicare, and community-based aging programs—do a poor job of serving people who need nonemergency transportation for urgent care such as dialysis and cancer therapy. Research is needed to better understand the gaps left by these programs in order to craft realistic policy and solutions.

Four areas fall outside of existing programs historically associated with transportation for older persons and are areas for potential policy development.

- **Promoting Coordination of Federally Funded Programs:** Expanded coordination could improve both the quantity and quality of human services transportation. Numerous provisions in federal programs encourage this coordination, including flexibility in the section 5310 program, the cost-sharing provisions in OAA-funded transportation, and waivers in Medicaid for transportation services brokerages and nonmedical transportation. Because of the pivotal role of the states in implementing these programs, further progress in promoting coordination will most likely require action at the state level with technical assistance from the federal government. States that have taken full advantage of the existing federal flexibility in the surface transportation program, and that promote coordination in their own legislation and policies, have been able to create a high degree of coordination. Given the flexibility that already exists in the federal programs, the most useful additional steps toward coordination at the federal level would be expanded funding in the section 5310 and 5311 programs and in OAA , with meaningful financial incentives to states for coordination.
- **Need for Supplemental Transportation:** Because ADA paratransit is extremely expensive for public transportation operators to provide, any added services for older people are likely to take other forms. They may be provided by local jurisdictions and nonprofit organizations and may make use of volunteers. Public investment to develop these programs could be helpful, as would measures that make it easier for people to volunteer their time, such as providing tax incentives to companies to allow employees to volunteer for a certain number of hours monthly or annually. Another option for increasing supplemental transportation would be to increase public support for caregivers, for instance, by disseminating information about the special transportation needs of fragile individuals and individuals with disabilities. Financial assistance in the form of stipends or mileage reimbursements could help caregivers assist family and friends with transportation and might lead to increased supplemental transportation.
- **Livable Communities through Neighborhood Design and Land-use Planning:** Federal efforts to promote smart growth and livable communities have been limited to relatively small-scale grant programs, awards, and information dissemination. Future efforts to promote pedestrian and public transportation access to neighborhood goods and services could benefit the mobility and independence of older people. The potential payoff of these efforts would be much enhanced by a program of research to understand how different designs work for older persons, especially those with limited mobility.
- **Cultural Diversity:** The increasingly diverse character of the older population will require more effort to understand how the needs of minority elders differ from those of other older people. Useful efforts may take the form of staff training, minority outreach involving community organizations that serve specific linguistic and ethnic minorities, and research into differences in travel patterns.

- **Research:** Encouraging and empowering older adults to continue driving safely later in life is critical in a society where community mobility depends so heavily on driving. Continued research on vehicle and roadway design, as well as driver education and testing, can contribute to enhancing driver safety. As the body of knowledge increases, it will be necessary to invest in promoting nationwide adoption of improved practices and designs.

Research is also needed to support improving and expanding transportation options for the growing number of older individuals who cannot or choose not to drive. This research could, for example, help determine how to encourage the use of existing public transportation or identify the gaps left by programs currently providing nonemergency medical transportation. Policymakers could benefit from this research in their efforts to craft successful policy and solutions.

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Appendix A: Acronyms

AAAs	area agencies on aging
AASHTO	American Association of State Highway and Transportation Officials
ADA	Americans with Disabilities Act
AoA	Administration on Aging
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
CTAA	Community Transportation Association of America
DOT	U.S. Department of Transportation
FHWA	Federal Highway Administration
FTA	DOT's Federal Transit Administration
FTA 1999	FTA Livable Communities Initiative
GAO	General Accounting Office (now called the Government Accountability Office)
HCBS	Home and Community-Based Services
HCFA	Health Care Financing Administration
HHS	U.S. Department of Health and Human Services
HMOs	health maintenance organizations
ISTEA	Intermodal Surface Transportation Efficiency Act
NCSL	National Conference of State Legislatures
NHTSA	National Highway Traffic Safety Administration
OAA	Older Americans Act
PACE	Program of All-inclusive Care for the Elderly
SRC	Seniors' Resource Center Inc.
TEA-21	Transportation Equity Act for the 21 st Century
UAF	Urbanized Area Formula
VTA	Santa Clara Valley Transportation Authority

Appendix B: Summary Table—Federal Programs that Provide Transportation for Older Adults

Program	Annual Federal Funding	Annual Service Provided	Use by Older Adults
Conventional transit (secs. 5307 and 5309)	\$6.1 billion and \$1.1 billion flexible funding (2002)	8.7 billion trips	About 10% of trips are taken by riders age 65 or older.
ADA paratransit	None	45 million trips	Probably more than half of ADA paratransit trips are taken by older individuals.
Elderly and disabled transit (sec. 5310)	\$85 million (2002) \$102 million flexible funding	Unknown	Probably more than half.
Rural transit (sec. 5311)	\$230 million (2002) \$29 million flexible funding	Unknown	About one-third.
Older Americans Act Title III	\$68 million (2000)	44 million trips	100%
Older Americans Act Title VI	Amount for transportation is unknown.	700,000 trips	100%
Older Americans Act Home and Community-based Services	Amount for transportation is unknown.	80,000 individuals	100%
Medicaid	\$555 million federal share (2001)	110 million nonemergency trips	11% of beneficiaries are age 65 or older.
Medicare	\$1 billion (2000) (est.)	3 million nonemergency trips (est.)	87% of enrollees are age 65 or older