Program Evaluation

PROGRESS REPORT ON COORDINATED HUMAN SERVICE TRANSPORTATION SYSTEM

Adopted by Program Review and Investigations

PROGRAM REVIEW & INVESTIGATIONS

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FOREWORD

On September 9, 1999, the Legislative Program Review and Investigations Committee authorized staff to examine the implementation status of the Kentucky Coordinated Human Service Transportation Delivery Program. Kentucky is currently in the early stages of full implementation of what apparently is a unique coordinated human service transportation program.

The Program Review and Investigations Committee adopted the staff report and recommendations on November 9, 1999.

Staff would like to acknowledge the cooperation and assistance of Margaret Plattner, Executive Director, and other staff of the Office of Transportation Delivery in the Transportation Cabinet.

This report is the result of dedicated time and effort by LRC Staff Economists Perry Nutt and Mike Clark and Program Review staff Lowell Atchley, Doug Huddleston, Tom Hewlett, Joseph Hood, and Ginny Wilson, CSA.

Robert Sherman, Director
Legislative Research Commission

The Capitol
Frankfort, Kentucky
May 2000

MEMORANDUM

TO: The Hon. Paul E. Patton, Governor
The Legislative Research Commission, and
Interested Individuals

FROM: Representative H. "Gippy" Graham, Co-Chair
Senator Marshall Long, Co-Chair
Program Review and Investigations Committee

SUBJECT: Adopted Committee Staff Report: Progress Report on Coordinated Human Service Transportation System

DATE: May 2000

On September 9, 1999, the Legislative Program Review and Investigations Committee authorized staff to examine the implementation status of the Kentucky Coordinated Human Service Transportation Delivery Program. The Committee specifically asked staff to address the issue of the expected reduction in the growth rate in transportation expenditures, concerns about the quality of transportation services delivered to recipients, and the effect of program changes on providers. Because the program has been in operation for well under a year in most areas of the state, there was not sufficient data to allow a complete and accurate assessment of these issues.

The program was developed as the result of an Empower Kentucky report released in late 1996, which argued that placing the Commonwealth's various human services transportation systems under one umbrella and using a managed care approach could slow the growth of quickly escalating costs. The 1998 General Assembly formalized the proposed transportation delivery system with passage of House Bill 468.

Based on its review of the Coordinated Human Services Transportation Delivery Program, the overall conclusion is that the Coordinated Human Services Transportation Program has experienced several serious implementation problems and could benefit from

improved program oversight and management. However, there is not sufficient current evidence to conclude that implementation should not continue.

The following recommendations were submitted and approved by the Program Review and Investigations Committee on November 9, 1999:

1. The policies and procedures of the Coordinated Transportation Advisory Committee should be formalized. Minutes should be kept of each meeting indicating such things as items discussed and the outcome of votes taken.

2. Transportation and Medicaid officials should complete regular checks to ensure that there is no duplication of benefits in the coordinated transportation program.

3. The Transportation Cabinet, working closely with the contracting cabinets, should review its appeals procedures to assure their consistency with federal regulations and the State Medicaid Plan and to guarantee that recipients clearly know their rights when services are denied.

4. The Department for Medicaid Services should evaluate and review the objectives set forth in the waiver request to ensure that they are being met with the coordinated transportation program. Additionally, the Department for Medicaid Services should ensure that all reporting requirements, report analysis, and independent assessments have been completed within the time frames set by HCFA in the waiver continuation and that additional continuations will be sought in a timely manner.

5. Brokers should be required to develop methods to assure that non-emergency medical transportation clients are classified properly and to rectify the "first rider" problem.

6. The Transportation Cabinet should improve the procedures for collection, validation, and analysis of program cost data.

7. The Transportation Cabinet should place greater emphasis on the task of independently monitoring and enforcing the quality of transportation services delivered to program recipients. It should:

    7.1. Redesign the rider survey to obtain valid and objective results;

    7.2. Minimize reliance on complaint data collected and reported by brokers;

    7.3. Develop procedures to randomly check program quality indicators;

    7.4. Consider designating an independent investigator to receive complaints from recipients and to work for their fair resolution.

8. The Transportation Cabinet should be required to provide quarterly reports to the Legislative Research Commission for distribution to the Health and Welfare, Transportation, and other interested committees.

9. The Program Review and Investigations Committee should re-visit this program after the 2000 Session of the General Assembly.

The overall conclusion is that the coordinated human services transportation program has experienced several serious implementation problems and could benefit from improved program oversight and management. However, there is not sufficient current evidence to conclude that implementation should not continue.

Questions or requests for additional information should be directed to Dr. Ginny Wilson, Committee Staff Administrator for the Program Review and Investigations Committee.

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EXECUTIVE SUMMARY

Progress Report: Kentucky's Coordinated Human Service Transportation Delivery Program

The Program Review and Investigations Committee voted at its September 9, 1999, meeting to have staff examine the implementation status of the Kentucky Coordinated Human Service Transportation Delivery Program. Kentucky is currently in the early stages of full implementation of what apparently is a unique coordinated human service transportation program. The state Transportation Cabinet has contracts with the Health Services, Families and Children, and Workforce Development Cabinets to operate a transportation program that guarantees rides to Medicaid recipients seeking non-emergency treatments, welfare recipients needing job and child-care related trips, and others.

The program currently operates in almost all regions of the state with a system of brokers who are paid a capitated monthly amount to arrange client transportation. The Office of Transportation Delivery administers the day-to-day operations of the program.

The program was developed as the result of an Empower Kentucky report released in late 1996, which argued that placing the Commonwealth's various human services transportation systems under one umbrella and using a managed care approach could slow the growth of quickly escalating costs. The 1998 General Assembly formalized the proposed transportation delivery system with passage of House Bill 468.

Methodology

Program Review staff reviewed relevant state and federal statutes and regulations, other state and federal audits, and other relevant literature on the subject; interviewed various stakeholders in the program; and examined applicable documents and records. Because the program has only recently been implemented, staff recognized that there is not sufficient current data available to perform a complete evaluation of the program. Thus, this report is a progress report rather than a full program evaluation.

Section I: Coordinated Human Services Transportation Program

The Coordinated Human Services Transportation Program has its roots in an Empower Kentucky plan that cited rising costs, Medicaid non-emergency transportation fraud and abuse, and welfare reform as reasons to establish a transportation system serving a variety of human service needs. The system has replaced a Medicaid non-emergency transportation delivery system described as fragmented, costly, and vulnerable to fraud

and abuse. An Empower Kentucky committee presented a business case for changing the system, noting that costs were rising steadily.

The new human service delivery network must comply with assorted federal statutes and regulations, the Medicaid State Plan, a federal waiver, and state statutes and regulations, although one regulation has been found deficient. The waiver is a critical aspect because it allows the state to operate such a program under the Social Security Act. The waiver is subject to renewal.

The program seems to have made considerable progress under a network of brokers responsible for delivery of services to Medicaid non-emergency medical clients, transportation of TANF consumers, and others throughout the state. The brokers provide services that include recruiting transportation subcontractors, payment administration, gatekeeping, reserving and assigning trips, assuring quality, and providing oversight. The brokers operate their regional businesses with moneys received through a capitated rate system that gives them a certain amount per eligible recipient per month.

The transportation program functions under contracts between the Transportation, Health Services (Department of Medicaid), and Families and Children Cabinets. The contracts total almost $46 million. The Coordinated Transportation Advisory Committee, made up of representatives from the member cabinets, has a role in policy decisions for the coordinated transportation program. Also, Kentucky's umbrella human services transportation program apparently is unique among states and is considered by some to be a model undertaking.

Section II: Progress Report for the Coordinated Transportation Program

The Committee specifically asked staff to address the issue of the expected reduction in the growth rate in transportation expenditures, concerns about the quality of transportation services delivered to recipients, and the effect of program changes on providers. Because the program has been in operation for well under a year in most areas of the state, there is not sufficient data to allow a complete and accurate assessment of these issues.

The state's objectives through this waiver period are to reduce the rate of growth in expenditures, prevent unnecessary and inappropriate utilization, and assure adequate access to quality care for Medicaid beneficiaries and others served by the program.

The costs of the program to the Commonwealth are determined by the average capitation rate that is negotiated with brokers. To the extent that this average capitation rate is less than the average reimbursement under the voucher program, then the state will achieve a lower cost.

A staff analysis shows that it is likely a reduction in average rates for two trip categories–disoriented and non-ambulatory–has the potential to result in substantial program savings. In addition, another way in which growth in total program expenditures might be reduced is through better identification of fraud and abuse on the part of both providers and recipients. Local brokers have a financial incentive to reduce unnecessary program expenditures because their capitated payments are fixed and they have the ability to become more familiar with local utilization patterns within the region. For example, brokers have identified, investigated, and reported instances where fraud and abuse apparently have occurred.

Regional brokers are responsible for maintaining complaint tracking and resolution systems; however, the "complaints" logged in 1999 appear more in the nature of general administrative actions taken for a variety of reasons. Of those actions taken, a third constitute denials of service. In terms of denials of service, a staff analysis found that about 62 percent of those related to general eligibility denials are based on such factor as the recipient not being listed on the state database.

Brokers generally look on the appeals process as something that should be handled at the cabinet level. Some brokers told staff that initial non-emergency transportation denials are based on whether a recipient's name appears on eligibility lists maintained by the Department for Medicaid Services. If there is a question about eligibility, brokers tell recipients to check with their caseworker, the Department for Medicaid, or to phone the toll-free number at the Transportation Cabinet. Staff also determined that the number of complaints varies by region.

Several legislative committees have heard testimony from recipients, providers, brokers, and Transportation Cabinet officials regarding the program. Recipients generally complained about the lack of freedom of choice in selecting providers, the inconvenience of scheduling trips 72 hours in advance, poor pick-up reliability, and having to wait an hour or more for a pick-up after a medical appointment. Transportation officials and brokers offered two basic responses to these complaints. First was that many of the complaints were the result of start-up problems associated with changing the program structure. They also acknowledged that many of the complaints were associated with the move from a fee-for-service voucher system to a capitated broker system.

Staff examined the complaint data from January to September 1999 to see if the average number of complaints received by brokers tended to decline with increasing months of operation, which would indicate that many problems were related to the start-up process. In general, this trend was evident, although by no means uniform. The average number of complaints during this period was generally higher for brokers in operation for one-two months than for brokers in operation for six-seven months.

In general, the 16 brokers that Program Review staff contacted said they believe the current system of providing transportation service is an improvement over the previous system. They told staff the current system offers more services and opportunities to individuals attempting to move from welfare to work. They also told staff the current

system offers more flexibility for recipients by providing services 24 hours a day, seven days a week. The brokers said that, while some problems remain, the current system prevents some of the abuses by both providers and recipients that existed under the previous system. Also, a test of brokers' phone systems found no significant problems overall.

Several programmatic issues require additional consideration. As a coordinated program serving different human service programs, it is important that safeguards be developed against duplicative benefit payments. Where benefits are denied, it is important that recipients are informed of appeal procedures. The coordinated human service transportation system should guard against duplicative payments. Also, officials need to assure that the appeals process is consistent with federal requirements.

As a part of this review, staff examined encounter data, which brokers report on a monthly basis, and compared that data to the distribution of payments to providers in 1997 under the voucher system. Of 82 providers who operated under both programs, half had a larger regional market share in the new program than they had in the voucher program, and half had a smaller regional market share in the new program. Providers who gained market share received 14 percent of total reimbursement dollars under the voucher program, compared to 39 percent of total reported reimbursement dollars under the coordinated program. The comparable figures for providers who lost market share were 41 percent and 25 percent, respectively. This data indicates that, on average, smaller providers (as measured by voucher program market share) were not particularly disadvantaged by the program change, and may even have benefited when compared to larger providers. Overall, however, for the majority of providers who participated in both programs, the percent of total payments they received were reduced under the broker system. The analysis indicates that a number of providers lost market share as a result of the implementation of the new program. Without provider-specific information across all lines of their business, staff could not determine whether providers who lost market share suffered actual financial declines.

Finally, staff found inconsistencies within the data, normal data entry errors, miscoding of data (brokers reported as sub–brokers not reporting trips), duplicative records within files, inconsistent type of reporting across regions (text versus numeric), and unconventional or non-standard approach to reporting.

Section III: Conclusions and Recommendations

Based on the review of the Coordinated Human Services Transportation Delivery Program, this section summarizes the major conclusions in regard to program operations. A subsequent section offers recommendations.

Conclusions

1. Costs for Medicaid non-emergency transportation were increasing at a rapid pace under the voucher system, and stories of significant fraud and abuse were common.

2. Under a fee-for-service reimbursement system, such as the voucher system, the financial incentive for providers and recipients was to over-utilize services. The primary oversight responsibility of the Commonwealth was to restrict unnecessary utilization and fraudulent billing.

3. Under the capitated system, the financial incentive for brokers is to reduce trips and miles.

4. Brokers have different incentives from the providers who subcontract with them.

5. It is too early in program implementation to draw reliable conclusions about the effectiveness of program operations or whether the promised reduction in expenditure growth will be realized.

6. The potential exists for a significant reduction in the growth of program expenditures, but reliable estimates cannot be made at this time.

7. Recipients and their advocates have lodged a variety of complaints about the quality of the service rendered under the new program.

8. Subcontractors have complained that the reimbursement rates are too low to allow a profit and that brokers unfairly distribute trips.

9. While some providers, particularly those who are also brokers, increased their share of the regional Medicaid non-emergency transportation market under the new program, many experienced a decline in market share.

10. Now that it has gotten the program implemented in all regions of the state (excepting the Medicaid portion of Jefferson County), the primary task of the Transportation Cabinet is to monitor the program to assure that adequate quality of service is maintained.

11. Current procedures for the collection and analysis of data are judged inadequate for the task of monitoring and enforcing quality standards.

12. Many brokers do not currently record a claims amount for trips they provide in the encounter data submitted to the Transportation Cabinet. The absence of this data could significantly hamper the Cabinet's ability to determine actuarially fair capitation rates in the future.

13. The overall conclusion is that the coordinated human services transportation program has experienced several serious implementation problems and could benefit from improved program oversight and management. However, there is not sufficient current evidence to conclude that implementation should not proceed.

Recommendations

Based on the conclusions drawn about the coordinated transportation program, staff offers the following recommendations for Committee consideration.

1. The policies and procedures of the Coordinated Transportation Advisory Committee should be formalized. Minutes should be kept of each meeting, indicating such things as items discussed and the outcome of votes taken.

2. Transportation and Medicaid officials should complete regular checks to ensure that there is no duplication of benefits in the coordinated transportation program.

3. The Transportation Cabinet, working closely with the contracting cabinets, should review its appeals procedures to assure their consistency with federal regulations and the State Medicaid Plan and to guarantee that recipients clearly know their rights when services are denied.

4. The Department for Medicaid Services should evaluate and review the objectives set forth in the waiver request to ensure that they are being met with the coordinated transportation program. Additionally, the Department for Medicaid Services should ensure that all reporting requirements, report analysis, and independent assessments have been completed within the time frames set by HCFA in the waiver continuation and that additional continuations will be sought in a timely manner.

5. Brokers should be required to develop methods to assure that non-emergency medical transportation clients are classified properly and to rectify the "first rider" problem.

6. The Transportation Cabinet should improve the procedures for collection, validation, and analysis of program cost data.

7. The Transportation Cabinet should place greater emphasis on the task of independently monitoring and enforcing the quality of transportation services delivered to program recipients. It should:

    7.1. Redesign the rider survey to obtain valid and objective results;

    7.2. Minimize reliance on complaint data collected and reported by brokers;

    7.3. Develop procedures to randomly check, program quality indicators;

7.4. Consider designating an independent ombud to receive complaints from recipients and to work for their fair resolution.

8. The Transportation Cabinet should be required to provide quarterly reports to the Legislative Research Commission for distribution to the Health and Welfare, Transportation, and other interested committees.

9. The Program Review and Investigations Committee should re-visit this program after the 2000 Session of the General Assembly.

INTRODUCTION

The Program Review and Investigations Committee voted at its September 9, 1999, meeting to have staff examine the implementation status of the Kentucky Coordinated Human Service Transportation Delivery Program. Kentucky is currently in the early stages of full implementation of what apparently is a unique coordinated human service transportation program. The state Transportation Cabinet has contracts with the Health Services, Families and Children, and Workforce Development Cabinets to operate a human service transportation program that guarantees rides to:

- Medicaid recipients seeking non-emergency treatment,
- Welfare recipients needing job and child-care related trips,
- Mental health, mental retardation or Comprehensive Care Center clients, and
- Clients of Vocational Rehabilitation and Department for the Blind.

The program currently operates fully in all regions of the state except Louisville and Jefferson County (because of a temporary restraining order) with a system of brokers who are paid a capitated monthly amount to arrange client transportation. The transportation system seeks to hold down costs that were increasing rapidly, and to curb the fraud and abuse that was evidenced in the former Medicaid non-emergency transportation program. Transportation's Office of Transportation Delivery administers the day-to-day operations of the program.

The program was developed as the result of an Empower Kentucky report released in late 1996, which argued that placing the Commonwealth's various human services transportation systems under one umbrella and using a managed care approach could slow the growth of quickly escalating costs. The 1998 General Assembly formalized the proposed transportation delivery system with passage of House Bill 468. Essentially, the bill amended KRS 96A and 281 to give the Transportation Cabinet the authority to set up the program and to administer funds.

This report provides a discussion of the new program and the voucher program it replaced. As a very new program, there is insufficient data to fully evaluate program operations. Also, because the program is in its start-up phase, it is reasonable to question whether data from the early stages of the program would be an accurate predictor of steady-state operations. Within those limitations, the report presents an initial assessment of information relating to the program's potential to deliver significant cost savings to the Commonwealth while providing adequate transportation services to the eligible population. As requested by the Committee, specific attention is given to the question of how individual transportation providers were affected by the program change. Finally, the report offers recommendations intended to improve program operations.

Staff would like to acknowledge the assistance of the Transportation Cabinet's Office of Transportation Delivery in the preparation of this report. Once the Executive Director of that office received assurances of the impartiality of the review, full cooperation was promised and delivered.

METHODOLOGY

Program Review staff undertook a literature review of relevant state and federal statutes and regulations. The methodology included a review of other state and federal audits and other relevant literature on the subject. Various stakeholders in the program were interviewed, including personnel from the various affected agencies. Staff also examined applicable documents and records, including billing records, correspondence, contracts, and other pertinent files. Provider payments from the Medicaid portion of the previous voucher program were obtained and compared to payments to the same provider under the new program. Because the program has only recently been implemented, staff recognized that there is not sufficient current data available to perform a complete evaluation of the program. Thus, this report is more of a progress report than a complete program evaluation.

SECTION I

Coordinated Human Services Transportation Program

The Coordinated Human Services Transportation Program has its roots in an Empower Kentucky plan that cited rising costs, Medicaid non-emergency transportation fraud and abuse, and welfare reform as reasons to establish a transportation system serving a variety of human service needs. The system has replaced a Medicaid non-emergency transportation delivery system described as fragmented, costly and vulnerable to fraud and abuse. An Empower Kentucky committee presented a business case for changing the system, noting that costs were rising steadily. The cost of the program grew in $2-$4 million increments from the late 1980s to late 1990s.

The new human service delivery network must comply with assorted federal statutes and regulations, the Medicaid State Plan, a federal waiver and state statutes and regulations, although two regulations have been found deficient. The waiver is a critical aspect because it allows the state to operate such a program under the Social Security Act. The waiver is subject to renewal.

The program seems to have made considerable progress under a network of brokers who are responsible for delivery services to Medicaid non-emergency clients and TANF consumers, and others, throughout the state. The brokers are important to the system and provide services that include recruiting transportation subcontractors, payment administration, gatekeeping, reserving and assigning trips, assuring quality, and providing oversight. The brokers operate their regional businesses with moneys received through a capitated rate system that, under Medicaid, gives them a certain amount per client, per month.

Empower Kentucky Team Develops Plan For Kentucky's Human Service Delivery System

The coordinated transportation program was designed by an Empower Kentucky process team consisting of 12 staff people from the Health Services, Families and Children, and Transportation cabinets, and supported by Deloitte & Touche Consulting Group, developed a draft redesign report in December 1996 that presented a business case for the coordinated transportation plan. The report cited a need for change from the old system because:

- Kentucky's welfare reform initiative placed a major emphasis on integrating transportation delivery across multiple health, human services and workforce programs.
- Transportation delivery processes were fragmented, increasingly costly, and vulnerable to fraud and abuse.

- Transportation services were not readily accessible statewide.

Federal welfare reform also played a role in the need for change. The new federal program, Temporary Assistance for Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC) and parts of the JOBS programs with a single block grant. Under welfare reform, states are required to reduce welfare dependency and increase workforce participation. An element in workforce participation is enabling qualified low-income workers to get to and from work and to meet other work-related needs, such as for child care. Kentucky's version of TANF is referred to as the "Kentucky Temporary Assistance Program" (KTAP), and the welfare-to-work program within KTAP is referred to as "Kentucky Works."

Old Voucher System Described as Fragmented, Costly, Vulnerable to Fraud and Abuse

State officials acknowledged that the old Medicaid transportation delivery service was fragmented, costly and vulnerable to fraud and abuse. Cabinet heads, in a December 1, 1997, letter to the federal Health Care Financing Administration (HCFA) seeking a federal waiver to create the program (See Appendix A), noted that under fee-for-service, non-emergency medical transportation costs paid by Medicaid had increased dramatically over the past decade. They said the system was vulnerable to fraud and abuse, which was costly to detect and difficult to correct when identified. Further, the state was allocating funds to support audit, investigative, and legal services to detect the fraud and abuse. They said the payment system was administratively burdensome, requiring 55 full-time equivalent staff people to issue and process the more than a million vouchers per year associated with the fee-for-service payment system.

The voucher system did, in fact, require more work of caseworkers than the current broker system. Under the current system, a Medicaid non-emergency or TANF recipient simply calls a local broker to schedule a trip to the doctor, or school or work. The old Medicaid voucher system required a recipient to call his caseworker. The caseworker would determine eligibility, being sure to ask a client if he had an available, operable vehicle. Once the caseworker determined the recipient could receive non-emergency transportation, he issued a voucher form that arrived in the recipient's mail a few days before the scheduled visit. At the same time, a recipient was supposed to contact a transportation provider, such as a cab company, and arrange transportation. On the day of the medical visit, the transportation provider and medical provider would sign the voucher, confirming that the trip occurred, and the transportation provider would return the voucher to the local social service office to be processed for payment. There were variations to that routine, such as type of patient involved and the extent of the trip.

The current coordinated transportation system also is different from the varying approaches used, apart from the Medicaid voucher system. According to the 1996 redesign report, many agencies within Health Services, Families and Children, and Workforce Development took different approaches to providing transportation services to

their clients. Programs within the respective cabinets, such as JOBS, and employment and job training programs provided recipients with $3 per day payments for transportation. Those payments were mailed directly to recipients. The Division of Family Services within Families and Children had programs such as foster care and child protective services which used state staff to provide transportation services to Clients

State's Press Reported on Abuses,
Costs in Old Medicaid Non-Emergency System

The state's press also provided anecdotal evidence of abuses in a system in which cab and ambulance companies were paid a per-mile fee to transport Medicaid recipients to visit their doctors. Perhaps one of the more memorable incidents occurred in 1995 when the Human Resources Secretary learned from Department for Social Insurance officials that Livery Corporation, a private Lexington company, was paid to transport Medicaid patients in a stretch limousine. Ironically, in Fayette County, that was a cheaper mode of transportation than cab companies. In another case, a grand jury indicted two eastern Kentucky ambulance service operators for defrauding the state by transporting people who did not need an ambulance.

Medicaid Non-Emergency Transportation Costs
Grew Steadily Through Decade of 90s

The 1996 Empower Kentucky draft report presented a business case for changing the system and quelling costs that had risen steadily throughout the 1990s. The report said that "if no changes were made in the current NEMT delivery system, historical trends indicate an annual percentage increase of 20 percent in NEMT dollars or a total cost of $69.2 million by the year 2002." The entire program (including Department of Social Insurance programs, Workforce, vehicle and staff related costs, was projected to grow to $98.4 million by 2002. Adding other related costs (technology, administration) would have ballooned the figure to $103.7 million by that same year, according to the draft report.

Actual Medicaid non-emergency transportation costs were rising at a significant rate, as shown in Table 1. The cost of the program grew yearly in $2-$4 million increments from FY 1989 to FY 1997, for an average annual growth rate of 26 percent. From FY 1997 to FY 1999, the average annual growth rate fell to 15 percent.

Table 1					
Non-Emergency Medical Transportation					
10-Year Expenditure Comparison					
Fiscal Year	**Empower**	**Managed Care (est.)***	**Fee for Service**	**Total**	**Percent Increase**
1989			$ 4,574,542	$ 4,574,542	
1990			$ 5,788,552	$ 5,788,552	27%
1991			$ 7,586,050	$ 7,586,050	31%
1992			$ 10,396,730	$ 10,396,730	37%
1993			$ 13,620,922	$ 13,620,922	31%
1994			$ 16,589,920	$ 16,589,920	22%
1995			$ 20,657,719	$ 20,657,719	25%
1996			$ 23,161,705	$ 23,161,705	12%
1997			$ 27,911,481	$ 27,911,481	21%
1998	**$ 196,174**	**$ 2,690,079**	**$ 29,575,824**	**$ 32,462,077**	**16%**
1999	**$ 9,446,864**	**$ 5,776,727**	**$ 21,716,848**	**$ 36,940,439**	**14%**
*Non-emergency transportation is based on historical fee-for-service data.					
Source: Kentucky Transportation Cabinet					

A profile drawn from FY 1996 data helps illustrate the characteristics of the program in the mid-90s. As shown in Table 2, payments for the aged, blind, and disabled accounted for almost 90 percent of total Medicaid non-emergency transportation claims. Annualized utilization also was high for those groups. The Medicaid non-emergency transportation system probably can be characterized as a system for the elderly, disabled and blind, even though the coordinated program may not be as concentrated in this way, because it incorporates TANF work-related trips for parents, including transportation to and from child-care.

TABLE 2						
FY 1996 Medicaid Non-Emergency Transportation						
Claims and Utilization						
	Net Claims	**% of Total Net Claims**	**Units**	**Annualized Utilization per 1,000**	**Unit Cost**	**Per Member Per Month**
AFDC	$ 1,587,891	9.4%	63,024	$ 278.95	25.19	$ 0.59
Foster	235,090	1.4%	12,501	2,357.25	18.80	3.69
Pregnant Women and Children	255,985	1.5%	10,605	100.46	24.13	0.20
SSI with Medicare	4,696,282	27.9%	204,793	3,199.71	22.93	6.11
SSI without Medicare	10,049,803	59.7%	395,641	3,616.41	25.40	7.66
Total	**$ 16,825,051**	**100.0%**	**686,564**			
Source: Department for Medicaid Services						

Human Service Transportation System Must Comply With Federal and State Laws, Regulations

The coordinated human service transportation program must comply with various federal statutes and regulations, the Medicaid State Plan, a federal waiver, and state statutes and regulations, although two state regulations have been found deficient. In October 1998, the federal Health Care Financing Administration granted Kentucky a waiver for a two-year continuation of the coordinated human service transportation program. (Typically, states can seek exemptions to portions of the Social Security Act to carry out changes in Medicaid programs.) The waiver covers a period from November 1, 1998, through October 30, 2000. Kentucky may request that this authority be renewed.

The 1998 General Assembly formalized the transportation delivery system with passage of House Bill 468. Essentially, the bill amended sections of KRS 96A and 281, giving the Transportation Cabinet the authority to set up the program and to receive funds to administer it. In May, the Legislative Administrative Regulation Review Subcommittee found one regulation affecting the program, 603 KAR 7:080, to be deficient. The regulation would implement procedures required to administer the entire human service delivery program. It defines and outlines the regions, eligible groups to be served, broker selection, financing and contracting arrangements, and safety and accountability. At the May 1999 subcommittee meeting, both members and staff expressed concerns about various provisions in the regulation. committee member said the regulation was not ready for approval because of technical reasons, issues raised by citizens who wanted to voice concerns about the implementation of the regulation and its impact on recipients of non-emergency transportation. During the public testimony portion, witnesses expressed concerns about the loss of freedom of choice. Transportation officials will be drafting legislation to rectify the deficiency. Cabinet officials also are discussing possible legislative changes in the program, according to the Executive Director of the Office of Transportation Delivery.

In addition, in January 1999, the Interim Joint Committee on Health and Welfare found an accompanying regulation, 907 KAR, to be deficient. The regulation governs non-emergency medical transportation waiver services and payments to TANF recipients.

HCFA Waiver Key to Implementation of Non-Emergency Transportation Program

The Health Care Financing Administration's approval of a waiver is a critical aspect of the non-emergency transportation program. The Cabinet for Health Services obtained the necessary federal waivers of requirements under Section 1902(a)(23) of the Social Security Act, to participate in the Human Service Transportation Delivery Program. Medicaid program managers determined that the Section 1915(b) waiver was appropriate to meet the objectives of the transportation delivery process.

Under Section 1915(b), or freedom of choice waivers, states are allowed to place beneficiaries in primary case management programs that are run on a "managed" fee-for-

service basis using a gatekeeper concept, or operate on a prepaid capitated arrangement. At present, freedom of choice waivers, when approved, are for two-year periods and may be renewed at two-year intervals.

The purpose of freedom of choice waivers is to improve beneficiary access to care through enrollment in a guaranteed provider network that operates in a cost efficient manner. Such waivers also promote monitoring of beneficiary quality of care. Freedom of choice waivers must ensure that Medicaid beneficiaries have at least two or more providers.

All waiver requests under Section 1915(b) of the Social Security Act are subject to requirements that the state document the cost-effectiveness of the project, its effect on recipient access to services and its overall impact. The Cabinet for Health Services chose to apply for the freedom of choice waiver under Section 1915(b) that requires the state to demonstrate cost savings in expenditures rather than under Section 1115, which requires expenditures to remain cost neutral.

Federal Health Care Financing Administration Denied 1994 State Waiver Request

Waivers are not always approved. For example, HCFA denied a waiver request to develop a contract for the provision of non-emergency medical transportation from the Department of Medicaid Services in 1994. The department based the waiver on a plan to contract for non-emergency medical transportation services in three metropolitan areas and one rural area development district of the state. The contracting agencies would have become a sole source provider in the areas specified.

On the basis of the requirements of Section 1915(b), HCFA stated the 1994 waiver request did not appear to provide sufficient documentation to determine that requirements could be met. Federal officials listed numerous concerns in their response to the waiver requests. Many of those concerns dealt with general issues. Specifically, HCFA wanted greater assurance that access to services would not be substantially impaired, that state agencies would restrict providers to only those who "meet, accept, and comply with state reimbursement, quality and utilization standards," and that cost effectiveness and quality of care would be achieved. Other issues were that vehicle specifications should conform to transportation laws as well as the Americans with Disabilities Act, what class license should be required of drivers, and whether the recipients would receive information informing them of their rights involving complaints and grievances.

Modification of Waiver Request Received HCFA Approval in 1996

In 1996, HCFA approved a Department for Medicaid Services request to operate the Kentucky Non-Emergency Transportation Program to provide non-emergency medical transportation for all Medicaid eligible beneficiaries, including AFDC. AFDC-related,

Supplemental Security Income (SSI), and SSI-related in seven service areas throughout the state. The modification allowed the state to change the date of implementation; to add western Kentucky, the Big Sandy, and Pennyrile area development districts to the service area; add flexibility, in certain areas, to either contract using the competitive bidding process or to contract with other governmental agencies (transit authorities); and allow contractors to authorize trips through an on-line computerized system connected to the state's eligibility system.

HCFA based its approval on submitted evidence that indicated the state's proposed waiver modification was consistent with the purpose of the Medicaid program, would improve beneficiary access, enhance quality of care, and would be a cost effective means of providing Kentucky's Medicaid non-emergency transportation services to Medicaid recipients residing in the affected areas of the state. Approval of the request granted Kentucky a modification of its waiver program under Section 1915(b)(4) of the Social Security Act for a period of two years, beginning 90 days from the approval date of July 25, 1996.

Waiver Subject to Renewal in 2000;
Independent Assessment Needed

In October 1998, HCFA approved a request for a continuance of the waiver for the Department for Medicaid Services. The request was granted even though the program was not operational during the previous two-year waiver period. Approval of the request was contingent on the state’s conducting an independent assessment of the overall waiver program and submitting the assessment three months prior to the end of the waiver period.

The Department of Medicaid Services currently contracts with the Transportation Cabinet to administer the program. The current contract amount is approximately $33 million. The state also has created the Coordinated Transportation Advisory Committee (CTAC) that includes representatives from each of the participating human services programs.

Transportation Cabinet Has Number
of Roles, Responsibilities Under Contract

The Transportation Cabinet has a number of roles and responsibilities under its contracts with the Health Services and Families and Children cabinets to assure that the coordinated human service transportation system functions properly. Among its duties, the Cabinet is responsible for contracting with transportation brokers to provide non-emergency transportation services to clients; implementing and monitoring contract compliance, including determining if brokers are meeting standard performance measures; conducting field compliance reviews; reviewing broker annual audits; and reviewing broker credentialing. The Cabinet must maintain a complaint tracking system, collect encounter and other pertinent transportation data, review monthly broker invoices, provide program progress reports, and assure that federal and state regulations are

followed. Also, the Cabinet is responsible for renegotiating funding amounts in programs and evaluating capitation rates, maintaining a toll-free watts line, maintaining the necessary records and accounts, including personnel and financial records, and reporting suspected cases of fraud and abuse. In turn, the other cabinets are supposed to supply the information and support needed for Transportation to fulfill the contract.

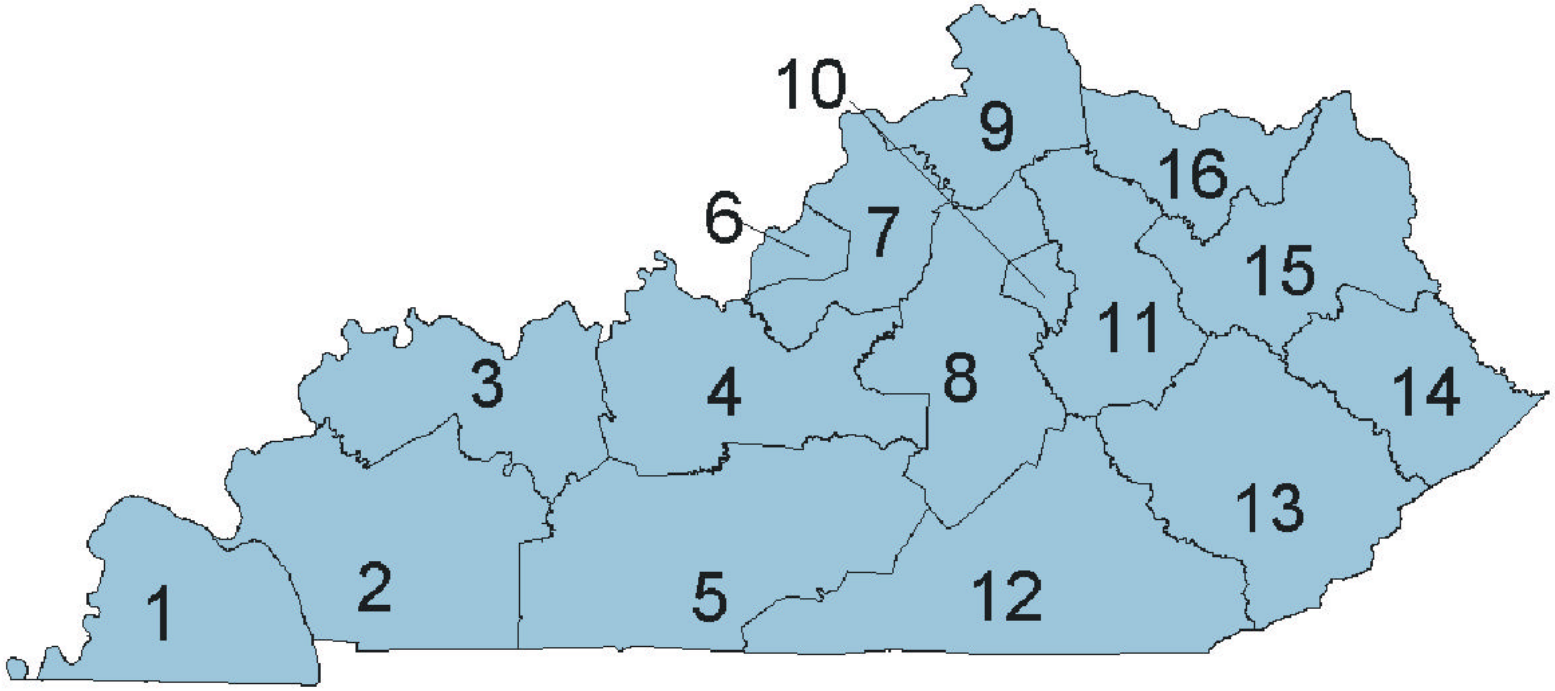
As noted earlier, the Office of Transportation Delivery handles the day-to-day operations of the program. Officials said the office has not been fully staffed since inception. The office has a staff complement of 15, including the executive director, with three pending positions. The office has two sections– the human service delivery division, which serves as a client advocate branch, and the public transportation division, which assures provider compliance.

System of Transportation Brokers
Set Up Throughout Kentucky to Serve Clients

The Transportation Cabinet appears to have made considerable progress in getting the program under way. The cabinet first divided the state into 16 multi-county regions based on the potential number of Medicaid non-emergency and TANF recipients, the geography of the regions, population, and existing public transit systems. (See Figure A.) In June 1998, the Transportation, Health Services, Families and Children, and Workforce Development Cabinets launched a pilot program in the five-county Big Sandy Region (Floyd, Johnson, Magoffin, Martin and Pike counties) with Sandy Valley Transportation Services providing a system for transporting Medicaid clients to medical appointments and providing rides to Kentucky Works participants. Since that time, transportation brokers have been selected for 16 regions. The brokers are fully operational, except in Region 6 (Jefferson County), where a restraining order issued by a Franklin circuit judge has limited the broker there to servicing only TANF recipients. The restraining order resulted from a lawsuit filed by Senior Executive Coach (doing business as Lifeline Transit), which protested the awarding of the contract to Yellow Transportation Management. Other plaintiffs ultimately joined the suit, arguing, among other things, for freedom of choice to persons with disabilities and special needs. The plaintiffs argued that sudden and frequent change in routine adversely affects persons with disabilities and special needs, as well as their family members. Changes contemplated by the new system would be severely detrimental to the health and well-being of disabled persons using Medicaid transportation voucher, the plaintiffs argued.

The judge's order, issued in late August 1999, restrained the Transportation Cabinet from implementing the contract for brokerage except for Welfare to Work recipients. Subsequently, the cabinet and broker entered into what amounts to an emergency contact that remains in effect.

KENTUCKY HUMAN SERVICE TRANSPORTION REGIONS



Brokers Important Components In Human Services Transportation Delivery System

Brokers are important components in the transportation process and serve as gatekeepers in the system. The Transportation Cabinet uses a request for proposals (RFP) process to select brokers for the regions. The Cabinet is responsible for contracting for service, making all payments to brokers, monitoring service delivery, reporting to the funding cabinets, and maintaining a complaint monitoring system for all recipients as well as for brokers.

According to Transportation Cabinet officials, 11 of the regional brokers are federal transit agencies, three are private for-profit taxi systems, two are brokers who do not provide any service, one is a for-profit broker, and one is a non-profit broker. (See Table 3).

TABLE 3			
Coordinated Human Service Transportation Network			
Region	**Counties**	**Provider/Broker & Location**	**Contract Date**
1	Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, McCracken, Marshall	Paducah Area Transit System, Paducah	May 20, 1999
2	Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, Trigg	Pennyrile Allied Community Services, Hopkinsville	Jan. 20, 1999
3	Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster	Audubon Area Community Services, Owensboro	Jan. 7, 1999
4	Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson	Transportation Management System, Bowling Green	July 1, 1999
5	Adair, Allen, Barren, Butler, Edmonson, Green, Hart, Logan, Metcalfe, Simpson, Taylor, Warren	Yellow Cab Co., Bowling Green	April 14, 1999
6	Jefferson	Yellow Transportation Management (TANF only)	Oct. 1, 1999
7	Bullitt, Henry, Oldham, Shelby, Spencer, Trimble	American Red Cross Louisville, Louisville	June 9, 1999
8	Anderson, Boyle, Casey, Franklin, Garrard, Jessamine, Lincoln, Mercer, Scott, Washington, Woodford	Bluegrass Community Action, Frankfort	Aug. 27, 1998
9	Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton	Region 9 Transportation LLC, Newport	Jan. 8, 1999
10	Fayette	Federated Transportation Services of the Bluegrass, Lexington	Sept. 21, 1998
11	Bourbon, Clark, Estill, Harrison, Madison, Montgomery, Nicholas, Powell	Kentucky River Foothills Development Council, Richmond	Sept. 21, 1998
12	Bell, Clinton, Cumberland, Knox, Laurel, McCreary, Monroe, Pulaski, Rockcastle, Russell, Wayne, Whitley	Rural Transit Enterprises Coordinated	Aug. 27, 1998
13	Breathitt, Clay, Harlan, Jackson, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe	Leslie, Knott, Letcher and Perry Community Action Council (LKLP), Red Fox	Nov. 1, 1998
14	Floyd, Johnson, Magoffin, Martin, Pike	Sandy Valley Transportation Services, Prestonsburg	May 18, 1998
15	Bath, Boyd, Carter, Elliott, Greenup, Lawrence, Menifee, Morgan, Rowan	Community Action Council, Carlisle	Aug. 1, 1999
16	Lewis, Robertson, Mason, Fleming, Bracken	Licking Valley Community Action Program, Flemingsburg	Aug. 26, 1998
Source: Compiled by Program Review staff from information supplied by Transportation Cabinet			

Brokers are required to provide six broad areas of services, according to the network plan. Those are:

- Recruiting and negotiating with transportation providers;
- Payment administration;
- Gatekeeping;
- Reservation and trip assignments;
- Quality assurance; and
- Administration oversight and reporting.

Brokers are responsible for arranging for or providing transportation to eligible recipients to and from stated points of origin or from specific reimbursable services at the request of clients. Generally, they establish a network of independent transportation providers to deliver transportation and negotiate specialized service delivery rates with each qualified transportation entity. They provide payment to each transportation provider based on authorized services rendered.

The regional brokers also must manage the day-to-day operations necessary to deliver services and maintain appropriate records and systems of accountability. They are supposed to maintain office arrangements, including adequate staff, records, and accessible phone service, including a toll-free number.

Brokers serve as gatekeepers by:

- Verifying the recipient's current transportation eligibility;
- Assessing the recipient's needs for non-emergency transportation;
- Selecting the most appropriate transportation to meet the recipient's needs; and
- Educating recipients in the use of network services.

The Transportation Cabinet has the right to conduct on-site reviews of brokers to assure compliance with RFP requirements. These include such aspects as the number of times the phone should ring, driver requirements, and attendant and service personnel training. The cabinet can check for vehicle safety. The cabinet also has a complaint tracking system. In the past, according to Transportation officials, there was no monitoring of provider quality.

The Cabinet uses an operational readiness test that brokers must complete prior to being allowed to begin service. This includes an adequate phone system, installation of a toll-free number, complaint tracking, vehicle inspections, proof that drivers have undergone drug testing, and verification that all contract requirements are met.

Brokers Maintain Working Relationship With Transportation Providers in Regions

Brokers maintain a working and contractual relationship with transportation providers in the 16 regions. The brokers are required by regulation to allow all willing transportation providers in their regions to participate in the program, as long as they accept the specified reimbursement rates. The providers, such as cab companies and ambulance services, must meet safety and other program requirements before being allowed to participate. The regional contractors must assure that transportation providers:

- Meet health and safety standards for vehicle maintenance;
- Meet operation and inspection requirements;
- Have specified driver qualifications and training;
- Conduct drug and alcohol testing;
- Have procedures for recipient problem and complaint resolution; and
- Ensure delivery of courteous, safe and timely transportation services.

Generally, providers must agree to comply with the applicable federal and state laws, have proper licenses, proofs of ownership and insurance, maintain appropriate records, allow record inspections by appropriate agencies, and maintain the confidentiality of information. They are required to maintain an office with regular business hours. Given the special needs of many of the recipients of the program, providers are required to provide door-to-door service for those certified to need the extra care.

Under the contractual relationship, brokers reimburse their subcontractors for services rendered. There are approximately 160 providers (Appendix C) operating in the program. Provider payment rates vary across regions and, in some cases, across providers within a particular region. Recipients are certified for one of four types of service, as shown in Table 4.

TABLE 4

CATEGORIES OF TRANSPORTATION SERVICES

Code	Category	Description
02	Taxi	Regular taxi service
04	Bus	Regular bus service
07	Disoriented	Transportation for those confused as to time, place or persons such that assistance is required.
08	Non-Ambulatory	Transportation for those who need physical assistance that can be provided by one individual, but not those requiring stretcher transport.

Source: Kentucky Transportation Cabinet

Capitated Payment System Has Replaced Old Voucher System

The Cabinet has replaced the old voucher payment system with a system based, for the most part, on a capitated rate. This is a flat amount per month paid for each eligible recipient in the region. Under this system, capitated payments go directly to a single

broker in each region. In return, brokers guarantee transportation for every Medicaid, TANF or other eligible client. Funding is transferred to the Transportation Cabinet through interagency agreements with Health Services, Families and Children, and Workforce Development.

Under the voucher system, providers were paid on a fee-for-service basis. Thus, the more trips and miles they reported, the greater their gross income. The incentive was to provide more services. Without sufficient monitoring to control excess billing, a fee-for-service structure can result in large expenditure increases, as was experienced in the Kentucky Medicaid non-emergency transportation program. In contrast, under the capitated rate structure, payments to brokers are fixed and do not increase with an increase in the number of trips or miles during the contract period. The greater the number of claims against the total capitated payment amount to the broker, the less money the broker keeps. Thus, the broker has a strong incentive to monitor providers to ensure that all trips and miles are billed appropriately. The greatest need for monitoring is to ensure that brokers do not respond so strongly to the financial incentives to reduce trips and miles that they render service of an unacceptable quality.

The actuarial firm of Milliman & Robertson developed the initial capitation rates for non-emergency transportation in the 16 regions. The following data sources were used to develop the rates.

- Medicaid eligibility data extracts for state fiscal years 1995-97;
- Voucher payment extracts for state fiscal years 1995-97;
- Enrolled provider files;
- Job Opportunities and Basic Skill/Kentucky Works Program (JOBS/KWP) payment summaries;
- Partial summaries on fleet sizes by number of vehicles and capacity; and
- Documentation on both the historical and proposed non-emergency transportation programs.

The original capitation rates ranged from $3.89 to $5.43 per region. Medicaid non-emergency medical transportation and TANF trips account for virtually all human service trips (Table 5). These are covered by capitated rates. The remainder (Vocational Rehabilitation and Industries for the Blind) are on a fee-for-service basis or a specified amount per mile. The current capitated rates are shown in Table 6.

TABLE 5		
Coordinated Human Services-Transportation Program		
Trips January - July 1999		
Program	**Number**	**Percent**
Department of Blind	81	0%
Medicaid	419,448	45%
TANF	518,683	55%
Vocational Rehabilitation	126	0%
Total	**938,338**	**100%**
Source: Kentucky Transportation Cabinet.		

TABLE 6		
Per Member Per Month Capitation Rates		
FY 2000		
Region	**TANF**	**MEDICAID**
1	8.08	$5.46
2	7.37	$4.62
3	7.27	$4.26
4	7.23	$5.01
5	7.11	$5.50
6	6.96	$5.94
7	7.16	$4.98
8	8.09	$5.06
9	7.03	$4.48
10	6.95	$4.88
11	7.12	$5.24
12	7.68	$5.42
13	8.38	$5.69
14	8.49	$5.87
15	8.13	$4.98
16	7.08	$4.95
Source: Kentucky Transportation Cabinet		

In FY 2000, the total reimbursements to the Transportation Cabinet for capitation payments and administrative costs is limited to $32.4 million from Medicaid and $12.6 million from the Cabinet for Families and Children.

Program Operates Under Series of Contracts Between Cabinets

The Cabinets for Health Services (Department for Medicaid Services) and Families and Children have contracted with the Transportation Cabinet to provide transportation services to eligible Medicaid and TANF recipients. Each cabinet contracts individually

with the Transportation Cabinet to secure high quality human service delivery for non-emergency transportation, welfare-to-work, and other programs.

The current contract between the Department of Medicaid Services and the Transportation Cabinet is for $33 million. Currently the Transportation Cabinet receives $444,000 in administrative cost to implement the non-emergency medical transportation program. The administrative costs will increase to $602,000 in FY 2000 with full implementation.

Currently, the contract between the Families and Children and Transportation Cabinets is $12.6 million. The Cabinet for Families and Children has limited payment to the Transportation Cabinet for indirect administrative costs to no more than 10 percent of the contract total or $1.2 million. (Indirect administrative cost means those costs for administrative activities within an organization that are not specifically identifiable with a particular project, service, or program activity.)

Panel of Agency Officials Advises Cabinet in Operation of Transportation System

According to a Transportation Cabinet official, the CTAC exists as a "communications tool" between the various contracting agencies and attempts to keep the other cabinets informed about Transportation's activities and to assure that Transportation is responsive to the other agencies. Because the committee actually casts votes on such issues as the recommending the awarding of RFPs, the panel's voting powers are weighted. The Transportation, Health Services, and Families and Children Cabinets each have two votes; the Workforce Development Cabinet has one.

The head of the Office of Transportation Delivery sets the agenda for CTAC meetings, which have been taking place since April 1997. The CTAC has met on successive months since that time, and sometimes twice a month, but has had periods of times when it has not met, according to meeting agendas. Because there are no minutes of the meetings, staff was unable to determine what issues the panel discussed and what votes they have taken in the meetings. However, an analysis of the agendas showed 36 percent of topics scheduled for discussion seemed to involve program implementation, and policies and procedures issues. Topics involving RFPs and the regions made up 29 percent; topics relating to the affected programs consumed 13 percent. The remaining issues included legislative and regulatory topics, CTAC responsibilities, and other general discussion items.

Kentucky's Umbrella Human Services Transportation Program Termed Unique

Kentucky's umbrella program apparently is unique among states. An article in the February/March 1998 issue of *Community Transportation* magazine called the program, "Kentucky's Great Experiment." The article said, "This plan is untested, but innovative, and other states are sure to keep a sharp eye on the situation as it develops."

The executive director of the National Transportation Consortium of States (NTCS), based in Birmingham, Ala., told Program Review staff, "Many states have expressed a great deal of interest in the human services transportation of Kentucky because it is considered a model program." According to NTCS, 19 states have legislatively enacted coordination programs. (See Appendix B.)

The NTCS official cited some common problems in implementing coordinated human service transportation programs:

- Difficulty in developing an acceptance by private providers that their services cannot pick and choose best routes;
- Issues related to whether transportation brokers can also be providers and cull out the best routes for themselves;
- The difficulty in setting the right local capitated rate; and
- "No show" problems with clients making reservations and then failing to be available.

SECTION II

Progress Report for the Coordinated Transportation Program

In response to the Committee's request, this section provides a status report on the implementation of the coordinated human services transportation program. The Committee specifically asked staff to address the issue of the expected reduction in the growth rate in transportation expenditures, concerns about the quality of transportation services delivered to recipients, and the effect of program changes on providers. Because the program has been in operation for well under a year in most areas of the state, there is not sufficient data to allow a complete and accurate assessment of these issues. Much of the information available is in the form of projections and anecdotes. While such information is not useless, it is often more subject to bias than data collected on all encounters and that is subject to standard validation procedures.

Potential for Significant Cost Savings Exists

The state's objectives through this waiver period are to reduce the rate of growth in expenditures, prevent unnecessary and inappropriate utilization, and assure adequate access to quality care for Medicaid beneficiaries, and others served by the program. The state has projected savings of $1.8 million over the two-year waiver period. A letter to the Director of the LRC from the Health Services Secretary suggests that a 20 percent reduction in costs should result through improved access to transportation services. Note that these savings estimates represent the difference in expected costs with and without the program. It is not anticipated that the program would cause future expenditures to be 20 percent less than current expenditures, in absolute terms.

The costs of the program to the Commonwealth are determined by the average capitation rate that is negotiated with brokers. To the extent that this average capitation rate is less than the average reimbursement under the voucher program, then the state will achieve a lower cost. The reimbursement rates paid to providers under the capitated system affect the broker's net costs, but do not directly affect the Commonwealth. However, because the capitation rate received by the broker must at least cover reimbursement rates, these rates indirectly affect the capitation rate that can be negotiated.

Rates for each category of transportation for each region were drawn from a review of provider contracts and rate sheets supplied by the Kentucky Transportation Cabinet. There was significant variation in the schemes used in different regions to define rate structures. Instead of attempting to display these complicated and non-comparable rate structures, staff used the different Medicaid non-emergency rate structures to calculate the rate for one-way daytime trips for a single recipient in each category. Rates were calculated for trips of 5, 10, 25, 50, and 75 miles. Rates paid under the previous Medicaid voucher program were calculated for comparison. The calculated rates are shown in Tables 7 - 10.

Table 7
Medicaid Non-Emergency Transportation Rates Paid to Providers
Single Recipient Daytime One-Way Trip

Category 02
Taxi

	Provider	Amount Paid for No Show	Length of Trip: 5 miles	10 miles	25 miles	50 miles	75 miles
------	**Previous Medicaid Voucher Rates**	**$ -**	**$ 6.00**	**$ 12.00**	**$ 20.00**	**$ 30.00**	**$ 75.00**
	Coordinated Human Services Transportation Rates						
1	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00
2	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00
3	All Providers in Region	$ -	$ 4.50	$ 9.00	$ 22.50	$ 45.00	$ 67.50
4	All Providers in Region	$ -	$ 6.25	$ 10.50	$ 23.25	$ 27.00	$ 39.50
5	All Providers in Region	$ -	$ 4.75	$ 9.50	$ 20.00	$ 45.00	$ 75.00
6	All Providers in Region	$ -	$ 5.50	$ 9.00	$ 24.00	$ 28.50	$ 71.25
7	All Providers in Region	$ -	$ 20.00	$ 20.00	$ 20.00	$ 20.00	$ 20.00
8	Frankfort Taxi; PK Cab; & Bluegrass Cab	Paid one-way	$ 5.40	$ 10.80	$ 18.00	$ 27.00	$ 67.50
	Life First	Paid one-way	$ 5.15	$ 10.25	$ 17.10	$ 25.65	$ 64.10
	Frankfort Active Day; Caretenders	Paid one-way	$ 4.50	$ 9.00	$ 22.50	$ 45.00	$ 65.00
9	All Providers in Region	$ -	$ 6.00	$ 12.00	$ 20.00	$ 30.00	$ 75.00
10	All Providers in Region	$ -	$ 9.90	$ 17.90	$ 41.90	$ 81.90	$ 121.90
11	All Providers in Region	Paid one-way	$ 5.50	$ 11.00	$ 18.00	$ 27.00	$ 67.50
12	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00
13	Jackson Cab; Medi-Cab; Ingram's Taxi; Riley's Taxi; McIntosh Taxi;& Allen Taxi	$ -	$ 5.70	$ 11.40	$ 19.00	$ 28.50	$ 71.25
	Appalachian Transportation	$ -	$ 5.28	$ 10.56	$ 17.60	$ 26.40	$ 66.00
	Tackett's Taxi	$ -	$ 2.50	$ 5.00	$ 12.50	$ 25.00	$ 37.50
	James Seals Cab Co.	$ -	$ 4.00	$ 8.00	$ 20.00	$ 40.00	$ 60.00
14	All Providers in Region	$ -	$ 5.70	$ 11.40	$ 19.00	$ 28.50	$ 71.25
15	All Providers in Region	$ -	$ 5.00	$ 11.00	$ 18.00	$ 28.00	$ 67.50
16	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00

Source: LRC staff analysis of provider contracts and rate sheets supplied by the Kentucky Transportation Cabinet Office of Transportation Delivery.

Table 8
Medicaid Non-Emergency Transportation Rates Paid to Providers
Single Recipient Daytime One-Way Trip

Category 04
Bus

Region	Provider	Amount Paid for No Show	5 miles	10 miles	25 miles	50 miles	75 miles
——	**Previous Medicaid Voucher Rates**	**$ -**	**$ 2.50**	**$ 5.00**	**$ 12.50**	**$ 25.00**	**$ 37.50**
	Coordinated Human Services Transportation Rates						
1	All Providers in Region	$ -	$ 3.25	$ 0.65	$ 16.25	$ 32.50	$ 48.75
2	All Providers in Region	$ -	No Bus Service				
3	All Providers in Region	$ -	No Bus Service				
4	All Providers in Region	$ -	$ 6.25	$ 10.50	$ 23.25	$ 27.00	$ 39.50
5	All Providers in Region	$ -	No Bus Service				
6	All Providers in Region	$ -	No Bus Service				
7	All Providers in Region	$ -	$ 20.00	$ 20.00	$ 20.00	$ 20.00	$ 20.00
8	Frankfort Transit (Category 03)	$ -	$ 0.50	$ 0.50	$ 0.50		
9	All Providers in Region	$ -	$ 6.00	$ 12.00	$ 20.00	$ 30.00	$ 75.00
10	American Red Cross Wheels	$ -	$ 0.50	$ 0.50	$ 0.50		
11	All Providers in Region	Paid one-way	$ 3.25	$ 0.65	$ 16.25	$ 32.50	$ 48.75
12	All Providers in Region	$ -	No Bus Service				
13	All Providers in Region	$ -	$ 0.50	$ 0.50	$ 0.50		
14	All Providers in Region	$ -	No Bus Service				
15	All Providers in Region	$ -	No Bus Service				
16	All Providers in Region	$ -	$ 0.50	$ 0.50	$ 0.50		

Source: LRC staff analysis of provider contracts and rate sheets supplied by the Kentucky Transportation Cabinet Office of Transportation Delivery.

Table 9
Medicaid Non-Emergency Transportation Rates Paid to Providers
Single Recipient Daytime One-Way Trip

Category 07
Disoriented Recipient

Region	Provider	Amount Paid for No Show	Length of Trip				
			5 miles	10 miles	25 miles	50 miles	75 miles
-------	**Previous Medicaid Voucher Rates**	$ -	$ 20.00	$ 27.50	$ 50.00	$ 87.50	$ 125.00
	Coordinated Human Services Transportation Rates						
1	All Providers in Region	$ -	$ 16.00	$ 21.00	$ 36.00	$ 61.00	$ 86.00
2	All Providers in Region	$ -	$ 16.00	$ 21.00	$ 36.00	$ 61.00	$ 86.00
3	Medical Transport; Concare	$ -	$ 9.50	$ 14.00	$ 27.50	$ 50.00	$ 72.50
	Yellow Ambulance	$ -	$ 14.00	$ 19.00	$ 34.00	$ 59.00	$ 84.00
4	All Providers in Region	$ -	$ 14.25	$ 18.50	$ 31.25	$ 35.00	$ 47.50
5	All Providers in Region	$ -	$ 16.00	$ 21.00	$ 36.00	$ 61.00	$ 86.00
6	All Providers in Region	$ -	$ 15.50	$ 20.50	$ 35.50	$ 60.50	$ 85.50
7	All Providers in Region	$ -	$ 20.00	$ 20.00	$ 20.00	$ 20.00	$ 20.00
8	Life First	Paid one-way	$ 17.10	$ 23.50	$ 42.70	$ 74.70	$ 106.70
	Frankfort Active Day	Paid one-way	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00
	Frankfort Transit	$ -	$ 11.25	$ 11.25	$ 11.25	$ 11.25	$ 11.25
	Caretenders	Paid one-way	$ 18.00	$ 24.75	$ 45.00	$ 78.75	$ 112.50
9	All Providers in Region	$ -	$ 16.00	$ 21.00	$ 36.00	$ 61.00	$ 86.00
10	Georgetown Adult Daycare	$ -	$ 15.00	$ 15.00	$ 15.00	$ 15.00	$ 15.00
	Medical Transport & Caretenders		$ 18.00	$ 24.75	$ 45.00	$ 78.75	$ 112.50
	American Red Cross Wheels	$ -	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50
11	All Providers in Region	Paid one-way	$ 16.25	$ 22.50	$ 41.25	$ 72.50	$ 103.75
12	All Providers in Region	$ -	$ 18.00	$ 24.75	$ 45.00	$ 78.75	$ 112.50
13	Appalachian Transportation	$ -	$ 16.75	$ 23.50	$ 43.75	$ 77.50	$ 111.25
	Daniel Boone Dev Council Transit	$ -	$ 20.00	$ 27.50	$ 50.00	$ 87.50	$ 125.00
	Middle KY River; Red Bird Million; Harlan Community Action;; & Medi-Cab	$ -	$ 18.80	$ 25.80	$ 46.80	$ 81.80	$ 116.80
	McIntosh Taxi & Allen Taxi	$ -	$ 19.03	$ 26.18	$ 47.63	$ 83.38	$ 119.13
	Medi-Cab of Kentucky	$ -	$ 18.97	$ 26.07	$ 47.37	$ 82.87	$ 118.37
14	All Providers in Region	$ -	$ 18.97	$ 26.07	$ 47.37	$ 82.87	$ 118.37
15	All Providers in Region	$ -	$ 17.00	$ 23.00	$ 41.00	$ 71.00	$ 101.00
16	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00

Table 10
Medicaid Non-Emergency Transportation Rates Paid to Providers
Single Recipient Daytime One-Way Trip

Category 08
Non-Ambulatory Recipient

Region	Provider	Amount Paid for No Show	Length of Trip: 5 miles	10 miles	25 miles	50 miles	75 miles
------	**Previous Medicaid Voucher Rates**	**$ -**	**$ 32.50**	**$ 40.00**	**$ 62.50**	**$ 100.00**	**$ 137.50**
	Coordinated Human Services Transportation Rates						
1	All Providers in Region	$ -	$ 26.00	$ 31.00	$ 46.00	$ 71.00	$ 96.00
2	All Providers in Region	$ -	$ 26.00	$ 31.00	$ 46.00	$ 71.00	$ 96.00
3	Medical Transport; West KY Transport.	$ -	$ 22.50	$ 27.00	$ 40.50	$ 63.00	$ 85.50
	Yellow Ambulance	$ -	$ 25.00	$ 30.00	$ 45.00	$ 70.00	$ 95.00
	Grayson Co. EMS	$ -	$ 27.50	$ 32.50	$ 47.50	$ 72.50	$ 97.50
	Concare	$ -	$ 20.50	$ 25.00	$ 38.50	$ 61.00	$ 83.50
4	All Providers in Region	$ -	$ 23.00	$ 28.00	$ 43.00	$ 48.00	$ 63.00
5	All Providers in Region	$ -	$ 26.25	$ 32.50	$ 51.25	$ 82.50	$ 113.75
6	All Providers in Region	$ -	$ 26.00	$ 31.00	$ 46.00	$ 71.00	$ 96.00
7	All Providers in Region	$ -	$ 25.00	$ 25.00	$ 25.00	$ 25.00	$ 25.00
8	Life First	Paid one-way	$ 27.80	$ 34.20	$ 53.40	$ 85.40	$ 117.40
	Frankfort Active Day	Paid one-way	$ 22.00	$ 22.00	$ 22.00	$ 22.00	$ 22.00
	Frankfort Transit	$ -	$ 22.50	$ 22.50	$ 22.50	$ 22.50	$ 22.50
	Caretenders	Paid one-way	$ 29.25	$ 36.00	$ 56.25	$ 90.00	$ 123.75
9	All Providers in Region	$ -	$ 26.25	$ 32.50	$ 51.25	$ 82.50	$ 113.75
10	Georgetown Adult Daycare	$ -	$ 20.00	$ 20.00	$ 20.00	$ 20.00	$ 20.00
	Medical Transport; & Caretenders		$ 29.25	$ 36.00	$ 56.25	$ 90.00	$ 123.75
	American Red Cross Wheels	$ -	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50
11	All Providers in Region	Paid one-way	$ 26.25	$ 32.50	$ 51.25	$ 82.50	$ 113.75
12	All Providers in Region	$ -	$ 29.25	$ 36.00	$ 56.25	$ 90.00	$ 123.75
13	Appalachian Transportation	$ -	$ 26.60	$ 33.20	$ 53.00	$ 86.00	$ 119.00
	Daniel Boone Dev Council Transit	$ -	$ 32.50	$ 40.00	$ 62.50	$ 100.00	$ 137.50
	Middle KY River; Red Bird Million; Harlan Community Action;; & Medi-Cab	$ -	$ 30.50	$ 37.50	$ 58.50	$ 93.50	$ 128.50
	Medi-Cab of Kentucky	$ -	$ 30.85	$ 37.95	$ 59.25	$ 94.75	$ 130.25
14	All Providers in Region	$ -	$ 30.85	$ 37.95	$ 59.25	$ 94.75	$ 130.25
15	All Providers in Region	$ -	$ 26.00	$ 32.00	$ 50.00	$ 80.00	$ 110.00
16	All Providers in Region	$ -	$ 5.00	$ 10.00	$ 25.00	$ 50.00	$ 75.00

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The calculated rates for standard taxi service (02) were often, but not always, lower than the rates under the voucher program. This pattern was also exhibited in the nine regions that offer bus service (04). In contrast, virtually all of the calculated rates for disoriented (07) and non-ambulatory (08) recipients were below those of the voucher program. As was shown above, nearly 90 percent of FY 1996 Medicaid non-emergency transportation claims were for the aged, blind, and disabled population, which are more likely to qualify for these two categories of transport. So far under the new system, disoriented and non-ambulatory recipients have accounted for 26 percent of trips. (See Table 11.) Because brokers do not always record a reimbursement claim amount for trips they provide themselves, it is not possible to determine what share of paid claims were made for disoriented and non-ambulatory recipients in the coordinated program. However, it is likely that a reduction in average rates for these two trip categories has the potential to result in substantial program savings.

Table 11
Coordinated Human Services Transportation Program
Trips and Claims Since Program Inception
by Category of Trip

	Category of Trip	Number	Percent
01	Private Auto	8,743	1%
02	Taxi	205,590	34%
03	City Bus	3,689	1%
04	Non-Profit Bus	223,504	37%
07	Ambulatory Disabled (Disoriented)	97,887	16%
08	Non-Ambulatory Disabled	61,962	10%
	Total	**601,375**	**100%**

Source: LRC staff analysis of encounter data provided by Transportation Cabinet

Another way in which growth in total program expenditures might be reduced is through better identification of fraud and abuse on the part of both providers and recipients. Local brokers have a financial incentive to reduce unnecessary program expenditures because their capitated payments are fixed. They also have the ability to become more familiar with local utilization patterns within the region. This has the potential to lead to tighter program controls. For example, brokers have identified, investigated, and reported instances where:

- A taxi cab company was transporting wheelchair recipients in a car rather than a lift-equipped van.
- A recipient was arranging transport for a non-eligible friend rather than for herself.
- Vehicle inspections revealed vans for disoriented recipients with broken windows.

- A recipient scheduled several trips to a physician's office near a department store when she had no appointments scheduled.
- A provider was found to be charging non-ambulatory rates inappropriately.
- Recipients were seen by brokers driving cars that turned out to be their own.

Based on this small number of anecdotes, of course, it is not possible to determine whether there has been a change in the number of inappropriate claims identified. However, it is clear that brokers are responding to the incentive to search for instances of fraud and abuse.

Quality Issues Raise Concerns During Early Phase of Program

There was neither time nor staff resources available to conduct an in-depth assessment of the quality of services being delivered by the coordinated transportation program. As a condition of the waiver, the Department for Medicaid Services is to contract with an independent contractor to perform such an assessment. Funds have been included in the Cabinet's FY 2000 budget for that purpose.

To provide some information regarding the quality of services, staff reviewed complaint data collected by brokers and submitted to the Transportation Cabinet, reviewed tapes of legislative committee meetings where the program was discussed and contacted some individuals who had testified about problems, and reviewed all the contact sheets from the legislative Office of Constituent Services relating to either transportation or Medicaid. Additionally, staff interviewed the broker in each of the 16 regions, tested the telephone response system in each region, and considered several programmatic issues relating to federal requirements.

A review of complaints by recipients and subcontractors revealed some dissatisfaction with the coordinated transportation program. Recipients voiced concerns about lack of freedom of choice, untimely pick-up, and poor communication responses. he number of those complaints may be declining as brokers gain program experience. Subcontractors complained that reimbursement rates are too low and that brokers unfairly assign trips. Because these occurrences are consistent with the financial incentives incorporated into the program, it is not expected that these complaints will decline over time.

Denials of Service to Recipients Make Up Third of Brokers' Administrative Actions

Regional brokers are responsible for maintaining complaint tracking and resolution systems; however, the "complaints" being logged appear more in the nature of general administrative actions taken for a variety of reasons. Of those actions taken, a third constitute denials of service. Staff identified 481 such administrative actions from a compilation of what are labeled as "complaints" for a period of January-September 1999.

Brokers are required to handle complaints or other inquiries as part of their daily operations. Each broker should have his own procedures and include those in the operations manual. Transportation officials supply brokers with a complaint-tracking program prior to beginning operation at the regional level. Brokers log all complaints into the program and then submit those to the Office of Transportation Delivery. According to the Office of Transportation Delivery executive director, brokers are required to log all complaints, although "some log more than required," apparently to include the variety of inquiries ranging from outright complaints to denials of service, requests for information and the like. Brokers submit their complaint lists to the Frankfort central office via disk. Transportation Delivery staff compile them into one summary that also includes complaints filed directly with the central office. Another aspect is follow-ups, which are taken both at the regional level and from the central office level.

From the complaint compilation sheets, staff created seven categories–service denial, client or recipient no-show, untimely pick-up or scheduling problem, provider or vehicle complaint or concern, freedom of choice request, system or program complaint or concern, and general inquiry. As noted, staff determined there were 481 administrative actions taken as a result of 464 contacts. As Table 12 shows, 33 percent (160) of the administrative actions dealt with service denials. The other administrative actions ranged from a low of 6 percent (provider or vehicle complaint or concern) to 16 percent (general inquiry).

TABLE 12
Human Service Delivery Complaints/Concerns
January -September 1999

Administrative Action	Denial	Client/Recipient No-Show	Untimely Pick-up	Provider or Vehicle Complaint/Concern	Freedom of Choice Request	System/Program Complaint/Concern	General Inquiry
Number	160	68	56	31	37	51	78
Percentage	33%	14%	12%	6%	8%	11%	16%

Source: Compiled by Program Review from Office of Transportation Delivery Complaints Data Summaries.

Staff grouped service denials into three categories–denials because of evidence of an accessible vehicle, general eligibility (other than vehicle denials), and denials because recipients failed to properly schedule rides (Table 13). General eligibility denials, based on such things as not being listed on the state database, made up 62 percent (99); accessible vehicle denials accounted for 23 percent (36); failure to give adequate trip notice accounted for 16 percent (25). Under program rules, brokers may deny a trip or immediately discontinue a trip for any recipient found ineligible for Medicaid, Kentucky Works, vocational rehabilitation or Department for the Blind program services on the basis of the state database information. Medicaid recipients must be denied if brokers determine they have an accessible, operable vehicle at their disposal. Recipients also can risk being denied services if they misuse services, are uncooperative or abusive. For example, the Region 5 broker denied service to a recipient whose husband allegedly "threatened or harassed" a driver. Finally, recipients can be denied non-urgent trips not scheduled 72 hours in advance.

TABLE 13				
Human Service Delivery Service Denials				
January - September, 1999				
Denial Type	**Accessible Vehicle**	**General Eligibility (Other Than Vehicle)**	**Scheduling**	**Total**
Number	36	99	25	160
Percentage	23%	62%	16%	100%
Source: Compiled by Program Review from Office of Transportation Delivery Complaints Data Summaried.				

Providers Attempt to Rectify Denials

It appears brokers attempt to rectify denials short of sending out letters noting that denials are permanent. For example, the summary sheets list scenarios that seem to show brokers are taking steps to provide rides, even though an initial denial has occurred. In Region 9, a provider/broker denied service because the recipient failed to give a three-day trip notice. But the follow-up notation indicated "Client is new to program and failed to call in advance for trip; broker will try and schedule." In Region 12, a recipient was denied service because of a wrong county code. A follow-up notation said "RTEC will take care of problem and provide transportation." In Region 5, the provider/broker apparently denied service based on a vehicle being in the household. But a follow-up seems to indicate that the vehicle was inoperable. The recipient was "advised to get a mechanic's statement, stating car is inoperable."

As noted earlier, what Human Service Delivery officials list as "complaints" are, in many cases, administrative actions. From the compilation sheets, staff identified 40 (8 percent) outright complaints filed against the program itself, drivers, or providers. Under program rules, recipients can file a complaint and obtain mediation at the cabinet level. Brokers are to respond promptly to all complaints and attempt immediate resolution. The complaint must be elevated to the Transportation Cabinet only after provider/broker mediation has failed. If Transportation is unable to resolve the complaint, a recipient can obtain a hearing at the appropriate state program agency level.

Brokers generally look on the appeals process as something that should be handled at the cabinet level. Some brokers told staff (see subsequent section) that initial non-emergency transportation denials are based on whether a recipient's name appears on eligibility lists maintained by the Department for Medicaid Services. If there is a question about eligibility, brokers tell recipients to check with their caseworker, Department for Medicaid, or to phone the toll-free number at the Transportation Cabinet. Brokers also deny trips for non-covered services, having an operable vehicle in the home, or for not being a resident of the region. Brokers believe recipient appeals should be referred to

officials in Frankfort. At the same time, though, they attempt to work with recipients and arrange trips if they can.

If there is a denial, apparently brokers do not tell recipients up-front that they have appeals rights, but tell recipients they should call state officials. A few send form letters indicating to recipients that a denial has occurred and the steps to take. Staff obtained a copy of a form letter that one broker uses. The letter notes that a Medicaid trip was denied and gives the following reasons that can be checked:

- You have been determined to be ineligible for Medicaid Transportation.
- You are unwilling to accept transportation from the provider assigned to you.
- Other.

The letter says further, "You have the right to appeal this decision within twenty-one (21) days of the postmark date of this letter. You may appeal to your caseworker at your local Department of Social Insurance (DSI). If your problem is not resolved, you may then contact the person(s) listed below for further assistance." The form letter later says an appeals officer will contact the recipient for additional information.

Number of Complaints Varies by Region

Using data supplied by the Transportation Cabinet, staff calculated the complaints per 1,000 trips for January through July 1999 for Medicaid and TANF recipients (Table 14). For all the regions in operation during the period, there were 1,500 Medicaid trips for each complaint filed, versus nearly 10,000 TANF trips. Perhaps because they are more likely to have special needs and because they have become used to particular providers and rules under the voucher program, Medicaid recipients complain to brokers much more frequently than TANF recipients do. Brokers in Regions 3, 7, and 9 received substantially more total complaints per 1000 trips during this period than did other brokers. This may indicate that the Transportation Cabinet should pay particular attention to monitoring the quality of services in those regions.

Table 14

Human Service Transportation Delivery Program
Complaints to Brokers
January 1, 1999 thru July 31, 1999

	Medicaid				TANF				Total			
Region	Trips	Complaints	Complaints per 1000 Trips	Trips for Each Complaint	Trips	Complaints	Complaints per 1000 Trips	Trips for Each Complaint	Trips	Complaints	Complaints per 1000 Trips	Trips for Each Complaint
1	-	1			4,648	3	0.65	1,549	4,648	4	0.86	1,162
2	26,532	7	0.26	3,790	1,709	1	0.59	1,709	28,241	8	0.28	3,530
3	20,389	29	1.42	703	3,329	1	0.30	3,329	23,718	30	1.26	791
4	1,959	0	-	-----	5,251	3	0.57	1,750	7,210	3	0.42	2,403
5	19,399	14	0.72	1,386	5,685	2	0.35	2,843	25,084	16	0.64	1,568
6	*	*		*	*	*		*	*	*	*	*
7	1,681	5	2.97	336	15	0	-	----	1,696	5	2.95	339
8	55,381	13	0.23	4,260	15,113	5	0.33	3,023	70,494	18	0.26	3,916
9	18,934	24	1.27	789	2,106	2	0.95	1,053	21,040	26	1.24	809
10	28,792	7	0.24	4,113	72,462	1	0.01	72,462	101,254	8	0.08	12,657
11	31,236	18	0.58	1,735	15,717	0	-	----	46,953	18	0.38	2,609
12	69,028	50	0.72	1,381	46,075	20	0.43	2,304	115,103	70	0.61	1,644
13	73,222	16	0.22	4,576	128,560	6	0.05	21,427	201,782	22	0.11	9,172
14	66,466	83	1.25	801	212,316	8	0.04	26,540	278,782	91	0.33	3,064
15	*	*		*	*	*		*	*	*	*	*
16	6,429	6	0.93	1,072	5,697	0	-	----	12,126	6	0.49	2,021
Total	**419,448**	**273**	**0.65**	**1,536**	**518,683**	**52**	**0.10**	**9,975**	**938,131**	**325**	**0.35**	**2,887**

*Not in effect during this period.

Source: LRC staff analysis of data provided by the Kentucky Transportation Cabinet Office of Transportation Delivery.

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Legislators Hear Complaints About the Program

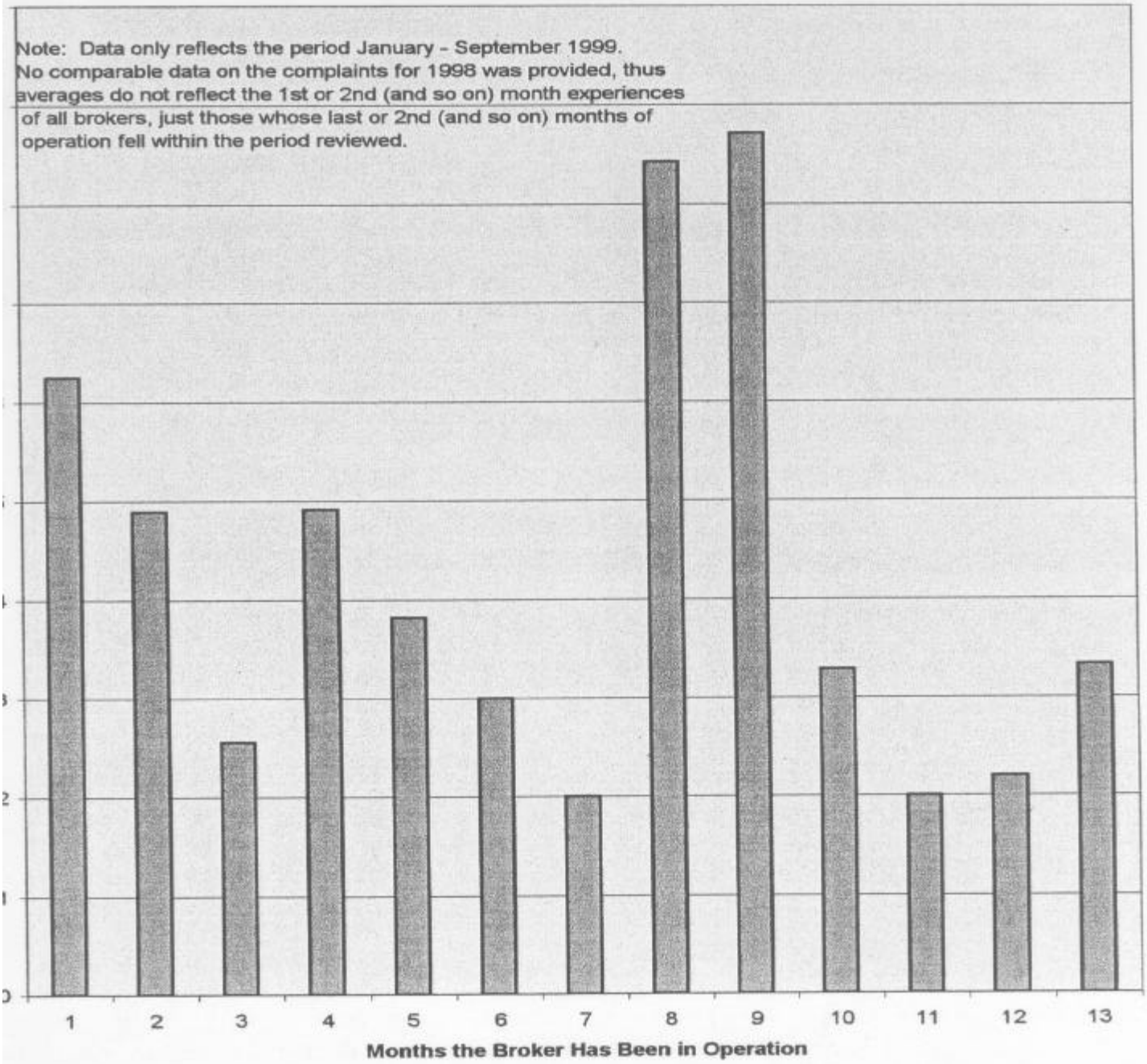
Several legislative committees, including the Transportation Committee, the Health and Welfare Committee, and the Administrative Regulations Review Committee, have heard testimony from recipients, providers, brokers, and Transportation Cabinet officials regarding the program. Recipients generally complained about the lack of freedom of choice in selecting providers, the inconvenience of scheduling trips 72 hours in advance, poor pick-up reliability, and having to wait an hour or more for a pick-up after a medical appointment. Various medical personnel complained about the lack of proper door-to-door care for disoriented recipients and insufficient precautions in the transport of non-ambulatory patients. Providers who subcontracted with brokers complained that the rates paid were too low to allow for a profit. They also complained that some brokers keep the most profitable trips for themselves and unfairly distribute trips among various providers.

Those same complaints are still prevalent. According to the president of the Kentucky Rural Transportation Association, providers have seen their business decline under the new system. Also, they believe brokers are not distributing business fairly through a system of rotating calls, and recipients whom they had served for years have lost their freedom of choice. "We want a fair playing field. It has not been that from Day 1," the transportation group president said. She said her own business in Bullitt and Jefferson counties has suffered under the new system.

Transportation officials and brokers offered two basic responses to these complaints. First was that many of the complaints were the result of start-up problems associated with changing the program structure. They assured legislators that they would respond to all legitimate complaints and were trying to work the bugs out of the new system. They also acknowledged that many of the complaints were associated with the move from a fee-for-service voucher system to a capitated broker system. The intent of such a move is to reduce costs. The means to achieve this is to reduce unnecessary trips, which may have existed under the voucher system, to restrict freedom of choice, and to reduce payments to providers to reduce the growth of total expenditures.

Staff examined the complaint data from January to September 1999 to see if the average number of complaints received by brokers tended to decline with increasing months of operation, which would indicate that many problems were related to the start-up process. In general, this trend was evident, although by no means uniform (Figure B). The average number of complaints during this period was generally higher for brokers in operation for one-two months than for brokers in operation for six-seven months. The large spike of complaints for brokers in operation for eight-nine months is due to a relatively large number of complaints received by the broker in Region 14 during January (30) and February (42), it's 8 and 9 months of operation. In March, this broker only received four complaints and kept a similar average for the rest of the period.

Figure B
Average Number of Complaints
January - September 1999



rce: LRC staff analysis of data provided by the Kentucky Transportation Cabinet Office of Transportation Delivery.

Staff also reviewed the requests for assistance related to this program received by the legislative Office of Constituent Services. The office addressed six complaints regarding the program in calendar 1998. Three were from providers who were unhappy with the new rates and procedures, and three were from recipients who were concerned about lack of access to desired services. Eleven complaints have been received so far in calendar 1999. Six were from recipients who had service concerns, four were from subcontractors unhappy with the rates, and one was from a County Judge Executive who did not think the program should continue.

Brokers Say Current Transportation Network Represents an Improvement Over Old System

Program Review staff contacted representatives of the regional brokers in each of the 16 human service transportation regions to discuss their methods for providing transportation services, their opinions about the advantages or disadvantages of the current system compared to the previous method of providing services, and their methods for preventing abuse of the current system. In general, the brokers told staff they felt the current system of providing transportation service was an improvement over the previous system. They told staff the current system offers more services and opportunities to individuals attempting to move from welfare to work. They also told staff the current system offers more flexibility for recipients, providing services 24 hours a day, seven days a week. Additionally, the brokers said that, while some problems remain, the current system prevents some of the abuses by both providers and recipients that existed under the previous system.

Eligibility Verification Among First Steps in Current Transport System

The regional brokers told staff that, under the current system, clients requesting transportation services call into the broker's office within each region. Though clients are encouraged to call during normal business hours, all brokers said they have the ability to handle client requests 24 hours a day, seven days a week. When the client calls into the broker's office, the first step is to verify that the client is eligible for services.

All regional brokers receive periodic updates to the eligibility lists. For Medicaid, those updates are received weekly, while updates for the TANF Welfare to Work program are received monthly. Nearly all the brokers download this information in electronic format and store it on their office computer systems. Only one regional broker reported using a paper system for verifying client eligibility. When a client calls in for services, the regional broker first attempts to verify eligibility against the downloaded list. If a client is not listed in the download, the regional brokers then attempt to contact Medicaid offices in Frankfort.

Medicaid's offices in Frankfort maintain a computerized eligibility database that regional brokers can access. All brokers reported that, if a client is not listed on the current eligibility download, they attempt to contact the system in Frankfort to determine if that client is listed as eligible on the Frankfort system. Some of the regional brokers reported problems accessing this system. They noted that, whereas they must be available to clients 24 hours a day, the Frankfort system is available only during weekday business hours. Additionally, most regional brokers said they could not access the system via the Internet or toll-free phone line and therefore incur expensive long distance charges to frequently access the system.

If the client was not listed either on the downloaded eligibility list or the list in Frankfort, or if the contractor could not access the Frankfort system, the regional contractors reported that either they called the client's caseworker or told the client to contact the case worker. Some brokers reported that they asked the client to describe his or her Medicaid card, or to fax a copy of the Medicaid card to the broker's office if eligibility could not be verified by any other method. Regional brokers told staff that they always tried to err on the side of the client if there was any doubt about the client's eligibility, even at the risk of providing transportation for which they would not be reimbursed.

After the client's eligibility has been determined, the regional broker determines the most efficient way to transport the client. If the client knows someone with a car, the broker can reimburse that individual's mileage if he or she will voluntarily transport the client. Some regional brokers told staff they provide welfare to work recipients with bus passes if the client's travel lies close to a bus route. Brokers in rural areas often complained that their costs were higher than in more urban regions. Rural regions usually do not have a mass transit system; therefore, the rural regional brokers cannot rely on existing mass transit systems and must contract with other carriers, such as taxi companies, which are often higher in cost and can be more logistically demanding than mass transit carriers with fixed routes and schedules. Additionally, rural areas often do not have the medical specialists that can be found in the urban areas of the state. This requires rural brokers to more frequently transport Medicaid clients long distances in order for them to receive specialty care.

All regional brokers stated that the current system for providing transportation service is an improvement over the previous system. Regional brokers stated that they are providing more flexible service and expanded hours of operation over what was available under the voucher system. They believe this increases their ability to respond to client needs. The brokers cited as examples the ability to provide transportation to night shift jobs for welfare to work clients. Another contractor provided an example of a client who had dropped a television set on her foot. Though this occurred during evening hours, they were able to provide non-emergency transportation to the local emergency room for the client for much less than an ambulance service would have cost.

The regional brokers did point out some difficulties with the new system, however. Some complained that information system requirements were not clearly defined in the

early stages of the program. They said brokers were left to select their own information systems and, as a result, there was some wasted effort because some programs were tried and found inadequate. Other brokers complained about the amount of data that is required for each client. Most brokers told staff, however, that these problems were encountered in the early stages of the program and are being overcome as they gain experience with the system. Many of the regional brokers also stated that they received more complaints from clients in the early stages of the new system. They asserted, however, that as they gained experience with the system and clients learned what to expect from the new system, complaints have decreased. Most regional brokers told us they do not receive many complaints from their clients.

Brokers Believe Fraud and Abuse Prevention Has Been Strengthened with System

Regional brokers told staff they believe the current system for providing non-emergency transportation services is less susceptible to fraud and abuse than the previous voucher system. All brokers reported that the current system originates with a client's call to the broker. The broker then determines the most efficient way of responding to the need and either provides the transportation itself or authorizes a subcontractor to provide transportation. Subcontractors are only paid for authorized trips, thus limiting the possibility of subcontractors manufacturing unnecessary trips. The capitated payment system provides an incentive for brokers to make only those trips that are necessary.

Another way that the previous system was alleged to be susceptible to abuse was in the mileage amounts providers charged. Five of the 16 regional brokers told staff they had purchased software mapping programs that allowed them to verify the mileage amounts their subcontractors reported. Several other regional brokers said that because they were familiar with the area and also provided transportation services, they were much more likely to detect mileage reports that were inflated. Additionally, while only four regional brokers mentioned a formal audit function dedicated to the program, most stressed that each payment voucher submitted by a subcontractor is closely examined and excessive mileage rates are recouped. `

Other methods the regional brokers cited for fraud and abuse prevention included:

- Calling physicians' offices to confirm client appointments
- Checking with Department of Motor Vehicles when alerted that clients might own a motor vehicle
- Follow-up surveys with clients
- Field inspections of provider vehicles to insure they meet quality standards.

Regional Brokers Believe Some Weaknesses Remain in the Current System

Several regional brokers noted that weaknesses remain in the current system and that fraud or abuse remains a concern. One of the most frequently mentioned concerns was the potential for improperly classifying Medicaid eligible clients. Payment for transportation services varies across the Medicaid eligible population, based upon the client's transportation needs. Standard non-emergency medical transportation is the cheapest form of Medicaid transportation. Higher rates are paid for the transport of disoriented clients and clients requiring wheelchair medical transportation. Five of the regional contractors mentioned having concerns that some of their Medicaid clients might be improperly classified, resulting in higher than necessary payments to the subcontractor providing the transportation services. For example, in Region 11 the subcontractor payment rate for transportation of standard non-emergency clients is as follows:

0 to 5 miles	$5.50
6 to 10 miles	$11.00
11 to 25 miles	$18.00
26 to 50 miles	$27.00
Over 50 miles	$.90 per mile not to exceed $75.00 per trip

For disoriented clients, however, the payment is $10 per pick up plus $1.25 per mile, not to exceed $100 per trip. For wheelchair bound clients the payment rate is $20 per pick-up plus $1.25 per mile, not to exceed $100 per trip. For a trip of 10 miles the standard rate would result in a payment of $11. The payment for transporting a disoriented client would be $22.50, and payment for a wheelchair bound client would total $32.50. A representative for the Region 4 broker said he believes this is a particular problem in his area. The Region 4 representative said he plans to send out a region-wide mailing directly to the physicians in the region, requesting that they reclassify all Medicaid non-emergency transportation eligible clients. By explaining the consequences of the classification system and directly communicating with the physician, it was anticipated that a more accurate classification could be obtained and costs controlled.

Another concern raised by numerous regional contractors was the exaggerated listing of "first riders." The rates quoted above are for the first rider on each trip. For example, if more than one passenger of the same type is included in the same trip, the payment for the second and subsequent passengers is only $4 each. Several regional brokers indicated a concern that the subcontractors were listing multiple passengers on each trip as "first riders" and recouping a higher than deserved payment. Closely monitoring the vouchers for each trip is necessary to control this potential problem. The broker in Region 4 told staff he is attempting to develop a software program that will allow his staff to sort trips by ZIP code and time, so that the staff can more closely examine the number of trips from each region and the clients participating in each trip.

Broker Telephone Answering Responses Tested

A test of brokers' phone systems found no significant problems overall. In the complaint data, some recipients had criticized brokers for not answering their phones in a timely manner, or being difficult to reach by phone. As indicated earlier, the regional contractors are required to maintain toll-free lines for recipients' to use.

Program Review staff tested the phone systems by calling each broker five times on various days and at various times during October 1999. As shown in Table 15, 79 percent (63) of these calls were answered by an employee within six rings. No answer was received after six rings in 5 percent of the calls. Sixteen percent of the calls were answered with a recorded message that no employees were available to take the call. In nine of these instances, the recorded message asked the caller to hold on the line for the next available employee. In these cases, the time on hold ranged from 12 to 45 seconds.Finally, in four calls, with three of them being to the same broker, the recorded message asked the caller to leave a telephone number so the call could be returned at some later time. The conclusion is that most brokers are providing responsive telephone access, but that some improvement could be made.

TABLE 15					
Provider/Broker Phone Survey Results					
	Result			If Busy	
Broker	Answered	6 Rings Without Answer	Busy	Average Time on Hold	Recorded Message requesting caller to leave a # for a later return call
Paducah Area Transit System (PATS)	5				
Pennyrile Allied Community Services (PACS)			5	12 seconds	
Audubon Area Community Services	3		2	30 seconds	
Transportation Management System	5				
Yellow Cab Company, Inc.	4	1			
Yellow Transportation Management	4		1	45 seconds (then no sound)	
American Red Cross Louisville	4	1 disconnect			
Bluegrass Community Action	3		2	30 seconds	1
Region 9 Transportation, L.L.C.	5				
Federated Transportation Services of the Bluegrass	5				
Kentucky River Foothills Development Council	5				
Rural Transit Enterprises Coordinated (RTEC)	4	1			
Leslie, Knott, Letcher and Perry Community Action Council (LKLP)	5				
Sandy Valley Transportation Services	5				
Community Action Council	2		3		3
Licking Valley Community Action	4	1			
Total	**63**	**4**	**13**		
Percent of Total	**79%**	**5%**	**16%**		
Source: Program Review Telephone Survey					

Programmatic Issues Concerning Duplication of Payments Appeal Rights Requirements Remain

Several programmatic issues require additional consideration. As a coordinated program serving different human service programs, it is important that safeguards be developed against duplicative benefit payments. Where benefits are denied, it is important that recipients are informed of appeal procedures.

Coordinated Human Service Transportation Should Guard Against Duplicative Payments

The objective of the waiver program is to reduce federal and state costs of providing transportation services to the eligible populations. In section 1915(b)(1) of the capitated waiver request submitted by the state, duplication of benefits is discussed. The state gave assurances in its waiver request that the systems in place would avoid duplicate payments.

Reviews of procedures and interviews with Transportation Cabinet staff have indicated the potential for duplication exists within the system.

The TANF program provides for recipients to be paid a gas stipend for use of a personal vehicle, or a vehicle they have access to, for transportation. Using the federal definition of "necessary" transportation, only recipients who have specific individual needs should be considered for non-emergency medical transportation services if they are also eligible for the gas stipend under the TANF Program. According to Transportation Cabinet officials, no check has been done to rule out such duplication in benefits.

Appeals Process Should be Consistent with Federal Requirements

The Department of Medicaid Services and Transportation Cabinet should review the procedures used by brokers when transportation services are denied to ensure they are consistent with federal regulations. The Kentucky Coordinated Human Service Transportation Delivery Network Plan indicates the broker is responsible for promptly responding to all complaints and attempting immediate resolution. The complaint is elevated to the Transportation Cabinet after mediation by the provider has failed. The transportation broker is to mediate and resolve 95 percent of all complaint calls received.

In regard to appeals, the network plan stipulates that, if the mediation process fails, the complainant will be given the opportunity to have the dispute elevated to Transportation Cabinet staff for further review and resolution. When the Transportation Cabinet is unable to resolve the complaint, the complainant will be given written final notice informing him/her of a fair hearing to be conducted by the appropriate state program agency. (See earlier discussion regarding appeals processes.)

This process appears to be inconsistent with federal regulations for non-emergency medical transportation programs. The Code of Federal Regulations (42 CFR) 431.200 indicates that a state plan should provide an appeal opportunity for any person whose claim for assistance is denied or not acted upon promptly. The regulation also prescribes procedures for a fair hearing if the Medicaid agency takes action to suspend, terminate, or reduce services. The federal regulation under 431.206 also stipulates that the agency must inform every applicant or recipient in writing of the right to a hearing or the method for which a hearing may be obtained. This must occur at the time services are denied. The Department for Medicaid Services and the Transportation Cabinet should review the appeal procedures to insure beneficiaries are properly notified of their rights as prescribed under the State Medicaid Plan when brokers deny transportation services.

Change from Voucher Program to Coordinated Transportation Program Affected Providers in Various Ways

Detailed data regarding services provided to clients is contained in the encounter data reported by brokers on a monthly basis. These data generally reflect information associated with each one-way trip taken by program recipients who reside in a broker's region. Staff obtained the encounter data reported by each region for each month of operation.

The information captured via the encounter data includes a unique number associated with each one-way trip. For each trip, the record contains identifiers for region, month, recipient-specific information, date of service, type of transport, pick-up and arrival times, pick-up and destination locations, number of miles traveled, the rate per mile, whether the trip was made by a contractor or a broker, the claim submission date and the claim payment date, among others.

The encounter data are important for a number of reasons. First, some of the variables reported must be sent to HCFA as part of the waiver requirements allowing implementation of the coordinated transportation program. Also, data of this type can be useful in monitoring the type of trips, amounts paid, and timeliness of payments. Moreover, the data capture total miles, total trips, type of trips and amounts paid to subcontractors, and thus could be useful in updating trends in costs and utilization rates.

Along with the encounter data reported by the brokers to the Transportation Cabinet, staff requested non-emergency medical transportation data from the Department for Medicaid Services from 1997 to the present. The data obtained reflected the year, county, number of trips, provider name and number, the amount paid, and the type of transportation.

The intent in analyzing this data was to evaluate the distribution of payments to providers in 1997 under the voucher system, and then, by using the encounter data, to assess changes in the distribution of payments to providers under the coordinated transportation program. Specifically, the data were analyzed to make estimates regarding how providers have fared in moving from one system to another. The 1997 Medicaid non-emergency transportation data were used as the baseline because it represents the last year in which the voucher system was in place.

Table 16 shows the results from the comparative analysis of data from the voucher system and the new coordinated transportation program. Note that the results are not reported by regions or by provider name, in order to protect the confidentiality of providers, but the comparisons were done on a regional basis. Initially, the 1997 data were summed to the regional level for each provider. For example, if there were 10 providers in Region 1, all of the payments received by these providers were summed to calculate the percent of the total payments in Region 1, by provider. For the encounter data, payments to subcontractors were summed to the regional level and then payments as a percent of the total capitated payments received was calculated for that region.

Table 16
Market Share of Individual Providers
1997 Medicaid
1999 Coordinated Transportation Program

	1997	1999	Regional Market Share	Regional Market Share	Percentage Point Difference
1	$ 282,819	$513,233	12%	60%	48%
2	$ 33,675	$ 16,657	31%	59%	28%
3	$ 60,572	$ 44,292	4%	31%	27%
4	$ 77,603	$ 10,581	6%	29%	23%
5	$ 14,652	$ 7,472	1%	21%	20%
6	$ 70,059	$ 12,580	5%	23%	18%
7	$ 51,425	$116,463	5%	22%	17%
8	$ 62,855	$ 27,316	5%	21%	16%
9	$ 36,108	$ 58,238	3%	17%	14%
10	$ 60,750	$ 64,731	6%	19%	13%
11	$ 5,841	$ 17,710	0%	13%	13%
12	$ 36	$ 31,861	0%	11%	11%
13	$ 8,718	$ 94,561	0%	11%	11%
14	$ 33,213	$280,348	2%	13%	11%
15	$ 140,619	$ 25,159	20%	30%	10%
16	$ 204,931	$ 99,357	29%	38%	9%
17	$ 9,588	$ 25,686	1%	10%	9%
18	$ 191,335	$165,328	40%	48%	8%
19	$ 8,240	$ 6,732	1%	8%	7%
20	$ 21,233	$ 26,193	2%	8%	6%
21	$ 7,863	$ 7,215	1%	6%	5%
22	$ 40,891	$ 10,642	3%	8%	5%
23	$ 62,458	$ 51,060	6%	10%	4%
24	$ 132,475	$107,679	28%	31%	3%
25	$ 3,732	$ 8,911	1%	3%	2%
26	$ 3,011	$ 10,174	1%	3%	2%
27	$ 21,091	$ 88,511	1%	4%	3%
28	$ 52,398	$ 8,769	4%	7%	3%
29	$ 21,431	$ 23,628	2%	4%	2%
30	$ 71,810	$ 43,178	3%	5%	2%
31	$ 8,031	$ 720	1%	2%	1%
32	$ 2,469	$ 1,852	0%	1%	1%
33	$ 2,587	$ 30,243	0%	1%	1%
34	$ 20,581	$ 10,818	3%	4%	1%
35	$ 62,035	$111,214	4%	5%	1%
36	$ 7,604	$ 4,554	1%	1%	1%
37	$ 79,915	$ 27,222	7%	8%	1%
38	$ 952	$ 3,420	0%	1%	1%
39	$ 4,613	$ 7,979	0%	1%	1%
40	$ 78,979	$ 27,722	3%	3%	0%
41	$ 31,981	$ 9,159	3%	3%	0%

	1997 MEDICAID	1999 HSTD	Regional Market Share	Regional Market Share	Percentage Point Difference
42	$ 29,250	$ 11,369	3%	2%	-1%
43	$ 45,003	$ 54,550	3%	2%	-1%
44	$ 93,330	$ 2,221	7%	6%	-1%
45	$ 26,123	$ 1,548	2%	1%	-1%
46	$ 59,772	$ 69,031	4%	3%	-1%
47	$ 35,553	$ 2,510	3%	2%	-1%
48	$ 72,029	$ 6,181	6%	5%	-1%
49	$ 78,435	$ 20,730	7%	6%	-1%
50	$ 26,412	$ 14,534	6%	5%	-1%
51	$ 21,235	$ 45	2%	0%	-2%
52	$ 47,454	$ 38,148	4%	2%	-2%
53	$ 54,375	$ 6,272	2%	0%	-2%
54	$ 19,775	$ 8,014	5%	3%	-2%
55	$ 48,529	$ 11,893	7%	4%	-3%
56	$ 64,650	$ 16,551	8%	5%	-3%
57	$ 76,725	$ 2,595	3%	0%	-3%
58	$ 109,478	$ 10,023	15%	11%	-4%
59	$ 63,180	$ 305	4%	0%	-4%
60	$ 89,802	$ 15,733	9%	5%	-4%
61	$ 168,060	$ 59,858	15%	11%	-4%
62	$ 112,352	$ 72,889	8%	4%	-4%
63	$ 151,014	$ 15,620	6%	2%	-4%
64	$ 225,036	$233,750	15%	11%	-4%
65	$ 230,780	$239,248	16%	11%	-5%
66	$ 329,455	$ 34,755	47%	41%	-6%
67	$ 61,912	$ 296	6%	0%	-6%
68	$ 128,026	$ 51,886	9%	2%	-7%
69	$ 111,020	$ 12,872	10%	3%	-7%
70	$ 171,844	$ 5,193	11%	4%	-7%
71	$ 283,728	$ 37,728	11%	4%	-7%
72	$ 120,076	$ 7,412	17%	9%	-8%
73	$ 246,117	$ 12,553	20%	9%	-11%
74	$ 315,691	$ 17,540	13%	2%	-11%
75	$ 264,457	$149,605	18%	7%	-11%
76	$ 276,684	$ 13,983	22%	11%	-11%
77	$ 140,100	$ 4,168	13%	1%	-12%
78	$ 316,350	$ 84,918	45%	32%	-13%
79	$ 263,683	$ 35,217	25%	10%	-15%
80	$ 216,398	$ 10,841	28%	4%	-24%
81	$ 581,277	$ 1,750	45%	3%	-42%
82	$ 726,734	$ 1,350	85%	1%	-84%

By making the comparison as described above, estimates of the percent of total non-emergency medical transportation business in each region were obtained for each provider that received a payment in 1997 and for each provider operating as providers under the new coordinated transportation program. Providers were then matched across the two data sets to determine those who were operating in both programs.

Overall, there were 158 providers identified for the Medicaid voucher program and 180 providers identified for the coordinated transportation program. Eighty-two providers operated in both programs. Seventy-six providers who had operated in the voucher program do not participate in the coordinated transportation program, and 98 providers not in the voucher program joined the new program.

Of those who operated in both programs, half had a larger regional market share in the new program than they had in the voucher program, and half had a smaller regional market share in the new program. Providers who gained market share received 14 percent of total reimbursement dollars under the voucher program, compared to 39 percent of total reported reimbursement dollars under the coordinated program. The comparable figures for providers who lost market share were 41 percent and 25 percent, respectively.

Finally, providers who lost regional market share in the move to the new program had an average market share in the voucher program of 14 percent, compared to 6 percent for providers who gained market share in the move. This data indicates that, on average, smaller providers (as measured by voucher program market share) were not particularly disadvantaged by the program change, and may even have benefited when compared to larger providers.

Overall, however, the data in Table 16 indicates that for the majority of providers who participated in both programs, the percent of total payments they received were reduced under the broker system. Such a result is not surprising because, for a number of regions, brokers are providers. In addition to managing the transportation services delivered within the region, they provide direct transportation services as well. To the extent that brokers have increased their percentage of trips supplied, other providers have felt the effects. What the results suggest is that a number of providers who received payments during this time have experienced a reduction in market share because of the change in the system. If the broker/provider has taken more of the trips but can do so at a lower cost, this is an intended consequence of the new program.

The broker system has had an effect not only on commercial entities but others as well. Under the voucher system, reimbursement for trips made by private autos were allowed; and reimbursements were much more prevalent in those areas where availability of commercial transportation providers was limited. Brokers now are responsible for providing adequate accessibility to transportation providers in all regions and for reducing opportunities for unnecessary trips. Likely as a result of these efforts, the number of trips and amount of transportation dollars going to private auto trips has decreased in a number of regions.

The analysis indicates that a number of providers lost market share as a result of the implementation of the new program. Without provider-specific information across all lines of their business it could not be determined whether providers who lost market share suffered actual financial declines. Moreover, the corollary to the results is, if these providers lost market share, then who gained it? In a number of instances, other providers increased their market shares, and to a lesser extent, new providers came into the program. Also, in some cases existing providers did actually increase their market shares.

Serious Concerns about Data Quality

Segments of the encounter data analyzed above are used in the development of summary reports by the Transportation Cabinet regarding non-emergency medical transportation services provided via the brokers. These summary reports are forwarded to the Department for Medicaid Services and, as previously mentioned, a subset–20 variables–of the encounter data is also sent to HCFA. Overall, staff found inconsistencies within the data, normal data entry errors, miscoding of data (such as brokers reporting as subcontractors or brokers not reporting their own trips), duplicative records within files, inconsistent type of reporting across regions (text versus numeric), and unconventional or non-standard approach to reporting.

On a monthly basis, each broker electronically submits encounter data for the region to the Transportation Cabinet. The data are then summarized and reported based on the month received. The summary reports are not month-specific–e.g., they represent the month data were received, but not the actual month encounters occurred. The data received in May could actually be a combination of trips in both May and April, along with trips incurred in other months, but just now being reported. A standard approach would be to take the data, and report it based on the month of service. Another point to note is that at any given time the data will not reflect what has happened to-date. Reports developed based on the month of service would still not capture those trips that have taken place, but have not been reported to the broker. To the extent that the reports are not adjusted for services provided in one month but reported in a different month, the encounter data are not being accurately portrayed.

For those regions where duplicative records occur, the number of total trips is overstated. Moreover, because a number of other fields in the summary reports are derived based on the unique number of trips, if the number of trips is overstated, then other variables will be overstated as well. For example, if the number of trips is overstated, that affects total miles, total trips by subcontractors and brokers, and the amount paid to subcontractors. In short, duplicative records within a data set introduce error into every summary statistic reported.

Besides duplicative records within the encounter data, miscoding of information was a problem as well. In a number of instances, the code for separating broker encounters from subcontractor encounters was not entered correctly. To the extent this occurs within the data set, summary data based on the variables for brokers and subcontractors is incorrect. Along those same lines, it was found that information reported by the brokers on their trips varied a

great deal. For instance, since brokers receive capitated payments, they will not report amounts for the individual trips they make themselves. They will report information for each trip regarding the person transported, pick-up and destination points, etc. In reviewing the encounter data for the brokers, in a number of instances staff found that brokers were not reporting miles, thus affecting the accuracy of the summary reports.

SECTION III

Conclusions and Recommendations

Based on the review of the Coordinated Human Services Transportation Delivery Program, this section summarizes the major conclusions in regard to program operations. A subsequent section offers recommendations.

Conclusions

1. **Costs for Medicaid non-emergency transportation were increasing at a rapid pace under the voucher system, and stories of significant fraud and abuse were common.** Between 1989 and 1997 the average annual increase in expenditures for the Medicaid non-emergency voucher program was 26 percent. This reflected an increase from $4.5 million in 1989 to $27.9 in 1997. Although total expenditures continued to increase to $36.9 million in 1999, the annualized rate of increase had fallen to 15 percent. Stories of inappropriate trips by recipients and excessive billing by providers were common.

2. **Under a fee-for-service reimbursement system, such as the voucher system, the financial incentive for providers and recipients was to over-utilize services. The primary oversight responsibility of the Commonwealth was to restrict unnecessary utilization and fraudulent billing.** The voucher system reimbursed providers on a per mile basis. Thus, the more trips and miles they reported, the more they were reimbursed. They had no incentive to ensure that trips were legitimate and that shortest routes were selected. This responsibility fell to the Department for Medicaid Services.

3. **Under the capitated system, the financial incentive for brokers is to reduce trips and miles.** The current program pays brokers a fixed amount per month for each eligible recipient in the region. If the per member per month payment is $5 and there are 25,000 eligible recipients in the region, the broker receives $125,000 per month no matter how many trips are made by recipients. The broker must either provide the trips directly or subcontract with another provider to supply the covered transportation. If the total cost of the transportation is less than $125,000 for the month, the broker gets to keep the excess; however, if the total cost is more that $125,000, the broker has to absorb the loss. Thus, the broker has a strong financial incentive to reduce unnecessary trips and excessive miles. Regional brokers may be better able than state officials to monitor unnecessary trips and excessive miles because they are more familiar with local patterns and practices.

4. **Brokers have different incentives from the providers who subcontract with them.** While brokers are paid on a capitated basis to arrange for the provision of all required transportation services, subcontractors are still reimbursed on a per trip and, usually, a per mile basis. Thus, to the extent that reimbursement rates are high enough to allow

for a profit, the incentive for the subcontractor is still to increase trips and miles. This is in contrast to the broker who has an incentive to reduce the trips and miles allowed. Brokers who are also providers have a financial incentive to assign less profitable trips to subcontractors and keep more profitable trips for themselves. For example, say two trips have equal reimbursement rates of $25, but one has associated costs (fuel, labor, fixed costs) of $18 while the other has associated costs of $22. The broker will earn a higher net profit by retaining the less costly trip and assigning the more costly trip to a subcontractor. While it may have been necessary to allow brokers to also be providers in order to elicit their bids, the arrangement represents a clear conflict of interest in the assignment of trips to subcontractors.

5. **It is too early in program implementation to draw reliable conclusions about the effectiveness of program operations or whether the promised reduction in expenditure growth will be realized.** Only four of the regions have been in operation for a full year and, because of the court injunction in Jefferson County, the program has not yet been fully implemented in the Commonwealth's largest county. There have not been enough months of data collected to reliably estimate cost and quality changes. Also, the data that has been collected likely reflects the higher average costs and program confusion that are often associated with any start-up period. Thus, they may not be generalizable to expectations about steady-state performance.

6. **The potential exists for a significant reduction in the growth of program expenditures, but reliable estimates cannot be made at this time.** The average annual growth rate in Medicaid non-emergency transportation expenditures fell from 26 percent between 1989 and 1997 to 15 percent between 1997 and 1999. However, it is not possible to determine if the current moderation in expenditure growth will continue and, if it does, whether it can be attributed to the implementation of the coordinated transportation system. However, it is clear that the capitated fee structure gives brokers a strong financial incentive to reduce unnecessary trips and excessive miles. Also, reimbursement rates for trips for disoriented recipients and non-ambulatory recipients are generally below the previous Medicaid voucher rates. Since the aged, blind, and disabled accounted for 90 percent of 1996 non-emergency transportation expenditures, the fact that these rates are lower indicates that savings may be achieved, at least in the short-run.[1]

7. **Recipients and their advocates have lodged a variety of complaints about the quality of the service rendered under the new program.** These complaints have been made to brokers, Transportation Cabinet officials, and legislators. Recipients generally complained about the lack of freedom of choice in selecting providers, the inconvenience of scheduling trips 72 hours in advance, poor pick-up reliability, and

[1] Note that the level of reimbursement rates does not directly affect the amount of savings the Commonwealth may realize. Reimbursement rates are negotiated between the broker and providers and determine the amount of the capitated payment that brokers will get to keep. It is the per member per month capitation rates paid to brokers that directly determine the total expenditures for the Commonwealth. However, since these must adequately cover the reimbursement rates in the long run, there is an indirect link between reimbursement rates and the growth rate in state expenditures.

having to wait an hour or more for a pick-up after a medical appointment. Various medical personnel complained about the lack of proper door-to-door care for disoriented recipients and insufficient precautions in the transport of non-ambulatory patients. There was some indication that the average number of complaints to brokers generally declines with increased months of operation. This would suggest that some of the complaints might be related to the confusion associated with the start-up of a new program.

8. **Subcontractors have complained that the reimbursement rates are too low to allow a profit and that brokers unfairly distribute trips.** If providers cannot make a profit they will not continue to supply services. However, if the goal of the Commonwealth is to reduce program growth by providing an incentive for brokers to reduce costs, it must be acknowledged that subcontractors are the ultimate source of that reduction. Because the complaints of subcontractors are related to the financial incentives built into the program, it is not expected that the frequency of their complaints will decline with longer operation of the program.

9. **While some providers, particularly those who are also brokers, increased their share of the regional Medicaid non-emergency transportation market under the new program, many experienced a decline in market share.** Providers who lost regional market share in the move to the new program had an average market share in the voucher program of 14 percent, compared to 6 percent for providers who gained market share in the move. This data indicates that, on average, smaller providers (as measured by voucher program market share) were not particularly disadvantaged by the program change, and may even have benefited, when compared to larger providers.

10. **Now that it has gotten the program implemented in all regions of the state (excepting the Medicaid portion of Jefferson County), the primary task of the Transportation Cabinet is to monitor the program to assure that adequate quality of service is maintained.** The incentive for brokers is not just to reduce unnecessary trips and excessive miles, but to reduce <u>all</u> trips and miles and to provide trips in the least costly manner possible. Thus, the financial incentive is to underserve the eligible recipients. The freedom of choice of provider in the voucher program allowed recipients to be the arbiters of quality. If they did not believe they were receiving quality service, they had the freedom to select another provider. Under the capitated program, freedom of choice is restricted. Therefore, the task of monitoring and enforcing quality standards falls to the Transportation Cabinet. Because brokers and subcontractors will have a financial incentive to reduce costs, and because recipients are not always free to change providers, quality assurance must become a primary task of the Transportation Cabinet.

11. **Current procedures for the collection and analysis of data are judged inadequate for the task of monitoring and enforcing quality standards.** Data collected and submitted by brokers is incomplete, inconsistent, and poorly validated. There is also a concern that brokers may not report complaint data completely and impartially.

Providers, recipients, and medical personnel may be reluctant to complain to brokers because of a real or imagined fear of retribution. Cabinet officials appear to do little more with the data collected than aggregate cells into inaccurate summary reports. There is little checking of the data and little comparative analysis of the data across brokers or across time.

12. **Many brokers do not currently record a claims amount for trips they provide in the encounter data submitted to the Transportation Cabinet. The absence of this data could significantly hamper the Cabinet's ability to determine actuarially fair capitation rates in the future.** Staff attempted to assess the total expenditures in the coordinated transportation program by program (Medicaid, TANF) and subgroup (disoriented recipients, non-ambulatory recipients). However, this was not possible because many brokers do not record a reimbursement claim amount for the trips they provide. Only the reimbursement claims paid to subcontractors are always reflected in the data. Across all regions, 75 percent of the trips recorded by brokers do not have an associated claim amount entered in the encounter data. It is understandable that brokers may not feel the need to report money they pay themselves and that they may be reluctant to report data that could allow others to calculate the amount of money they keep from the capitated payments. However, over time the absence of complete claims data on the various programs and subgroups will seriously hamper the ability of state officials to negotiate capitation rates that are actuarially fair. Since the brokers will have access to all relevant claims data, they will have a significant information advantage in the bargaining process.

13. **The overall conclusion is that the coordinated human services transportation program has experienced several serious implementation problems and could benefit from improved program oversight and management. However, there is not sufficient current evidence to conclude that implementation should not continue.** With any new and unique program implementation problems should be expected to arise. Few programs are implemented without significant correction and refinement. The mark of a successful program is not the complete absence of implementation mistakes, but is that program managers quickly and successfully respond to problems as they arise. Full cooperation by the Office of Transportation Delivery in this review indicates that program managers are open to identifying problems and working toward their resolution.

Recommendations

Based on the conclusions drawn about the coordinated transportation program, staff offers the following recommendations for Committee consideration.

1. **The policies and procedures of the Coordinated Transportation Advisory Committee should be formalized. Minutes of its meetings, indicating such things as items discussed and the outcome of votes taken, should be kept of each meeting.** Even though the Coordinated Transportation Advisory Committee has been described as a "communications tool," it appears the body is setting policies and

procedures, or at least is making recommendations regarding them. It is also making other programmatic recommendations, including the awarding of contracts. While the existence and role of the CTAC as a conduit and communications body between contracting cabinets is acknowledged, as a policy body it should be duly constituted in some official manner.

2. **Transportation and Medicaid officials should complete regular checks to ensure that there is no duplication of benefits in the coordinated transportation program.** As indicated, the Health Care Financing Administration has issued a clear definition of "necessary" transportation and has an expectation that a Medicaid recipient with accessible and operable transportation can be denied non-emergency transportation under usual circumstances. This may be important in the future when HCFA audits the program. A regular procedure should be instituted for determining that those receiving daily gasoline stipends under TANF do not normally receive transportation services under the coordinated program.

3. **The Transportation Cabinet, working closely with the contracting cabinets, should review its appeals procedures to assure their consistency with federal regulations and the State Medicaid Plan, and to guarantee that recipients clearly know their rights when services are denied.** By contract, the Transportation Cabinet requires brokers to mediate and resolve 95 percent of all complaints received by brokers. Many of those issues can be handled adequately at that level. However, the Cabinet should make sure that clients know they have a right of appeal extending through the Transportation Cabinet to the appropriate contracting cabinets. That could be done in the literature that recipients receive initially. Also, brokers should provide a written explanation of the appeals process anytime that services are denied. The Transportation Cabinet should check to make sure that brokers are sending the proper letters to recipients who have been denied service.

4. **The Department for Medicaid Services should evaluate and review the objectives set forth in the waiver request to ensure that they are being met with the coordinated transportation program. Additionally, the Department for Medicaid Services should ensure that all reporting requirements, report analysis and independent assessments have been completed within the time frames set by HCFA in the waiver continuation and that additional continuations will be sought in a timely manner.** Although most of the requirements of the non-emergency transportation waiver request are contingent on the performance of the contract with the Transportation Cabinet, the Department of Medicaid Services is ultimately responsible for demonstrating the success of the program to HCFA. The Department of Medicaid Services should monitor the terms of its contractual agreement with the Transportation Cabinet to ensure the terms are being met and that reporting requirements can be achieved in an accurate and timely fashion. In particular, the Department for Medicaid Services should work with the Transportation Cabinet to develop a standard electronic claims comparison routine that would indicate that non-emergency medical transportation claims have associated medical claims on the same

date. This would reduce payments for inappropriate trips and should result in lower capitation rates.

5. **Brokers should be required to develop methods to assure that non-emergency medical transportation clients are classified properly and to rectify the "first rider" problem.** Trips for disoriented and non-ambulatory recipients are reimbursed at a higher rate. After the first rider on any trip, the reimbursement for each additional rider is usually reduced. In the interviews with staff, brokers said that some subcontractors report incorrect classifications to achieve the higher reimbursements. Although this higher reimbursement comes at the cost of brokers and does not directly affect state program costs, a pattern of incorrect classifications is likely to result in an upward pressure on capitation rates. Therefore, the Transportation Cabinet should take an active role in assuring that brokers develop procedures to prevent such abuses. If the Transportation Cabinet develops the data capabilities recommended below, it should have the ability to electronically check the encounter data for multiple "first riders" for the same trip.

6. **The Transportation Cabinet should improve the procedures for collection, validation, and analysis of program cost data.** In working with the encounter data collected and reported to the Cabinet by brokers, staff identified several problems that materially compromise the validity of the summary reports that are derived from the data. Brokers do not report trips for comparable periods, 75 percent do not report reimbursement rates for the trips they provide themselves, and 2 percent of the records appeared to be duplicates. These problems with program cost data will seriously hamper the ability of Cabinet officials to accurately demonstrate program cost savings to state and federal officials and, in the long run, could compromise the state's ability to develop actuarially fair capitation rates for the various Medicaid and TANF populations.

7. **The Transportation Cabinet should place greater emphasis on the task of independently monitoring and enforcing the quality of transportation services delivered to program recipients.** A policy decision has been made to move to a capitated rate structure in order to reduce the growth of expenditures in the human services transportation program. Under such a system, both local brokers and subcontractors have a financial incentive to reduce the costs of the services they deliver. The freedom of recipients to select a new provider in the event of poor service is restricted. Therefore, independent and effective monitoring of service quality by both the contracting cabinet and the Transportation Cabinet is critical to the program's successful operation. At this time it does not appear that the Cabinet is collecting sufficient valid and impartial data to fulfill its oversight role. In particular the Cabinet should:

7.1. Redesign the rider survey to obtain valid and objective results.

Results from the existing surveys are of little use because of unacceptable data collection protocols. Surveys should be conducted by an independent entity with the expertise to design and administer a valid survey instrument.

7.2. Minimize reliance on complaint data collected and reported by brokers. Brokers have an incentive to underreport the frequency and seriousness of complaints. Also, even if they do accurately report the complaints they receive, some recipients and medical personnel have said they are reluctant to report complaints to brokers because of a real or imagined threat of retribution. To the extent that this reluctance exists, broker complaint data is a biased measure of program quality.

7.3. Develop procedures to independently check, on a random basis, program quality indicators. For example, the Cabinet could send unannounced observers to pick-up and delivery sites to assess timeliness and interaction quality. Cabinet officials also could conduct test calls to brokers as if they are clients to see how recipients with various characteristics are handled. Spot checks of vehicle condition should be made to assure that providers are following program requirements.

7.4. Consider designating an independent ombud to receive complaints from recipients and to work for their fair resolution. Cabinet officials have worked very closely with brokers during the implementation phase of the program. It is understandable that they may see brokers as partners in the delivery of services. However, because of the particular financial incentives that exist in the program, Cabinet officials must assert their roles as advocates for recipients and monitors of brokers. This stance is necessary to ensure that the contracting cabinets actually receive the services they purchase, and to demonstrate to state and federal policymakers that the citizens they have chosen to serve with the appropriated funds are the true program beneficiaries.

8. **The Transportation Cabinet should be required to provide quarterly reports to the Legislative Research Commission for distribution to the Health and Welfare, Transportation, and other interested committees.** Legislators have received several complaints about the operation of the coordinated transportation program. Regular reporting will allow them to respond more accurately to constituent concerns and will better allow them to perform their own oversight role.

9. **The Program Review and Investigations Committee should re-visit this program after the 2000 Session of the General Assembly.** It was concluded that the program was too new to have generated sufficient indicators of performance quality for any definitive conclusions to be drawn about its effectiveness. Even if the data were of sufficient quantity to allow such analysis, the fact that it would be drawn from the start-up period could make it a poor indication of steady-state program performance. However, since this review has identified some problems that, if allowed to continue, could compromise long term program effectiveness, it is recommended that the

Committee plan a follow-up review to evaluate the more complete data and to determine if Committee recommendations have been implemented.

APPENDIX A

Background Information Regarding Kentucky's Coordinated Human Service Transportation Systems Waiver

APPENDIX B

National Transportation Consortium of States Letter

APPENDIX C

Non-Emergency Medical Transportation Providers by Type and Region

NON-EMERGENCY MEDICAL PROVIDER NUMBERS

Region	Name of Provider	Provider Type
1	Paducah Transit Authority	04
1	Paducah Transit Authority	07
1	Paducah Transit Authority	08
1	Fulton County Transit Authority	04
1	Fulton County Transit Authority	07
1	Fulton County Transit Authority	08
1	Murray Calloway Co. Transit Authority	04
1	Murray Calloway Co. Transit Authority	07
1	Murray Calloway Co. Transit Authority	08
1	Medical Transport Services	04
1	Medical Transport Services	07
1	Medical Transport Services	08
1	Security Taxicab, Inc.	02
1	Security Taxicab, Inc.	07
1	Security Taxicab, Inc.	08
1	Mayfield Radio Cab	02
2	Security Taxicab, Inc.	02
2	Security Taxicab, Inc.	07
2	Security Taxicab, Inc.	08
2	Greenville Med Van, Inc.	02
2	Greenville Med Van, Inc.	07
2	Greenville Med Van, Inc.	08
2	Yellow Enterprise Systems, Inc.	07
2	Yellow Enterprise Systems, Inc.	08
2	Medical Center Ambulance, Inc.	07
2	Medical Center Ambulance, Inc.	08
2	Western KY Transportation, Inc.	02
2	Western KY Transportation, Inc.	07
2	Western KY Transportation, Inc.	08
2	Madisonville Yellow Cab Company	02
2	Haddock Blueline Cab Company	02
2	Haddock Blueline Cab Company	07
2	Haddock Blueline Cab Company	08
2	Medical Transports	02
2	Medical Transports	07
2	Medical Transports	08
2	PACS	04
2	PACS	07
2	PACS	08
2	Custom Carriage	02
2	Trans-Med, Inc.	07
2	Trans-Med, Inc.	08

Region	Name of Provider	Provider Type
2	Mercury Ambulance	08
2	OK Cab	02
2	Babbage Cab	02
2	Lyon County Ambulance	08
2	Todd County Ambulance	08
2	Convalescent Care	07
2	Convalescent Care	08
2	Crittenden County Ambulance	08
2	Star Community	02
2	Caldwell County EMS	02
2	Caldwell County EMS	07
2	Caldwell County EMS	08
2	Med-Carrier	07
2	Med-Carrier	08
2	Med-First Transportation	07
2	Arrow Convalescent	07
2	Arrow Convalescent	08
3	Audubon Area Comm. Service	07
3	Audubon Area Comm. Service	08
3	Audubon Area Comm. Service	04
3	Yellow Cab	08
3	Yellow Cab	07
3	Yellow Cab	02
3	Yellow Ambulance	08
3	Yellow Ambulance	07
3	Medical Transportation	07
3	Medical Transportation	02
3	Medical Transportation	08
3	Con Care	07
3	Con Care	08
3	Custom Carriage	07
4	Medical Transport Services	02
4	Medical Transport Services	07
4	Medical Transport Services	08
4	Breckinridge Co. Ed. Assn. For Handicapped	04
4	Breckinridge Co. Ed. Assn. For Handicapped	07
4	Breckinridge Co. Ed. Assn. For Handicapped	08
4	Med-First Transport, Inc.	07

Region	Name of Provider	Provider Type
4	Med-First Transport, Inc.	08
4	Twin Lakes Taxi, Inc.	02
4	Grayson County EMS, Inc.	07
4	Grayson County EMS, Inc.	08
4	Elizabethtown Dixie Cab, Inc.	02
4	Manakee Professional Service	07
4	Manakee Professional Service	08
4	Lifefirst, Inc.	02
4	Lifefirst, Inc.	07
4	Lifefirst, Inc.	08
4	Marion Co. Assn. For Handicapped	07
4	Marion Co. Assn. For Handicapped	08
4	Lewis Taxi	02
4	CKCAC	02
4	CKCAC	07
4	CKCAC	08
5	Life First, Inc.	02
5	Life First, Inc.	07
5	Life First, Inc.	08
5	Med First Transport, Inc.	07
5	Med First Transport, Inc.	08
5	H & H Taxi	02
5	A-1 Performance Transport	02
5	A-1 Performance Transport	07
5	A-1 Performance Transport	08
5	Yellow Cab of Bowling Green	02
5	Yellow Cab of Bowling Green	07
5	Yellow Cab of Bowling Green	08
5	CASK	04
5	CASK	07
5	CASK	08
5	Howard's Taxi	02
5	ACSR, Inc.	07
5	ACSR, Inc.	08
5	Green County Taxi	02
5	Green County Ambulance	07
5	Green County Ambulance	08
5	Hart County Taxi Service	07
5	Hart County Taxi Service	08
5	Jordan's Taxi Service	08
5	Medical Transport Services	04
5	Medical Transport Services	07
5	Medical Transport Services	08
5	Phil E. Gregory	02
5	Phil E. Gregory	07
5	Phil E. Gregory	08

Region	Name of Provider	Provider Type
5	Yellow Cab of Russellville	02
5	Greenville Med-Van, Inc.	07
5	Greenville Med-Van, Inc.	08
5	Rodgers Transportation	02
5	Rodgers Transportation	07
5	Rodgers Transportation	08
6	Yellow Cab Company of Louisville	
6	Mainstream Transportation Authority	
6	Mainstream Transportation Authority	
6	American Red Cross Wheels	
6	American Red Cross Wheels	
6	American Red Cross Wheels	
6	Medical Transport Services, Inc.	
6	Care-A-Van	
6	Care-A-Van	
6	Kidz Wheelz	
6	Lifeline Transit & Taxicab	
6	Lifeline Transit & Taxicab	
6	Elizabethtown Dixie Cab, Inc.	
6	Elizabethtown Dixie Cab, Inc.	
6	Elizabethtown Dixie Cab, Inc.	
6	Caretenders of NJ, Inc.	
6	Caretenders of NJ, Inc.	
7	Caretenders of NJ, Inc.	
7	Caretenders of NJ, Inc.	
7	All County	
7	All County	
7	All County	
7	Lifefirst	
7	Lifefirst	
7	Lifefirst	
7	Oldham County Cab, Inc.	
7	Valley Medical Transport	
8	BUS	04
8	BUS	07
8	BUS	08
8	Life First, Inc. EMS	02
8	Life First, Inc. EMS	07
8	Life First, Inc. EMS	08
8	Frankfort Adult Day Care	07
8	Frankfort Adult Day Care	08
8	Frankfort Taxi Service	02

Region	Name of Provider	Provider Type
8	City of Frankfort/Frankfort Transit	
8	City of Frankfort/Frankfort Transit	
8	PK Cab	02
8	Bluegrass Cab	02
9	Handi-Van, Inc.	
9	Handi-Van, Inc.	
9	Northern KY Transit	
9	Northern KY Transit	
9	Northern KY Transit	
9	Senior Services of Northern KY	
9	Senior Services of Northern KY	
9	Senior Services of Northern KY	
9	The Community Cab Company	02
9	Yellow Cab Company of Newport, Inc.	
9	Yellow Cab Company of Newport, Inc.	
9	Lifefirst, Inc.	
9	Lifefirst, Inc.	
9	Med-Cab of Kentucky, Inc.	
9	Med-Cab of Kentucky, Inc.	
9	Med-Cab of Kentucky, Inc.	
9	Country Cab	02
9	Bennett's Personal Care Home	02
10	United Transportation	08
10	United Transportation	02
10	United Transportation	02
10	United Transportation	02
10	Nurse's Registry Medical	08
10	Nurse's Registry Medical	07
10	Lexington Red Cross	
10	Lextran	
11	Kelly's Kab	02
11	CATS	04
11	CATS	08
11	CATS	
11	Winchester Taxi	02
11	Central Transport Service, Inc.	08
11	Central Transport Service, Inc.	02
11	Central Transport Service, Inc.	07
11	KRFDC	04
11	KRFDC	08
11	KRFDC	07
11	Harrison County Senior Citizens	04

Region	Name of Provider	Provider Type
11	Harrison County Senior Citizens	04
11	Harrison County Senior Citizens	04
11	P K Cab	02
11	Colonel's Cab Company, Inc.	02
11	Huguely Taxi	02
11	Mt. Sterling City Cab	07
11	Mt. Sterling City Cab	08
11	Mt. Sterling City Cab	02
11	Hearne Medical Taxi, Inc.	02
11	Stanton Taxi Service, Inc.	02
12	Chester Martin Enterprises	02
12	RTEC	
12	RTEC	
12	RTEC	
12	Med-Transport	
12	Med-Transport	
12	Med-Transport	
12	Clinton Transport	
12	Smith's Taxi	02
12	Ambulance Inc. of Laurel County	
12	Ambulance Inc. of Laurel County	
12	Conrad C. Smith, EZ Ride	
12	Conrad C. Smith, EZ Ride	
12	Conrad C. Smith, EZ Ride	
12	Cumberland Cab Company	02
12	Wayne County Taxi	02
13	Daniel Boone Development	04
13	Daniel Boone Development	07
13	Daniel Boone Development	08
13	Harlan Community Action Agency	04
13	McIntosh Medical Transport	02
13	McIntosh Medical Transport	07
13	Jackson Cab Company	02
13	Middle KY River ADC	04
13	Middle KY River ADC	07
13	Allen's Taxi	02
13	Red Bird Mission	04
13	Medi-Cab of Kentucky, Inc.	07
13	Medi-Cab of Kentucky, Inc.	08
13	Tackett's Taxi Service	02
13	Ronny S. King	02
13	Appalachian Transportation	02
13	Appalachian Transportation	07
13	Appalachian Transportation	08

Region	Name of Provider	Provider Type
13	LKLP	04
13	LKLP	07
13	LKLP	08
13	Medi-Cab	02
13	Riley's Taxi	02
13	Ingram's Taxi	02
14	SVTS	04
14	SVTS	07
14	SVTS	08
14	Medi Cab of KY	07
14	Medi Cab of KY	08
14	Allen's Taxi	02
14	Martin City Cab	02
14	Appalachian Transportation	02
14	Appalachian Transportation	07
14	Appalachian Transportation	08
14	Prestonsburg City Cab	02
14	East Ky Transportation	02
14	Mountain Transportation	02
14	Whitten's Taxi	02
14	Gambill's Medical Taxi	02
14	Gambill's Medical Taxi	07
14	Gambill's Medical Taxi	08
14	William's Cab	02
14	Quicksilver	07
14	Quicksilver	08
14	D & B Taxi	02
14	Appalachian 1st Response	07
14	Phelps Cab	02
14	Southside Taxi	02
14	Charles Hampton	02
14	Montgomery Taxi	02
14	Magoffin Specialty Carrier	02
14	Magoffin Specialty Carrier	07
14	Magoffin Specialty Carrier	08
14	Lewis Taxi	02
14	Lewis Taxi	07
14	Lewis Taxi	08
14	Stephen's Taxi	02
15	Medical Transport Service	02
15	Medical Transport Service	07
15	Medical Transport Service	08
15	Medi-cab	02
15	Medi-cab	07

Region	Name of Provider	Provider Type
15	Medi-cab	08
15	Yellow Cab of Ashland	02
15	Yellow Cab of Ashland	08
15	Yellow Cab of Ashland	07
15	Magoffin Specialty Carrier	02
15	Magoffin Specialty Carrier	07
15	Magoffin Specialty Carrier	08
15	City Cab Company	02
15	Portsmouth Ambulance	08
15	Portsmouth Ambulance	
15	Portsmouth Ambulance	
15	Quicksilver	07
15	Quicksilver	08
15	Cougar Cab	02
15	Caskey Cab Company	02
15	A J & L Taxi, Inc.	02
15	Morehead/Rowan Co. EMS	08
16	Maysville Transit System	
16	LVCAP	08
16	LVCAP	07
16	LVCAP	04
16	Medi-cab	02
16	Medi-cab	07
16	Medi-cab	08
16	Geno's Taxi	02