LEGISLATIVE RESEARCH COMMISSION

Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges

Research Report No. 319

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Program Review and Investigations Committee

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Foreword

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Robert Sherman
Director

Frankfort, Kentucky
May 13, 2004

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Executive Summary

At its September 2003 meeting, the Program Review and Investigations Committee directed staff to review aspects of Kentucky's Human Service Transportation Delivery (HSTD) program. The review was to focus on how the Transportation and Health Services cabinets had addressed recommendations from an earlier study, whether the broker system of nonemergency medical transportation has resulted in cost savings, and if quality of service and protections for recipients has been maintained. The study also was expected to provide an update on the status of the situation in Region 6, which has experienced problems in implementing the broker system.

Major Conclusions

The Office of Transportation Delivery (OTD), which administers the Human Service Transportation Delivery program, uses a telephone complaint line as well as field and phone surveys to track problems that Medicaid recipients and providers experience. The system appears weak, however, in identifying specific concerns of riders with the quality of services provided.

As the HSTD program has matured, now may be the time for the program to institute a quality improvement plan. Such a plan would be helpful for program managers by identifying both short-term and long-term targets for improvement and would show how quality monitoring and utilization measures could be used to improve the system.

Program Review staff also found monitoring to be inadequate in regard to OTD's encounter database. Brokers report encounter data for each trip provided, such as service date, transport type, and miles traveled. The encounter data was found to have errors that may have implications for monitoring quality and calculating future rates.

The current provider rate structure is not based on an objective formula but developed from incremental changes to a system that allowed brokers to negotiate rates with providers in their regions. Rates vary from region to region. The efficient grouping of trips also continues to be a problem in some regions. Additionally, some providers are still concerned about distribution of trips by brokers, based on the results of a Program Review staff survey. The dissatisfaction level in some regions is higher than in others.

Program use has also been increasing and may be expected to continue increasing based on population trends. Transportation Cabinet and Medicaid officials should communicate more effectively and examine more effective ways of measuring system use for future planning.

Some groups of recipients are having a disproportionate impact on the provision of services. Allowing some recipients to choose who they want to transport them may result in the unintended consequence of inhibiting brokers' ability to coordinate trips

efficiently. The transportation of Medicaid recipients served by Adult Day Care and Supports for Community Living waiver programs also is putting cost pressures on the nonemergency medical transportation system.

The next several months may be an opportune time for OTD and Medicaid to review the necessity for 15 HSTD regions, considering the administrative costs related to each of those regions. Kentucky also may be able to adopt some of the cost-saving measures used in other states.

Recommendations

2.1 The Department for Medicaid Services, in conjunction with the Office of Transportation Delivery, should ensure that rider satisfaction surveys and survey methodology are redesigned to obtain valid results that can be generalized to all users of nonemergency medical transportation. If existing staff does not have the expertise in survey design and research, external resources should be consulted, such as the Government Services Center.

2.2 The Department for Medicaid Services, in collaboration with the Office of Transportation Delivery, should develop a quality improvement plan, employing quality improvement standards from the National Committee for Quality Assurance and guidance from the Centers for Medicare and Medicaid Services. The plan, which should mesh well with the current quality committee, should set forth specific quality improvement measures to be reviewed by HSTD's existing quality committee. The plan should incorporate and expand on existing data collection efforts, identify performance indicators, detail baseline data, set forth goals for each indicator, and identify action plans as needed to reach goals.

2.3 Brokers should be held accountable for the submission of timely, correct encounter data. OTD should maintain a database with the number and types of errors by broker for each month. This would allow for monitoring of the number of errors per month and whether brokers are resubmitting corrected data. This should be an indicator within the HSTD quality improvement plan.

2.4 OTD should match broker financial statements against encounter data to determine whether payments to providers are accurate.

3.1 The Office of Transportation Delivery should examine the current rate structure for transportation providers in conjunction with representatives of brokers and transportation providers. Recognizing the cost factors set out in 603 KAR 7:080 §17, rates should also be uniform, simple, and adequate, and should provide incentives for efficient grouping of trips. Such factors could be included in an actuarial analysis done in conjunction with the analysis currently performed to determine the capitation rates for each region.

3.2 OTD should periodically survey transportation providers to determine if rides are being properly scheduled and equitably distributed. The satisfaction of providers should be included as a quality indicator within the HSTD quality improvement plan. Perceptions of unfairness or dissatisfaction should be reviewed against the information collected in the HSTD database, and, as warranted, further investigation should be undertaken to ensure the equity of the system.

3.3 Any decision to alter the freedom of choice rule should be predicated on maintaining or improving the current level of quality in the HSTD program. However, to ensure that the freedom of choice rule is not being abused, encounter data should be examined periodically for regions with high numbers of single-passenger trips and for regions in which the broker has a substantial percentage of disoriented (code 07) and nonambulatory (code 08) passengers. If OTD determines that the freedom of choice rule is being abused or having particularly negative effects in a region, OTD should intervene by performing an independent review of the selection of providers for these types of riders. After validating the recipients' selections of particular providers, OTD should attempt to ensure that trips are grouped as efficiently as possible. Providers should be discouraged from inappropriately marketing their services to recipients.

4.1 The Office of Transportation Delivery, working in cooperation with the appropriate Cabinet for Health and Family Services (CHFS) divisions, including the Department for Medicaid Services, should gather valid and reliable data on whether transportation providers that also provide Medicaid services contribute to overutilization of transportation services. Depending on the results of analyzing this data and a study of the impact of existing regional rate caps, OTD and CHFS may consider imposing caps for all regions. Options could include setting maximum rate caps for those providing transportation and other Medicaid services or establishing maximum payment amounts by region.

4.2 Transportation, Medicaid Services, and other interested parties should examine the distribution of regions across the state. Based on analysis of regions' administrative costs, consideration should be given to consolidating regions with low usage or realigning some regions with similar geography where sufficient infrastructure is in place to deal with the added population. Reducing administrative costs should be a goal in any such regional adjustment, but this should be balanced against the need to guarantee the overall quality and effectiveness of the system.

4.3 Officials of the Office of Transportation Delivery and the Department for Medicaid Services should consult with their counterparts in other states to determine the cost-control measures that would be practical for Kentucky's capitated system. Any suggestions for promising cost-control measures should then be made to the General Assembly.

Chapter 1

Description and Background of the Human Service Transportation Delivery Program

Introduction

The Human Service Transportation Delivery (HSTD) program was established to coordinate trips among social service agencies and control costs.

Kentucky established the Human Service Transportation Delivery (HSTD) program in 1998 in an effort to control spiraling Medicaid nonemergency transportation costs and coordinate trips among social service agencies.

The key aspect of cost containment in Kentucky's HSTD program is the network of regional brokers who contract with the state under a capitated payment system. Each broker receives a payment for each Medicaid recipient in his or her region. Payments vary by region and range from about $5 to more than $8 per month. Because the brokers receive a set rate per month to meet the transportation needs of the Medicaid population, they have an incentive to reduce costs. Brokers also coordinate services, grouping riders into fewer separate trips and often subcontracting with a variety of transportation providers—for services ranging from buses to specialized wheelchair lift-equipped vehicles—to arrange appropriate means of transportation at the lowest cost.

Agencies making a business case for the program in 1996 predicted that, if left unchecked, direct Medicaid nonemergency expenditures would grow from $23.1 million that year to more than $69 million in 2002 (Commonwealth, 1996). The nonemergency transportation program prior to HSTD relied on a voucher system with insufficient controls over fraud and abuse. Based on the actuarial cost projection, the HSTD program appears to be containing cost growth. The fiscal year (FY) 2004 contract for Medicaid nonemergency transportation is $48.8 million.

The two main HSTD cabinets are Transportation, which administers the program; and Health and Family Services, which houses Medicaid Services, the program's largest participant. The state Departments for the Blind and Vocational Rehabilitation also participate in the program, but to a far lesser extent than Medicaid.

Kentucky's experience with increasing Medicaid nonemergency transportation costs is not unique. A number of states have introduced initiatives to combine nonemergency medical transportation with other transportation needs, including welfare to work. Many states also use the transportation broker system.

The HSTD program has undergone changes through legislation and turnover of brokers. Implementation in the Louisville area has been especially difficult.

Since the first brokers began operating in 1998, the HSTD program has experienced changes, some through legislation and some due to the turnover of brokers. In particular, Region 6, which includes the Louisville metro area and neighboring counties, is only now beginning to operate smoothly after numerous implementation problems from 2000 to 2002. (Implementation of the broker system in Region 6 is detailed in Appendix A.)

The success of the HSTD program may be measured in a variety of ways: whether the quality of service is adequate, whether it has reduced cost growth, and whether the administration of the program has been effective in addressing emerging risks and new programmatic requirements. This report addresses these issues.

Description of This Study

How This Study Was Conducted

For this report, staff surveyed service recipients and transportation brokers and providers.

The Program Review and Investigations Committee voted on August 22, 2003, to conduct a study of the HSTD program. In conducting the study, staff surveyed more than 2,800 Medicaid recipients who had used nonemergency medical transportation within a six-month period. Staff also surveyed nonemergency transportation providers in all regions of the state and conducted a phone survey of all regional brokers. Staff also visited broker facilities in central and northern Kentucky to observe and discuss the daily operations of a regional broker.

Staff interviewed officials with the Transportation Cabinet, the Cabinet for Health Services, and the Atlanta Regional Office of the Centers for Medicare and Medicaid Services. Staff accompanied a member of the Office of Transportation Delivery on a field survey trip during which service recipients were interviewed at a health care facility and while being transported to appointments with doctors. Staff reviewed pertinent statutes, administrative regulations, and health industry standards on quality improvement programs.

Organization of the Report

This report is organized as follows:

The remainder of Chapter 1 summarizes the major conclusions of this report, briefly explains the history of the HSTD program, and describes the current system.

Chapter 2 reviews the method of cost control used by managed care systems such as HSTD and the implications those cost controls may have on the quality of services provided. The chapter describes customer satisfaction with the HSTD system and documents problems clients have in understanding the process for filing complaints.

Chapter 3 explains the concept of coordination and discusses factors that may limit efforts at coordination of services, such as the subcontractor fee structure and the freedom of choice rule.

Chapter 4 identifies some of the key cost drivers in the HSTD system. Major cost-related issues are the overall growth in system utilization, current and future use by Adult Day Care and Supports for Community Living populations, and the administrative structure of the broker system.

Appendix A contains a brief history of difficulties associated with the region in and around Jefferson County. Appendix B contains the agency response to a prior Program Review and Investigations Committee study. Appendix C details how the surveys of riders, transportation providers, and brokers were completed; and provides respondents' answers to questions from the surveys. Appendix D is the Office of Transportation Delivery's response to this report.

Major Conclusions

The Office of Transportation Delivery (OTD), which administers the Human Service Transportation Delivery program, uses a telephone complaint line and field and phone surveys to track problems that Medicaid recipients and providers experience. The system appears insufficient to determine the problems that riders may have with the system and the quality of provided services.

The major conclusions of this report are that the current system is insufficient to determine problems that riders may have, a quality improvement plan should be implemented, encounter data from brokers and coordination of trips should be improved, and the freedom of choice rule and utilization of services should be evaluated.

A quality improvement plan could help program managers overcome program fragmentation and show how monitoring efforts and utilization reports fit together.

Valid encounter data from brokers are critical for monitoring service quality and for setting capitation rates. Brokers collect encounter data for each trip, such as service date, transport type and time, destination, miles traveled, and the identity of the provider. Brokers also submit claims information as a part of the encounter data. The encounter data contain errors and OTD's monitoring of the encounter database is insufficient. OTD cannot be sure that the data correctly reflects the trips being provided or reimbursements to providers.

Coordination of trips, one of the key factors in reducing program costs, has not been pursued as aggressively as possible. The rates paid for providing transportation services could be used as an incentive to more effectively coordinate trips. Brokers should be monitored to ensure that they are efficiently coordinating trips. The Office of Transportation Delivery is responsible for establishing rates for each region and for monitoring broker performance.

Allowing some recipients to choose their transportation providers may also inhibit brokers' ability to coordinate trips effectively. Because of data limitations, it is impossible to determine the degree to which freedom of choice affects the number of trips and thus payments to providers. However, OTD should take steps to ensure that transportation providers or brokers are not abusing the freedom of choice rule.

Utilization of nonemergency medical transportation is increasing. Transportation and Medicaid officials should devise better ways of measuring utilization to improve planning.

Clients of the Adult Day Care and Supports for Community Living waiver programs comprise disproportionate shares of the users of nonemergency medical transportation services. Continued growth in the number of participants in those programs will likely increase the costs of transportation services.

Several Programs Were Consolidated To Create the HSTD Program

The Human Service Transportation Delivery program was designed as a cooperative venture among cabinets. The state established the program in 1998 as a coordinated system primarily to provide nonemergency medical transportation to preapproved activities for Medicaid recipients and Kentucky Transitional Assistance (K-TAP) participants.

The transportation delivery program consolidated the transportation services previously provided or assured by various governmental agencies, including Medicaid. The program provides more than two million one-way trips annually via public transit systems, taxicabs, and specially equipped vans and buses for Kentucky's Medicaid recipients, as well as clients of the Departments for the Blind and Vocational Rehabilitation. About 600,000 Kentuckians are eligible for human service transportation.

Medicaid recipients comprise the largest number of nonemergency medical transportation users.

The two main participants in the program are the Transportation Cabinet through its Office of Transportation Delivery, which administers the program; and the Cabinet for Health and Family Services' Department for Medicaid Services (DMS), which serves almost all the clients who use the program. The state Departments for the Blind and Vocational Rehabilitation also participate, but their clients make up less than 1 percent of the total served. The Cabinet for Families and Children, which oversees the K-TAP program, ended its participation in the HSTD program in 2002 because of budget constraints.[1]

To use the system, Medicaid recipients must be deemed eligible to receive benefits, having qualified under Medicaid's categorical, income, and asset tests. Generally, participants must not have other means of transportation available to any reimbursable Medicaid service for the purpose of receiving treatment, medical evaluation, or follow-up. Under a federal waiver, target groups of recipients eligible for the nonemergency medical transportation include those participating in Temporary Assistance to Needy Families, those collecting Social Security and related income, and the medically needy.

[1] The Cabinet for Families and Children was a separate cabinet in 2002. Through Executive Order 2003-064 (issued December 23, 2003), it and the Cabinet for Health Services were consolidated into the Cabinet for Health and Family Services.

The Departments for the Blind and Vocational Rehabilitation pay a per-trip fee for clients using the nonemergency medical transportation system. The Workforce Development Cabinet pays brokers $1 per mile for its clients to ride to their destinations. Trip authorization must be made by Workforce Development, with authorization forms sent to brokers.

According to the Program Review survey, the average user is 52 years old, and 68 percent of users are female. The survey found that 80 percent of recipients use the transportation system to visit their doctors or medical clinics.

The Transportation Cabinet Manages the HSTD Program

The Transportation Cabinet has a contracting and administrative role and must ensure that brokers meet performance measures.

The Transportation Cabinet's Office of Transportation Delivery, working with the Finance and Administration Cabinet and the Cabinet for Health and Family Services, contracts with transportation brokers based on a number of factors, including overall quality of transportation delivery, experience, ability to coordinate trips, and operational abilities. Contracts are for one year, with three one-year renewals allowed. Most current broker contracts will expire in FY 2005.

Before a broker may begin operation, OTD must be satisfied as to its operational readiness. After a broker begins operations, OTD continues to have many roles and responsibilities related to the administration of the program. OTD's responsibilities include:

- implementing and monitoring contract compliance with each broker to ensure brokers meet standard performance measures;
- conducting field compliance reviews and inspections;
- reviewing brokers' annual audits;
- maintaining a complaint tracking system;
- collecting encounter and other pertinent data as specified by DMS; and
- reviewing monthly invoices and making payments for services rendered.

Kentucky Has 15 Transportation Regions, Each With Its Own Broker

Kentucky is divided into 15 transportation regions of varying size and population.

Under the Human Service Transportation Delivery program, Kentucky is divided into 15 regions of varying size and population. A regional nonprofit agency or private company is awarded a

contract through a competitive bid process. With one exception, each broker administers one region.[2]

Brokers serve as regional transportation coordinators and are supposed to provide service efficiently. They can act as transportation providers themselves, contract with other transportation subcontractors (generally called "providers") or act solely as brokers by contracting out all transportation provision. Brokers can contract with transportation providers, including non-profit agencies, for-profit medical service providers, for-profit medical transportation companies, taxicab companies, municipal transit systems, and private individuals.

The state pays brokers on a capitated basis per eligible recipient per month.

The state pays brokers on a capitated basis to arrange for the provision of required transportation services, with an incentive to control costs. Key aspects of the system include:

- the capitated rate per eligible person, per month;
- that the broker gets a flat rate per month, regardless of the number of trips; and
- that the broker must manage the system efficiently to increase profits.

Drivers are subject to drug tests and background checks.

Drivers for HSTD brokers and providers are subject to pre-employment and random drug testing as well as criminal and driving record checks. Drivers are required to complete first aid, CPR, and passenger assistance training prior to transporting passengers. Vehicles must meet state and federal standards for safety and equipment and are inspected periodically.

The type of transport depends on the level of eligibility of the rider. The types are private auto, taxicab, bus, nonprofit system, and specialty carriers for disoriented or nonambulatory riders.

Different types of recipients use the system. By statute, the level of eligibility dictates the type of transport. The transportation service certificate types are as follows:

01 – private automobile;
02 – taxicab service;
03 – bus service;
04 – nonprofit transit system;
07 – specialty carrier certified to transport nonemergency, ambulatory disoriented persons; and
08 – specialty carrier, using lift-equipped vehicles in compliance with the Americans with Disabilities Act, certified to transport nonemergency, nonambulatory persons.

[2] The nonprofit Leslie Knott Letcher Perry (LKLP) Community Action Council, Inc. operates as a broker for Regions 5, 13, and 15.

Normally, those who are mentally or physically able will use category 01, 02, 03, or 04 carriers. Those who are not mentally or physically able will use category 07 or 08 carriers.

The HSTD Program Replaced the Voucher System

The HSTD program replaced a system in which vouchers were issued to service recipients who then arranged for transportation.

The HSTD program has its roots in an Empower Kentucky initiative that identified rising costs, fraud and abuse, and welfare reform as reasons to establish a transportation system serving a variety of human service needs. Under the previous system, welfare caseworkers at the county level would issue a voucher to a recipient, who would contact a transportation provider to take him or her to the doctor or other medical facility. Providers would then submit the vouchers for payment. The per-trip payment structure of the program encouraged demand for and provision of services. Without proper controls, utilization and costs grew rapidly, often inappropriately.

Fraud was widespread in the voucher program and costs were increasing rapidly.

Abuses of that system, such as billings for excessive mileage and shopping trips, have been well documented. In the mid-1990s, newspapers reported on fraud occurring throughout the state. In one case, ambulance service operators were imprisoned for defrauding the Medicaid system based on mail fraud and improper billings (Wagar). Another highly publicized incident involved the use of a stretch limousine to transport a patient to Medicaid services (Brammer).

The Empower Kentucky program began looking at the possibility of a consolidated nonemergency transportation system in the mid-1990s as a way to quell steadily rising costs. According to a 1996 report, without changes to the nonemergency medical transportation system, costs would increase by 20 percent annually to more than $69 million by 2002 (Commonwealth, 1996).

An Empower Kentucky team consisting of staff from the Health Services, Families and Children, and Transportation Cabinets, supported by the Deloitte & Touche Consulting Group, designed the Human Service Transportation Delivery program.

Benefits anticipated from the program included:

- providing recipients the capability to access medical care, social services, and job training within the state;
- providing cost controls for transportation delivery and management controls to discourage fraud and abuse;
- reducing state agencies' administrative costs;

- consolidating administrative responsibility and accountability through a contracted provider; and
- increasing the emphasis on the quality of service to recipients (Commonwealth, 1997).

The General Assembly formalized the HSTD program in 1998 and established criteria for escorting certain types of Medicaid recipients in 2003.

The 1998 General Assembly formalized the transportation delivery system with passage of HB 468, amending sections of KRS 96A and 281 to give the Transportation Cabinet authority to establish the program and receive funds to administer it.

In 2000, the General Assembly enacted HB 488, which included provisions for the creation of a cross-agency Coordinated Transportation Advisory Committee and establishment of a pool of program coordinators to resolve complaints and other issues. The bill also allowed disoriented (category 07) and nonambulatory (category 08) recipients freedom of choice among transportation providers but with the requirement that brokers be fair in assigning trips for those who do not choose. The measure deleted an earlier provision allowing any willing and able provider to offer transport service. HB 488 also defined further the Transportation Cabinet's responsibilities for overseeing the program.

Responding to a need to clarify the use of escorts for some Medicaid recipients, the 2003 General Assembly enacted SB 168. Among other provisions, the measure established criteria for escorting disoriented and nonambulatory Medicaid recipients. The legislation required that a parent or guardian accompany a child under 13 using HSTD services.

Transportation officials are in the process of amending 603 KAR 7:080. The amendment will update the state regulation by adopting current federal regulations and changes enacted by the 2003 General Assembly, including the new language on escorts. The amendment will consolidate and update some regional alignments and strengthen safety and reporting requirements for vehicles and operators engaged in transportation services. The amendment also reflects the departure of the Cabinet for Families and Children from the HSTD program.

A CMS Waiver Is Required for the Program

A federal waiver allows Kentucky Medicaid Services to operate the nonemergency medical transportation system.

A waiver from the federal Centers for Medicare and Medicaid Services (CMS) is required for the Kentucky Department for Medicaid Services to continue to operate a nonemergency transportation system. A Medicaid waiver is a result of the process whereby the federal government allows or grants states permission

to waive certain federal requirements to operate a specific kind of program.

CMS authorized the Human Service Transportation Delivery program under section 1915(b)(4) of the Social Security Act. The current waiver covers the period through June 5, 2005. The waiver allows the state to restrict Medicaid beneficiaries' choice of transportation services through a brokerage system operating in 15 service regions. The Department for Medicaid Services also must undergo a periodic compliance review. CMS forwarded the results of its last compliance review to the state in March 2003.

Waivers for the Adult Day Care and Supports for Community Living programs also affect the transportation program.

Waivers for the Adult Day Care (ADC) and Supports for Community Living (SCL) programs have directly affected the HSTD program. The ADC waiver allows the state flexibility in developing alternatives to placing individuals in facilities such as nursing homes. The SCL waiver assists Medicaid-eligible individuals who have mental retardation or developmental disabilities and who meet requirements for residence in an intermediate care facility for persons with mental retardation. These waivers can have a significant impact on the HSTD program because clients of these programs typically use nonemergency medical transportation at rates much higher than average.

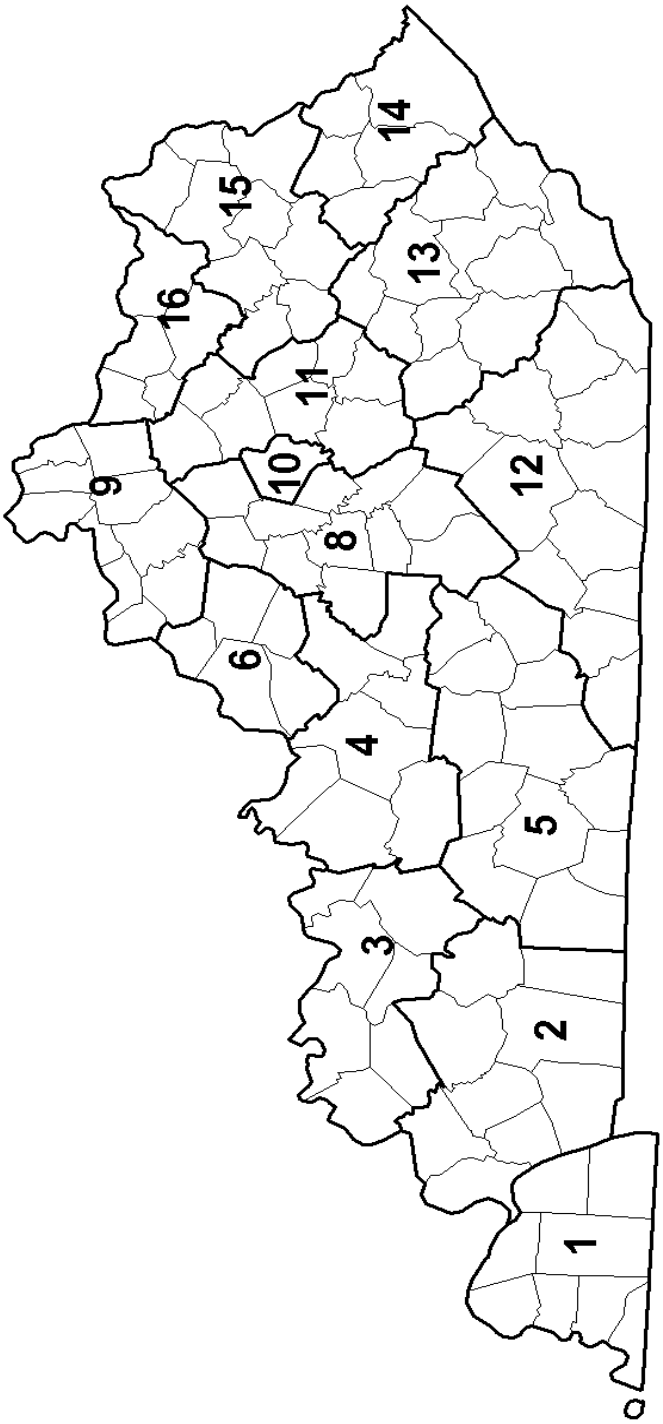
The Broker System

During formation of the HSTD program, the Transportation Cabinet divided the state into 16 multicounty regions based on the potential number of nonemergency and Temporary Assistance to Needy Families recipients; the geography of the regions; population; and existing transit systems, fleet sizes, and service delivery capabilities. The regions, which do not split counties or cities, are shown in Figure 1.A.

The system of regional brokerages was not stabilized until early 2003.

The program began in 1998 with a five-county pilot program. The system of regional brokers (shown in Table 1.1) did not stabilize statewide until early 2003 mainly because of ongoing problems in Region 6, which consists of the Louisville-Jefferson metro area and surrounding counties. In 2000, the broker for Region 7 withdrew from its contract and the region was discontinued. The counties that formerly comprised Region 7 were added to Regions 6 or 9. Appendix A details the difficulties of implementing the broker system in Regions 6 and 7.

Figure 1.A
Human Service Transportation Delivery Regions



Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Table 1.1
Human Service Transportation Delivery Regions

Region	Counties	Broker, Location	Profit/Nonprofit, Transports?
1	Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, McCracken	Paducah Area Transit System, Paducah	Nonprofit, transports
2	Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, Trigg	Pennyrile Allied Community Services, Hopkinsville	Nonprofit, transports
3	Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster	Audubon Area Community Services/ Green River Intra-county Transit System, Owensboro	Nonprofit, transports
4	Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson	Central Kentucky Community Action Agency, Lebanon	Nonprofit, transports
5	Adair, Allen, Barren, Butler, Edmonson, Green, Hart, Logan, Metcalfe, Simpson, Taylor, Warren	LKLP Community Action Council, Jeff	Nonprofit, transports
6	Jefferson, Bullitt, Oldham, Shelby, Spencer	LogistiCare Inc., Louisville	For profit, does not transport
8	Anderson, Boyle, Casey, Franklin, Garrard, Jessamine, Lincoln, Mercer, Scott, Washington, Woodford	Bluegrass Community Action, Frankfort	Nonprofit, transports
9	Boone, Campbell, Carroll, Gallatin, Grant, Henry, Kenton, Owen, Pendleton, Trimble	Region 9 Transportation LLC, Newport	For profit, does not transport*
10	Fayette	Federated Transportation Services of the Bluegrass, Lexington	Nonprofit, does not transport
11	Bourbon, Clark, Estill, Harrison, Madison, Montgomery, Nicholas, Powell	Kentucky River Foothills Development Council, Richmond	Nonprofit, transports
12	Bell, Clinton, Cumberland, Knox, Laurel, McCreary, Monroe, Pulaski, Rockcastle, Russell, Wayne, Whitley	Rural Transit Enterprises Coordinated, Mt. Vernon	Nonprofit, transports
13	Breathitt, Clay, Harlan, Jackson, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe	LKLP Community Action Council, Jeff	Nonprofit, transports
14	Floyd, Johnson, Magoffin, Martin, Pike	Sandy Valley Transportation Services, Prestonsburg	Nonprofit, transports
15	Bath, Boyd, Carter, Elliott, Greenup, Lawrence, Menifee, Morgan, Rowan	LKLP Community Action Council, Jeff	Nonprofit, transports
16	Bracken, Fleming, Lewis, Mason, Robertson	Licking Valley Community Action Program, Flemingsburg	Nonprofit, transports

*The Region 9 broker acts solely as a broker, but the same company that owns the brokerage also owns a cab company that provides nonemergency transportation.
Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Brokers Are Responsible for Coordination Within Regions

Regional brokers provide six broad areas of service, including recruiting subcontractors.

The regional brokers are selected through a competitive request for proposals. They are responsible for coordinating and subcontracting transportation services and are paid a capitated rate per eligible recipient per month. Services provided by brokers include:

- recruiting and negotiating with transportation subcontractors;
- administering payments;
- serving as gatekeepers to verify clients' eligibility for service, assess their need for nonemergency transportation, select appropriate transportation, and provide education on the availability of services;
- taking reservations and assigning trips; and
- assuring quality of services.

Brokers arrange trips for eligible recipients to and from specific providers of health care services. Generally, they establish a network of independent transportation providers, paying them specific amounts based on the types of recipients transported. The Office of Transportation Delivery sets the payment rates for transportation providers.

The Capitated Payment System

The incentive under the previous voucher system was to provide more services because transportation providers were paid on a fee-for-service basis. Under the current capitated rate method, the state pays each broker a set amount per month for each eligible recipient in the region. In contrast to the voucher system, payments to brokers are fixed and do not increase with an increase in the number of trips or miles during the contract period. Thus, the broker has an incentive to monitor providers to ensure that all trips and miles are billed appropriately. This necessitates effective monitoring to assure that brokers do not reduce trips and mileage so much as to result in an unacceptable quality of service to recipients. Monitoring must also assure that brokers that also provide transportation assign trips fairly to other providers.

Capitated rates vary by region. Rates generally increased from FY 1999 to FY 2002 but have since remained stable in most regions.

The Milliman & Robertson actuarial firm developed the initial capitated rates for nonemergency service in the original 16 regions. Data sources used to set those rates included Medicaid eligibility data, voucher payments in fiscal years 1995 to 1997, enrolled provider files, Kentucky Works payment summaries, summaries of fleet sizes, and other historical documentation. Tichenor &

Associates reviewed the capitation rates in 2001, considering such data as total Medicaid costs adjusted by increases or decreases in utilization, allowances for future expansion in certain Medicaid programs, allowances for Medicaid population growth, and inflation factors. Officials with the Governor's Office for Policy and Management reduced the rates that Tichenor recommended. Because of budget constraints, the rates have remained virtually unchanged in FY 2003 and FY 2004. Table 1.2 shows capitated rates by region from FY 1999 through FY 2004.

Table 1.2
Capitated Rates for Brokers by Region
(Fiscal Years 1999 to 2004)

	Fiscal Year					
Region	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
1	$4.99	$5.46	$5.62	$6.15	$6.20	$6.20
2	4.22	4.62	4.71	5.66	5.60	5.60
3	3.89	4.26	4.35	5.08	5.05	5.05
4	4.58	5.01	5.16	6.41	6.41	6.41
5	5.03	5.50	5.83	6.91	6.91	7.01
6	5.43	NA	NA	NA	5.43	8.20
7*	4.55	4.98	NA	NA	NA	NA
8	4.62	5.06	5.68	6.03	6.41	6.42
9	4.09	4.48	4.70	5.00	5.40	5.40
10	4.46	4.88	6.17	6.36	6.50	6.50
11	4.79	5.24	6.11	6.30	6.34	6.34
12	4.95	5.42	5.43	5.60	6.36	6.36
13	5.20	5.69	5.70	6.74	6.98	6.98
14	5.36	5.87	6.10	6.34	6.34	6.34
15	4.55	4.98	4.99	5.55	5.55	5.55
16	4.52	4.95	4.96	5.14	5.14	5.14

*Counties from the original Region 7 are now in Regions 6 or 9.
Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Brokers are obligated to pay transportation providers with which they contract. These payments vary among regions but are the same within each region. OTD is required by regulation to set the transportation providers' payment rates based on a range of factors, including geographic terrain, trip distances, recipient population, availability of medical facilities, labor and economic factors, and service utilization.

Payments vary by category of transportation service.

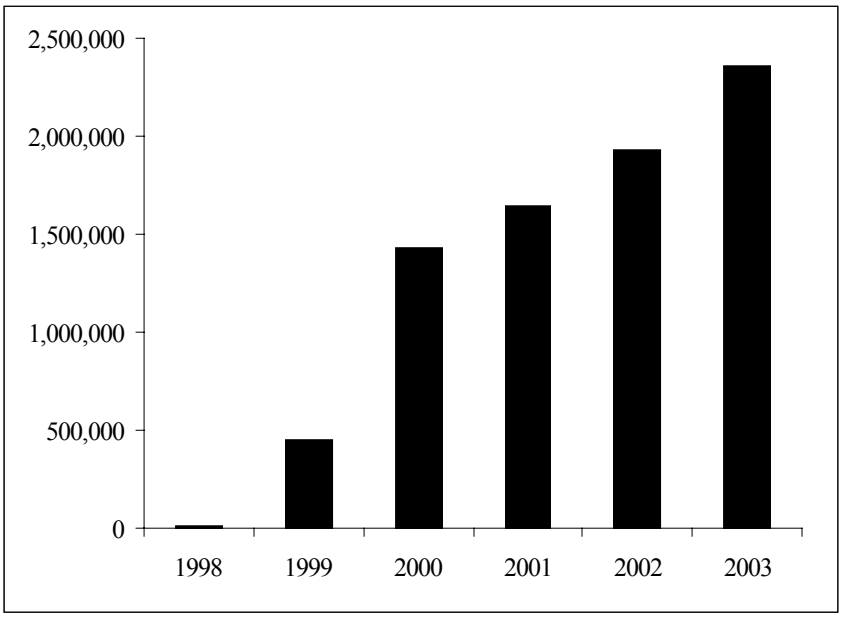
The payments also vary by category of transportation service. Generally, providers are paid more for 07 (disoriented riders) and 08 (nonambulatory) trips than for 02 (taxicab) trips because of the

nature of the transport. Also, an 08 trip usually pays more because a specialty carrier is involved and drivers often have to assist recipients in entering and exiting the vehicle.

The transition to the broker system has been gradual.

The transition to the broker system for transportation delivery has been gradual, as reflected by the number of trips provided through the HSTD broker system depicted in Figure 1.B. A trip is defined as a single recipient traveling from one point to another: a recipient going from his or her home to a doctor's office and then returning home from the doctor's office would count as two trips.

Figure 1.B
Number of HSTD Trips Per Year
(Fiscal Years 1998 to 2003)



Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

In 2003, there were more than 2.3 million trips. The cost per trip has declined in recent years.

In FY 1998, only Region 14 was operational—for one month. By FY 2003, with all regions operational except for Region 6, the annual number of trips had reached more than 2.3 million, amounting to more than 60 million total miles driven for the year.

During the same period, the total amount paid to the brokers has increased. The cost per trip has fluctuated but has decreased in recent years, as demonstrated in Table 1.3.

Table 1.3
Annual Trips, Payments to Brokers, and Cost Per Trip
(Fiscal Years 1998 to 2003)

Fiscal Year	Trips	Total Paid to Brokers	Cost Per Trip
1998	10,271	$194,677	$18.95
1999	449,926	$9,208,615	$20.47
2000	1,427,019	$29,093,826	$20.39
2001	1,646,849	$31,615,311	$19.20
2002	1,928,750	$35,490,727	$18.40
2003	2,361,562	$41,634,372	$17.63

Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Three Studies of the HSTD Program

Recipients' use and satisfaction have been themes in various studies of the HSTD program.

Recipient, provider, and broker satisfaction, and recipient usage rates were the subjects of three studies of the HSTD program since its creation in the late 1990s. The Kentucky Transportation Center, the actuarial firm of Tichenor & Associates, and the Program Review and Investigations Committee have reviewed different aspects of the program, but all examined recipient satisfaction and utilization.[3]

According to the 2000 Kentucky Transportation Center report, most service recipients were satisfied and brokers were adjusting well to the system, but providers were dissatisfied with some aspects of the program.

Kentucky Transportation Center. As part of a requirement under the original Medicaid waiver, the Commonwealth contracted with the Kentucky Transportation Center (KTC), affiliated with the University of Kentucky, to provide an independent assessment of the transportation program. According to the KTC's 2000 report, service recipients were satisfied with the program generally, less so with punctuality aspects. Recipients cited as "particularly bad experiences" late pick-ups, missed appointments, or no pick-ups.

Transportation providers, especially for-profits, were the most displeased with the program. They reported an increase in administrative costs and a revenue decrease from the previous system. Some providers felt frustrated by the lack of control over decisions related to transporting clients, such as recipient "no-shows" or abusive recipients. The report concluded that brokers were adjusting well to their new responsibilities and believed the

[3] A new actuarial review is ongoing. According to OTD officials, the company conducting the review, PricewaterhouseCoopers LLP, is to focus on capitation rates adjusted to actual costs.

new system was effective in reducing fraud because they were rewarded for detecting and eliminating fraudulent practices.

A 2001 report by Tichenor & Associates expressed caution about growing utilization rates, especially among some groups of service recipients.

Tichenor & Associates. The state retained Tichenor & Associates to review and revise the nonemergency transportation capitation rates for Medicaid recipients and Temporary Assistance to Needy Families clients (who no longer use the program). The firm's January 2001 report identified certain risk factors that could have a financial impact on the program. For example, some regions have relatively high utilization levels: 56 percent in the region with the highest rate. The firm predicted that the impact of the Adult Day Care and Supports for Community Living programs on brokers would increase as Kentucky's population ages.

A 1999 Program Review and Investigations Committee study was prompted by complaints from service recipients and transportation providers.

Program Review and Investigations Committee. A Program Review and Investigations Committee study was prompted by on-going complaints by service recipients and transportation providers about the program, which was not fully implemented when the study took place in late 1999. The report concluded that the program was experiencing several serious implementation problems and could benefit from improved oversight and management. Among the recommendations, the review suggested that the Transportation Cabinet should place a greater emphasis on independently monitoring and enforcing the quality of transportation services delivered to program recipients. (See Appendix B for the Office of Transportation Delivery's responses to the report's recommendations

Chapter 2

Balancing the Cost and Quality of Services

The capitated rate structure is designed to control costs by giving brokers a flat rate per month for each Medicaid-eligible recipient.

The broker system is designed to promote efficiency by controlling costs but still allowing for-profit companies to realize a profit and non-profit organizations to generate enough revenues for investment in needed equipment. Capitated rates are supposed to control costs by giving brokers a flat rate per month to operate transportation services. A broker's monthly payment is based on a capitated fee for each individual in the region who is determined eligible for Medicaid nonemergency transportation services.

Capitated systems are useful in reducing fraud and abuse, but a quality improvement plan is essential for any program structured to control costs.

Generally, capitated systems have been implemented to control costs and the incidence of fraud and abuse, but services can potentially suffer. A quality improvement plan is essential when developing and maintaining a program structured to constrain costs. Managers implement quality improvement plans to identify initiatives to measure, improve, monitor, and remeasure specific aspects of quality. Organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance have developed quality standards for organizations to use to measure and report their performance.

The overall satisfaction of recipients with the Human Services Transportation Delivery (HSTD) system appears to be high, but a survey of recipients by Program Review and Investigations Committee staff indicates that the current quality assessment system developed by OTD officials may be insufficient. Steps may need to be taken to ensure that recipients are better informed of their rights under the program and that brokers are not limiting transportation services unnecessarily.

The HSTD System Is Structured To Control Costs

Coordinated transportation systems like the HSTD program are promoted as cost-effective and efficient means of transporting social service recipients and others to their destinations. By coordinating transportation, governments save taxpayer money

through pooling funding from greater numbers of sources; increasing vehicle efficiency, productivity, and safety; and enhancing the ability of clients using such systems to access health care or other social services.

The HSTD program appears to have reduced fraud and abuse.

Kentucky's system of contracting with regional brokers appears to have achieved many of the goals set out by the original Empower Kentucky studies. Officials from the Health and Family Services and Transportation Cabinets assert that the spiraling costs under the voucher system have been brought into check. About half of the brokers indicated in a telephone survey conducted by Program Review staff that abuse is still a concern, but more than 70 percent volunteered that the broker system has lowered abuse or that brokers catch most attempts at abuse.[1]

Transportation delivery processes are no longer as fragmented as they were before the advent of the HSTD program. With the departure of the Cabinet for Families and Children from the program, coordination of services is now concentrated in the Medicaid nonemergency transportation aspect of the program. Transportation services are now readily accessible statewide. OTD officials also emphasize that vehicles are safer and more secure under the HSTD program due to field inspections. Drivers are screened before hiring and trained to improve customer safety and satisfaction.

Incentives are insufficient to guarantee high levels of service in all aspects of the delivery system.

Incentives are built into the HSTD program to control costs, but there are insufficient incentives to guarantee high levels of service in all aspects of the delivery system. The Program Review staff's survey of riders conducted for this report found that, although 88 percent of the riders are satisfied, they do have concerns about particular aspects of the program, including

- dissatisfaction with the 72-hour notice requirement for scheduling transportation;
- mistakes in scheduling or transporting that result in clients missing their rides;
- problems with providers such as speeding, rude, and unsafe drivers; and
- problems with the complaint process.

[1] There is no consensus among brokers about the most serious type of abuse. Each of seven brokers worried about abuse cited a different concern (see answers to broker question 8 in Appendix C).

Monitoring for Quality Is Important

In 1999, the Program Review and Investigations Committee's progress report on the HSTD system recommended that the Transportation Cabinet place greater emphasis on the task of independently monitoring and enforcing the quality of transportation services delivered to program recipients. The report suggested redesigning the survey of riders to obtain valid and objective results, minimizing reliance on complaint data collected and reported by brokers, and developing procedures to check indicators of program quality independently and on a random basis.

Although monitoring efforts have been implemented and utilization reports are being produced, the efforts seem fragmented and it is unclear how they are being used. OTD's surveys of riders have been sporadic.

Since the report, OTD has implemented broker-monitoring efforts that include semi-annual, on-site broker assessments; analysis of complaints by region; and assessment of brokers' vehicle inspection programs. OTD managers produced various types of utilization reports for Program Review staff for this study. Monitoring efforts have been implemented and utilization reports are being produced, but the efforts seem fragmented and their impact is unclear.

The quality of the HSTD program as measured by recipient satisfaction has been addressed by OTD surveys. Their assessments consist of surveys conducted with riders as they use the system and phone surveys of random users. Agency officials admitted that their surveys of riders have been sporadic. As many as three workers had conducted surveys in the past, but recently only one person has conducted them, and not as a full-time task.

OTD's rider surveys have not changed substantially from the initial Program Review report in 1999. The Program Review and Investigations Committee recommended in 1999 that the Transportation Cabinet place a greater emphasis on the task of independently monitoring and enforcing the quality of transportation services. This necessitates redesigning the rider survey to obtain valid and objective results.

Many problems remain with the sampling methodology. The sample sizes are relatively small, which makes generalization to all HSTD riders problematic. Ideally, enough recipients from each region would be surveyed each year so that results could be compared across regions, providing useful monitoring of individual brokers. OTD staff said they share the survey results with brokers, but larger samples would make the information more valuable. Instead of providing brokers with ad hoc reports of

problems, results representative of the entire region would help in assessing quality of services.

As an example, OTD staff perform telephone surveys of riders to gauge satisfaction with the program. For calendar year 2002, 118 recipients were surveyed statewide. A sample of this size can be useful, but the margin of error would be plus or minus 9 percentage points.[2] A sample this size will not be useful for many questions. For example, if it was found that 62 percent of riders were satisfied with services, the margin of error means the number could be as low as 53 percent or as high as 71 percent.

Beyond the issue of sample size, it is questionable whether the sample is unbiased. Phone surveys conducted by state employees during business hours are unlikely to contact recipients of the Adult Day Care or Supports for Community Living programs who spend most days in group facilities. Such recipients are among the heaviest users of the HSTD program.

The phone surveys have been sporadic in their sampling of regions. In 2002, 50 recipients from Region 11 were surveyed by phone. However, no phone surveys were conducted with recipients from Regions 1, 2, 3, 5, or 13. Assessing a broker's performance can be done more effectively if comparisons can be made with the quality of services in other regions.

Surveys are also conducted at service sites or during transit.

Surveys of riders are conducted in person at service sites or during transit. These can provide useful information, but it is impossible for current OTD staff to conduct enough of these surveys to sample an adequate number of recipients to be representative. Interviews conducted in facilities in which health care providers could also be providing transportation services may be biased. The surveys could be administered at a neutral site or by mail in order to prevent unintended response biases as recipients try to answer questions in ways they think will please those asking the questions.

Program Review staff accompanied an OTD employee on some of the in-person surveys of riders and observed the process. All recipients interviewed during the observed period expressed satisfaction with their transportation service. Their answers, however, provided little specificity about the service provided. Recipients may feel somewhat intimidated being questioned by a government official about a government program. Answers to written questions administered by an independent entity, with a

[2] This assumes a random sample, a 95 percent confidence interval, and an evenly split distribution.

guarantee of recipient anonymity, might provide more detailed and unbiased information.

When surveys are not analyzed in depth, opportunities to identify areas for improvement are limited unnecessarily.

The questionnaire used for rider surveys contains individual questions on scheduling difficulties, arriving on time, driver issues, cleanliness of the vehicle, and safety issues. The analysis of the surveys provided to Program Review staff, however, showed the surveys classified as positive or negative, with no analysis of individual questions. When surveys are not analyzed in depth, opportunities to identify strengths or opportunities for improvement are limited.

Recommendation 2.1

The Department for Medicaid Services, in conjunction with the Office of Transportation Delivery, should ensure that rider satisfaction surveys and survey methodology are redesigned to obtain valid results that can be generalized to all users of nonemergency medical transportation. If existing staff does not have the expertise in survey design and research, external resources should be consulted, such as the Government Services Center.

A Quality Improvement Plan Is Needed

The National Committee for Quality Assurance's standards for quality improvement can provide guidelines for a quality improvement plan for nonemergency medical transportation.

The National Committee for Quality Assurance (NCQA) is a non-profit accrediting body with the mission of improving the quality of health care. NCQA accredits managed care programs, preferred provider organizations, managed behavioral health organizations, and many other systems that are structured to control costs. NCQA's standards for quality improvement can provide guidelines for developing a quality improvement plan for nonemergency medical transportation.

Managers from OTD and the Department for Medicaid Services have formed a joint quality committee and have begun meeting. It is recommended that the committee develop a quality improvement plan. The plan should

- describe the quality improvement program;
- explain how recipient satisfaction and broker compliance will be monitored;
- specify how utilization would be monitored to guard against overutilization and underutilization; and
- establish a quality improvement committee to govern the program and update the description regularly.

The committee would oversee monitoring of the provision of services, take steps to improve weaknesses, and monitor progress of initiatives and the overall goals of the program.

A quality improvement plan would be useful for program managers.

Quality improvement efforts benefit not only program recipients, but program managers as well. A quality improvement plan aids in identifying exemplary areas in the operations of the program and provides managers with the information they need to make decisions for change. It gives them the opportunity to identify the effectiveness of their initiatives, as well as the information they need to validate claims about quality of the program. Furthermore, such a plan aids management by identifying areas within the program that need additional work.

According to the Centers for Medicare and Medicaid Services (CMS), states can improve performance in particular areas through the ongoing monitoring and evaluation of the quality of performance under an Individual Quality Improvement Plan. In addition to NCQA's standards on developing a quality improvement plan, CMS provides guidelines for developing quality improvement plans. CMS identifies the following components as essential for a quality improvement plan:

- staff responsible for the quality improvement plan,
- short-term goals and long-term target performance levels,
- performance indicators,
- data identification, collection, and analysis methods,
- action plan formulation, and
- action plan implementation.

Rider satisfaction is a specific example of a performance indicator that needs to be developed further within a quality improvement plan. The satisfaction survey may contain several performance indicators. One such measure might be the overall satisfaction of riders. OTD reports overall satisfaction, but a quality improvement plan would define what an acceptable level of satisfaction is.

Recommendation 2.2

The Department for Medicaid Services, in collaboration with the Office of Transportation Delivery, should develop a quality improvement plan, employing quality improvement standards from the National Committee for Quality Assurance and guidance from the Centers for Medicare and Medicaid Services. The plan, which should mesh well with the current quality committee, should establish specific quality improvement measures to be reviewed by HSTD's existing

quality committee. The plan should incorporate and expand on existing data collection efforts, identify performance indicators, detail baseline data, set forth goals for each indicator, and identify action plans as needed to reach goals.

A Survey of Users of Nonemergency Medical Transportation

Program Review staff conducted a survey by mail to determine riders' views of the quality of services.

An obvious measure of the quality of any service is the judgment of those who use it. Program Review staff conducted a mail survey of riders to determine their views of the system, their experiences using the system, problems that they are having, and suggestions for change.

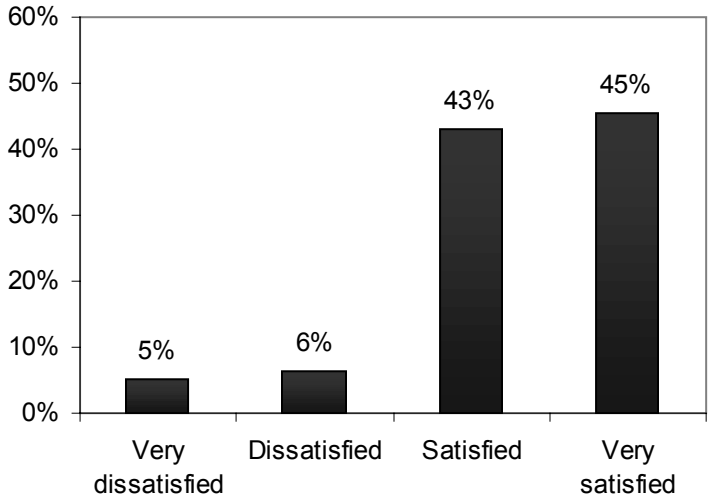
Staff sent questionnaires to almost 7,000 Medicaid recipients who had used nonemergency medical transportation within a six-month period (April 2003 through September 2003). The sample was chosen randomly while ensuring that each region had about the same number of surveys distributed. Of the more than 6,822 questionnaires mailed to riders, 2,881 completed surveys were returned for a 42 percent response rate.[3] Appendix C contains details on how the survey was administered, wording of questions, and respondents' answers to each question. As discussed in the appendix, the evidence suggests that the survey results can be generalized to all users of HSTD services.

Eighty-eight percent of respondents said they were satisfied or very satisfied overall with nonemergency medical transportation services.

As depicted in figure 2.A, about 9 out of every 10 Medicaid recipients responding to the survey expressed overall satisfaction with the nonemergency medical transportation system. Forty-five percent of riders said they were very satisfied with transportation services; 43 percent said they were satisfied.[4]

[3] Not every respondent answered every question, so the number of respondents answering any given question will be less than 2,881.
[4] Rider satisfaction with the transportation service did not appear to vary significantly by gender or by whether the survey was completed by the Medicaid recipient or by his or her guardian or parent.

Figure 2.A
Overall Dissatisfaction or Satisfaction With Nonemergency Medical Transportation Services (2,547 respondents)



Source: Program Review survey of riders.

As shown in Table 2.1, there is some variation across regions, but the main theme is that levels of satisfaction and dissatisfaction are similar across the state. There are four regions that are statistically different—two better and two worse—from the statewide percentage of riders who reported being very satisfied.[5] In Region 4, the percentage of riders who were very satisfied (55 percent) is significantly higher than the state figure of 45 percent. In Region 16, the percentage that reported being very satisfied (53 percent) is higher. In Region 6, the percentage of riders who reported being very satisfied (31 percent) is significantly lower than the state figure. In Region 10, the percentage of riders who answered that they were very satisfied (36 percent) is lower.

[5] The margin of error for the statewide sample is 1.7. This means that, for example, although the best estimate of the statewide percentage of riders who are very satisfied is 45 percent, we can be 95 percent confident that the true value lies within plus or minus 1.7 percentage points of 45. Because the sample sizes for each region are much smaller than the statewide sample, the margin of error for each region is larger. The margins of error for the 15 regions range from 5.9 to 7.7.

Table 2.1
Overall Dissatisfaction or Satisfaction With Nonemergency Medical Transportation Services by Region
(2,547 respondents)

Region	Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied	Number of Respondents
01	4%	7%	41%	48%	172
02	4	2	49	46	158
03	6	4	43	46	179
04	3	6	36	55*	168
05	8	7	39	45	183
06	7	10	51	31**	162
08	5	5	45	45	204
09	8	10	41	41	135
10	8	8	49	36**	145
11	3	7	45	46	200
12	2	6	49	43	181
13	6	4	41	50	175
14	8	9	32	50	171
15	4	9	43	44	176
16	1	4	43	53*	138
State	5%	6%	43%	45%	2,547

*Higher than statewide percentage, statistically significant.
**Lower than statewide percentage, statistically significant.
Source: Program Review survey of riders.

Additional questions revealed similar satisfaction with aspects of the program, such as 93 percent of riders were satisfied or very satisfied with the quality of vehicle they ride in; 88 percent indicated that people on the phone were usually or always polite; 93 percent replied that drivers were usually or always polite; and 92 percent answered that the vehicle was usually or always clean. Responses to open-ended questions revealed some specific concerns with quality.

More than half the riders were unaware a complaint process exists or did not know how to use it.

Difficulties With the Complaint Process

The Program Review survey contained a series of questions related to the ability of recipients to file complaints about the nonemergency transportation system. Twenty-five percent of respondents indicated they do not understand their right to file complaints about the transportation services they receive. Of the 75 percent that indicated they understood they have a right to complain, only 51 percent answered that they know the process for registering complaints. In other words, it seems likely that

complaints will not be registered by more than half of the users of HSTD services if they have problems.

Reliance on complaints generated by recipients is an insufficient indicator of quality.

A complaint system can be a useful indicator of the quality of services. The current system would seem to be an insufficient indicator based on the results of the Program Review survey of recipients, however. If OTD continues to rely on complaints as a measure of quality, it needs to ensure that more riders understand how to make their concerns heard. Riders' responses to the questions about the complaint process point to a need on the part of OTD and brokers to better inform clients of their right to file a complaint and the process for filing a complaint.

Some Recipients Are Displeased With the 72-hour Rule

A consequence of recipients not being aware of their right to file a complaint or not knowing the process to file a complaint can be illustrated in problems recipients have encountered with the 72-hour rule. Under 603 KAR 7:080, a recipient or his or her guardian must phone a regional broker to schedule a trip at least 72 hours prior to the appointment for which transportation is needed. Brokers indicated that the 72 hours are needed to arrange for transportation, check eligibility, and plan and coordinate trips adequately.

More than 20 percent of recipients answering a question on needed changes to the system indicated that they would change the 72-hour notification rule.

The governing regulations provide exceptions to the 72-hour rule for urgent care or when a licensed medical provider verifies a request. For example, when a person wakes up with a fever or needs prompt, but not emergency, medical attention, the exception for urgent care should be applicable. An example of the provider exception would be if a medical provider verified that the patient needed to be seen in less than 72 hours for a test.

When the Program Review survey asked recipients what changes they would make to the system for nonemergency transportation, 21 percent of the 1,193 recipients who responded to the question volunteered that they would change the 72-hour notification rule.

Some recipients and guardians were unaware that exceptions can be made to the 72-hour rule.

The 72-hour rule is one of the most frequent reasons riders cited for service denial. Comments provided by recipients indicate that many do not understand the exceptions to the 72-hour rule and how they might access services with less than 72 hours' notice. They described instances requiring same-day medical attention, but being told by the broker that they would have to reschedule. Because many recipients do not understand their right to file a

complaint or the process by which they should file a complaint, denial of service may be higher than appropriate. Brokers can deny a recipient under the 72-hour rule and, if there is no appeal by the recipient, legitimate exceptions to the rule may not be made.

Staff learned from interviews with brokers that some require a doctor's office to send a fax to them outlining that the recipient requires an exception to the 72-hour notice rule. A physician's office reported spending in excess of two hours trying to send a fax to a broker that would never transmit. The patient ended up being transported by ambulance.

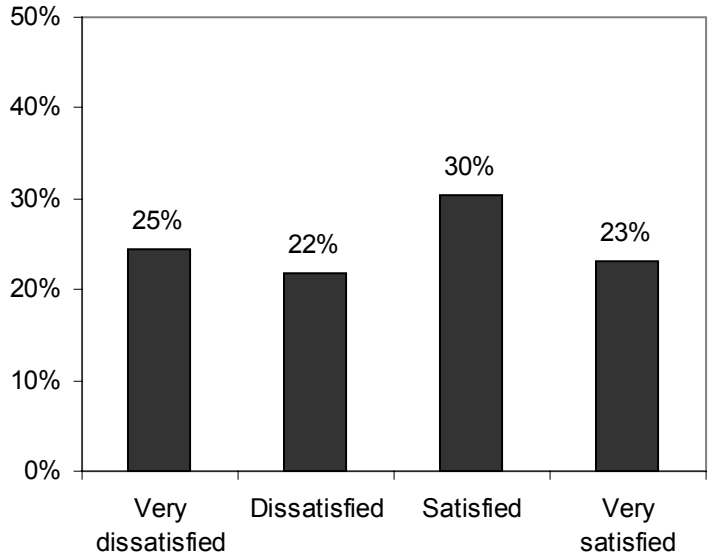
KRS 281.876 allows verification to waive the 72-hour rule to be submitted by any one of several methods. Physicians may submit the notification orally over the telephone, electronically by computer or fax, or in writing. The broker does not have the authority to limit the method by which the physician's office may transmit the notification.

This example also highlights the necessity of conducting periodic surveys of recipient satisfaction. The responses to the Program Review survey indicate problems with the education of recipients about the complaint process. Additionally, misuse of the 72-hour rule illustrates the consequences of having a poor quality control system in which recipients do not know how to complain, and the monitoring system in place does not provide sufficient information to alert management to potential problems.

Seven percent of survey respondents had filed a complaint.

The Program Review survey also asked respondents if they have ever filed a complaint about transportation services they have received. Seven percent of survey respondents had filed a complaint. Of those who had filed a complaint, 43 percent indicated that the problem involved pick-up or delivery for an appointment or return trip home, such as being late to an appointment or not being picked up. When asked if they were satisfied with the way the complaint was handled, about half were very satisfied or satisfied; the other half were either very dissatisfied or dissatisfied, as depicted in Figure 2.B.

Figure 2.B
Dissatisfaction or Satisfaction With Handling of Most Recent Complaint (151 respondents)



Source: Program Review survey of riders.

Problems Experienced During Transport

Fourteen percent of respondents indicated they had experienced a problem while being transported that made them feel uncomfortable.

The survey asked riders if they ever had a problem while being transported that made them feel uncomfortable. Fourteen percent indicated they had experienced such a problem. Of those experiencing an uncomfortable situation, more than half indicated that it was related specifically to driver behavior. Examples included speeding, rudeness, unsafe driving, harassment, inappropriate behavior, and being picked up late. Such information could be helpful in assessing the performance of brokers and transportation providers.

Additional Tools for Monitoring Quality

Analysis of encounter data submitted by brokers is another means to assess system quality, but current analysis is insufficient.

Another method available to OTD officials to assess the quality of the HSTD system is analyzing the encounter data submitted by the brokers. These data include information such as the name of the recipient, the type of transportation provided, mileage, the time of pick-up and drop-off, and the amount paid for the trip.

The analysis of encounter data is insufficient. The data contain numerous errors each month. OTD managers said that they have seen a significant reduction in error reports since FY 2003 but

admitted that they have been examining submitted data closely only since summer 2003. Program managers said staffing shortages and the difficulties associated with Region 6 prevented them from devoting more resources to verifying brokers' encounter data.

Significant problems with the data include:

- submission of duplicate trips by brokers;
- incorrect entries in the miles and claim amount fields; and
- expired Medicaid numbers for several providers, which prompt the Medicaid information system to reject those trips.

OTD has difficulty determining if the amounts paid for trips are correct.

OTD also has difficulty determining if the amounts paid for trips are correct. Without a uniform method of determining mileage, it is difficult to determine the amount that should be paid. OTD also has difficulty determining whether the rate paid for a trip is incorrect or if it is the rate paid for a second passenger on a trip. These factors make the reliability of encounter data submitted by brokers suspect.

The OTD Procedures Manual states that "An encounter data feedback form will be mailed to every broker each month. The feedback form will list any errors that were found and corrections that should be made to the data." This is an essential first step, but a database should be maintained to identify problem brokerages and allow OTD to focus on areas in need of additional staff attention.

Recommendation 2.3

Brokers should be held accountable for the submission of timely, correct encounter data. OTD should maintain a database with the number and types of errors by broker for each month. This would allow for monitoring of the number of errors per month and whether brokers are resubmitting corrected data. This should be an indicator within the HSTD quality improvement plan.

Recommendation 2.4

OTD should match broker financial statements against encounter data to determine whether payments to providers are accurate.

Chapter 3

Coordination of Transportation Services

The HSTD program was designed to control costs through better coordination of services.

The Human Service Transportation Delivery (HSTD) program was designed to contain transportation costs through better coordination of services. A 1996 Empower Kentucky study recommended that agencies from the Families and Children, Health Services, and Workforce Development Cabinets participate. It was noted that staff from these agencies performed manual, repetitive tasks associated with administering the voucher-based system and providing transportation services, which reduces the time available for their main responsibilities. Each agency administered its own program, resulting in duplication of effort and confused policies and procedures (Commonwealth 1996, 7). By moving to a broker-based program, much of the administrative burden could be shifted to a broker providing services to programs in different cabinets.

CFC's Withdrawal From the HSTD Program

In February 2002, the Cabinet for Families and Children announced that it would stop using the HSTD program to provide transportation for K-TAP recipients because of budget constraints.

In February 2002, the Cabinet for Families and Children (CFC) announced its withdrawal from the HSTD program at the end of the fiscal year. As a cost-saving measure necessitated by a budget shortfall, the secretary stated that the cabinet would return to its previous transportation authorization system.

CFC participated in the HSTD program to provide transportation services to clients of the Kentucky Transitional Assistance Program (K-TAP), a temporary cash assistance program for families with a dependent child lacking the support of one or both parents. K-TAP is intended to help adults find jobs or get training that leads to jobs. Transportation for K-TAP recipients included trips to jobs, school, job training programs, and day care centers. More than 31,000 recipients were transported through the HSTD program in FY 2002. Their 1.6 million trips cost $7.6 million.

K-TAP recipients now receive a monthly stipend to defray travel expenses.

According to CFC officials, the cabinet no longer funds each trip a K-TAP recipient takes. Those getting assistance through K-TAP receive monthly stipends to help defray travel expenses: $9 per

month for those traveling less than 4 days during the month, $35 for 4 to 16 travel days, and $60 for 17 days or more.

Unlike Medicaid recipients using HSTD services, a K-TAP recipient is not denied service if he or she owns a vehicle. In fact, K-TAP recipients can be reimbursed for using their own cars for transportation to approved destinations. CFC officials stated that the need for coordination was reduced because many K-TAP recipients could use their own vehicles or be issued bus passes. Cabinet officials indicated that using the stipend system allowed them to redirect $3.5 million to other needs.

Coordination Efforts for Medicaid Recipients

Cost-saving efforts are now focused on the Medicaid portion of the HSTD program.

With the withdrawal of K-TAP recipients from the HSTD program, cost-saving efforts are now confined primarily to the Medicaid portion of the program. Clients of the Workforce Development Cabinet's Department for the Blind and Department of Vocational Rehabilitation are still transported by the program. There are relatively few such riders, however, and only a handful of regions transport Workforce Development clients.[1]

Coordination of services can no longer focus on reducing costs by eliminating duplication of effort in multiple cabinets. Instead, coordination is confined to grouping passengers efficiently into fewer trips and identifying the most efficient transportation providers and routes.

Brokers have an important role in coordinating trips.

Brokers have an important role in coordinating trips. Calls for transportation services come into a broker's office in each region. It is the broker's responsibility to screen each call to ensure that the caller is eligible for transportation services, though only the Office of Transportation Delivery can deny services generally. Once the broker determines that the caller is eligible and the trip request is for a covered service, an appropriate transportation provider is identified.

Most recipients have their transportation providers assigned by the broker. Brokers make the assignment based on a number of factors, including geographic proximity, the ability to group several stops into a single trip, and vehicle availability. If the transportation is

[1] In October 2003, 10 Workforce Development clients were transported in Region 8, 192 in Region 12, and 21 in Region 14. By comparison, Region 12 had more than 78,000 eligible Medicaid recipients in August 2003.

being requested for an individual who is either classified as disoriented or nonambulatory, the recipient has freedom of choice in selecting his or her transportation provider.

In some regions, brokers determine the routes that transportation providers must follow in picking up recipients. In other regions, brokers simply assign trips to providers and rely on them to determine the most effective ways to pick up and deliver recipients to their appointments.

The Transportation Cabinet Sets Rates for Providers

The Transportation Cabinet sets the rates paid to transportation providers. Statutes governing HSTD emphasize the need for uniformity in establishing rates, fees, and reimbursement procedures. The current fee structure is based on rates negotiated by brokers and providers in prior years.

Since 2000, the Transportation Cabinet has set the rates transportation providers are paid. Statutes governing the HSTD program emphasize the need for uniformity. The Transportation Cabinet is assigned the responsibility to promulgate administrative regulations governing the uniform criteria for establishing capitated rates, fees, and reimbursement procedures in all delivery areas as well as uniform criteria for contractual agreements between subcontractors and brokers in all delivery areas.[2] Previously, rates paid to providers were negotiated between each region's broker and its subcontractors.

HB 488 of the 2000 General Assembly mandated the current system. Transportation Cabinet officials stated that they do not have a formula to calculate fees paid to subcontractors. Officials stated that since the passage of HB 488, they have established subcontractor rates by making incremental changes to the past rates negotiated between brokers and providers. Transportation Cabinet officials stated that this avoided sudden changes to the system that could have resulted in significant difficulties for subcontractors.

Because the earlier rates were negotiated within each region—and differed before Transportation began setting them—rates still vary by region and type of transportation provided. Under Transportation's oversight, however, rates paid to providers are consistent within each region. For example, rates for the 02, 07, and 08 service categories might differ, but the rates would be the same for each category for each provider within a region. Fees have generally increased since Transportation began setting subcontractor rates, but in at least one region, rates were decreased because the broker was encountering financial difficulty.

[2] KRS 281.875(1)f), KRS 281.875(1)h

Transportation Cabinet officials noted that there is some variation in costs due to regional differences. For example, trips in regions in far eastern or western Kentucky may be longer on average because of the need to transport relatively more riders to larger metropolitan areas for appointments with specialists. Transportation Cabinet officials also stated that the terrain in eastern Kentucky requires transportation providers to purchase more four-wheel drive vehicles to reach some areas during the winter.

According to 603 KAR 7:080 §17, the following factors should be considered in determining rates:

- geographic terrain,
- trip distance,
- recipient population,
- availability of medical facilities,
- labor and economic factors, and
- utilization of services.

The diversity of rates still reflects the differences in rates negotiated by each broker in the past. Incremental adjustments to the rates have not produced the structured approach called for by administrative regulations, and payments for similar trips in similar areas may still differ.

An illustration of the effect of the current rate structure is shown in Table 3.1, which depicts the fees in five regions for a 10-mile trip for three categories of riders. Across the regions, the fees range from $11 to $15 for a rider in a taxicab, from $15 to more than $25 for a disoriented rider, and from $15 to $40 for a nonambulatory rider.[3] Within each region, the variation for types of trips differs as well. For example, in Region 16, the rate is the same for each type of transport. In Region 6, the rate for nonambulatory riders is more than three times the fee for a taxicab rider.

Table 3.1
A Comparison of Reimbursements for 10-mile Trips in Five Regions

Region	Taxicab	Disoriented Riders	Nonambulatory Riders
2	$11.00	$19.91	$34.12
5	$13.70	$15.00	$28.50
6	$12.00	$27.50	$40.00
14	$12.43	$26.02	$39.77
16	$15.00	$15.00	$15.00

Note: Regions 2 and 5 are in western Kentucky, Region 6 is Jefferson County and surrounding counties, and Regions 14 and 16 are in eastern Kentucky.
Source: Analysis by Program Review staff based on HSTD data.

Table 3.2 depicts the regional rate structure established by OTD for FY 2004. The table is a complicated one due to the complexity and diversity of rates. Regional differences in provider rates include pick-up fees, payments for additional riders, maximums per trip, and rates per mile.

[3]This example illustrates the differences in rates for these types of trips only and may not be indicative of regional differences in payments for other kinds of trips.

Transportation Provider Rates by Region by Category of Riders (FY 2004)

	Category 02-Taxi					03-Bus	04-Nonprofit				
		Rate per mile						Rate per mile			
Region	Pickup	1-5 miles	>5 miles	Per Add'l Rider	Max. Per Trip		Pickup	1-5 miles	>5 miles	Per Add'l Rider	Max. Per Trip
1	$0	$1.05	$1.05	$5.24	$250.00[1]	$24/mth	$0	$1.05	$1.05	$5.24	$250[1]
2	$5.50	$0	$1.10	$4.40		$0	$5.50	$0	$1.10	$4.40	
3	$0	$1.19	$1.19	$0		Bus fare	$0	$1.08	$1.08	$0	
4	$4.48	1-25 $1.12	26+ $.56	$3.36		$0	$0	1-25 $.95	26+ $.56	$3.36	
5	*See below*					$0	$0	$0.70	$0.70	$0	$250[2]
6	*See below*				$75.00[3]	Bus fare	*See below*				$75
8	$0	$5.40/trip	$1.03	$0		$0.52	$0	$1.03	$1.03	$0	
9	$0	$6.15/trip	*See below*			$0	$0	$0.96	$0.96	$0	
10	$1.90	$1.80	$1.80	$0		$1.00	$12.70	Van load $76		$0	
11	$0	$5.60/trip	*See below*	$0.50	$75.20	$0	$0	$0.66	$0.66	$0	
12	$0	$7.11/trip	$1.02	$.51/mi.	$200.00	$0	$0	$4.06	$0.80	$0.51	$200
13	$0	$1.10	$1.10	$0	$85.00	$0	$0	$0.70	$0.70	$0	$250
14	$0	$6.16/trip	*See below*	$3.08	$81.83	$0	Same as category 02				$250[2]
15	$0	$5.50/trip	$1.00	$3-$5[4]		$1.00	$0	$0	$0	$0	
16	$0	$1.50	$1.50	$0		$0.80	$0	$1.50	$1.50	$0	

	07-Specialty carrier for disoriented					08-Special carrier for nonambulatory				
		Rate per mile					Rate per mile			
Region	Pickup	1-5 miles	>5 miles	Per Add'l Rider	Max. Per Trip	Pickup	1-5 miles	>5 miles	Per Add'l Rider	Max. Per Trip
1	$0	$1.05	$1.05	$5.24	$250[1]	$17.80	$1.05	$1.05	$5.24	
2	$9.91	$1.00	$1.00	$4.40		$23.12	$1.10	$1.10	$22.20	
3	$6.50	$1.08	$1.08	$3.25		$21.68	$1.08	$1.08	$4.34	
4	$10.09	<25 $.95	26+ $.56	$5.04		$20.18	$0.95	$0.95	$10.09	
5	$4.00	$1.10	$1.10	$5.00		$15.50	$1.30	$1.30	$10.50	
6	$12.50	$1.50	$1.50	$4.00		$25.00	$1.50	$1.50	$4.00	
8	$11.34	$1.39	$1.39	$3.71		$23.19	$1.39	$1.39	$3.71	
9	$11.25	$1.03	$1.03	$4.10		$22.56	$1.38	$1.38	$12.31	
10	$12.70	Van load $76.00		$0		$12.70	Van load $76		$0.00	
11	$10.00	$1.27	$1.27	$4.06		$20.31	$1.27	$1.27	$4.06	
12	$0	1-10 $10.64/trip	>10 $1.17	$4.06		$21.84	$1.17	$1.17	$4.06	
13	$8.00	$1.50	$1.50	$5.00	$250	$20.00	$1.50	$1.50	$8.00	
14	$11.22	$1.48	$1.48	$10.20		$24.47	$1.53	$1.53	$15.30	
15	$7.50	$1.40	$1.40	$6.00	$250	$16.00	$1.40	$1.40	$11.00	
16	$0	$1.50	$1.50	$1.50/mi.		$0.00	$1.50	$1.50	$1.50/mi.	

[1]Per trip out of region.
[2]Per van/car load on any one-way.
[3]Maximums for providers serving own clients: $40 (02, 04), $50 (07), $75 (08).
[4]1-17 miles, $3; 18 or more miles, $5

Table 3.2 continued on next page.

Table 3.2 continued

Region 5: Category 02	
Mileage	**Rate**
1-17	$3.20+$1.05/mile [5]
18-25	$21.00
26-37	$31.00
38-49	$41.00
50-74	$1 per mile
75-99	$76.00
100-149	$100.00
150+	$125.00

Region 6: Category 02, 04	
Mileage	**Rate**
1-5	$6.00
6-10	$12.00
11-25	$20.00
26-50	$30.00
>50	$1 per mile

Region 9: Category 02	
Mileage	**Rate**
6-10	$12.31
11-15	$15.38
16-20	$20.51
21-25	$25.64
26-30	$30.77
31-35	$35.89
36-40	$41.02
41-45	$46.15
46-50	$51.28
51-55	$56.40
56-60	$61.53
61-65	$66.66
66-70	$71.79
71-75	$76.91
76-80	$82.04
81-85	$87.17
86-90	$92.30
91-95	$97.42
96-100	$102.55
>100	$102.55+$1.03 per mile

Region 11: Category 02	
Mileage	**Rate**
6-11	$11.20
12-25	$18.30
26-50	$27.45
>50	$0.95 per mile

Region 14: Category 02, 04	
Mileage	**Rate**
6-10	$12.43
11-25	$20.73
26-50	$31.67
51-75	$1.04 per mile
>75	$81.83

[5]Additional passenger: 1-17 miles, $2.50; 18 + miles, $4.50.

Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Providers have complained about the fairness and adequacy of reimbursement rates.

Providers have complained about the fairness and adequacy of reimbursement rates. As part of the Program Review survey, transportation providers were asked to identify the biggest problem they faced. This was an open-ended question; there were no response categories from which to choose, and some transportation providers gave more than one answer. Table 3.3 presents the most common responses. Thirty-five percent replied that making a profit at the current reimbursement rate was the biggest problem. Thirteen percent answered that trips are not distributed fairly.

Transportation providers were also asked about changes they would make to the system. Sixty-three providers answered this question and as a group they offered a wide range of options. The most common response (14 percent) to this question was that the reimbursement rates should be increased.

Table 3.3
Most Common Problems Faced by Transportation Providers
(Survey of Transportation Providers)

Making a profit with current reimbursement rates	35%
Trips are not distributed fairly	13%
72-hour notice	8%
Broker operations	8%
Number of respondents: 80	

Note: No other answer was given by more than 3 percent of providers.
Source: Program Review survey of HSTD providers. The question was "As a provider of Medicaid nonemergency transportation services, what is the biggest problem you face?" (Question 32). Program Review staff categorized the responses.

Better Coordination of Trips Can Be Encouraged Through the Fee Structure for Transportation Providers

Fees can be used to promote more efficient grouping of trips. The current rate structure may not promote efficient grouping of trips.

The fees paid to transportation providers can be used to promote more effective grouping of trips to improve the overall efficiency of the system. The pricing structure differs considerably among regions, but in general the rate paid for a trip is based on the first rider. Payments for additional riders picked up at other stops are often calculated as add-ons to the initial amount. For example, in Region 1, a trip to pick up a person classified as disoriented (code 07) is reimbursed at $1.05 per mile. If an additional 07 passenger is picked up and transported, the reimbursement for that passenger is fixed at $5.24, regardless the distance transported.

The amount paid for each additional passenger can serve as an incentive for providers to better consolidate trips. Loading multiple passengers on each trip can reduce the overall cost of the system by requiring fewer trips, fewer vehicles, and fewer drivers to provide the same amount of service. The rates across regions, however, differ dramatically in the amount of incentive providers receive to group multiple riders on a single trip. As an illustration, Table 3.4 shows the fees that would be paid to providers in five regions for a single 10-mile trip with one category-07 passenger compared to a single 10-mile trip with three category-07 passengers. In three regions, two additional passengers add $8 to $10 to the fee. In one region, the extra passengers increase the fee by $20. In Region 16, the increase is $30. In the latter region, there would appear to be little incentive to better coordinate this type of trip. The payment for three riders sharing transport would be the same as for three separate trips.

Table 3.4
A Regional Comparison of Provider Fees for Transporting One or Three Category-07 Riders

Region	Fee for a 10-mile Trip With One Rider	Fee for a 10-mile Trip With Three Riders	Difference
2	$19.91	$28.71	$8.80
5	$15.00	$25.00	$10.00
6	$27.50	$35.50	$8.00
14	$26.02	$46.42	$20.40
16	$15.00	$45.00	$30.00

Source: Developed by Program Review staff based on data provided by OTD.

Officials of LogistiCare, the broker for Region 6, have stated that, based on their experience in other states, they do not feel the current fee structure provides an adequate incentive for their providers to group trips efficiently.

Forty-one percent of riders surveyed indicated there were usually no other passengers in the vehicle. There is no evidence that coordination of trips has improved significantly over the past year.

According to the Program Review survey of HSTD riders, 41 percent of respondents answered that there were usually no other passengers in the vehicle. More than 62 percent of respondents indicated that there were usually one or fewer other riders. Table 3.5 summarizes the responses to the open-ended question asking how many riders are usually in the vehicle when services are provided.

There is no evidence that coordination of trips has improved significantly over the past year. One of the questions in the survey of transportation providers was whether the average number of

HSTD riders in their vehicles per trip had increased, decreased, or remained the same over the past 12 months. Of the 80 transportation providers answering the question, only 15 percent indicated that the number of riders per trip had increased in the past year. Sixty-three percent reported that the average number of riders per trip had remained the same over that period; 23 percent reported a decrease.

Table 3.5
Number of Other Riders Usually in the Vehicle
(Survey of Riders)

Number of Other Riders	%
None	41.4
1	20.6
2 to 3	23.5
4 to 7	10.2
8 to 14	3.8
15 or more	0.5
Number of respondents: 2,528.	

Source: Program Review survey of HSTD riders. The question was "Other than the driver, how many other riders are usually in the vehicle with you?" (Question 6). Program Review staff grouped the responses into the above categories.

Transportation Cabinet officials have said a failure to coordinate rides was a factor in the demise of CTG, the former broker for Region 6.

The failure to coordinate rides can have serious financial consequences for a broker. For brokers to operate effectively under the capitated system, they must provide services efficiently but at an acceptable level of quality. Transportation Cabinet officials have pointed to a failure to coordinate rides as one of the factors in the demise of CTG, the former broker for Region 6. Cabinet officials said the broker provided too many single-passenger trips and did not efficiently load vehicles with multiple passengers.

Without a market rate for services, the Transportation Cabinet must structure rates at fair and sufficient amounts.

In the absence of a market rate for the services of transportation providers, the Transportation Cabinet must make every effort to structure rates at fair and sufficient amounts. Rates must also provide an incentive to deliver services efficiently and effectively.

Recommendation 3.1

The Office of Transportation Delivery should examine the current rate structure for transportation providers in conjunction with representatives of brokers and transportation providers. Recognizing the cost factors set out in 603 KAR 7:080 §17, rates should also be uniform, simple, and adequate, and should provide incentives for efficient grouping of trips. Such factors could be included in an actuarial analysis done in conjunction with the analysis currently performed to determine the capitation rates for each region.

Brokers Have an Important Role in Coordinating Trips

Brokers should assign trips fairly and effectively.

Setting rates that provide an incentive to have more than one rider per trip is not sufficient to ensure that trips are efficiently coordinated throughout the HSTD system. Brokers also must assign trips to transportation providers fairly and effectively. HB 488 specified that "the broker shall establish a system that fairly and equitably distributes requests for transportation services in the delivery area among the broker and all subcontractors certified to transport Certificate Type 07 or Certificate Type 08."

Typically, payments to providers are highest for category 07 (disoriented riders) and 08 (nonambulatory) riders. Some subcontractors have stated that brokers who also serve as transportation providers may have an inherent bias to reserve the most lucrative trips for themselves.

Question 33 of the Program Review survey of transportation providers asked: "What changes, if any, would you make to the Medicaid nonemergency transportation system?" Sixty-three providers responded to Question 33. There was a wide variety of responses, but some responses demonstrate the concerns providers have about the equity of the current system. Fourteen percent of the providers who responded indicated that they would increase the reimbursement rates. Ten percent indicated that they thought brokers should not be allowed to provide transportation services, and another 8 percent said that trips should be distributed more equally among providers.

Forty percent of providers disagreed or strongly disagreed that rides are fairly distributed.

As shown in Table 3.6, when the Program Review survey asked specifically about the distribution of trips, 60 percent of transportation providers reported that they were satisfied with the way trips were scheduled. Forty percent, however, indicated dissatisfaction with the way their brokers scheduled trips.

There were some regional differences in responses to the survey. Four of the six (67 percent) providers who responded to the survey from Region 11, and five of the seven (71 percent) providers responding from Region 13 indicated that they were dissatisfied or very dissatisfied with trip scheduling.

Table 3.6
Dissatisfaction or Satisfaction With Brokers' Scheduling of Trips (Survey of Transportation Providers)

Very dissatisfied	25%
Dissatisfied	15%
Satisfied	42%
Very Satisfied	18%
Number of Respondents: 79	100%

Source: Program Review survey of transportation providers. The question was "How dissatisfied or satisfied are you with the way your broker schedules your trips?" (Question 8).

The Encounter Data Used by OTD Should Be Improved

OTD officials review encounter data to determine if rides are equitably distributed. The quality of the encounter data has been a cause of concern.

Program Review staff asked Office of Transportation Delivery officials how they ensure that brokers who are also transportation providers do not distribute rides inappropriately. The officials stated that they review encounter data submitted by the brokers to determine if rides are being equitably distributed. Encounter data consist of information supplied by the broker on each approved trip, including the date and time of pickup and delivery, mileage, and the cost of the trip. OTD officials acknowledged, however, that encounter data have been unreliable, and the differences in the ways brokers calculate mileage complicate analysis.

Brokers who also provide transportation services have different numbers and types of vehicles in their fleets. Some brokers have extensive territories; some are limited to a few counties. Therefore, a simple comparison of the percentage of category 07 or 08 trips that a broker provides may not give an adequate perspective on the region's trip distribution. For example, data provided by OTD revealed that the percentage of category 07 trips provided by

brokers varies from 94 percent in Region 3 to less than 2 percent in Region 5. The broker in Region 3 has operating authority in all counties in the region and has an extensive vehicle fleet. The broker in Region 5, however, has limited operating authority and does not actively seek to transport a large number of recipients in the region.

Recommendation 3.2

OTD should periodically survey transportation providers to determine if rides are being properly scheduled and equitably distributed. The satisfaction of providers should be included as an indicator of quality within the HSTD quality improvement plan. Perceptions of unfairness or dissatisfaction should be reviewed against the information collected in the HSTD database, and, as warranted, further investigation should be undertaken to ensure the equity of the system.

An unintended consequence of the freedom of choice rule is to increase the difficulty of reviewing the distribution of rides among providers.

The Freedom of Choice Rule May Affect Data's Usefulness. Brokers, providers, and OTD officials have also indicated that unintended consequences of the freedom of choice rule may make it more difficult to review the distribution of rides by brokers. HB 488 mandated the freedom of choice rule. The rule provides that recipients categorized as disoriented (code 07) or nonambulatory (08) have the freedom to choose who they want to provide their transportation service, thereby removing the broker's ability to assign rides when a recipient indicates a preference.

If such riders do not express preferences, the broker can schedule a trip with any provider. A broker also may offer freedom of choice to category 02 (taxicab) riders, but is not required to do so. Five brokers interviewed for this report allow some freedom of choice for riders other than those classified as disoriented or nonambulatory.

If a category 07 or 08 recipient does not exercise freedom of choice and allows a broker to arrange transportation, the broker is required under regulations (603 KAR 080 §16) to distribute the trip with coordination and cost efficiency in mind. If those criteria are not met, the broker is to rotate category 07 and 08 trips among providers, including the broker. Route efficiencies also must be considered.

Difficulties can arise in determining whether trips are appropriately distributed because recipients may select some providers more than

others. Freedom of choice can lead to an uneven distribution of trips, but a distribution that is appropriate based on riders' choices. Another factor that makes it difficult to review the distribution of trips by brokers is the procedure for requesting trips. Recipients call the brokers to request transportation and to identify their preferred transportation provider if they have freedom of choice. Brokers report this information in their monthly submission of data to OTD. Brokers who are also transportation providers have an incentive to provide as many of the category 07 and 08 trips as possible themselves because of the relatively high rate for those trips in most regions. Since brokers receive the requests for transportation, and report the requests to OTD, there is an opportunity for brokers to inflate the number of trips they are requested to provide.

The Availability of Freedom of Choice and Its Effect on Coordination of Services

Freedom of choice gives a measure of comfort and reassurance to disoriented and nonambulatory riders.

Freedom of choice does provide some measure of comfort, reassurance, and consistency to disoriented and nonambulatory riders by allowing them to remain with the same vehicle, and perhaps the same driver, trip after trip. The rule allows recipients to choose providers with whom they feel comfortable or who perform exceptionally well.

Meaningful choice, however, may not always be available in some regions due to the limited number of providers in the immediate area. A provider's operating authority determines the type of vehicle he or she may operate and the types of clients who can be transported. Subcontractors also have designated counties in which they can operate. Thus, there may be few vehicles equipped to transport patients confined to wheelchairs in some parts of the state, and riders may have few providers from which to choose.

Brokers indicate that freedom of choice can inhibit their ability to group rides.

Brokers have indicated that the freedom of choice rule can inhibit their ability to group riders most efficiently. One OTD official reported observing numerous taxicabs picking up recipients one at a time at a facility on a recent field inspection. The recipients had freedom of choice and had selected a number of different transportation providers, eliminating the opportunity to group a number of trips into a single route.

Some brokers have set up what are called "recurring trip" or "subscription trip" schedules with Supports for Community Living or Adult Day Care facilities. Under those arrangements, clients

technically have freedom of choice, but their transportation is set up for them for several days in a row. One broker has instituted a process to authorize trips over a two-week period. The trips generally are from a single residence to a single facility at about the same time each day and the same number of miles.

Some providers have been marketing their services to disoriented and nonambulatory riders.

Brokers and OTD officials have also reported that some providers have begun marketing their services to category 07 and 08 recipients. Providers have been accused of offering recipients the opportunity to stop by the store on the way home or other special favors, in return for being selected as their transportation providers. While such offers may satisfy some of the immediate needs of recipients, they do not meet the overall purpose of the HSTD system. If recipients are enticed to switch back and forth from one provider to another inappropriately, efficient scheduling of trips becomes even more difficult.

Recommendation 3.3

Any decision to alter the freedom of choice rule should be predicated on maintaining or improving the current level of quality in the HSTD program. However, to ensure that the freedom of choice rule is not being abused, encounter data should be examined periodically for regions with high numbers of single-passenger trips and for regions in which the broker has a substantial percentage of disoriented (code 07) and nonambulatory (code 08) passengers. If OTD determines that the freedom of choice rule is being abused or having particularly negative effects in a region, OTD should intervene by performing an independent review of the selection of providers for these types of riders. After validating the recipients' selections of particular providers, OTD should attempt to ensure that trips are grouped as efficiently as possible. Providers should be discouraged from inappropriately marketing their services to recipients.

Chapter 4

System Utilization and Growth Patterns

In their respective regions, brokers are paid a flat rate per month for each Medicaid recipient who is eligible to receive nonemergency transportation. In turn, brokers must reimburse any subcontractors for each trip provided. Overall use of the system has been growing, and this is expected to continue. Some types of riders pose a greater financial risk to brokers because their demand for services is higher than average. For example, a group comprising less than 1 percent of the total users of nonemergency transportation accounted for 28 percent of the total cost of trips during one month in 2002. The regional organization of the program should be examined to ensure that it is efficient and structured to meet projected future demand.

Utilization of Nonemergency Medical Transportation

Program utilization has continued to increase. Current utilization, as measured by OTD, is about 35 percent.

In its 2000 report, Tichenor & Associates indicated the nonemergency transportation system had become a "victim of its own success" because utilization at the time—26 percent—was more than double the 10 percent rate predicted by the first actuarial study.

The utilization rate is calculated by dividing the number of one-way trips by the number of nonemergency transportation-eligible Medicaid recipients, multiplied by 100 so the rate can be expressed as a percentage.[1] As shown in Table 4.1, HSTD utilization as measured by the Office of Transportation Delivery has grown since FY 2000. The utilization rate was at 26 percent in FY 2000. By FY 2002, the rate had grown to 34 percent and remained stable through FY 2003. The utilization rate for the first two months of FY 2004 was 35 percent.

[1] Note that the utilization rate does not measure the percentage of people eligible for the program who use HSTD services.

Table 4.1
Utilization of Nonemergency Medical Transportation
(Fiscal Years 2000 to 2004)

Fiscal Year	Eligibles Per Year	Average Monthly Trips	Utilization Rate (%)*
2000	464,776	118,918	26
2001	481,965	137,237	28
2002	478,436	160,729	34
2003	587,351	196,797	34
2004**	598,729	211,106	35

*The number of one-way trips divided by the number of Medicaid recipients eligible for nonemergency transportation, multiplied by 100.
**Utilization for July and August 2003 only.
Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Utilization varies by region, with Region 10 having the highest rate in FY 2003.

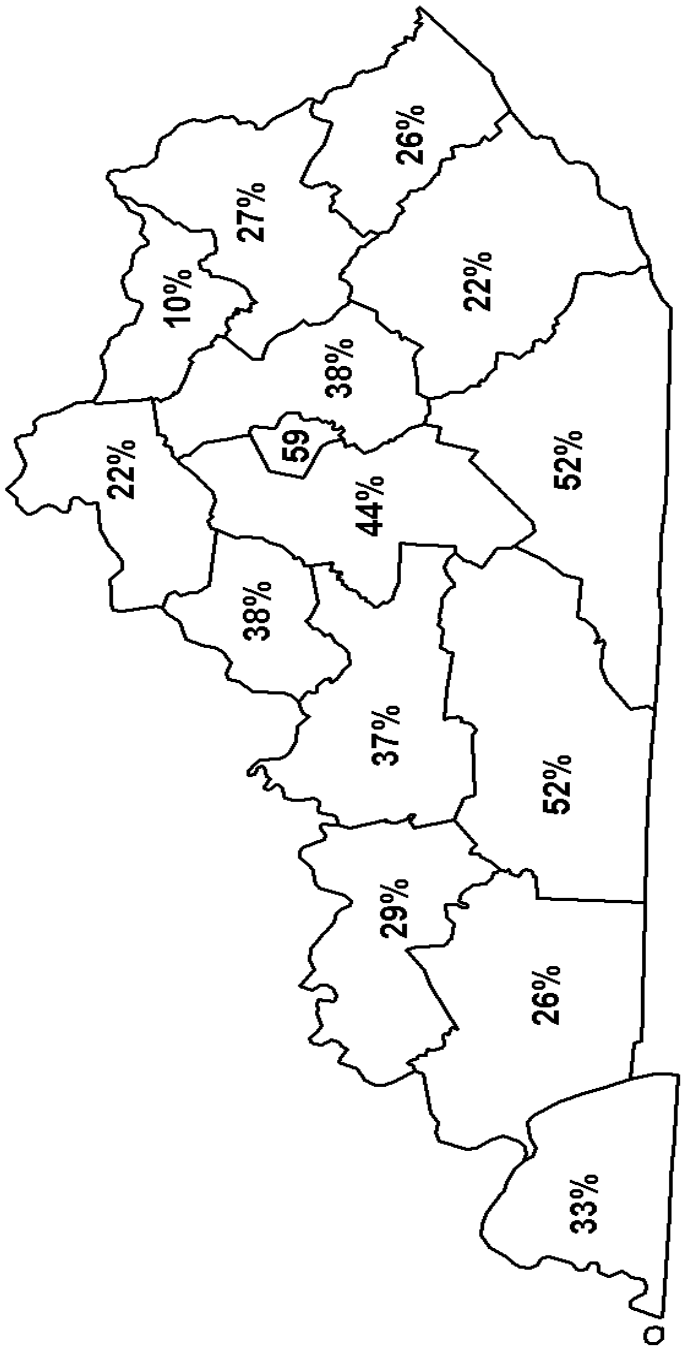
As shown in Figure 4.A, utilization varies by region.[2] Region 10, which includes Lexington, had the highest utilization rate in FY 2003: 59 percent. Region 16 had the lowest rate: 10 percent. Region 12 had a high number of eligible recipients in FY 2003 and also a relatively high utilization rate. Region 6 had the highest number of eligible recipients, but its utilization percentage was close to average. Region 16 had the lowest number of eligible recipients and the lowest utilization rate.

The number of people eligible for Medicaid services has increased steadily.

State executive branch officials have stated that Kentucky could face an $888 million shortfall in the Medicaid program by 2005. The officials predict the amount of the shortfall will escalate because of the steady increase in people eligible for Medicaid. According to the secretary of the Cabinet for Health Services, the average annual number of people eligible for Medicaid rose from nearly 603,000 in FY 2001 to approximately 666,000 in FY 2004 (Morgan 24). Whether the usage rate will remain stable in FY 2004 is unclear, but recent developments may indicate higher utilization.

[2] The map on page 11 shows the counties included in each region.

Figure 4.A
Regional Utilization Rates, FY 2003



Note: Utilization is defined as the number of one-way trips divided by the number of people eligible for HSTD services.
Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

The Aging of Kentucky's Population May Affect Utilization

The increase in the number of elderly Kentucky residents may affect the nonemergency medical transportation program.

The nonemergency medical transportation system serves the poor, disabled, children, and the elderly, but the system may face increasing numbers of clients from the latter group. According to the Kentucky State Data Center, Kentucky's population aged 65 and older grew to more than 500,000 from 1990 to 2000, an 8.1 percent increase. The U.S. Bureau of the Census predicts that there will be more than 900,000 residents 65 and older by 2025 (*Projections*). This would be an 80 percent increase from 2002, more than the national average growth rate. In 1995, Kentucky had the 28th highest proportion of elderly residents. By 2025, Kentucky is projected to rank 14th among all states (U.S. Bureau of the Census, *Kentucky's*).

It appears that Kentucky's nonemergency medical transportation system has done a good job in curtailing the fraud and abuse that plagued the voucher system, and cost growth has been restrained compared to the previous system. However, increases in future demand for nonemergency transportation services can be expected to increase total costs. Adequate planning and cost control measures may need to be pursued, while maintaining an appropriate level and quality of service.

Clients of the Supports for Community Living and Adult Day Care Programs Account for a Disproportionate Share of Riders and Costs

Adult Day Care (ADC) and Supports for Community Living (SCL) clients are disproportionate users of nonemergency medical transportation services.

Two waiver programs have led to additional pressures on the nonemergency medical transportation system in recent years: the Adult Day Care (ADC) and Supports for Community Living (SCL) programs. Users of ADC and SCL services comprise a disproportionate share of nonemergency transportation riders and their numbers are increasing. Specifically, the state's authorized expansion of SCL and the continued aging of Kentucky's population means that demand for adult day care is likely to rise.

These pressures are not new. According to Tichenor & Associates' 2001 actuarial analysis, brokers said that the increase in these two categories of the Medicaid population was the biggest risk they were encountering (Tichenor 14). Brokers and Office of Transportation Delivery staff have also identified the two programs as major factors in overall program costs. When Program Review staff asked brokers if there was a better way to set capitation rates, one-third volunteered that they were concerned about the long-term effect of the number of SCL clients.

ADC is a community-based group program aimed at older citizens and other recipients.

Adult Day Care. Adult Day Care is a community-based program designed to provide health care and related support for the aged and disabled. ADC services are limited to six hours per day and are set up to meet recipients' needs. ADC is viewed as an alternative to nursing home care or institutionalization and often allows a recipient's spouse, relative, or caretaker to work. Most ADC clients are elderly, but the program is open to qualified recipients aged 21 and older. An ADC provider may offer help with self-administration of medications, personal care services, self-care training, social activities, and recreation. ADC participants often use nonemergency transportation daily to and from the day care facility and also rely on it for trips from the facility to doctors and other health care providers. As the percentage of Kentucky's elderly population grows in the coming decades, it is likely that the demand for adult day care will rise as well.

ADC riders were less than 1 percent of eligible riders in August 2002 but accounted for 28 percent of total payments to transportation providers.

OTD officials looked at the cost of transporting ADC recipients for a single month. Table 4.2 indicates that the ADC population was less than 1 percent of the total Medicaid population in August 2002; those recipients utilized 28 percent of the transportation dollars that month.

Table 4.2
Adult Day Care Trips and Costs for August 2002

Eligible for Nonemergency Transportation	490,795
ADC-eligible Waiver Recipients	2,219
ADC as % of Eligibles for Nonemergency Transportation	0.41%
Total Trips	188,849
ADC Trips for Month	54,812
ADC Trips as % of Total Trips	29%
Total Payments by Brokers to Transportation Providers	$2,883,226
Total ADC Cost for Month	$815,843
ADC Cost as % of Total Payments	28%

Note: Region 6 is not included.
Source: Office of Transportation Delivery, Kentucky Transportation Cabinet.

Table 4.2 does not show the numbers by regions, but Region 5 deserves mention. OTD officials stated this region has experienced financial difficulty, and they attributed part of that difficulty to the relatively high utilization by ADC and SCL populations. In August 2002, ADC clients comprised less than 1 percent of eligible recipients but accounted for 48 percent of total payments to transportation providers. There are 15 ADC facilities in Region 5 according to the Cabinet for Health Services' Division of Aging

Services. Other regions have faced similar cost pressures. In the same month, ADC trips made up 39 percent of the total trips in Regions 8 and 12 according to OTD officials' analysis.

The SCL program serves individuals with mental retardation or developmental disabilities with an array of services. The number of funded SCL positions has doubled over the past five years.

Supports for Community Living. The Supports for Community Living program serves Medicaid recipients with mental retardation or developmental disabilities who meet requirements for residence in an intermediate facility for persons with mental retardation. The program was created as an alternative to institutionalization. Program services allow these individuals to remain in or return to the community as an alternative to institutional care. The number of individuals served is based on population and is apportioned throughout the state.

Table 4.3 shows the number of funded SCL positions and people on the waiting list for the past five years. The General Assembly authorized the provision of SCL services to 500 additional participants in FY 2004, bringing the total number of participants in the program to 2,682. Despite this increase, the number on the waiting list has grown steadily to 2,503 as of July 2003.

Table 4.3
Funded Supports for Community Living Positions and Waiting List (1999 to 2003)

Date	Funded SCL Positions	Number on Waiting List
July 1, 1999	1,374	1,428
July 1, 2000	1,624	1,931
July 1, 2001	1,932	2,026
July 1, 2002	2,182	2,418
July 1, 2003	2,682	2,503

Source: Department for Mental Health and Mental Retardation Services, Cabinet for Health Services.

Although SCL participants may live at home with their families or in group homes, they still receive an array of services. Those services include behavior supports, occupational and physical therapy, and community habitation experiences such as field trips and site visits. As Tichenor reported, SCL clients use the nonemergency transportation program extensively, sometimes five to six days a week and some of the trips can involve long distances (Tichenor 4-5). Because SCL clients are such frequent users of nonemergency transportation, any significant increase in their numbers is likely to have a strong impact on the use and costs of the nonemergency transportation system.

SCL client transportation costs an average of $552 per month.

In documentation to support approval of the transportation waiver, Medicaid officials pointed out that the average monthly cost to transport SCL clients is $552. Table 4.4 shows the statewide and regional cost of transportation for SCL recipients who made use of the HSTD system in August 2002. Cost per recipient varies by region, ranging from about $300 to more than $1,100. The numbers of SCL recipients also differ, contributing to substantial regional differences in payments. Total payments ranged from zero in Region 16 to more than $50,000 each in four regions.

Table 4.4
Supports for Community Living
Transportation Costs for August 2002

Region	SCL Recipients	Payments to Providers	Cost Per SCL Recipient	FY 2003 Capitation Rate
1	70	$82,967.08	$1,185.24	$6.20
2	36	15,948.64	443.02	5.60
3	34	24,490.56	720.31	5.05
4	3	2,222.48	740.83	6.41
5	102	63,017.80	617.82	6.91
8	68	36,857.20	542.02	6.41
9	65	33,299.86	512.31	5.40
10	162	51,544.06	318.17	6.50
11	53	24,415.60	460.67	6.34
12	148	79,322.86	535.97	6.36
13	10	4,124.12	412.41	6.98
14	36	17,931.48	498.10	6.34
15	51	26,290.88	515.51	5.55
16*	0	0.00	—	5.14
Total	838	$462,432.62	$551.83	

Note: Region 6 is not included.
*No SCL clients were transported in Region 16 during August 2002.
Source: Department for Medicaid Services, included in additional waiver information to Centers for Medicare and Medicaid Services, April 2003.

The amounts paid to providers for ADC and SCL transportation added up to almost $1.3 million for the sample month, accounting for 44 percent of total payments to providers.

ADC officials stated that their clients should not be affecting nonemergency medical transportation to the degree claimed.

ADC transportation services appear costly when viewed in the context of the entire nonemergency transportation program, but ADC officials interviewed for this report stated that the program should not be affecting the nonemergency system to the degree claimed. They said the ADC provider pool is shrinking and the number of recipients has remained relatively stable. SCL officials confirmed that transportation costs for SCL clients are going up. They attributed the increasing costs to the growing numbers of individuals served and service providers.

Adjustments for ADC/SCL Utilization Are Permitted

Medicaid and OTD have a process to adjust capitated rates to help brokers deal with the financial impact of ADC and SCL transportation.

Faced with the growing number of recipients covered in assorted waivers, Medicaid and OTD officials instituted a process to adjust capitated rates to help brokers deal with the financial impact. The provision allowing for the adjustment is not in statutes but is included in brokers' contracts.

If a region experiences a 10 percent increase in the number of ADC and SCL riders who take at least one trip in a one-month period, a broker can request a cap rate hike. Medicaid officials use a formula included in the contracts to determine if a rate increase or decrease is merited. Under the formula, each waiver program is considered separately and each program has a benchmark date. Brokers must request a rate increase in writing and certify that encounter data is complete. There is a limited amount of time during which brokers can seek an increase. Rate revisions can be effective on July 1, October 1, January 1, or April 1.

One broker complained to staff about the time it took for Medicaid and OTD to adjust the applicable capitated rate.

The broker in Region 9 told staff that he applied for and received a rate increase because of growing numbers of ADC and SCL clients. The impact of the increase was felt in 2002, but the adjustment did not become effective until 2003. As a result, the brokerage operated at a loss for several months. He said state officials do not have a sense of the financial impact on brokerages caused by the ADC and SCL increases.

Region 5's broker received a capitation rate increase in FY 2004 because of the ADC/SCL impact. The capitated rate was adjusted from $6.91 to $7.01. OTD officials indicated they cannot raise provider rates in the region because the capitated rate is only intended to help the broker improve financially. Brokers in Regions 8 and 12 requested adjustments in August and September 2003 respectively. The requests were pending at the time of this report.

Some Facilities Offering Medicaid Services Also Provide Transportation

Some medical service providers also transport their own clients.

ADC and SCL facilities that have transportation operations may subcontract with regional brokers and provide transportation services themselves. The Program Review survey of providers showed that 36 percent (28 of 78) of nonemergency transportation providers offer other Medicaid services. The number of ADC facilities that provide transportation varies across the state according to OTD officials. Although OTD was not able to provide the number of ADC facilities that transport their own clients, the results of the provider survey show that 14 percent of transportation providers also provide ADC services. OTD officials indicated that no SCL facilities provide transportation for their clients, and the Program Review survey revealed no transportation providers who are also SCL providers. Staff did visit a facility that transported clients and provided ADC and SCL services.

Facilities that provide transportation as well as health care services may have an opportunity to inflate the need for transportation services. Transportation providers are paid for each trip. Facilities that serve ADC and SCL recipients have a legitimate role in providing transportation for services or experiences that they have arranged for their recipients. However, the facilities also have a role in determining the number and types of trips recipients take. Many trips may be necessary and legitimate under the assorted waiver recipient care plans. But there also may exist an incentive and opportunity for service providers, who also are transportation providers, to increase trips beyond what is necessary.

Some regions have payment caps for medical service providers that also transport recipients.

Some regions have payment caps for medical service providers that also transport recipients. For example, Region 6 service providers transporting their own clients have a maximum per day rate of $40 for type 02 and 04 riders, $50 for type 07, and $75 for type 08. Region 9 also has maximums for service providers transporting their own clients: $16 per passenger per day for types 02, 04, and 07; and $30 per passenger per day for type 08. Region 1 has a $250 maximum for types 02, 04, and 07 trips out of region. Region 13 has a $250 maximum per vanload for a one-way trip for types 04 and 07. Region 15 has a $250 maximum per vanload for a one-way trip for type 07.

Recommendation 4.1

The Office of Transportation Delivery, working in cooperation with the appropriate Cabinet for Health and Family Services (CHFS) divisions, including the Department for Medicaid Services, should gather valid and reliable data on whether transportation providers that also provide Medicaid services contribute to overutilization of transportation services. Depending on the results of analyzing this data and a study of the impact of existing regional rate caps, OTD and CHFS may consider imposing caps for all regions. Options could include setting maximum rate caps for those providing transportation and other Medicaid services or establishing maximum payment amounts by region.

Regional Boundaries Have Remained Stable

The work to create the original regional boundaries was considered a milestone. It may be time to revise the regional divisions.

The 1996 Empower Kentucky team that designed the current program considered its work in dividing the state into 16 distinct transportation service delivery regions to be a significant milestone.[3] The task was daunting given all the possible regional groupings, but it may be the time to rethink the regional divisions.

Creating the boundaries involved collecting data from various programs showing the regions as defined by each program at that time, along with historic transportation utilization statistics for each social service program. Those working on the project also gathered data on population trends, existing transportation provider authority boundaries, fleet sizes, and service delivery capabilities (Commonwealth, 1997, 16).

The regions vary considerably in geography, population size, and the amount of transportation services provided.[4] The coming months are an opportune time for OTD and Medicaid officials to review the need for regional reconfigurations since broker contracts will be up for bid in FY 2005. OTD and Medicaid officials may wish to examine combining some regions with lower usage rates or splitting some of the regions with high usage rates, if such patterns could be demonstrated to more efficiently serve the needs of the program.

The overall number of regions may also need to be considered. Kentucky officials should look at other states to see whether broker

[3] There are now 15 regions.
[4] Figure 4.A on page 51 shows the regional utilization rates.

systems operating with fewer regions are effective and efficient. According to the CMS 1915(b) program summary, Georgia's 159 counties are divided into five service regions. In other regions of the country, some states have a single region serving the entire state. Officials should examine the number of regions necessary to most effectively provide services to the different regions of Kentucky. It is possible that having fewer regions could reduce administrative costs and provide for quality service delivery as well.

Recommendation 4.2

Transportation, Medicaid Services, and other interested parties should examine the distribution of regions across the state. Based on analysis of regions' administrative costs, consideration should be given to consolidating regions with low usage or realigning some regions with similar geography where sufficient infrastructure is in place to deal with the added population. Reducing administrative costs should be a goal in any such regional adjustment, but this should be balanced against the need to guarantee the overall quality and effectiveness of the system.

Communication Could Be Improved

Relevant agencies do communicate, but communication regarding some program areas could be improved.

There are avenues of communication between OTD and Medicaid, but staff saw examples of needed improvement in that area in the course of this review. In one instance, after years in a cooperative venture Medicaid still had not provided OTD with an official list of covered services to allow effective planning and gatekeeping functions. Gatekeeping can involve verification of recipients' eligibility, assessment of recipients' needs for services (including special transport), and information for recipients about the use of services. Medicaid is a complicated program and it may not be commonly known what services are covered.

Another example of a needed improvement in communication involves the issue of escorts provided for riders who may pose a threat to themselves or others. Transportation brokers and providers have called for more guidance on the rights and responsibilities of escorts, noting that escorts are uncertain about the liability associated with restraining riders who may become violent. DMS has not provided guidelines on this issue.

Medicaid and the Department for Mental Health-Mental Retardation also have apparently failed to advise OTD about the location of upcoming SCL enrollees. Because Health Services officials know the identities of SCL recipients on the waiting list, they could inform the OTD as new program participants are approved. This would allow planning and resource allocation to begin before individuals are moved from the waiting list to the program. Such information would be useful to brokers, yet it has not been made available.

Service Limits and Administrative Controls in Other States

Some states have limitations to help control transportation costs.

Forty-three states offer some type of nonemergency transportation service. Some of them utilize certain service limits or eligibility requirements intended to help control nonemergency transportation costs. For example, Kentucky is among 19 states that require prior approval for nonemergency trips. Kentucky's brokers also appear to be vigilant in screening potential users such as those with a usable vehicle in the household. Some states have limitations that Kentucky does not have. Of those states with nonemergency transportation programs, six have a co-pay requirement ranging from 50 cents to $3 per trip. Some states impose limits on the number or types of covered trips. For example, Alabama limits trips to two per month. Alaska limits its trips to weekday business-hour travel. In Kansas, trips are limited to 50 miles, one-way. In Pennsylvania, each user is limited to $50 in total cost per month (Kaiser).

Administrative controls are used in other states in an effort to help manage costs.

The use of brokerages is viewed as an innovative way to control Medicaid transportation costs, but some states have also instituted in-house administrative controls to manage costs and utilization of services (Community Transportation Association 12). Some of these could possibly be adapted to Kentucky's brokerage system, such as

- eliminating mileage charges and adopting fixed or flat reimbursement rates;
- contracting with providers to obtain volume discounts;
- capping the number of trips per recipient;
- capping transportation expenditures by county or region;
- promoting the use of volunteer drivers;
- offering incentives to recipients to drive themselves; and
- including transportation for special populations in special waiver programs.

The foregoing list of social service transportation cost-control measures is not all-inclusive. It would benefit the Office of Transportation Delivery and the Department for Medicaid Services to review other states' social service transportation cost containment measures to determine which measures would work in Kentucky.

Recommendation 4.3

Officials of the Office of Transportation Delivery and the Department for Medicaid Services should consult with their counterparts in other states to determine the cost-control measures that would be practical for Kentucky's capitated system. Any suggestions for promising cost-control measures should then be made to the General Assembly.

Works Cited

Brammer, Jack. "Limo Took Medicaid Patients to Doctor." *Lexington Herald-Leader* June 7, 1995.

Centers for Medicare and Medicaid Services. *State Operations Manual, Part 8: Program Evaluation*. July 3, 2002. Nov. 28, 2003 <http://www.cms.hhs.gov/manuals/pub07pdf/part-08.pdf/>.

---. *The State of Georgia 1915(b) Program*. May 29, 2002. Nov. 26, 2003 <http://www.cms.hhs.gov/medicaid/1915b/ga06fs.asp>.

Commonwealth of Kentucky. Empower Kentucky. *Implementation Strategy Recommendation Report, Transportation Delivery Process*. Frankfort: 1997.

---. ---. *Transportation Delivery Process Redesign for the Commonwealth of Kentucky*. Frankfort: 1996.

Community Transportation Association of America. *Medicaid Transportation: Assuring Access to Health Care, A Primer for States, Health Plans, Providers and Advocates.* Washington D.C.: Jan. 2001. Aug. 25, 2003 <http://www.ctaa.org/data/report.pdf>.

Joint Commission on Accreditation of Healthcare Organizations. Nov. 28, 2003. <http://www.jcaho.org/general+public/who+jc/index.htm>.

Kaiser Commission on Medicaid and the Uninsured and National Conference of State Legislatures. *Non-Emergency Medical Transportation Services*. Nov. 3, 2003 <http://207.22.102.105/medicaidbenefits/nonemergtransp.html>.

Kentucky State Data Center. "Census 2000 Summary File 1 Highlights." *KSDC News* 19.2 (2001). November 3, 2003 <http://ksdc.louisville.edu/sdc/newslet/KSDC01_2. pdf>.

Morgan, Marcia. Secretary, Cabinet for Health Services, Commonwealth of Kentucky. Presentation to the Foundation for a Healthy Kentucky's Forum on Kentucky Medicaid Decision Making in Tough Times. "Kentucky's Roadmap in Closing the Gap." Sept. 8, 2003. <http://www.healthyky.org/PDFs/Marcia%20Morgan.pdf>.

National Committee for Quality Assurance. Nov. 28, 2003 <http://www.ncqa.org/index.htm>.

Tichenor & Associates, LLP. *Report on the Capitation Rates for the Human Service Transportation Delivery Program for the Commonwealth of Kentucky Transportation Cabinet*. Frankfort: 2001.

Transportation Research Board of the National Academies. *Economic Benefits of Coordinating Human Service Transportation and Transit Services*. Washington, D.C.: 2003.

University of Kentucky. Kentucky Transportation Center. *Evaluation of Medicaid Transportation Service Delivery in Kentucky Human Service Transportation Regions*. Lexington: 2000.

U.S. Bureau of the Census. Population Division. *Kentucky's Population Projections: 1995 to 2025*. 1996. September 18, 2003 <http//www.census.gov/population/projections/state/9525rank/kyprsrel.txt>.

---. ---. *Projections of the Population by Age and Sex of States: 1995 to 2025*. 1996. September 18, 2003 <http//www.census.gov/population/projections/state/stpjage.txt>.

Wagar, Kit. "Four Men Sentenced in Medicaid Fraud Case." *Lexington Herald-Leader* February 21, 1996.

Appendix A

Implementation Problems in Region 6

Jefferson and surrounding counties have had transportation problems for years.

The transportation region in and around Jefferson County has been a problematic area for several years. Despite these difficulties, OTD and Medicaid may have learned some vital lessons in the provision of transportation services, including the importance of coordination. Originally, the contract for brokerage services in Region 6, which at that time was Jefferson County alone, was awarded to Yellow Transportation Management in 1999. A separate contract was issued to American Red Cross Louisville for a brokerage in the counties around Jefferson County, including Bullitt, Henry, Oldham, Shelby, Spencer, and Trimble.

Region 7 was discontinued, and the original counties were assigned to Region 6 and Region 9.

American Red Cross Louisville began providing broker services to Temporary Assistance to Needy Families (TANF) recipients in Region 7 on May 1, 1999. It began providing Medicaid nonemergency transportation one month later. Because of financial difficulties encountered by the broker; however, it withdrew from the contract effective June 30, 2000. The OTD decided to discontinue Region 7. The original counties were assigned to Region 6 and Region 9: Bullitt, Oldham, Shelby, and Spencer counties assigned to Region 6; and Henry and Trimble counties becoming part of Region 9.

Legal action prevented Yellow Transportation Management from fully implementing brokerage services.

Within the Jefferson County region, legal actions prevented Yellow Transportation Management from fully implementing brokerage services. A judge issued a restraining order against Yellow Transportation Management in August 1999 in response to a lawsuit protesting the award. The restraining order limited Yellow Transportation Management to serving only TANF recipients in the region. Unable to fully implement its brokerage services, Yellow ended its contract for TANF on December 31, 2001.

Only one response was received to the Region 6 Request for Proposals, and it was judged nonresponsive.

A Request for Proposals (RFP) was issued for the 15 remaining regions on January 16, 2001. Only one response was received for Region 6. Coordinated Transit Group (CTG) submitted the response, but it was deemed to be nonresponsive by the Finance and Administration Cabinet. On April 20, 2001, a new RFP was issued for Region 6 only.

On May 3, 2001, CTG filed a protest alleging the Commonwealth erred in finding its response to the January RFP nonresponsive. The protest halted all activity on the award of a Region 6 contract

until August 2002, when the protest was resolved in favor of the Commonwealth and the RFP proceeded.

The second RFP for Region 6 also received only a single response. The contract was awarded to Coordinated Transit Group (CTG).

Only a single proposal was received in response to the second RFP for Region 6. The response was again from CTG. This proposal was deemed responsive and CTG was awarded the contract to serve as broker for the region on September 26, 2001. After some post-award negotiation, the contract was approved on October 30, 2001.

In January 2002, Yellow Cab of Louisville notified OTD that it would not subcontract with CTG for Region 6 transportation. Yellow Cab was a major provider of transportation services in Region 6, and its decision not to participate in the program led to concerns about CTG's ability to provide the necessary services.

The contract with CTG for Region 6 took effect July 1, 2002.

The contract with CTG for transportation services in Region 6 took effect July 1, 2002. The contract was based on a capitated rate of $5.43 per client per month, the same amount that had been approved for the region in 1999. Usage rate estimates also were based on 1999 data.

Concerns about the quality of service provided by CTG arose almost immediately.

Concerns about the quality of service provided by CTG arose almost immediately. A large number of complaints began to surface about the quality and reliability of the service provided by CTG during its first month. Transportation Cabinet officials stated that complaints are not unusual during the startup period of any broker; however, more than 700 complaints were recorded during CTG's first month of service. By contrast, only 362 complaints were filed against all regions for the entire preceding fiscal year.

Subcontractors also began to complain.

While the number of recipient complaints did decrease over time, with only 253 complaints recorded against Region 6 in September 2002, subcontractors also began to complain. Subcontractors stated that CTG was not paying for services rendered in a timely manner or was not paying the full amount due. CTG, in turn, complained that the state was at fault for setting the capitated rate unrealistically low and for underestimating the number of rides per month, since the numbers had not been updated from the 1999 study.

When asked about the capitation rate and usage estimates for Region 6, officials from both the Transportation Cabinet and the Cabinet for Health Services noted that these rates were included in the Request for Proposal, and CTG had agreed to both when it signed the contract. Transportation Cabinet officials also pointed

out that there was a clause in the contract allowing CTG to request a rate increase; however, CTG could never provide data to support a rate increase. Transportation officials noted that they still lack acceptable data on transportation service provided during CTG's tenure as the Region 6 broker.

CTG filed bankruptcy and ceased providing services.

On October 21, 2002, three subcontractors filed suit in federal court in an attempt to force CTG into involuntary bankruptcy to collect money they said CTG owed them. On November 12, 2002, the state filed a motion in U.S. Bankruptcy Court to terminate its contract with CTG and asked the court to appoint a trustee to provide transportation services to Medicaid recipients in Region 6. In its motion, the state listed poor service, failure to properly reimburse subcontractors, use of unapproved subcontractors, and failure to provide requested data as causes to terminate the contract. On November 25, 2002, before the federal court had issued a ruling on the state's request, CTG filed a motion for voluntary bankruptcy and cancelled its contract with the state. CTG ceased to provide services as a broker at midnight, November 30, 2002.

The state implemented an interim system until another broker could be placed under contract.

After CTG ceased providing services, the state implemented an interim system to provide transportation services in Region 6 until another broker could be placed under contract. The interim system allowed subcontractors to bill Medicaid directly. The Transportation Cabinet and DMS advertised in the region and explained that recipients should call the subcontractors directly for transportation services.

Transportation officials have pointed out that, while this system served during the interim, it lacked any monitoring system to keep out inappropriate rides. Additionally, there was no monitoring to ensure that providers were conforming to safety and other standards. The system sufficed for the period of time it took to get a new broker under contract.

LogistiCare's contract for Region 6 has the highest capitation rate in the state.

During the interim period in Region 6, the state issued two RFPs for broker services. The first RFP, with a capitated rate of $7, received no responses. The capitated rate was increased to $8.25 for the second RFP, which elicited three responses. LogistiCare, a national company headquartered in Atlanta, Georgia, was deemed to be the most responsive. DMS staff stated that, after selecting LogistiCare based upon their technical merits, they negotiated the capitated rate down to $8.20 per eligible recipient per month.

DMS staff justified the unusually high capitated rate by stating that the cabinet was in a poor negotiating position because it did not

know the volume of business that LogistiCare could expect. Data from CTG had been unreliable, and its predecessor, Yellow Transportation Management, had never provided Medicaid nonemergency transportation. Transportation officials also pointed to the amount of negative press associated with the failure of CTG as a factor in the difficulty in negotiating a broker contract for Region 6.

LogistiCare began providing broker services in Region 6 on May 1, 2003.

LogistiCare began providing broker services in Region 6 on May 1, 2003. LogistiCare is a specialized transportation network manager providing no transportation itself but acting as a broker and transportation coordinator. In addition to Kentucky, LogistiCare provides transportation management services for seven other states and the District of Columbia as well as a number of school districts. Though LogistiCare maintains offices and staff in Louisville, the call center for the Region 6 brokerage is located in Atlanta, Georgia.

According to Transportation Cabinet officials, the new Region 6 broker is doing a better job of coordinating services.

Transportation Cabinet officials have contrasted startup efforts by LogistiCare and the previous effort by CTG. Transportation officials noted that LogistiCare, in part due to its experience in other states, has done much better at anticipating startup costs and coordinating services. Additionally, the number of complaints reported to the Office of Transportation Delivery (shown below) has been strikingly less than the number reported during the startup period for CTG.

Region 6 Complaints: 2003	
May	24
June	13
July	10
August	6
September	6
October	2

Source: Office of Transportation Delivery, Kentucky Transportation Cabinet,

Despite its experience with coordinating transportation systems in other states, LogistiCare has encountered some of the typical startup difficulties experienced by most new brokerages in the state. Officials with the Transportation Cabinet and LogistiCare have indicated that, despite the high capitated rate in Region 6, the broker lost money in the region during the first few months of operation. LogistiCare officials stated that this is largely due to startup costs and inefficiencies within the current system. They anticipate this will improve as they refine their operations in Kentucky.

Appendix B

1999 Program Review Report's Recommendations and Agencies' Responses

In September 1999, the Program Review and Investigations Committee directed staff to examine the implementation status of the Human Service Transportation Delivery (HSTD) program. The subsequent report resulted in several recommendations directed at the efficiency and effectiveness of the program. The Office of Transportation Delivery (OTD) and Medicaid responded to some of the recommendations. Following are the original recommendations and responses to those recommendations:

Recommendation 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.

Response
The 2000 Session of the General Assembly passed HB 488 formalizing and placing into statute the CTAC. OTD staff record minutes of each meeting documenting all discussion items and outcomes of any votes taken.

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

Response
Since FY 2002 with the Cabinet for Families and Children's decision to remove TANF from the HSTD program, any potential for duplication of benefits within the programs was eliminated.

The OTD believes the Program Coordinator program has significantly enhanced services to Medicaid Members while assisting with monitoring of the HSTD program. Since the LRC's Program Review of 1999, with the addition of Program Coordinators the OTD has vastly improved their ability to assist brokers with enforcing regulations regarding the availability of free and appropriate transportation, i.e., "Car in the household". The Coordinator's now have access to vehicle registration records enabling them to quickly assess if Medicaid members have licensed vehicles. Drivers frequently initiate investigation of this issue because they observe vehicles at the Medicaid member's home as they pick them up or drop them off. Brokers refer all denials to the OTD Coordinators who research and respond appropriately.

Recommendation 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.

Response
Since 1999, the OTD performed an extensive review of the denial process resulting in significant changes. In 2002 during a review of the HSTD program, the Centers for Medicare and Medicaid Services determined that the denial process met federal requirements.

Changes since 1999 include:
- Only the OTD can deny services.
- Program Coordinators resolve all controversies regarding calling in with less than 72 hours notice.
- All denial letters include appeal procedures and appropriate regulation citations.

Recommendation 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.

Response
DMS routinely reviews and evaluates objectives of the federal waiver. Since 1999, DMS has met all reporting requirements, report analysis and independent assessments resulting in the Centers for Medicare and Medicaid renewing Kentucky's Waiver twice (2000, 2003).

Recommendation 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.

Response
Last year the OTD and the DMS performed an extensive review of the process of classification for medical transportation. As a result of that review the HSTD program revised the classification form and instituted new processes to assure appropriate classification of Medicaid members for medical transportation. New processes include:
- Subcontractors are no longer allowed to seek medical certification/classification.
- Brokers may forward questionable forms, via OTD, to the DMS Peer Review Organization for additional review by a physician.

To rectify the "first rider" issue, brokers review each request for reimbursement from a subcontractor to insure that subcontractors count first riders correctly. In addition, some individual brokers have installed software programs that help monitor this situation.

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

Response
Since 1999 encounter data format and collection process has significantly changed. Those changes include:

- Reduction of required data fields from 42 to 25;
- Brokers now reporting costs for the trips they provide themselves using the rates set by the State; and
- The OTD now sends back encounter data to the broker for corrections (duplicates, etc.).

As a result of these changes the OTD has seen a significant reduction in error reports during FY 2003.

Recommendation 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.

Response
Since 1999 the OTD has implemented significant improvements in the broker-monitoring program. Components of this program include semi-annual, on-site broker assessments, conduction of rider surveys and telephone surveys, region specific analysis of complaints, broker facility inspections, assessment of broker vehicle inspection programs, broker driver education and monitoring programs, and other monitoring activities.

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

Response
The OTD believes that the rider survey and telephone surveys currently used are valuable tools. Staff extensively analyzes results and routinely follows up with issues. In addition, the OTD forwards results of the surveys and complaint summaries to the brokers and discusses them at the semi-annual, on-site broker assessments. Brokers also submit complaint tracking reports monthly (required for payment) and OTD discusses the reports with brokers during semi-annual assessments.

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

Response
Since 1999 the OTD has minimized reliance on complaint data collected and reported by brokers. With implementation of the Program Coordinators function and the toll-free "888" complaint line, most complaints are referred directly to the Program Coordinators. By law the OTD must have Program Coordinators. Coordinators handle recipient and subcontractor complaints and assist Brokers with determining member eligibility. OTD Coordinators deny or confirm trip eligibility as well. All denials must come through the OTD Program Coordinators. The OTD maintains records of all Coordinator denials, complaints and questions received.

Recommendation 7.3
Develop procedures to independently check, on a random basis, program quality indicators.

Response
OTD staff will randomly call to check on a broker's "800" line and/or TTY device. A computer program chooses a percentage of HSTD broker/subcontractor employees each month for random drug testing. OTD staff performs random vehicle inspections. Unscheduled site visits will increase in the future.

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

Response
Program coordinators perform this function as stated in 7.2 above.

Recommendation 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.

Response
OTD provides reports or testimony whenever requested and will be submitting more in-depth reports on the state of the HSTD program to DMS.

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

Response
Review currently being conducted.

Appendix C

The Surveys of Riders, Providers, and Brokers

This appendix details how the surveys were developed and conducted and provides evidence that respondents are representative of users and providers of Kentucky's nonemergency transportation services. Frequency tables of the responses of riders, providers, and brokers are provided.

Rider and provider survey questions were developed based on interviews with brokers, interviews with staff of the Office of Transportation Delivery and the Department for Medicaid Services, and surveys of riders and providers conducted by the Kentucky Transportation Center (University of Kentucky).

How the Surveys Were Conducted

Riders. The Transportation Cabinet provided nonemergency medical transportation (NEMT) encounter data for the period April to September 2003. Staff selected 500 riders at random from each region except Region 16. The entire population of 385 was sampled for that region. The Department for Medicaid Services provided a mailing address and information on gender and race for each person in the sample. Riders without valid mailing addresses were eliminated from the sample.

A two-page survey was mailed to 6,822 users of NEMT or to the parent or guardian of the recipient for those under the age of 18. A follow-up postcard was sent to each recipient a week after the survey was mailed. Those who did not respond after the first mailing or postcard were mailed a second copy of the survey. Surveys were returned by 2,881 recipients for a response rate of 42 percent.

Sixty-eight percent of respondents were female and 32 percent were male. The average age of respondents was 51.

Providers. Staff asked brokers for a mailing list of all of NEMT providers in their region. All 128 providers in the 15 regions were mailed a two-page survey. A follow-up postcard was sent to each provider a week after the survey was mailed. Those who did not respond after the first mailing or postcard were mailed a second copy of the survey.

Of the 128 providers, 84 returned a survey for a response rate of 66 percent.

Brokers. Staff conducted telephone interviews of 12 brokers, representing all 15 NEMT regions.

Representativeness of the Sample

Rider Survey. It can never be ruled out that those who choose to respond to surveys hold meaningfully different opinions from those who do not respond. It is possible, however, to analyze available information to increase confidence that a sample is representative.

One way to address the question of response bias is to compare certain characteristics of those who returned questionnaires to the total sample—those sent questionnaires, whether they returned them or not. As shown in the tables below, those who responded to the survey appear to be typical in terms of gender and race.

Gender of Sample and Survey Respondents

	Percent of Sample	Percent of Respondents
Female	64	68
Male	36	31

Race for Sample and Survey Respondents

	Percent of Sample	Percent of Respondents
White	76.79	76.52
Black	14.62	13.89
Other	8.11	9.45
Hispanic	0.44	0.07
Asian	0.04	0.07

Another way to address the question of potential bias is to compare those who responded to the survey quickly to those who responded later. The logic if that is there is a response bias, those who responded later may be similar to those who did not respond at all. For example, a worry with most surveys is that those who have especially strong attitudes about the topic of the survey are more likely to respond with little prompting. If early respondents are very different from late respondents, that could indicate response bias. To see if that is the case here, surveyed recipients were divided into those who responded after receiving the questionnaire in the mail once and those who did not respond until after receiving the second questionnaire. The answers of late respondents were then used as proxies for those who did not respond to the survey. Based on this assumption, it was possible to project what survey results would have been if the response rate was 100 percent.

The actual and projected results are shown in the tables below for three questions regarding Medicaid nonemergency transportation that were asked of program participants. The differences between the actual and projected results are small. The representativeness of a sample cannot be guaranteed, but all indicators suggest that those who responded to the survey are typical program participants in terms of their views on the Medicaid nonemergency transportation program.

How dissatisfied or satisfied are you with the quality of the vehicle you usually ride in?

	Survey %	Projected %
Very Dissatisfied	3	3
Dissatisfied	3	3
Satisfied	51	54
Very Satisfied	38	33
No Answer	5	7

Have you ever been denied Medicaid nonemergency transportation services?

	Survey %	Projected %
No	75	73
Yes	20	20
No Answer	5	7

Overall, how dissatisfied or satisfied are you with the nonemergency transportation service provided by Medicaid?

	Survey %	Projected %
Very Dissatisfied	5	4
Dissatisfied	6	5
Satisfied	38	40
Very Satisfied	40	37
No Answer	12	14

Provider Survey. The provider survey likely reflects the views of all providers as evidenced by the number of surveys returned from providers in each region as depicted in the table below and the overall response rate of 66 percent.

Region	Completed Surveys	Providers in Region	% of Providers Completing Surveys
1	5	5	100
2	3	6	50
3	1	4	25
4	4	5	80
5	9	14	64
6	11	22	50
8	6	8	75
9	6	10	60
10	2	4	50
11	6	6	100
12	7	7	100
13	10	14	71
14	7	10	70
15	6	11	55
16	1	2	50
Total	84	128	66

Survey of Riders
Responses to Questions

1: How did you find out about Medicaid nonemergency transportation?

From my doctor/clinic	653	23%
From a friend or relative	846	29%
From a case worker	883	31%
Directly from a transportation provider or person who schedules my transportation	521	18%
Advertisement	84	3%
Other	309	11%
Number of riders answering the question	3,296	*

*More than one response could be checked, total percentages add to more than 100%.

2: When you call to schedule a ride, how often is the person on the phone helpful?

Seldom or Never	84	3%
Sometimes	288	11%
Usually	622	23%
Always	1672	63%
Total	2666	100%

3: When you call to schedule a ride, how often is the person on the phone polite?

Seldom or Never	94	4%
Sometimes	240	9%
Usually	602	23%
Always	1,729	65%
Total	2,665	100%

4: When you call to schedule a ride, are you usually offered a choice of transportation?

No	1,796	69%
Yes	821	31%
Total	2,617	100%

Please Respond to Questions 5 to 15 based on the transportation provider you use most often.

5: Where does the transportation provider usually take you?

Doctor/clinic	2,315	80%
Physical therapy	284	10%
Day treatment/adult daycare	522	18%
Other	360	12%
Number of riders answering the question	3,481	*

*More than one response could be checked, total percentages add to more than 100%.

*6: Other than the driver, how many other riders are **usually** in the vehicle with you?*

[Open-ended question, responses coded by Program Review staff.]

0	1,047	41%
1	522	21%
2 or 3	595	23%
4 to 7	257	10%
8 to 14	95	4%
15 or more	12	1%
Total	2,528	100%

7: How often do you get to the place you're going on time?		
Seldom or Never	76	3%
Sometimes	259	9%
Usually	836	31%
Always	1,562	57%
Total	2,733	100%

8: How often is the vehicle clean?		
Seldom or Never	38	1%
Sometimes	175	6%
Usually	709	26%
Always	1,797	66%
Total	2,719	100%

9: How often are the drivers polite?		
Seldom or Never	30	1%
Sometimes	165	6%
Usually	533	20%
Always	1,985	73%
Total	2,713	100%

10: How often do the drivers drive safely?		
Seldom or Never	30	1%
Sometimes	143	5%
Usually	563	21%
Always	1,977	73%
Total	2,713	100%

11: How often are the drivers helpful?		
Seldom or Never	59	2%
Sometimes	185	7%
Usually	516	19%
Always	1,953	72%
Total	2,713	100%

12: How often do you think the vehicle you ride in is safe?		
Seldom or Never	37	1%
Sometimes	148	5%
Usually	575	21%
Always	1,936	72%
Total	2,696	100%

13: How long do you usually have to wait for your return trip home?		
15 minutes or less	1,176	45%
16 to 30 minutes	776	30%
31 minutes to 1 hour	444	17%
Over an hour	224	9%
Total	2,620	100%

14: How dissatisfied or satisfied are you with the quality of the vehicle you usually ride in?

Very dissatisfied	97	4%
Dissatisfied	98	4%
Satisfied	1,456	53%
Very satisfied	1,093	40%
Total	2,744	100%

15: Have you ever had a problem while being transported that made you uncomfortable?

No	2,323	86%
Yes	373	14%
Total	2,696	100%

IF YES, please explain.

[Open-ended question, responses coded by Program Review staff.]

Driver-related			203	65.9%
Speeding/Reckless/Unsafe	88	28.6%		
Rudeness	40	13.0%		
Rider not secured	19	6.2%		
Harassment	15	4.9%		
Other	41	13.3%		
Pickup/Return			61	19.8%
(includes late or early pickup, not being picked up, late or no pickup for return trip)				
Trip-related			60	19.5%
Other riders	33	10.7%		
Crowded	13	4.2%		
Other (includes ride too long, too bumpy, road conditions)	14	4.5%		
Vehicle (includes safety concerns, climate control, inappropriate vehicle)			54	17.5%
Other			15	4.9%
Number of riders answering the question			308	*

*More than one response could be given, total percentages add to more than 100%.

16: Have you ever been denied Medicaid nonemergency transportation services?

No	2,160	79%
Yes	562	21%
Total	2,722	100%

If YES, why were you denied?

Medical service not covered	68	12%
Household member has vehicle	80	14%
Mistake by person scheduling or providing transportation	165	29%
Trip not covered (for example, trip to drugstore)	69	12%
Other	266	47%
Number of riders answering the question	561	*

*More than one response could be given, total percentages add to more than 100%.

Other, please specify:
[Open-ended question, responses coded by Program Review staff.]

Not enough notice: 72-hour requirement	147	48.7%
Request not covered (includes requests for emergencies, drugstores, out of area providers, out of state trips)	52	17.2%
Vehicle in household	28	9.3%
Broker error	19	6.3%
Eligibility denied	17	5.6%
Transportation unavailable	12	4.0%
Alternate transportation available	9	3.0%
Pickup error	7	2.3%
Other	13	4.3%
Number of riders answering the question	302	*

*More than one response could be given, total percentages add to more than 100%.

17: Do you understand your right to file a complaint about the transportation services you receive?

No	677	25%
Yes	1,997	75%
Total	2,674	100%

If YES, do you know the process for registering complaints?

No	927	51%
Yes	888	49%
Total	1,815	100%

18: Have you ever filed a complaint about the transportation services you've received?

No (Skip to Question 21)	1,787	93%
Yes	132	7%
Total	1,919	100%

19: What was your complaint(s)?
[Open-ended question, responses coded by Program Review staff.]

Pickup/Return (includes late or early pickup, not being picked up, late or no pickup for return trip, dropped at wrong place)			103	84.4%
Driver-related			37	30.3%
Speeding/Unsafe	12	9.8%		
Rudeness	10	8.2%		
Harassment	6	4.9%		
Other	9	7.4%		
Trip-related (includes ride too long, uncomfortable, crowded)			5	4.1%
Vehicle (includes unsafe, poor climate control, inappropriate vehicle)			7	5.7%
Vehicle in household			7	5.7%
Broker			7	5.7%
72-hour rule			6	4.9%
Other			16	13.1%
Number of riders answering the question			122	*

*More than one response could be given, total percentages add to more than 100%.

*20: How dissatisfied or satisfied were you with the way your **most recent** complaint was handled?*

Very dissatisfied	37	25%
Dissatisfied	33	22%
Satisfied	46	30%
Very satisfied	35	23%
Total	151	100%

21: Overall, how dissatisfied or satisfied are you with the nonemergency transportation service provided by Medicaid?

Very dissatisfied	131	5%
Dissatisfied	164	6%
Satisfied	1,097	43%
Very satisfied	1,155	45%
Total	2,547	100%

22. What changes, if any, would you make to the system for Medicaid nonemergency transportation?
[Open-ended question, responses coded by Program Review staff.]

Change 72-hour rule			250	21.4%
More reliable, timely pickups and returns			217	18.6%
Broker-related			100	8.6%
Improve broker's performance	28	2.4%		
Improve broker's courtesy	27	2.3%		
More hours of service	20	1.7%		
Less multiloading of riders	16	1.4%		
Replace current broker	9	0.8%		
More services (more people eligible, more destinations acceptable [such as drugstores], better handling of doctors' referrals)			86	7.4%
Driver-related			75	6.4%
Improve drivers' performance	53	4.5%		
Improve drivers' courtesy	22	1.9%		
More freedom of choice of providers/drivers			63	5.4%
More providers/drivers/vehicles			59	5.0%
Better, more appropriate vehicles			51	4.4%
Better service for special-needs riders			38	3.3%
More flexible vehicle-in-household rule			35	3.0%
Determine eligibility quicker and more accurately			34	2.9%
Allow family member(s) to accompany rider			17	1.5%
End broker system			8	0.7%
Other			75	6.4%
No changes/compliment			235	20.1%
Number of riders answering the question			1,169	*

*More than one response could be given, total percentages add to more than 100%.

23: Who completed this survey?

Medicaid recipient	1,263	47%
Parent	487	18%
Guardian	270	10%
Other	643	24%
Total	2,663	100%

Survey of Providers

1: When did you first become a Medicaid nonemergency transportation services provider?
[Open-ended question, responses coded by Program Review staff.]

1999 to 2003	31	42%
1994 to 1998	24	33%
1974 to 1993	18	25%
Total	73	100%

2: How would you describe your organization?

Private, for profit	57	69%
Not for profit	21	25%
Other	5	6%
Total	83	100%

3: Do you provide other Medicaid-covered services to the clients you transport, for example Adult Day Care or Supports for Community Living?

No	50	64%
Yes	28	36%
Total	78	100%

If YES, please specify the service(s) you provide:
[Open-ended question, responses coded by Program Review staff.]

Adult Day Care	12	75%
Doctor Appointments	2	13%
Home Care	1	6%
Nursing Homes	1	6%
Total	16	100%

4: What are your hours of operation? (Please fill in your hours for each day or select "Closed.")
[Open-ended question, responses coded by Program Review staff. Tables show hours providing Medicaid transportation.]

Opening times	**Monday to Friday**		**Saturday**		**Sunday**	
Open 24 hours	27	35%	26	34%	24	31%
Before 7:00 a.m.	30	39%	22	29%	4	5%
7:00 to 7:59 a.m.	11	14%	1	1%		
8:00 to 8:59 a.m.	3	4%	1	1%		
9:00 to 9:59 a.m.	1	1%				
12:00 to 1:00 p.m.					2	3%
As needed	4	5%	3	4%	5	6%
If scheduled			2	3%		
Closed			21	27%	42	55%
Open 7 hours			1	1%		
Open 12 hours	1	1%				
Total	77	100%	77	100%	77	100%

Closing Times	Monday to Friday		Saturday		Sunday	
Open 24 hours	27	35%	26	34%	24	31%
1:00 p.m. or earlier			2	3%	1	1%
4:00 to 4:59 p.m.	5	6%	1	1%		
5:00 to 5:59 p.m.	7	9%	5	6%		
6:00 to 6:59 p.m.	20	26%	10	13%	1	1%
7:00 to 7:59 p.m.	4	5%	2	3%		
8:00 to 10:00 p.m.	6	8%	2	3%	2	3%
Later than 10:00 p.m.	3	4%	2	3%	2	3%
As needed	4	5%	3	4%	5	6%
If scheduled			2	3%		
Closed			21	27%	42	55%
Open 7 hours			1	1%		
Open 12 hours	1	1%				
Total	77	100%	77	100%	77	100%

*5: What types of vehicles do you have available for Medicaid nonemergency transportation? (Select all that apply. For those selected, please indicate the number you have available and the percentage of your Medicaid nonemergency transportation trips that each covers.)**

[Open-ended question, responses coded by Program Review staff. The percentages shown are based on the 82 providers who answered the question.]

Number of Vehicles	Buses		Taxis		Lift-equipped Van		Standard Van		Other	
1	8	10%	3	4%	7	9%	8	10%	2	2%
2			3	4%	11	13%	8	10%	1	1%
3 to 5	1	1%	15	18%	21	26%	7	9%	1	1%
6 to 10	4	5%	11	13%	6	7%	9	11%	2	2%
11 to 19	3	4%	6	7%	4	5%	4	5%		
20 or more			3	4%	3	4%	1	1%		
Total	16	20%	41	50%	52	63%	37	45%	6	7%

*Based on the responses, the part of the question dealing with the percentage of Medicaid trips covered by each type of transportation was unclear. Answers are not shown.

*6: What percentage of your business **revenue** is generated through Medicaid nonemergency transportation services?*

Less than 25%	20	24%
25% - 49%	8	10%
50% - 74%	4	5%
75% or more	50	61%
Total	82	100%

*7: What percentage of your **total trips** does Medicaid nonemergency transportation services account for?*

Less than 25%	14	17%
25% - 49%	9	11%
50% - 74%	8	10%
75% or more	51	62%
Total	82	100%

8: How dissatisfied or satisfied are you with the way your broker schedules your trips?

Very dissatisfied	20	25%
Dissatisfied	12	15%
Satisfied	33	42%
Very Satisfied	14	18%
Total	79	100%

Please explain your answer:

[Open-ended question, responses coded by Program Review staff.]

Complimented broker	18	36%
Unfair distribution of trips	12	24%
Problems with scheduling	8	16%
Problems due to 72-hours notice rule	4	8%
Problems with payments	3	6%
Not enough work	3	6%
Other	6	12%
Number of providers answering the question	50	*

*More than one response could be given, total percentages add to more than 100%.

*9: Do you disagree or agree that the **number of rides** is distributed fairly among providers in your region?*

Strongly disagree	15	19%
Disagree	13	17%
Agree	39	51%
Strongly agree	10	13%
Total	77	100%

*10: Do you disagree or agree that the various **types of rides** (02, 03, 04, 07, 08) are distributed fairly among providers in your region?*

Strongly disagree	16	21%
Disagree	16	21%
Agree	33	44%
Strongly agree	10	13%
Total	75	100%

11: How dissatisfied or satisfied are you with the timeliness of your payments?

Very dissatisfied	3	4%
Dissatisfied	9	11%
Satisfied	45	56%
Very Satisfied	24	30%
Total	81	100%

12: Have you been assessed liquidated damages or fines for not meeting a contractual agreement with the broker?

No	82	100%
Yes	0	0%
Total	82	100%

Please respond to the following questions based on the past 12 months.

13: The average number of recipients riding in your vehicles at one time has:

Increased	12	15%
Remained the same	50	63%
Decreased	18	23%
Total	80	100%

14: The length of the average trip has:

Increased	11	14%
Remained the same	63	79%
Decreased	6	8%
Total	80	100%

15: The average length of time a recipient waits to be picked up has:

Increased	4	5%
Remained the same	67	84%
Decreased	9	11%
Total	80	100%

16: The number of Supports for Community Living (SCL) trips has:

Increased	13	23%
Remained the same	33	59%
Decreased	10	18%
Total	56	100%

17: The number of Adult Day Care (ADC) trips has:

Increased	7	11%
Remained the same	36	55%
Decreased	23	35%
Total	66	100%

18: The number of escorts required has:

Increased	16	23%
Remained the same	46	65%
Decreased	9	13%
Total	71	100%

19: The number of no shows has:

Increased	20	26%
Remained the same	51	66%
Decreased	6	8%
Total	77	100%

20: Have you ever filed a complaint against your broker?

No (Skip to Question 23)	71	88%
Yes	10	12%
Total	81	100%

21: What was your complaint?

[Open-ended question, responses coded by Program Review staff.]

Rides distributed unfairly	4	40%
Insufficient payments	3	30%
Slow response or no response to requests	3	30%
Broker should not be a provider	2	20%
Poor communication	2	20%
Not honoring freedom of choice	1	10%
Unfair treatment	1	10%
Number of providers answering the question	10	*

*More than one response could be given, total percentages add to more than 100%.

*22: How dissatisfied or satisfied are you with the way your **most recent** complaint **against your broker** was handled?*

Very dissatisfied	8	89%
Dissatisfied	1	11%
Satisfied	0	0%
Very Satisfied	0	0%
Total	9	100%

*23: Have you filed any complaints **against a recipient of transportation services?***

No (Skip to Question 26)	75	90%
Yes	8	10%
Total	83	100%

24: What was your complaint?

[Open-ended question, responses coded by Program Review staff.]

Not showing up for scheduled trips	4	50%
Unnecessary trips	2	25%
Violence against driver	1	13%
Rider using unregistered car	1	13%
Unreasonable requests	1	13%
Verbal abuse	1	13%
Not following safety procedures	1	13%
Drunk	1	13%
Number of providers answering the question	8	*

*More than one response could be given, total percentages add to more than 100%.

*25: How dissatisfied or satisfied were you with the way your **most recent** complaint **against a recipient** was handled?*

Very dissatisfied	2	25%
Dissatisfied	2	25%
Satisfied	4	50%
Very satisfied	0	0%
Total	8	100%

26: Were you a Medicaid nonemergency transportation service provider under the voucher system (the system prior to the current broker system)?

Yes	66	83%
No (Skip to Question 32)	14	18%
Total	80	100%

Compared to the voucher system, how have the following changed under the current broker system?

27: The average number of recipients riding in your vehicles at one time has:

Increased	14	23%
Remained the same	23	38%
Decreased	23	38%
Total	60	100%

28: The length of the average trip has:

Increased	8	13%
Remained the same	41	68%
Decreased	11	18%
Total	60	100%

29: The average length of time a recipient waits for pick-up has:

Increased	7	12%
Remained the same	46	77%
Decreased	7	12%
Total	60	100%

30: The number of escorts required has:

Increased	17	31%
Remained the same	29	53%
Decreased	9	16%
Total	55	100%

31: The number of no shows has:

Increased	19	33%
Remained the same	33	58%
Decreased	5	9%
Total	57	100%

32: As a provider of Medicaid nonemergency transportation services, what is the biggest problem you face?
[Open-ended question, responses coded by Program Review staff.]

Insufficient revenues/High costs	33	42%
Trips are not distributed fairly	8	10%
Poor broker operations	8	10%
Not enough trips	6	8%
Problems related to pickups or returns	5	6%
Inaccurate or slow reimbursements	5	6%
72-hour rule	5	6%
Requirements for riders too strict	4	5%
Too much bureaucracy or paperwork	3	4%
More freedom of choice/Honor existing freedom of choice	3	4%
Brokers are unaccountable/Have too much power	3	4%
Not enough group trips or use of public transportation	2	3%
Lack of providers or vehicles	2	3%
ADC and SCL populations	2	3%
Other	3	4%
No problems	7	9%
Number of providers answering the question	79	*

*More than one response could be given, total percentages add to more than 100%.

33: What changes, if any, would you make to the Medicaid nonemergency transportation system?
[Open-ended question, responses coded by Program Review staff.]

Increase reimbursement rates	11	17%
Decrease or eliminate 72-hour notice	10	15%
Brokers should not provide transportation	9	14%
Better communication/More meetings	7	11%
No brokers/return to vouchers	6	9%
Distribute trips more fairly	6	9%
Prompter/more accurate payments	6	9%
Reduce paperwork	3	5%
Honor/expand freedom of choice for clients	3	5%
Award brokerages more fairly	2	3%
Less waiting time for return trips	2	3%
Some rates could be lowered	2	3%
More training	2	3%
No changes	5	8%
Other (Any response given by only one provider coded as "Other")	14	21%
Number of providers answering the question	66	*

*More than one response could be given, total percentages add to more than 100%.

Survey of Brokers

Program Review staff conducted interviews by phone with all regional brokers. All questions were open-ended and were coded by staff.

The same broker is responsible for Regions 5, 13, and 15. In each of the following tables, that broker's answer is counted as three responses.

1: How long have you been a broker?

1998	7	47%
1999	4	27%
2000	1	7%
2001	2	13%
2003	1	7%
Total	15	100%

2: Are you also a transportation provider?

Yes	12	80%
No (Skip to Question 4)	3	20%
Total	15	100%

Brokers also functioning as transportation providers answered questions 3a, 3b, and 3c.

3a: How do you record the trips you provide, as opposed to the trips provided by subcontractors?

Same as other providers	10	83%
Differently	2	17%
Total	12	100%

3b: Do you track the mileage on trips you provide?

Yes	12	100%
No	0	0%
Total	12	100%

3c: Do you track cost per trip on trips you provide?

Yes	12	100%
No	0	0%
Total	12	100%

4: How do you notify Medicaid recipients in your region of your services?

Through providers of health care services	9	60%
Brochures, flyers, or newsletters	6	40%
Letter from office for Medicaid, food stamps, or social insurance	5	33%
Through local DCBS office	3	20%
Public service messages in local media	3	20%
Info provided by drivers or posted in vehicles	2	13%
Ad in phone book	1	7%
Website	1	7%
Mailing to recipients	1	7%
Does not advertise	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

*5: Do the capitated rates adequately cover your expenses? Have you appealed the capitated rates set for your region?**

Yes	14	93%
No	1	7%
Total	15	100%

*Four brokers have appealed rates.

5a: Is there a better way to set rates?

No	4	27%
Not sure	2	13%
Concerned about ADC/SCL clients or rapid increase in usage	5	33%
Consider administrative costs	2	13%
Higher rates for rural areas	1	7%
Rate adjustments should be quicker	1	7%
Total	15	100%

6: Since you first became a broker, has the Medicaid rider's trip length changed? If so, how?

No		11	73%
Yes		4	27%
Shorter	2		
More out-of-region trips	1		
Longer in some counties, shorter in others	1		
Total		15	100%

7: Since you first became a broker, has the typical Medicaid rider's wait time changed? If so, how?

Wait time remains the same	8	57%
Wait time has decreased	4	29%
Wait time has increased	2	14%
Total	14	100%

8: Do you have any concerns about abuse within the current system?

Broker system has lowered abuse/brokers catch most attempts	11	73%
Vehicle in household	1	7%
Riders will not use bus	1	7%
No shows	1	7%
Yes (no specific abuse cited)	1	7%
Inappropriate trips	1	7%
Inflated mileage by providers	1	7%
Overuse of after-hours system	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

8a: Do you think that misclassification of recipients (i.e. classifying an 02 as an 07 or 08) is a problem in your region?

Yes*	9	60%
No	6	40%
Total	15	100%

*Two brokers answered that Category 07 is a particular problem; two others emphasized misclassification of 08s.

8b: Do you think listing too many "first riders" is a problem in your region?

Yes	3	20%
No	12	80%
Total	15	100%

8c: Are there other ways transportation providers can take advantage of the system under the current structure? If yes, how?

One broker mentioned drivers trying to pad mileage, one mentioned vehicles in the home, and another mentioned advertising by contractors offering services that should not be covered (e.g. grocery trips).

9: How do you select providers?

Select from qualified providers	6	55%
Select providers meeting qualifications for program	4	36%
Newspaper ad	2	18%
Annual meeting	1	9%
Mailing to providers	1	9%
Number of brokers answering the question	11	*

*More than one response could be given, total percentages add to more than 100%.

9a: How do you make sure that you have the right transportation providers to meet the needs of the Medicaid recipients in your region?

Broker provides more trips as necessary	4	27%
Formula/computer system	3	20%
Using all available providers	3	20%
Add capacity as needed	2	13%
Has sufficient capacity	1	7%
Training and screening of providers	1	7%
Has grading system for providers	1	7%
Assesses needs of clients	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

10: How were the rates that you pay the transportation providers in your region set?

Set by Transportation Cabinet	15	100%
Total	15	100%

10a: Are the rates the same for all providers in your region or do you have different rates for different providers?

Same	15	100%
Different	0	0%
Total	15	100%

10b: Do you have any input into the provider rates established for your region, or is that mandated by the Transportation Cabinet?

Some input	10	67%
Rates are mandated	4	27%
Not sure	1	7%
Total	15	100%

11: How do you distribute trips among providers?

Provide choice for 07s, 08s	6	40%
Based on capacity or proximity of providers	5	33%
Rotate rides among providers	4	27%
Based on categories of riders	2	13%
Based on client choice	2	13%
Broker provides most transportation	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

11a: Are recipients offered a choice?

Yes	15	100%
No	0	0%
Total	15	100%

11b: Are non-07 and non-08 recipients offered a choice of providers?

Yes	5	33%
No	9	60%
Sometimes	1	7%
Total	15	100%

12: Are there any providers that you have a contract with but that you no longer refer clients to them?

Yes	0	0%
No	15	100%
Total	15	100%

13: Have you terminated a contract with a provider?

Yes	4	29%
No	10	71%
Total	14	100%

13a: If yes, how many?

One	2	50%
Two	2	50%
Total	4	100%

13b: What were the reasons?

Fraud	2	50%
Provider was unprofitable	2	50%
Would only transport some riders	2	50%
Unreported accidents	1	25%
Inappropriate vehicles	1	25%
Poor performance	1	25%
Number of brokers answering the question	4	*

*More than one response could be given, total percentages add to more than 100%.

14: How do you handle complaints from providers, specifically:

14a: How do you typically receive complaints?

Telephone	8	53%
Get few complaints	2	13%
Write down and contact client	1	7%
Computer tracking system	1	7%
Form	1	7%
Survey	1	7%
Complaints go to Transportation Cabinet first	1	7%
Total	15	100%

14b: How do you handle complaints?

Work with providers to resolve	7	47%
Try to resolve, refer to Transportation if necessary	3	20%
Complaint tracking system	3	20%
Write down and contact client to get more info	1	7%
Get few complaints	1	7%
Total	15	100%

14c: What complaints do you hear most often?

Want more trips	8	53%
Clients are late or do not show up	6	40%
Get few complaints	2	13%
Verbal abuse from clients	1	7%
Need better coordination of trips	1	7%
Payment amounts for trips	1	7%
Lack of notification for cancelled trips	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

14d: Do you track provider complaints along with their resolution over time?

Yes	11	67%
No	3	20%
Entered in the state's complaint system	1	7%
Total	15	100%

15: How do you handle complaints from riders, specifically:

15a: How do you typically receive complaints?

Phone	15	100%
Total	15	100%

15b: Do you have a recipient complaint line?

Yes	1	7%
No dedicated complaint line	14	93%
Total	15	100%

15c: How do you handle complaints?

Try to resolve in house	5	45%
Try to resolve in house, submit information to Transportation	4	36%
Record complaint, submit information to Transportation	1	9%
Resolve some complaints in house, forward others to Transportation	1	9%
Total	11	100%

15d: What complaints do you hear most often?

Denied service			14	93%
72 hours notice not given	5	33%		
Type of trip not covered	4	27%		
Vehicle in household	3	20%		
Other	2	13%		
Late pickup			9	60%
Not allowed to smoke			3	20%
Vehicle uncomfortable (AC or heating)			2	13%
Rider does not want to share vehicle			1	7%
Other passengers' behavior			1	7%
Rude driver			1	7%
Trip takes too long			1	7%
Number of brokers answering the question			15	*

*More than one response could be given, total percentages add to more than 100%.

15e: Do you track recipient complaints along with their resolution over time?

Yes	13	93%
No	1	7%
Total	14	100%

16: If you cannot resolve a recipient or provider complaint, how do you deal with it?

Refer to Transportation Cabinet's coordinators	11	73%
If it's a rider's complaint, switch his or her provider	3	20%
Refer to corporate office	1	7%
Total	15	100%

17: Have you or any of your providers had an 'adverse incident' in the past year (this could include a driver being assaulted, a recipient assaulted, a traffic accident, or other incident with unintended consequences)?

Drivers assaulted	11	73%
Minor accident	10	67%
Riders assaulted by other riders	5	33%
Riders abusing themselves	2	13%
Major accidents	2	13%
Vandalism of vehicles	1	7%
Driver stole a vehicle	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

18: Have the new rules on escorts affected your operations?

Yes, slightly	1	7%
No	14	93%
Total	15	100%

19: What changes, if any, would you make to the broker system?

Rethink freedom of choice	3	20%
More broker input, have broker member of Coordinated Transportation Advisory Committee	3	20%
More money to upgrade computers, software	2	13%
Clients should go to closer facilities	2	13%
Providers should not have to provide escorts	1	7%
Have health care providers schedule trips	1	7%
OTD coordinators should do more to help brokers combat abuse by clients	1	7%
More money for upgrading computers	1	7%
People traveling out of their area for services	1	7%
Providers should not be responsible for providing escorts	1	7%
Need clear, consistent rules for what qualifies as an authorized trip	1	7%
Eliminate out-of-region report	1	7%
Number of ADC, SLC clients can increase quickly but process to change rates is slow	1	7%
More efficient system to track trips	1	7%
Allow purchase of more vehicles	1	7%
More interaction among brokers to develop best practices	1	7%
More money	1	7%
Allow brokers to negotiate rates	1	7%
Too many clients classified as 07s	1	7%
Number of brokers answering the question	15	*

*More than one response could be given, total percentages add to more than 100%.

The Office of Transportation Delivery's Responses to the Recommendations of This Report

2.1 The Department for Medicaid Services, in conjunction with the Office of Transportation Delivery, should ensure that rider satisfaction surveys and survey methodology are redesigned to obtain valid results that can be generalized to all users of nonemergency medical transportation. If existing staff does not have the expertise in survey design and research, external resources should be consulted, such as the Government Services Center.

Outside Resource: OTD has been meeting with the Governmental Services Center since December 2003, discussing the need for a new design for rider and provider survey forms for non-emergency medical transportation. GSC has agreed to assist in the development of the form. This recommendation has been presented to both the Executive Quality Management Committee and the Coordinated Transportation Advisory Committee. These surveys will be mailed out to ensure anonymity and to have a better sampling. Our target date for the first survey is August 2004.

Internal Staff Resource: In addition to the outside resource mailings, OTD staff will continue to conduct face to face rider surveys and when needed, target areas of concern following complaints. For example, additional rider surveys have been conducted in a region in response to a subcontractor complaint.

2.2 The Department for Medicaid Services, in collaboration with the Office of Transportation Delivery, should develop a quality improvement plan, employing quality improvement standards from the National Committee for Quality Assurance and guidance from the Centers for Medicare and Medicaid Services. The plan, which should mesh well with the current quality committee, should set forth specific quality improvement measures to be reviewed by HSTD's existing quality committee. The plan should incorporate and expand on existing data collection efforts, identify performance indicators, detail baseline data, set forth goals for each indicator, and identify action plans as needed to reach goals.

A Quality Improvement Plan has been drafted. OTD is seeking GSC's input to finalize the plan. The QIP is scheduled to be in effect on July 1, 2004. The draft has been presented to the Executive Quality Management Committee.

2.3 Brokers should be held accountable for the submission of timely, correct encounter data. OTD should maintain a database with the number and types of errors by broker for each month. This would allow for monitoring of the number of errors per month and whether brokers are resubmitting corrected data. This should be an indicator within the HSTD quality improvement plan.

OTD has developed an NEMT encounter error tracking data system. Brokers will be held accountable for the submission of timely, correct encounter data.

2.4 OTD should match broker financial statements against encounter data to determine whether payments to providers are accurate.

The financial documents reflect actual broker expenses and the encounter data only includes paid or adjudicated trips. For example, the broker may pay a taxi company for a recipient no show trip. This cost will be reflected on the financial line item budget but not on the encounter data. Therefore the documents cannot agree. However, OTD has included a comparison box to reconcile the difference between the two documents. The new form has been sent to the brokers.

3.1 The Office of Transportation Delivery should examine the current rate structure for transportation providers in conjunction with representatives of brokers and transportation providers. Recognizing the cost factors set out in 603 KAR 7:080 §17, rates should also be uniform, simple, and adequate, and should provide incentives for efficient grouping of trips. Such factors could be included in an actuarial analysis done in conjunction with the analysis currently performed to determine the capitation rates for each region.

OTD is waiting on the Actuarial Study of the broker cap payments before the subcontract rate structure can be revised. We anticipate receiving the new rates the week of May 3-8, 2004. OTD will review and revise the subcontractor rates with the following priorities:

1. Region 5 - Increase the subcontractor rates to assist the taxi companies and other providers in meeting the cost of the trip.
2. Set a cap for all regions with a ceiling on the provider providing transportation services to their own clients and also providing other Medicaid services. This is in conjunction with the LRC recommendation 4.1.
3. Review for uniformity, simplicity, adequacy and incentives for efficient grouping of trips. Also where possible, seek a method for standardizing the rate structure statewide.

3.2 OTD should periodically survey transportation providers to determine if rides are being properly scheduled and equitably distributed. The satisfaction of providers should be included as a quality indicator within the HSTD quality improvement plan. Perceptions of unfairness or dissatisfaction should be reviewed against the information collected in the HSTD database, and, as warranted, further investigation should be undertaken to ensure the equity of the system.

The draft QIP includes provider satisfaction indicators. OTD has conducted an in depth analysis of one broker regarding the trip distribution process. From the assessment, it was determined the broker was distributing trips fairly. However, due to the fact that one subcontractor continues to raise concerns regarding trip distribution, an unscheduled follow-up site visit will be made to the broker to again witness the dispatching process. Additionally, a meeting will be scheduled with the subcontractor regarding trip distribution.

During all future broker assessments, OTD staff shall witness dispatching and/or scheduling processes. In addition the OTD staff will continue to review the monthly summary reports to determine trip distribution and freedom of choice designation.

3.3 Any decision to alter the freedom of choice rule should be predicated on maintaining or improving the current level of quality in the HSTD program. However, to ensure that the freedom of choice rule is not being abused, encounter data should be examined periodically for regions with high numbers of single-passenger trips and for regions in which the broker has a substantial percentage of disoriented (code 07) and nonambulatory (code 08) passengers. If OTD determines that the freedom of choice rule is being abused or having particularly negative effects in a region, OTD should intervene by performing an independent review of the selection of providers for these types of riders. After validating the recipients' selections of particular providers, OTD should attempt to ensure that trips are grouped as efficiently as possible. Providers should be discouraged from inappropriately marketing their services to recipients.

During a broker assessment an in depth analysis was made of their process of allowing freedom of choice for 07's and 08's. Again, from the findings, everything was conducted along the regulations and the freedom of choice was given to those recipients who were classified 07 and 08.

Some brokers have utilized a Provider Preference form to be completed by a recipient or their guardian in order to designate their choice of provider. Subcontractors have obtained this form and have had the form filled out by recipients or facilities without the knowledge of the broker. HSTD regulations state, under 603 KAR 7:080 Section 8(10), that "A subcontractor shall not participate in determining recipient eligibility or type of transport." The form, however, is a good tool for verifying that a recipient has been given a choice. Therefore, we have developed a new form that recipients in all brokerages will have to fill out for their freedom of choice. The form will have a line for the signature of the broker to show that the form and the choice are legitimate. It will help us verify that a choice was given and help prevent abuse.

OTD is running queries of the Encounter Data and ascertaining 07/08-type trips for utilization and cost patterns.

The brokers have been asked to submit to OTD any suspicion of 07/08 certificate abuse. The documentation has been forwarded to DMS for Medicaid PRO Review (Peer Review Organization, Physicians reviewing Physicians).

4.1 The Office of Transportation Delivery, working in cooperation with the appropriate Cabinet for Health and Family Services (CHFS) divisions, including the Department for Medicaid Services, should gather valid and reliable data on whether transportation providers that also provide Medicaid services contribute to overutilization of transportation services. Depending on the results of analyzing this data and a study of the impact of existing regional rate caps, OTD and CHFS

may consider imposing caps for all regions. Options could include setting maximum rate caps for those providing transportation and other Medicaid services or establishing maximum payment amounts by region.

OTD will be imposing caps (ceilings) for all regions statewide with transportation providers that also provide Medicaid services effective July 1, 2004 for the FY 2005 year.

4.2 Transportation, Medicaid Services, and other interested parties should examine the distribution of regions across the state. Based on analysis of regions' administrative costs, consideration should be given to consolidating regions with low usage or realigning some regions with similar geography where sufficient infrastructure is in place to deal with the added population. Reducing administrative costs should be a goal in any such regional adjustment, but this should be balanced against the need to guarantee the overall quality and effectiveness of the system.

Transportation and Medicaid Services are examining the current distribution of regions and should have recommendations for FY 2006. All regions will be rebid for services for FY 2006.

4.3 Officials of the Office of Transportation Delivery and the Department for Medicaid Services should consult with their counterparts in other states to determine the cost-control measures that would be practical for Kentucky's capitated system. Any suggestions for promising cost-control measures should then be made to the General Assembly.

OTD and DMS have informally talked to other states regarding their NEMT practices. After the above recommendations have been completely addressed, OTD and DMS shall take more action to formalize the approach to recommendation 4.3.

As a footnote OTD/DMS attended "United We Ride," a National Leadership forum on Human Service Coordination in February 2004 and networked with other states on best practices for human service transportation.

Kentucky's participation in the National Leadership Forum in February 2004 has led to many states contacting Kentucky for information on the Human Service Transportation Delivery Program (HSTD). One state, Maryland, is even visiting this summer. These contacts will lead to communication that will be helpful to both parties as we pursue this national coordination initiative, in which Kentucky is at the forefront.

The President signed an Executive Order Feb. 24, 2004 instructing the federal government to coordinate transportation through an Interagency Transportation Coordinating Council on Access and Mobility.