



OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Medical Nonemergency Transportation

FEBRUARY 2011

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OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2011

Members of the Legislative Audit Commission:

The State of Minnesota is required by federal law to provide medical nonemergency transportation assistance to recipients of Medical Assistance (MA). We found that the state has established an administrative structure for the program that is duplicative and confusing. We recommend that the Legislature require the Minnesota Department of Human Services to present a proposal to the 2012 Legislature that creates a single administrative structure for the program.

We found that using a broker to help determine MA recipients' eligibility and schedule rides has reduced certain transportation costs, but data limitations prevented us from determining whether total savings outweighed the costs of using a broker. Finally, we found that oversight of the program by the Department of Human Services has been weak, and we make recommendations to improve data collection and program accountability.

Our evaluation was conducted by Jo Vos (evaluation manager), Dan Jacobson, and David Kirchner. The Department of Human Services, Medical Transportation Management, Inc., and various other groups and individuals cooperated fully with our evaluation. We thank them for their assistance.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jim Nobles'.

James Nobles
Legislative Auditor

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Medical Nonemergency Transportation

Minnesota should simplify its complex and confusing administrative structure for the medical nonemergency transportation program.

Major Findings:

- In fiscal year 2010, Minnesota spent about \$38 million on medical nonemergency transportation for Medical Assistance (MA) recipients covered by the state’s fee-for-service system. (p. 13)
- Minnesota has two separate administrative structures for nonemergency transportation, “access” and “special,” that are duplicative and confusing. (pp. 4-8; 19-22)
- The Department of Human Services’ (DHS) oversight of nonemergency transportation has been weak, and it collects very little data on the program statewide. (pp. 49-60)
- More specifically, DHS administers key elements of “special” transportation (which offers the most costly and highest levels of service) in an ad hoc fashion, without using rulemaking procedures, developing formal policies, or notifying the public about changes in practice. (pp. 21-22)
- Since 2004, DHS has contracted with a private company to “broker” or coordinate varying parts of its nonemergency transportation program. (pp. 41-43)
- Through its broker, DHS has frequently limited recipients’ eligibility for “special” transportation to very short time

periods—often one day—which is inconsistent with contract language. (pp. 28-32)

- Brokering has reduced certain transportation costs, although total savings are unclear. (pp. 43-46)

Key Recommendations:

- The Legislature should require DHS, with input from interested parties, to present a proposal to the 2012 Legislature that creates a single administrative structure for medical nonemergency transportation. (p. 32)
- The Department of Human Services should propose statutory changes to address the length of time recipients are eligible for “special” transportation and the frequency of assessments. (p. 33)
- The Legislature should clarify state law on eligibility for “special” transportation when appropriate “access” transportation is not available. (p. 33)
- The Department of Human Services should publish “special” transportation eligibility policies and seek comments from interested parties when changing them. (p. 34)
- The Department of Human Services should identify, collect, and report key measures related to program performance statewide and periodically verify data submitted by the broker and counties. (p. 60)

Minnesota uses two separate administrative structures to help Medical Assistance recipients obtain nonemergency transportation to and from medical appointments.

Administration of the nonemergency transportation program has lacked transparency.

Report Summary

The federal government requires states to provide Medicaid recipients with medical nonemergency transportation assistance to the nearest qualified provider for covered services, using the least expensive type of appropriate transportation. The program’s purpose is to help lower overall medical costs by enabling recipients to receive routine, preventive health care. Although transportation services are federally mandated, states have wide latitude in how to administer services. In Minnesota, the Department of Human Services (DHS) oversees the program for Medical Assistance (MA) recipients covered by its fee-for-service system.

Minnesota’s two administrative structures for nonemergency transportation are duplicative and confusing.

Minnesota has two separate categories of nonemergency transportation: access and special. “Access” transportation is available to all MA recipients. The program pays mileage when recipients drive to and from medical appointments or when family, friends, or volunteers drive them. It also pays for public transit and taxi-style vehicles where drivers provide limited assistance to recipients. Counties are primarily responsible for access transportation, and they vary widely in how they administer the program and the types of transportation available in their communities.

In contrast, “special” transportation is only available to MA recipients who have a physical or mental impairment that prohibits them from safely using access transportation. Special

transportation drivers must provide certain “driver-assisted services,” including helping recipients into and out of medical facilities. State-certified taxi-style vehicles provide ambulatory, wheelchair, and stretcher services. Primary responsibility for special transportation for MA recipients rests with DHS; counties do not play a direct role.

Although access and special transportation share the same goal—to transport MA recipients to and from medical appointments—they differ in terms of recipient eligibility, program administration, types of transportation available, and data collection. Transportation providers often offer both types of service, and some MA recipients move back and forth between the two categories, sometimes in the same day.

The Department of Human Services administers key elements of special transportation in an ad hoc fashion.

The department has contracted with a private company (Medical Transportation Management, Inc., or MTM) to determine special transportation eligibility statewide since 2004. But DHS has provided MTM with few written instructions or formal guidelines on how to determine eligibility beyond the vague guidance contained in the contract and state law. Instead, DHS has relied on informal verbal and e-mail communications to tell MTM how to perform its duties. Also, DHS has made key implementation decisions administratively without the public notice and comment periods required by the rulemaking process. Finally, DHS has not routinely informed recipients and other interested parties of changes in the eligibility process.

Administrative rules for the program are outdated.

The way in which DHS has defined special transportation eligibility has resulted in a few MA recipients falling “between the cracks.” They appear eligible under state law, but are not eligible in practice. Also, state law defines eligibility for special transportation based on recipients’ inability to safely use access transportation. But DHS has consistently determined that MA recipients are not eligible for special transportation when appropriate types of access transportation are simply unavailable for them to use.

The Legislature has made many changes to the nonemergency transportation program over the last decade, but DHS has not significantly changed its special transportation rules since 1987. The rules are generally silent on many important matters open to interpretation, and some do not reflect current law.

The department has limited many recipients’ eligibility for special transportation to very short time periods.

The department’s contract with MTM requires that special transportation eligibility periods generally parallel those used for Social Security Insurance Disability determinations, which are, at a minimum, six months. However, MTM granted eligibility for only one day to 40 percent of special transportation recipients needing ambulatory or wheelchair services over the last three years.

Furthermore, the 2010 Legislature directed that, barring changing circumstances, eligibility assessments not be done more than once a year on any individual (previously twice a year). While this gives DHS discretion to initiate assessments when needed, statutes anticipate that

frequent assessments will be the exception, not the rule.

While brokering has reduced certain transportation costs, total savings are unclear.

The department has contracted with MTM to “broker” varying parts of its nonemergency transportation program since 2004. Brokering includes determining eligibility, scheduling trips, and distributing those trips among providers.

Because of data limitations, we cannot say whether using a broker has saved the state more money than it has cost. However, we identified three areas where savings have occurred. First, after the 2003 Legislature made DHS, not physicians, primarily responsible for determining special transportation eligibility, the department hired MTM to determine eligibility. Subsequently, there was a large shift in trips provided from special transportation to less-costly access transportation. This shift has reduced nonemergency transportation costs by about \$400,000 a year. Second, when MTM brokered special transportation in the Twin Cities area (October 2007 through January 2008), the number of miles special transportation providers were reimbursed for trips dropped, saving about \$400,000 to \$600,000 a year. Third, after MTM began brokering access transportation in the Twin Cities area in 2004, the proportion of trips that used taxi-style vehicles to provide curb-to-curb service increased, while the proportion providing more-costly door-to-door service decreased, which saved about \$140,000 to \$200,000 in fiscal year 2010.

When Twin City area counties began contracting with MTM to broker access transportation instead of DHS, total administrative costs declined.

Weak oversight by the Department of Human Services has resulted in the state paying more than it should have for some parts of the program.

The counties paid MTM \$4.4 million in fiscal year 2010, or about \$5.70 per completed trip. In comparison, DHS paid MTM \$6.7 million for fiscal year 2009, or about \$8.30 per trip.

Transportation spending per eligible MA recipient has decreased in the Twin Cities area since 2004, but has increased outstate.

Between fiscal years 2000 and 2010, average spending per eligible person in the Twin Cities area declined from \$222 to \$166. At the same time, outstate spending increased from \$88 to \$131 per eligible person. Outstate counties' costs were less because they used more lower-cost types of travel. In 2010, 69 percent of their spending was for reimbursing volunteer drivers and recipients (or their families or friends) for mileage. In contrast, 93 percent of Twin Cities area spending was for taxi-style vehicles, a higher-cost option.

Statewide, about 4 percent of eligible MA recipients used special transportation in fiscal year 2010. Because DHS does not collect comparable data on access transportation, statewide usage is unknown. In the Twin Cities area, about 18 percent of eligible MA recipients used access transportation in 2010.

The department provides little statewide oversight of the program.

Although its most recent contract with the broker set forth numerous oversight mechanisms, DHS did not implement a formal quality assurance program to monitor the broker. Department oversight has largely consisted of informal communication and frequent meetings.

Weak monitoring and oversight contributed, in part, to DHS paying its broker about \$1 million more than the amount agreed to in its contract for fiscal year 2006. Furthermore, DHS's decision to give MTM an inappropriate cost-of-living adjustment resulted in DHS paying the broker about \$1.5 million too much in fiscal year 2009. Also, DHS recently examined special transportation reimbursements for transporting nursing home residents and found it had paid some providers about \$500,000 for trips that did not appear to qualify for special transportation reimbursement.

State oversight of outstate counties is also lax, partly because DHS collects aggregate spending data, not individual trip data.

The department must improve its data collection efforts.

The department's data collection efforts vary, both across and within the two categories of nonemergency transportation (access and special). Furthermore, DHS does very little systematic checking to make sure that the data submitted from counties, transportation providers, or its broker are accurate or reasonable.

Given state and county budget problems, policy makers need better information about the cost-effectiveness of transportation assistance statewide. The department should routinely collect information, such as the number of individual participants, number of trips by type of transportation, and costs per trip on a statewide basis, regardless of how programs are administered.

Lack of consistent and reliable data has hampered oversight efforts.

Introduction

Minnesotans enrolled in Medical Assistance (MA), Minnesota's version of the federal Medicaid program, are eligible to receive nonemergency transportation assistance to obtain health-related services. Although a federally mandated benefit, Minnesota has considerable flexibility in how to provide transportation support, and it does so in various ways. Nearly two-thirds of Minnesota's MA population are enrolled in, and eligible to receive transportation help through, managed care health plans. The remaining one-third is covered by the state's fee-for-service system that allows them to receive transportation help through counties or the Department of Human Services (DHS).

Over the last several years, the state's approach for providing transportation assistance to MA recipients served by its fee-for-service system has frequently changed, most often regarding DHS's use of a private vendor to deliver different aspects of the program. On March 26, 2010, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate medical nonemergency transportation for MA recipients under the state's fee-for-service system.¹ We focused on the following research questions:

- **How have participation in, and costs for, medical nonemergency transportation for MA recipients changed over time, and why?**
- **Are special transportation eligibility assessments performed in a reasonable manner? To what extent have MA recipients appealed results?**
- **Has DHS exercised adequate oversight of transportation services statewide?**
- **To what extent do MA recipients receive appropriate and cost-effective nonemergency medical transportation?**
- **How do other states provide medical nonemergency transportation to Medicaid recipients?**

We used various research methods to answer these questions. First, we analyzed data collected by DHS and its contractor, Medical Transportation Management, Inc. (MTM), regarding program participants, trips, transportation provider reimbursements, costs, eligibility assessments, complaints, appeals, and customer satisfaction surveys. Second, we surveyed all county human services directors

¹ The Commission first directed OLA to evaluate medical nonemergency transportation in April 2009. Shortly thereafter, however, the Commission postponed the evaluation for one year due to program changes adopted by the 2009 Legislature.

about their transportation assistance programs.² Third, we collected data regarding MA recipient “no shows” from a small sample of transportation providers.³ Fourth, we examined contracts, budgets, reports, and other documents related to nonemergency transportation in Minnesota and across the nation. Finally, we interviewed staff from the departments of Human Services and Transportation and MTM, as well as representatives from various interest groups, local governments, and transportation providers.

Our evaluation focused on medical nonemergency transportation within Minnesota’s fee-for-service MA program; we excluded transportation services delivered through managed care health plans. We looked at transportation from a statewide perspective and, with the exception of examining DHS’s use of a contractor to administer transportation services in the Twin Cities area, did not evaluate transportation services in individual counties. Also, we did not analyze the adequacy of the reimbursement rates paid to transportation providers, nor did we assess how the Minnesota Department of Transportation performed its certification responsibilities related to special transportation providers.

This report is divided into three chapters. Chapter 1 provides background information on Minnesota’s medical nonemergency transportation program and data on participants, services, and costs over time. Chapter 2 examines issues specifically related to special transportation, including eligibility criteria, frequency of assessments, length of certifications, and appeals. Chapter 3 examines other management issues of interest to policy makers or interest groups, including using brokers, state oversight, and customer satisfaction.

² We sent questionnaires to 87 county human services directors and tribal health directors. We received responses from 78 directors, for an overall response rate of 90 percent.

³ “No shows” refer to instances when transportation providers travel to designated pick-up sites to transport MA recipients to or from health-related services, but the recipients do not show up for the scheduled rides.

BACKGROUND

The federal government requires Minnesota to help Medical Assistance (MA) recipients obtain transportation to and from medical appointments.

Created as a federal/state partnership in 1965, Medicaid is the nation's largest publicly funded health financing program for low-income people.¹ To qualify for Medicaid, an individual must meet financial criteria and belong to one of several eligibility categories: children under age 21, parents or caretakers of dependent children, pregnant women, persons who are blind or have a disability, and persons age 65 or older.² The federal government defines a minimum set of health-related services that must be offered to Medicaid recipients. This evaluation looks at one of those services, medical nonemergency transportation, within the context of Minnesota's fee-for-service system.

Medical nonemergency transportation is a federally mandated benefit that enables Medicaid recipients to access approved health-related services. The federal government requires state Medicaid programs to provide nonemergency transportation assistance to the nearest qualified provider for covered services, using the least expensive type of appropriate transportation. The program's purpose is to help lower overall medical costs by enabling Medicaid recipients to receive routine, preventive health care. National studies have shown that transportation-related barriers prevent many Medicaid recipients from obtaining health care.³ By providing transportation assistance for routine care, policy makers hope to better control nonemergency and emergency health care costs.

ADMINISTRATION

Although providing transportation assistance is a federal mandate:

- **States have wide latitude in how to administer medical nonemergency transportation for Medicaid recipients.**

Many factors can influence how states design and implement their transportation programs, including geography (urban vs. rural), population density, and the availability of transportation providers. According to the Kaiser Family Foundation, all 50 states and the District of Columbia provide some form of medical nonemergency transportation to Medicaid recipients, although program

¹ Social Security Act of 1965, Title XIX.

² For greater detail, see Minnesota House Research Department, *Medical Assistance* (St. Paul, October 2010); and Minnesota House Research Department, *Minnesota Family Assistance* (St. Paul, December 2009). States are free to extend services to additional populations as long as those services are paid for with state rather than federal funds. In the past, Minnesota has extended medical services to other groups such as unemployed single adults.

³ For example, see R. Wallace, P. Hughes-Cromwick, and S. Khasnabis, *Access to Health Care and Non-emergency Medical Transportation* (Washington, DC: Transportation Research Board), 2005; and T. A. Acury, J. Presser, W. Gesler, and J. M. Powers, "Access to Transportation and Health Care Utilization in a Rural Region," *The Journal of Rural Health*, 2, no. (Winter 2005).

Minnesota divides medical nonemergency transportation into two separate categories: “access” and “special.”

administration and services vary considerably.⁴ For example, some states administer their transportation programs through counties or regional entities, while others administer them at the state level. Also, states may use a variety of transportation options, such as reimbursing for mileage, distributing passes for public transit, and paying for taxi-style services.⁵

States can also place conditions on or limit recipients’ use of transportation services. For example, a few states require some Medicaid recipients to make copayments ranging from \$.50 to \$3.00 per trip.⁶ Some states restrict the number or type of trips they will provide. For example, Alabama limits Medicaid recipients to two trips per month, while Indiana pays for up to 20 one-way trips of less than 50 miles per year.⁷ Pennsylvania restricts recipients to trip costs of \$50 or less per month.⁸ California only pays for transportation when recipients’ medical or physical condition prevents them from using “ordinary” types of transportation such as privately-owned cars or public transit.⁹

In Minnesota, the Department of Human Services (DHS) oversees the state’s public assistance health care program and, more specifically, medical nonemergency transportation. In general:

- **Minnesota uses a two-pronged approach to provide transportation assistance that depends on recipients’ level of physical or cognitive impairment.**

In the late 1970s, the Legislature created two major categories of nonemergency transportation for Medical Assistance (MA) recipients: “access transportation” and “special transportation.”¹⁰ As shown in Table 1.1, these categories differ in terms of recipient eligibility, program administration, and types of transportation that are available.

⁴ Kaiser Family Foundation, “Benefits by Service: Non-Emergency Medical Transportation Services (October 2008),” <http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=4&cat=3&sv=21>, accessed June 9, 2010.

⁵ We use the term “taxi-style” services to refer to rides given in cars and vans operated by private companies, nonprofit groups, or public agencies. These vehicles operate in a similar fashion as taxis in that they provide individualized point-to-point service, but they generally focus on populations that have special needs. Taxi-style vehicles must also provide varying degrees of assistance to passengers not specifically required of taxis in general.

⁶ Kaiser Family Foundation, “Benefits by Service.”

⁷ *Ibid.*

⁸ Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, 2004), 60.

⁹ California Department of Health Care Services, *California’s Title XIX State Plan for Assurance of Transportation*, <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/StatePlan%20Attachment%203.1-D.pdf>, accessed November 26, 2010.

¹⁰ *Laws of Minnesota* 1978, chapter 560, sec. 10; and *Laws of Minnesota* Extra Session 1979, chapter 1, sec. 27. Early legislation referred to access transportation as “regular” transportation. For the sake of consistency, we use the term “access transportation” throughout this report.

Table 1.1: Minnesota’s Medical Nonemergency Transportation Program

	Access Transportation	Special Transportation
Eligibility	All Medical Assistance recipients	Medical Assistance recipients unable to use access transportation
Administrative Responsibility	County human services agencies	State departments of human services and transportation
Transportation Providers	Recipients, family, and friends; volunteer drivers; public transit (including buses, light rail, and paratransit); and taxi-style service providers	MnDOT-certified special transportation taxi-style service providers

SOURCE: Office of the Legislative Auditor.

Access Transportation

Access transportation includes taxi-style vehicles, public transit, and mileage reimbursement for using personal vehicles.

“Access transportation” is available to all MA recipients covered by the state’s fee-for-service system.¹¹ The Department of Human Services has defined access transportation to include: (1) vehicles owned by recipients, family, friends, and volunteers; (2) public transit, including fixed route buses and light rail, paratransit such as Metro Mobility, and other local options such as dial-a-ride; and (3) private or nonprofit taxi-style vehicles.¹² The department further requires that taxi-style vehicles provide recipients with either curb-to-curb or door-to-door assistance. Recipients receiving curb-to-curb services are responsible for getting themselves to the road or curb in front of their pick-up site before being helped by drivers. In contrast, drivers providing door-to-door services help recipients from outside the door of their pick-up site to outside the door of their drop-off site. The department further subdivides each of these two levels of service into ambulatory and wheelchair subdivisions.¹³ Table 1.2 lists the various types of access transportation available to MA recipients, organized from the least to the most expensive.

¹¹ Unless otherwise stated, we use the terms “Medical Assistance recipients” and “MA recipients” to refer to public assistance recipients covered by the fee-for-service system and, thus, eligible for transportation services through Minnesota’s medical nonemergency transportation program. The vast majority of these individuals are enrolled in MA, but other health program enrollees may be eligible to participate. Also, a small number of recipients enrolled in managed care health plans receive personal mileage and parking reimbursements through the transportation program set up for fee-for-service recipients.

¹² Paratransit is a term that refers to specialized transportation services required by the Americans with Disabilities Act (ADA) that respond to riders’ individual requests for service. Paratransit generally serves riders within specific fixed route service areas that are unable to safely use traditional bus services.

¹³ Consequently, DHS has defined four types of transportation assistance within the rubric of taxi-style services: ambulatory curb-to-curb, ambulatory door-to-door, wheelchair curb-to-curb, and wheelchair door-to-door.

Table 1.2: Types of Access Transportation Available to Medical Assistance Recipients

Type of Transportation	Description
Personal vehicles	MA recipients drive themselves to medical appointments; recipients may also be transported by family, friends, or others who have a personal relationship with recipients
Volunteer vehicles	Transportation provided by volunteers (individuals or organizations) with no relationship to recipients; services must be available to all community members
Public transit	Includes buses, light rail, paratransit, and other public transit services
Taxi-style vehicles	
Ambulatory, curb-to-curb	Drivers assist ambulatory MA recipients from the curb of the pick-up site to the curb of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Ambulatory, door-to-door	Drivers assist ambulatory MA recipients from the outside door of the pick-up site to the outside door of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Wheelchair, curb-to-curb	Drivers assist MA recipients in wheelchairs from the curb of the pick-up site to the curb of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Wheelchair, door-to-door	Drivers assist MA recipients in wheelchairs from the outside door of the pick-up site to the outside door of the drop-off site, including entering and exiting the vehicle and securing in the vehicle
Air travel	Private or commercial air travel; intra- or interstate carrier
Miscellaneous	
Parking	Recipients must use the most cost-effective option
Meals	Recipients must be traveling to, from, or at a medical appointment prior to 6 AM, between 11 AM and 1 PM, or after 7 PM; recipients must also be more than 35 miles from home
Lodging	Prior local approval required; community standards used to determine when lodging is appropriate

SOURCE: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010).

County human services agencies are primarily responsible for providing access transportation.

Counties are primarily responsible for access transportation, and they vary widely in how they administer the program and the types of transportation available. From July 2004 to July 2009, DHS contracted with a private company, Medical Transportation Management, Inc. (MTM), to broker access transportation for 11 counties in the Twin Cities area.¹⁴ When the 2009 Legislature specifically prohibited the department from contracting for access transportation, these counties jointly contracted with MTM to continue brokering services.¹⁵ Medical Assistance recipients who are covered by the fee-for-service

¹⁴ The 11 counties were: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. As we discuss in Chapter 3, brokers' responsibilities include taking requests and scheduling trips among transportation providers.

¹⁵ *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 34. Currently, 8 of the original 11 counties continue to jointly contract with MTM. Carver, Scott, and Wright counties opted to coordinate access transportation themselves.

system and need transportation in these counties call a central telephone number and MTM staff check eligibility, determine the most appropriate type of transportation, schedule rides, and reimburse transportation providers.¹⁶

In outstate counties, MA recipients under the fee-for-service system obtain transportation assistance in a variety of ways. In some counties, recipients contact their financial aid worker who verifies their eligibility, determines the most appropriate type of transportation, schedules trips, and submits the necessary paperwork for provider reimbursement. In other counties, financial aid workers, after verifying eligibility, refer recipients to a county transportation coordinator who determines the most appropriate type of transportation and schedules rides.

Special Transportation

“Special transportation,” in contrast, is only available to MA recipients who have a physical or mental impairment that prohibits them from safely accessing and using buses, taxis, other commercial transportation, or private automobiles.¹⁷ By law, special transportation drivers must provide certain “driver-assisted services,” including helping recipients into and out of medical facilities.¹⁸ The Department of Human Services has defined special transportation as (1) taxi-style vehicles certified by the Minnesota Department of Transportation (MnDOT) where drivers assist recipients from inside their homes or worksites to the inside of their medical providers’ offices (commonly referred to as door-through-door service) and (2) MnDOT-certified taxi-style vehicles providing stretcher services (also door-through-door).¹⁹ Table 1.3 lists the types of special transportation available to a subset of MA recipients, organized from the least to most expensive.

The Department of Human Services has primary responsibility for special transportation for MA recipients; counties do not play a direct role. The department contracts with MTM to determine whether MA recipients covered by the fee-for-service system are eligible for special transportation. Once MTM approves eligibility and sets a time frame for that eligibility, recipients or their caregivers call special transportation providers themselves when they need a ride to or from a medical appointment. Transportation providers submit their bills directly to the department for reimbursement.

Special transportation, administered by the Department of Human Services (DHS), provides assistance to MA recipients who cannot use access transportation.

¹⁶ In lieu of obtaining prior trip approval, MTM allows MA recipients claiming personal mileage to simply maintain trip logs signed by their health providers. Recipients periodically send the logs to MTM.

¹⁷ *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

¹⁸ *Ibid.*

¹⁹ The Minnesota Department of Transportation is responsible for regulating special transportation providers, drivers, and vehicles through a yearly certification and inspection program. *Minnesota Statutes* 2010, 174.30.

Table 1.3: Types of Special Transportation Available to Eligible Medical Assistance Recipients

Type of Transportation	Description
Ambulatory, taxi-style vehicles	Drivers assist ambulatory MA recipients to enter and exit through doors at pick-up and drop-off sites, including to or from their medical providers' appointment desks; drivers must also help recipients enter and exit vehicles and secure them into vehicles
Wheelchair, taxi-style vehicles	Drivers assist MA recipients in wheelchairs to enter and exit through doors at pick-up and drop-off sites, including to and from their medical providers' appointment desks; drivers must also help recipients enter and exit vehicles and secure them into vehicles
Stretcher vehicles	MA recipients travel in vehicles in a prone position

NOTE: Special transportation recipients may also be eligible to receive air travel, meals, and lodging, as listed in Table 1.2.

SOURCES: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010); and Office of the Legislative Auditor.

PARTICIPATION

In fiscal year 2010, about 776,000 Minnesotans were enrolled in the state's three major health care programs: Medical Assistance (MA), MinnesotaCare, and General Assistance Medical Care (GAMC).²⁰ Only a portion, however, were covered by the state's fee-for-service system and eligible to receive transportation assistance through their county of residence or DHS.²¹ Overall:

- **During fiscal year 2010, about 253,000 Minnesotans were covered by the state's fee-for-service system and eligible to receive medical nonemergency transportation.**

Most of the individuals eligible for assistance—91 percent—were enrolled in MA, which serves mostly children and families, individuals 65 years or older, and people who have disabilities. Approximately 21,000 GAMC enrollees, primarily childless adults, were eligible for access (but not special) transportation during most of fiscal year 2010, until the Legislature revoked their eligibility, effective June 2010.²² They made up about 8 percent of those eligible for transportation assistance in fiscal year 2010. The remaining 1 percent of the eligible population were children under 21 years and pregnant women enrolled in MinnesotaCare.

²⁰ Minnesota Department of Human Services, *Family Self-Sufficiency and Health Care Program Statistics* (St. Paul, January 2011), 30-32. Medical Assistance is the state's largest health care program and accounts for the vast majority of public assistance recipients receiving health benefits.

²¹ Approximately two-thirds of the state's Medicaid population are enrolled in managed care health plans. For the most part, these individuals receive transportation assistance through their respective health plans rather than DHS's transportation program.

²² Minnesota Department of Human Services, "Provider Impacts Due to GAMC Changes: Part 2," http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_150011#, accessed January 10, 2011.

Access Transportation

Medical nonemergency transportation is measured, in part, by “trips,” with each trip being one-way. Thus, an individual going to and returning home from a doctor’s visit is counted as making two trips—one trip to the doctor and another home again. Because trip data are not available on a statewide basis, our analysis focuses on trips in the Twin Cities area.²³

Detailed data for the Twin Cities area indicate that most MA recipients covered by the fee-for-service system do not use access transportation. Overall:

- **In fiscal year 2010, about 18 percent of Medical Assistance recipients in the Twin Cities area received access transportation, averaging 35 trips to or from medical appointments.**

Out of 137,000 persons eligible for access transportation in the Twin Cities area, about 25,000 actually received assistance in fiscal year 2010. They took about 853,000 trips, or an average of 35 trips per year (among recipients who took at least one trip). About half of these recipients took ten or fewer trips, including 6,000 who took two or fewer trips. About 2,200 persons took 100 or more trips during fiscal year 2010.

As noted earlier, access transportation options range from personal automobiles to more specialized taxi-style vehicles that provide varying levels of driver assistance. Table 1.4 lists the current reimbursement rates for access transportation. As the table shows, rates vary by the type of transportation provided and the length of the trip.

We looked at the types of trips provided most often and found that:

- **Taxi-style vehicles accounted for nearly three-fourths of the access transportation trips taken in the Twin Cities area in fiscal year 2010.**

As shown in Table 1.5, taxi-style vehicles accounted for 71 percent of all access transportation trips in the Twin Cities area in fiscal year 2010. The next most common were trips in which recipients—or their friends or relatives—obtained mileage reimbursement (21 percent), followed by public transit (7 percent).

Taxi-style vehicles have provided the majority of access transportation trips in the Twin Cities area since MTM began coordinating services in July 2004. During the last six years, the share of trips provided by taxi-style vehicles has grown from 59 to 71 percent, while the shares attributable to personal and volunteer mileage have declined from 30 to 21 percent and 3 to 1 percent, respectively. Public transit’s share has fluctuated between 5 and 8 percent.

Most access transportation trips using taxi-style vehicles have involved the least costly (ambulatory curbside) of the four service levels available, as shown in Table 1.6. Since fiscal year 2005, at least 80 percent of taxi-style trips each year

About half of the MA recipients in the Twin Cities area who received access transportation took ten or fewer trips in fiscal year 2010.

²³ Unless specifically noted, the term “Twin Cities area” covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright.

Table 1.4: Maximum Reimbursement Rates for Access Transportation, January 2011

Type of Reimbursement	Maximum Reimbursement Rate
Personal mileage	\$.20 per mile
Volunteer mileage	\$.51 per mile
Public transit buses/light rail	Full cost or \$1.25 to \$1.75 per trip; up to \$65 for a monthly pass
ADA paratransit	Full cost or \$2.25 to \$3.00 per trip
Curb-to-curb taxi	\$10 through the first 5 miles, plus \$1.45 per mile thereafter
Door-to-door taxi	\$12 through the first 5 miles, plus \$1.45 per mile thereafter
Curb-to-curb wheelchair	\$13 through the first 5 miles, plus \$1.45 per mile thereafter
Door-to-door wheelchair	\$15 through the first 5 miles, plus \$1.45 per mile thereafter ^a
Air travel	Full cost
Parking	Full cost
Breakfast	Full cost or \$5.50 maximum; must be in transit to, from, or at a medical appointment prior to 6 AM and be more than 35 miles from home
Lunch	Full cost or \$6.50 maximum; must be in transit to, from, or at a medical appointment between 11 AM and 1 PM and be more than 35 miles from home
Dinner	Full cost or \$8.00 maximum; must be in transit to, from, or at a medical appointment after 7 PM and be more than 35 miles from home
Lodging	\$50 per night unless recipient obtains prior county approval

^a. As we discuss in Chapter 3, the Department of Human Services, through the broker, has been reimbursing door-to-door wheelchair transportation providers in the Twin Cities area at a base rate of \$16 rather than \$15.

SOURCE: Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010).

were ambulatory curb-to-curb. Trips involving more expensive levels of service were much less common. For example, wheelchair trips, including curb-to-curb and door-to-door trips, have remained around 4 to 5 percent of all access transportation taxi-style trips.

Over the last several years, MTM has increasingly used the lower cost curb-to-curb service level for both ambulatory and wheelchair trips. Since fiscal year 2005, the share of ambulatory trips that are curb-to-curb has increased from 88 to 95 percent. The percentage of wheelchair trips that are curb-to-curb has increased substantially, going from 18 to 74 percent.

As we noted earlier, trip data are not available for counties outside the Twin Cities area. But as we show later in this chapter, DHS collects spending data statewide that indicate outstate counties rely primarily on personal and volunteer mileage reimbursement to provide access transportation.

Table 1.5: Access Transportation Trips in the Twin Cities Area, Fiscal Years 2005-2010

Type of Trip	Fiscal Year					
	2005	2006	2007	2008	2009	2010
Number of Trips (in thousands)	424	682	720	774	811	853
Percentage of Trips:						
Taxi-style vehicles	59%	65%	68%	70%	67%	71%
Driven by friend, relative, or self	30	26	22	21	23	21
Public transit	7	5	7	6	8	7
Volunteer drivers	3	4	3	3	1	1

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Table 1.6: Access Transportation Taxi-Style Trips in the Twin Cities Area, Fiscal Years 2005-2010

Type of Trip	Fiscal Year					
	2005	2006	2007	2008	2009	2010
Number of Trips (in thousands)	252	445	488	542	544	609
Percentage of Trips:						
Ambulatory	96%	95%	96%	96%	96%	95%
Curb-to-curb	88	88	83	86	92	95
Door-to-door	12	12	17	14	8	5
Wheelchair	4%	5%	4%	4%	4%	5%
Curb-to-curb	18	24	31	38	68	74
Door-to-door	82	76	69	62	32	26

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Since 2005, access transportation trips in the Twin Cities area have increased dramatically.

About 10 percent of MA recipients qualify for special transportation, which provides higher, more costly levels of service.

Special Transportation

Medical Assistance recipients may receive special transportation if they are certified as eligible for this service by MTM or if they live in a skilled nursing facility. In fiscal year 2010, about 10 percent of MA recipients were eligible for special transportation, including about 5,300 recipients that MTM certified as eligible for at least one day during the year and about 18,400 nursing home residents.²⁴

As a result, few MA recipients actually use special transportation:

- **Statewide, about 4 percent of Medical Assistance recipients received special transportation in fiscal year 2010, averaging 38 trips to or from medical appointments.**

Overall, 9,700 MA recipients used special transportation in fiscal year 2010. Altogether, they took about 373,000 trips, or an average of 38 trips (among recipients who took at least one trip). Forty percent of these trips transported MA recipients in wheelchairs and 0.5 percent transported recipients on stretchers.

Table 1.7 shows the current reimbursement rates for special transportation statewide. Because DHS sets access transportation rates to generally fall below the special transportation rates set by the Legislature, special transportation trips typically cost more than corresponding access transportation trips using taxi-style vehicles.²⁵ For example, as shown in Table 1.8, reimbursement for a ten-mile trip for an MA recipient in a wheelchair would be \$30.50 for special transportation and either \$20.25 (curb-to-curb) or \$23.25 (door-to-door) for access transportation.

Table 1.7: Reimbursement Rates for Special Transportation, January 2011

Type of Reimbursement	Minimum Reimbursement Rate
Ambulatory door-through-door	\$11.50 base, plus \$1.30 per mile
Wheelchair door-through-door	\$17 base, plus \$1.35 per mile
Stretcher	\$60 base, plus \$2.40 per mile and \$9 per attendant (if needed)

NOTE: Base rates for transportation providers serving MA recipients in “super-rural” parts of the state are 11.3 percent higher than shown and per mile rates for providers in “rural” and “super-rural” parts of the state are 12 to 25 percent higher, depending on the number of miles driven.

SOURCE: *Minnesota Statutes* 2010, 256B.0625, subd. 17(b)(1).

²⁴ Minnesota Department of Human Services, *Nursing Facility Fact Sheet* (St. Paul, 2010).

²⁵ Special transportation providers must provide a higher level of assistance, referred to as door-through-door as opposed to curb-to-curb or door-to-door. They must also meet MnDOT certification requirements, which counties may or may not require taxi-style access transportation providers to meet.

Table 1.8: Examples of Costs for Taxi-Style Access and Special Transportation, January 2011

Trip Length and Type	Access Transportation		Special Transportation	
	Curb-to-Curb	Door-to-Door	Regular Rate	Rural Rate
5 miles				
Ambulatory	\$10.00	\$12.00	\$18.00	\$19.63
Wheelchair	13.00	15.00	23.75	25.44
Stretcher	n/a	n/a	81.00	84.00
10 miles				
Ambulatory	\$17.25	\$19.25	\$24.50	\$27.75
Wheelchair	20.25	22.25	30.50	33.88
Stretcher	n/a	n/a	93.00	99.00
20 miles				
Ambulatory	\$31.75	\$33.75	\$37.50	\$40.43
Wheelchair	34.75	36.75	44.00	47.04
Stretcher	n/a	n/a	117.00	122.40
45 miles				
Ambulatory	\$68.00	\$70.00	\$70.00	\$76.58
Wheelchair	71.00	73.00	77.75	84.58
Stretcher	n/a	n/a	177.00	189.15

NOTES: Special transportation trips that take place in areas classified as “rural” and “super-rural” may be billed at higher rates (rates for “super-rural” areas are not shown). Costs shown for access transportation are the maximum amounts allowed; providers may opt to bill less. N/a means that the service is not applicable.

SOURCES: Office of the Legislative Auditor, analysis of rates listed in Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, DHS Bulletin #10-21-02, January 13, 2010; and *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

COST TRENDS

Medical nonemergency transportation makes up a very small share of Minnesota’s total MA spending. Overall:

- **In fiscal year 2010, total spending for medical nonemergency transportation was about \$38 million—less than 1 percent of Minnesota’s total Medical Assistance spending.**

In fiscal year 2010, MA spending in Minnesota totaled \$7.2 billion.²⁶ Of this, state and local governments spent about \$38 million on transportation assistance for MA recipients covered by the fee-for-service system, including \$26 million for access transportation and \$12 million for special transportation.²⁷ The federal

²⁶ Department of Human Services, *Family Self-Sufficiency*, 31.

²⁷ These figures exclude the administrative costs incurred by outstate counties for their access transportation programs (which are unknown), but include the administrative costs of the Twin Cities area counties that contract with MTM.

government funded about 62 percent of these expenditures, with state and local governments funding about 34 and 4 percent, respectively.²⁸

Between fiscal years 2000 and 2010, overall spending for medical nonemergency transportation increased from \$28 million to \$38 million. Furthermore:

- **Over the last decade, there was a large spending shift away from special transportation and toward access transportation.**

As shown in Figure 1.1, special transportation spending declined from \$23 million in fiscal year 2000 to \$12 million in 2010, while access transportation spending increased from \$5 million to \$26 million. During this time period, the state adopted several mechanisms to help control transportation costs, including using a “broker” to coordinate access transportation in the Twin Cities area and determine eligibility for special transportation statewide. These changes, which were designed to shift usage from special to access transportation, are discussed in Chapters 2 and 3.

Since fiscal year 2000, medical nonemergency transportation spending has increased at about the same rate as the number of persons eligible for the transportation program. Figure 1.2 shows how spending per eligible MA recipient has changed over time. Statewide, spending per eligible person increased from \$143 in fiscal year 2000 to a peak of \$177 in 2009 before declining to \$150 in 2010.

At the same time:

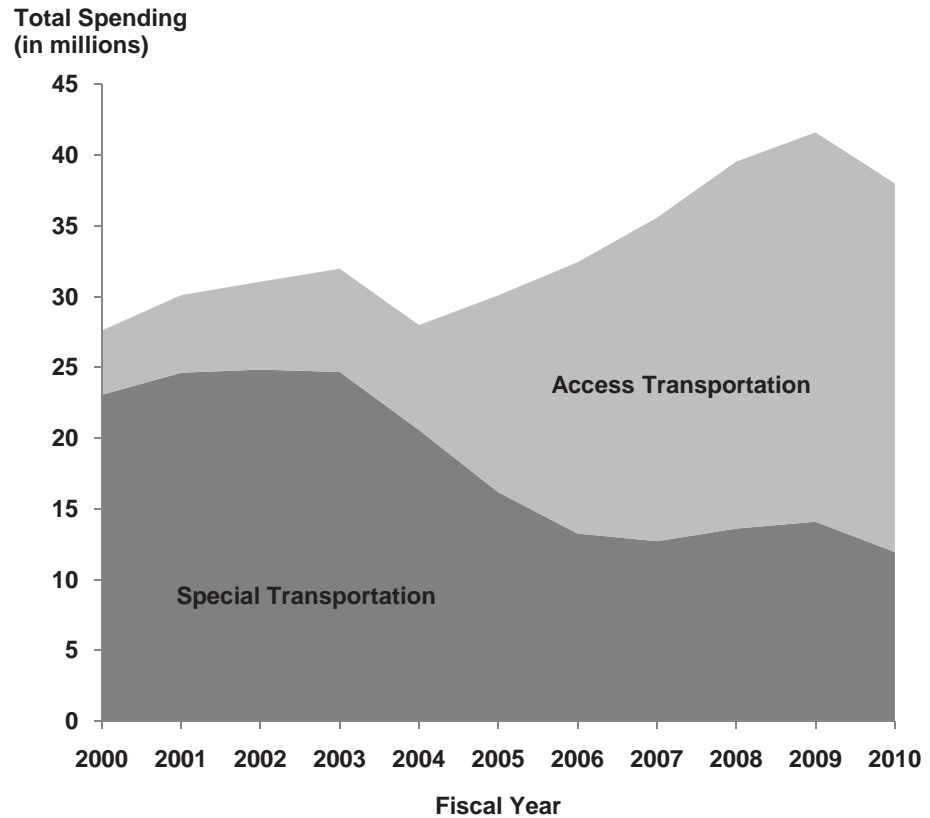
- **Medical nonemergency transportation spending per eligible Medical Assistance recipient has decreased in the Twin Cities area over the last ten years, but it has increased in outstate Minnesota.**

Between fiscal years 2000 and 2010, average spending per eligible person in the 11-county Twin Cities area declined from \$222 to \$166. During the same time period, spending in the other 76 counties increased from \$88 to \$131 per eligible person.

Over the last decade, special transportation costs have been cut in half, while costs for access transportation increased five-fold.

²⁸ The federal stimulus bill—the American Recovery and Reinvestment Act—increased the federal share from October 2008 through December 2010. The Education, Jobs, and Medicaid Assistance Act provided additional federal funding for the first six months of 2011, increasing the federal share to 53.2 percent for the first three months and to 51.2 percent for the next three months. The federal share is scheduled to return to its normal 50 percent level in July 2011. See House Research Department, *Medical Assistance*, 23.

Figure 1.1: Medical Nonemergency Transportation Spending, Fiscal Years 2000-2010

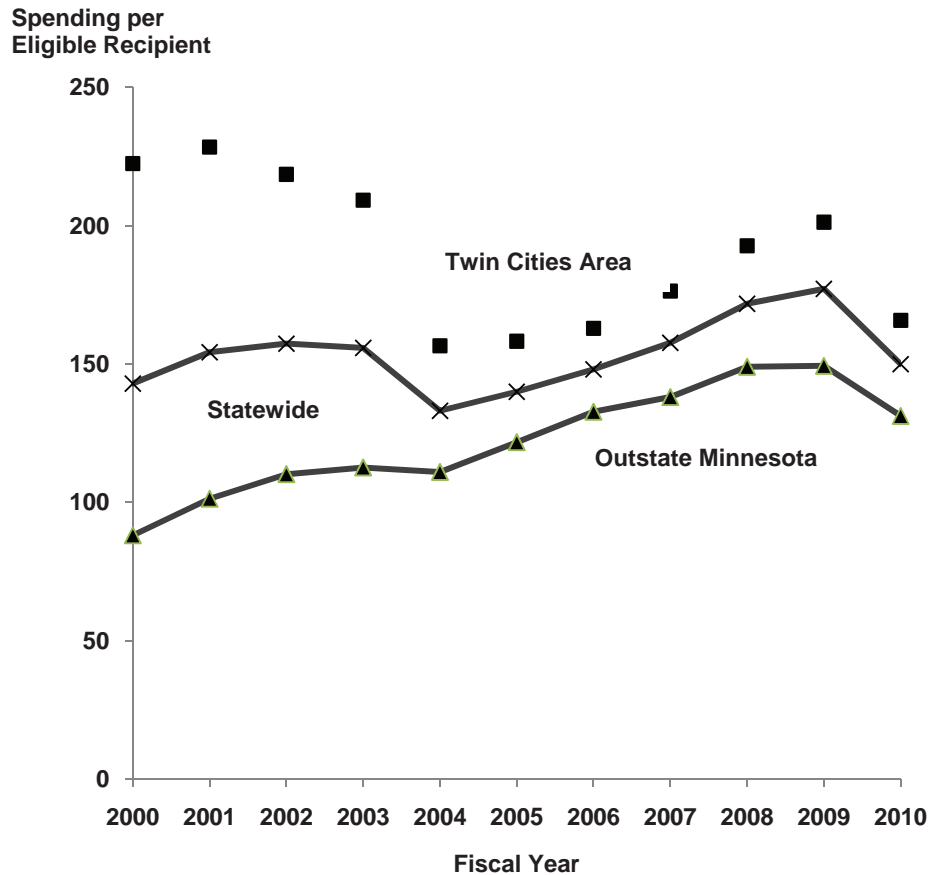


SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

Despite increasing over the last several years, costs are generally lower in outstate Minnesota. Our analysis of DHS spending data for access transportation found that:

- **Outstate counties have made greater use of low-cost options to provide access transportation to Medical Assistance recipients than counties in the Twin Cities area have.**

Figure 1.2: Medical Nonemergency Transportation Spending per Eligible Medical Assistance Recipient, Fiscal Years 2000-2010



Outstate counties rely significantly on personal vehicles to provide access transportation, while counties in the Twin Cities area rely more on taxi-style vehicles.

NOTE: The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Medical Assistance recipients refer to the average monthly number of public assistance recipients covered by the fee-for-service system and, thus, eligible for transportation services through Minnesota’s medical nonemergency transportation program.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

In fiscal year 2010, about 69 percent of outstate counties’ access transportation spending was for two low-cost options—personal mileage reimbursement and mileage reimbursement for volunteer drivers, as shown in Table 1.9. In contrast, 93 percent of access transportation spending in the Twin Cities area—excluding administrative fees—was for taxi-style vehicles, the high-cost option. Since reimbursement rates for personal and volunteer mileage are much lower than the rates paid for taxi-style vehicles, relying on volunteer drivers or recipients themselves helps keep spending lower in outstate Minnesota. For example, a ten-mile trip would cost \$2 if a recipient or relative of the recipient drove and \$5 if a county volunteer drove, but it would be \$17 for the least expensive taxi-style vehicle.

Table 1.9: Access Transportation Spending, Fiscal Year 2010

Type of Transportation	Twin Cities Area (in thousands)	Percentage of Twin Cities Area Spending	Outstate Minnesota (in thousands)	Percentage of Outstate Minnesota Spending	Total Spending (in thousands)	Percentage of Total Spending
Taxi-style vehicles	\$11,433	93%	\$656	7%	\$12,089	56%
Public transit	138	1	813	9	951	4
Personal mileage reimbursement	569	5	3,182	34	3,751	17
Volunteer mileage reimbursement	54	0.4	3,190	35	3,244	15
Meals and lodging	54	0.4	1,005	11	1,059	5
Other	79	1	414	4	493	2
Total	\$12,310	100%	\$9,250	100%	\$21,560	100%
Administrative fees	\$4,360		Unknown			

NOTES: The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Percentages exclude administrative fees. Percentages may not total 100 due to rounding.

SOURCE: Office of Legislative Auditor, analysis of Department of Human Services data.

About \$1 million was spent on parking, meals, and lodging in fiscal year 2010, nearly all in outstate counties where medical appointments can be far from recipients’ homes. Meals and lodging are only reimbursable when medical appointments require recipients to be more than 35 miles from home and either traveling or at medical appointments during certain times of the day.

We also found that:

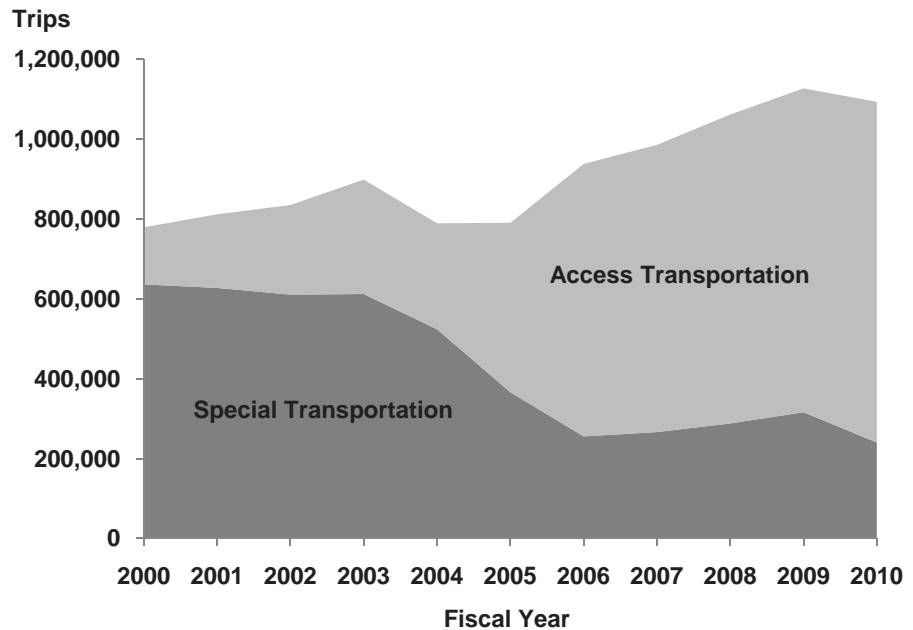
- **In the Twin Cities area, the average cost per trip for medical nonemergency transportation has declined since fiscal year 2000.**

According to our estimates, average trip costs, excluding administrative costs, dropped from about \$22 or \$23 per trip in fiscal years 2000 through 2003 to about \$16 in 2010. If we included administrative costs, average total costs would still fall, although by a smaller amount, going from \$23 or \$24 per trip in fiscal year 2000 to \$21 in 2010.

This drop is partly due to the large shift in trips from special to access transportation that began in the mid-2000s. As shown in Figure 1.3, the number of special transportation trips in the Twin Cities area exceeded 600,000 in each fiscal year from 2000 to 2003, but rapidly declined to 256,000 by fiscal year 2006 and has been under 300,000 for most years since then. In contrast, the number of access transportation trips increased, going from about 300,000 to 853,000 between fiscal years 2003 and 2010. Since special transportation trips cost more than access transportation trips, average trip costs in the Twin Cities fell.

Since 2000, average costs per trip for access transportation have fallen, partly due to the shift away from special transportation.

Figure 1.3: Medical Nonemergency Transportation Trips in the Twin Cities Area, Fiscal Years 2000-2010



NOTES: Each one-way trip counts as one trip. The Twin Cities area covers 11 counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services and Medical Transportation Management data.

Another reason for the decline in average trip costs in the Twin Cities area is that the average cost per trip for special transportation dropped over the last several years, going from about \$27 in fiscal years 2001 through 2003 to between \$23 and \$25 in fiscal years 2009 and 2010. Part of this drop was due to declining reimbursement rates for special transportation providers. In 2005, the Legislature decreased the base rates for most trips by \$.50 to \$1 and the per mile rates by \$.05.²⁹ In addition, as we discuss in Chapter 3, the average number of miles traveled per trip declined after MTM began brokering special transportation in the Twin Cities area in October 2006. Part of this drop persisted after MTM stopped brokering the service in February 2008.

Over the last ten years, spending on special transportation declined 63 percent in the Twin Cities area, much faster than the 14 percent decline in outstate counties. During the same time period, access transportation spending increased by 1,186 percent in the Twin Cities area, compared with an increase of 188 percent in outstate counties. One reason for these differences may be that outstate counties have reported greater difficulty finding providers willing to offer taxi-style access transportation, as we discuss in Chapters 2 and 3.

²⁹ *Laws of Minnesota* First Special Session 2005, chapter 4, art. 8, sec. 40. At the same time, the Legislature increased the base rate for stretcher rides by \$24 and the per mile rate by \$1. The Department of Human Services and Legislature set the maximum reimbursement rates for access transportation; rates for taxi-style vehicles within access transportation have increased slightly over the last several years.

Special Transportation

As we discussed in Chapter 1, Minnesota separates medical nonemergency transportation for Medical Assistance (MA) recipients into two categories: access transportation, available to all recipients, and special transportation, available only to the most seriously disabled. We begin this chapter by examining how creating a separate category for special transportation has worked overall. We then focus specifically on how the Department of Human Services (DHS) and its contractor, Medical Transportation Management, Inc. (MTM), have defined and implemented eligibility for special transportation.

MINNESOTA'S APPROACH

Minnesota has two separate administrative structures for delivering medical nonemergency transportation, one for access transportation and another for special transportation. Both, however, have essentially the same purpose—transporting MA recipients to or from medical appointments. This dual approach appears unique to Minnesota. Other states have not created separate frameworks to transport seriously disabled Medicaid recipients, although many provide different categories of service depending on recipients' needs.

Overall, we found that:

- **Minnesota's dual medical nonemergency transportation systems are duplicative and confusing.**

As we described in Chapter 1, most MA recipients in the Twin Cities area and many in outstate Minnesota use taxi-style vehicles to travel to or from medical appointments. While some of these trips are classified as access transportation and others as special transportation, the actual services provided are very similar. In both instances, drivers assist recipients in and out of vehicles and ensure that recipients are properly secured. Often, both services are provided by the same companies, using the same equipment and drivers. For taxi-style vehicles, the primary difference between access transportation and special transportation is how far into buildings drivers accompany MA recipients.¹

Despite the similarity of these two categories of transportation, Minnesota has two entirely separate structures for administering and delivering them. For example, two different payment systems are used. Counties are responsible for paying access transportation providers. Counties then submit reimbursement requests to DHS. In contrast, DHS pays special transportation providers directly, and counties are not involved.

Minnesota uses two separate structures to administer and deliver access and special transportation.

¹ There is less overlap in services between access and special transportation for other types of transportation, such as volunteer drivers or buses.

Some MA recipients shift back and forth between access and special transportation—sometimes in the same day.

Similarly, counties are primarily responsible for oversight of access transportation and may set standards for quality of service.² However, counties play no role in overseeing special transportation. Instead, oversight authority is divided between the Minnesota Department of Transportation (MnDOT) and DHS. State law requires MnDOT to set and enforce standards for special transportation providers regarding driver qualifications and training, appropriate safety equipment, inspection and maintenance of vehicles, and minimum insurance requirements.³ None of these standards apply to access transportation providers.

The separation of the two services can produce odd and confusing changes for MA recipients who have serious health problems. Though different counties have different procedures, it is generally the county's responsibility to arrange access transportation to or from medical appointments for resident MA recipients. But if a recipient's medical condition deteriorates to the point that special transportation is necessary, the county no longer has a role in arranging transportation. At that point, it becomes the recipient's responsibility to seek eligibility for special transportation and schedule transportation directly with a special transportation provider. If the recipient improves again, transportation once again becomes the county's responsibility. Recipients can flip back and forth between the two systems in the same day—a recipient may take access transportation to a medical facility, undergo a procedure requiring sedation, and then need special transportation to return home because of the effects of the sedative.

Complicating matters further, more than one definition of special transportation is used by different agencies. State law directs the Metropolitan Council to provide "special transportation" to residents of the seven-county metropolitan area, which it does through Metro Mobility.⁴ This version of special transportation can be used by any individual meeting Metro Mobility's eligibility criteria for any purpose, not solely MA recipients traveling to or from medical appointments. However, Metro Mobility drivers are not required to provide the same level of service to their passengers that special transportation providers must provide to MA recipients. In contrast to the "door-through-door" service required of MA special transportation drivers, which we described in Chapter 1, Metro Mobility drivers provide "first-door-through-first-door" service. Drivers escort passengers through the outside doors of the pick-up and destination sites, but do not escort individuals further inside buildings (for example, to a medical provider's office). The Department of Human Services classifies MA recipients that travel to or from medical appointments using Metro Mobility as using access transportation, not special transportation.

² Because DHS reimburses counties for access transportation costs using state and federal money, DHS has ultimate authority to ensure that payments are properly made and may launch audits or investigations, as needed.

³ *Minnesota Statutes* 2010, 174.30, subd. 2.

⁴ *Minnesota Statutes* 2010, 473.386.

We also found that:

- **The Department of Human Services has administered key elements of special transportation in an ad hoc fashion.**

The department has not used rulemaking procedures, provided formal written instructions and guidelines to its contractor, or informed transportation providers, recipients, and other interested parties of procedural changes. Furthermore, DHS has not significantly changed its special transportation rules since 1987. Some of these rules no longer reflect current law, and they are silent on many important matters of interpretation.⁵ The department has made key implementation decisions administratively without the public notice and comment periods required by the rulemaking process. For example, although state law sets different rates for ambulatory, wheelchair, and stretcher transportation, DHS has not promulgated rules that distinguish among these service levels.⁶ Similarly, the department has never asked for public comment on its interpretations of state law that a recipient must need “driver-assisted services” to receive special transportation or that the availability of access transportation is irrelevant when determining special transportation eligibility.

Despite changes to state law, DHS has not updated its special transportation rules since 1987.

Although DHS has contracted with MTM to perform special transportation eligibility assessments for more than six years, it has given MTM little formal written guidance on how assessments should be done beyond the vague guidance contained in the contract and state law.⁷ Even when the department has directed MTM to act in ways counter to contract language (as we describe later in this chapter with regard to the length of eligibility periods), it has not provided formal written guidance. Instead, the department has generally relied on informal verbal and e-mail communications to tell MTM how to perform its duties. For example, in January 2009, department staff verbally notified MTM that every minor under the age of 18 receiving medical nonemergency transportation must be accompanied by an adult. Because the accompanying adult could perform any “driver-assisted services” needed, all children therefore became ineligible for special transportation (except in unusual circumstances). The department never put this directive into a formal written document; it appeared only in MTM’s meeting minutes and in later e-mail discussions between DHS and MTM staff.

⁵ For example, current rules state that eligibility for special transportation is determined by county human service agencies based on a physician’s certificate. However, the 2003 Legislature changed this process by making DHS, not physicians, responsible for eligibility determinations. See: *Minnesota Rules* 2010, 9505.315, subp. 7A; and *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36.

⁶ *Minnesota Statutes* 2010, 256B.0625, subd. 17(b). The department has partly defined ambulatory, wheelchair, and stretcher services in its state Medicaid plan submitted to the federal government, but the plan does not clearly explain how these levels differ between access transportation and special transportation. See Minnesota Department of Human Services, *Title XIX State Plan, 3.1(c)(1) Assurance of Transportation* (St. Paul, undated).

⁷ Minnesota Department of Human Services and Medical Transportation Management, *Contract #432723*, as amended, June 15, 2004-June 30, 2006, II. H13; Minnesota Department of Human Services and Medical Transportation Management, *Contract #436466*, as amended, July 1, 2006-June 31, 2011, II. 13; and *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

Implementation decisions that DHS has made administratively have changed the experiences of some special transportation applicants. However, the department has not published these changes regarding special transportation eligibility, even in cases that would make some previously denied MA recipients eligible.⁸ For example, when DHS instructed its contractor in April 2010 to stop considering whether recipients would be accompanied to appointments by others, it made no public announcement of this change in practice.

ELIGIBILITY

From 1991 to 2003, MA recipients could become eligible for special transportation with written statements from their doctors. Transportation providers were required to keep a physician's authorization on file for each person they transported. However, DHS administrators told us that this system was open to fraud and abuse. Physicians had no incentive to limit authorizations to the most disabled patients, and many did not understand the distinctions among the types of transportation available.

In 2003, the Legislature made DHS, not physicians, responsible for determining eligibility for special transportation.⁹ Beginning in January 2005, DHS contracted with MTM to meet this responsibility statewide.¹⁰ In addition to determining eligibility, MTM also determines how long each recipient's eligibility for special transportation will last. The current contract between DHS and MTM calls for DHS to pay \$35 for each eligibility determination made.¹¹

To become eligible for special transportation, a recipient or a representative must contact MTM. MTM nurses assess information about the recipient's condition and determine whether the recipient needs "driver-assisted services." In some instances, the information provided in the initial phone call is sufficient to determine eligibility. At other times, MTM staff ask the recipient's medical providers to complete a form about the recipient's abilities, which is then used to reach an eligibility decision. Medical Assistance recipients that live in skilled nursing facilities do not go through this process; they are automatically eligible for special transportation under state law.¹²

An MA recipient whose request for eligibility is denied may request that MTM "reconsider" its decision. In a reconsideration, MTM generally seeks further

Since 2005, DHS has contracted with a broker to determine whether MA recipients are eligible for special transportation.

⁸ The department is unable to directly notify individuals previously denied services because it does not keep records of denied applications.

⁹ *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36. Eligibility determinations are referred to in law as "level of need determinations." See *Minnesota Statutes* 2010, 256B.04, subd. 14a.

¹⁰ Department of Human Services, *Contract #432723*, II. H13; and Department of Human Services, *Contract #436466*, II. H13.

¹¹ *Ibid.*, Amendment 7.

¹² *Minnesota Statutes* 2010, 256B.04, subd. 14a. If a nursing facility resident or a representative requests a stretcher trip, MTM will assess the recipient to determine whether stretcher service is needed. If the request is denied, the recipient is automatically eligible for ambulatory or wheelchair special transportation.

information from one or more additional treating health providers (such as specialists or mental health professionals). All information gathered is added to the recipient's record and a new determination is made. A recipient still dissatisfied with the outcome after the reconsideration process can file a formal appeal with DHS's Appeals and Regulations Division.¹³

Reviewing information from MTM and DHS, we found that:

- **The Department of Human Services paid its contractor for nearly 4,900 special transportation eligibility determinations made from January 2009 through June 2010, approximately two-thirds of which were approvals.**

The 4,875 determinations involved 3,984 separate MA recipients. The department paid for 3,358 individuals to be assessed for eligibility once during this time period, 461 to be assessed twice, and 165 to be assessed three or more times. A handful of individuals were assessed five or more times.¹⁴

It is difficult to state with certainty the percentage of determinations resulting in approvals because:

- **The Department of Human Services' recordkeeping regarding special transportation applications has been poor.**

The department does not keep records of applications for special transportation status that result in denials, and it keeps incomplete records of past approvals that have expired. Despite contract language requiring MTM to report on the "disposition" of special transportation assessments, DHS has not asked for basic information about each assessment billed to the state, such as the level of service requested (ambulatory, wheelchair, or stretcher) or whether the request was approved or denied.¹⁵ The department pays MTM based solely on the date of the assessment and the MA identification number of the person assessed. Further, MTM staff enter approvals for special transportation into a DHS database that is primarily designed to store current information. When new information is added, old information must often be discarded to make room.

Although MTM keeps its own records, it was not possible to completely match its records to DHS's payment records. For example, MTM's assessment records did not include 59 of the 4,875 assessments paid for by DHS but did include 486

Recordkeeping problems make it difficult to analyze long term trends in special transportation eligibility.

¹³ The reconsideration process has evolved over time and is not outlined in DHS's contract with MTM. When applicants contest their special transportation eligibility decisions, the contract allows for a "Level II" assessment, in which applicants are evaluated by an independent third party. However, only a handful of Level II assessments have taken place in recent years. The reconsideration process is less costly because MTM does not charge DHS for reconsiderations. Importantly, the process enables applicants to make a stronger case for eligibility because decisions are based on information received from their own medical professionals.

¹⁴ There is no limit on the number of unsuccessful applications for special transportation a single individual may make in a given time period.

¹⁵ Department of Human Services, *Contract #436466*, II. K1(a).

assessments for which DHS recorded no payment or denied payment.¹⁶ The dataset of assessment outcomes that MTM gave us appeared to double-count over 1,000 assessments and did not fully match MTM’s own billing records.¹⁷ Also, MTM does not systematically track the levels of service (ambulatory, wheelchair, or stretcher) requested or approved.

Consequently, it was impossible to track trends in special transportation eligibility over time. We cannot state confidently how many special transportation eligibility assessments have been conducted since DHS was given responsibility for special transportation eligibility in 2003, nor can we determine whether the percentage of approvals has changed over time.

Criteria

Some MA recipient advocates and transportation providers have contended that DHS and MTM have inappropriately denied special transportation to recipients who should receive it. We reviewed the eligibility process and found that:

- **The Department of Human Services has adopted special transportation eligibility criteria that are narrower than the criteria in state law.**

Consequently, a few MA recipients have fallen “between the cracks” of Minnesota’s special transportation eligibility process. They appear eligible under state law, but they are ineligible under DHS practice.

A few MA recipients have fallen “between the cracks” in terms of eligibility for special transportation.

In setting standards for special transportation, state law describes both which recipients are *eligible* for special transportation and what *services* are to be provided to those recipients. An individual is eligible for special transportation “if the recipient has a physical or mental impairment that would prohibit the recipient from safely” using access transportation.¹⁸ This description of eligibility makes no reference to the amount of assistance a recipient needs; it simply states that a recipient who cannot access and use commercial transportation or private automobiles is eligible. The law goes on to specify the services that must be provided to eligible individuals, including assistance into and out of medical facilities.¹⁹

When determining whether individuals are eligible for special transportation, DHS has combined the statute’s description of eligibility with its description of services. In addition to examining whether an individual can access other forms of transportation, the department has instructed MTM to evaluate whether a recipient needs the services outlined in statute:

¹⁶ Denials of payment were usually due to incorrect data such as wrong recipient identification numbers. In many cases, MTM later submitted corrected bills.

¹⁷ Because we had three nonmatching data sources, our finding that two-thirds of determinations resulted in approvals is based on analyzing each data source separately.

¹⁸ *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

¹⁹ *Ibid.*

To be certified as eligible for [special transportation], the client must have a physical or mental condition requiring the transportation driver to provide direct assistance to the client. The direct assistance by the driver must be required inside the residence to exit and enter and assistance into and out of the medical facility to and from the appropriate medical appointment desk.²⁰

Until recently, DHS had determined that MA recipients traveling with personal care attendants were not eligible for special transportation.

This approach to interpreting the law has left a few individuals in a gray area because they are unable to use access transportation but do not necessarily need driver assistance to reach an appointment desk. For example, practically all children are ineligible for special transportation because DHS expects parents or guardians to accompany them to appointments. The department's position is that parents or guardians can perform the services a special transportation driver would perform, so children do not need special transportation. Similarly, adult MA recipients who were often accompanied by family members, personal care assistants, or other individuals were considered ineligible for special transportation under the same reasoning. After being criticized at a legislative hearing, the department quietly reversed its direction to MTM regarding accompanying individuals in April 2010.²¹ However, the practice of denying children special transportation eligibility has not changed.

Some transportation providers contend that DHS has inappropriately denied special transportation eligibility to individuals who are transported in wheelchairs. We examined this claim and found that:

- **Policy decisions by the Department of Human Services, market forces, and ambiguities in state law have created barriers to medical nonemergency transportation for a small number of Medical Assistance recipients.**

The department has defined a level of access transportation for recipients who are transported in their wheelchairs.²² These recipients can maneuver themselves into and out of medical facilities independently (for example, by using a motorized wheelchair). However, they cannot safely sit in regular automobiles or bus seats and instead must use specially-equipped vehicles that can accommodate passengers who remain in their wheelchairs during rides.

Because taxi-style access transportation costs less but is otherwise indistinguishable from special transportation (except for escorting MA recipients inside medical offices), DHS's practice of classifying these trips as access transportation has reduced costs to the state while providing recipients with transportation that meets their needs. However, some special transportation providers that serve rural areas consider the maximum access transportation rates

²⁰ Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, DHS Bulletin #10-21-02 (St. Paul, January 13, 2010), 2.

²¹ This change in practice was not put in writing by DHS other than in an e-mail exchange with MTM staff.

²² Department of Human Services, *Access Transportation Services (ATS) Information*, 6.

When MA recipients file appeals about special transportation eligibility, administrative law judges have issued conflicting opinions on whether DHS has interpreted state law correctly.

for these services too low and will only provide these services at the higher special transportation rates.²³ As a result, in some parts of the state where only one or two special transportation companies operate, access transportation is not available for wheelchair-bound recipients.²⁴ According to the transportation providers we spoke with, overhead costs in rural areas are higher because drivers often travel many unreimbursed miles without a recipient in the vehicle to reach pick-up points. Some providers also believe that wheelchair transportation is essentially a special transportation service and should be reimbursed as such.

Under DHS practice, availability of appropriate access transportation is irrelevant when considering whether a recipient needs special transportation. If a recipient would be able to use access transportation if it were available, then the recipient is not eligible for special transportation. Under state law, though, MA recipients are eligible for special transportation if they cannot safely access and use access transportation.²⁵ It is unclear whether the Legislature intended this language to include instances where appropriate access transportation does not exist. When recipients have appealed special transportation denials based on the unavailability of appropriate access transportation, some DHS administrative law judges have agreed with recipients that DHS's practice runs counter to the intent of the law. One judge wrote:

There is no safe transportation option that exists in the area for the appellant and her scooter other than special transportation. The legislature certainly did not mean for special transportation to be denied because somewhere in the universe there is a common carrier vehicle that is wheelchair accessible that could accommodate the appellant's needs.²⁶

However, other administrative law judges have reached the opposite conclusion. In a reconsideration of an earlier appeals decision that was partly based on the lack of access transportation, a judge wrote:

I reject any conclusions of law that indicate lack of availability of other forms of transportation as a reason to approve special transportation. Lack of availability of other forms of transportation cannot be a reason to approve special transportation services.²⁷

²³ See Tables 1.4 and 1.7 for the reimbursement rates for access and special transportation, respectively.

²⁴ In some instances, county-based van services for disabled passengers are available for local trips, but recipients that travel in wheelchairs may not be able to use these services for longer trips.

²⁵ *Minnesota Statutes* 2010, 256B.0625, subd. 17(b).

²⁶ *N.C. vs. Minnesota Department of Human Services*, DHS Docket 110834, October 21, 2009, Fair Hearings Decision Database, <http://appeals.dhs.state.mn.us/AppealsSearch.aspx>, accessed May 20, 2010.

²⁷ *A.B. vs. Minnesota Department of Human Services*, DHS Docket 113042, December 18, 2009, Fair Hearings Decision Database, <http://appeals.dhs.state.mn.us/AppealsSearch.aspx>, accessed May 20, 2010.

Patient advocates have also raised concerns that DHS and MTM do not properly certify recipients with mental impairments as eligible for special transportation. We were unable to directly evaluate that claim because independently assessing recipients' mental impairments was beyond the scope of our evaluation. Our review of a sample of special transportation eligibility assessments did show that MTM has certified some individuals eligible for special transportation based primarily on mental impairments. However, we found that:

- **The broker's assessment forms for determining special transportation eligibility have focused mostly on physical impairments and have asked for little information about mental impairments.**

Nurses that work for MTM use a standardized form to gather information about a recipient's impairments when speaking to the recipient or a representative. A very similar form is often sent to medical providers to gather further information. Most of the questions on the two forms are related to physical mobility. For example, the forms ask if the recipient can ambulate independently, if he or she uses a mobility aid, and if assistance from others is needed for the recipient to physically move around the community. The forms have a single question that refers to mental impairments, but it is directed solely at the recipient's ability to use public transportation and does not ask whether the recipient would have difficulty using other types of access transportation. For example, the forms do not ask whether the recipient can independently find his or her way from an outside curb to the appropriate medical office within a large office building, or whether the recipient can distinguish the proper vehicle to board when exiting a building at the end of an appointment.

There is a space for "additional information, comments, or concerns" on the forms, so it is possible to convey information about a recipient's mental impairments. But the forms' direct questions would not necessarily elicit information about severe mental disabilities that could make a recipient eligible for special transportation.²⁸ MTM has recently proposed new versions of these forms that would, among other changes, ask more directly about mental impairments. For example, instead of asking if the recipient needs "direct physical assistance" from the driver, the proposed forms use the phrase "physical/cognitive assistance."

Various stakeholders have also raised concerns about whether conflicts of interest have affected eligibility decisions. The department uses the same contractor, MTM, to determine special transportation eligibility statewide as counties use to coordinate access transportation in the Twin Cities area.²⁹ To some policy makers and transportation providers, this dual role creates a conflict of interest because recipients in the Twin Cities area who are denied special transportation would most likely use access transportation that MTM arranges.

The department's broker has proposed changes to its special transportation eligibility forms to better assess MA recipients' mental impairments.

²⁸ By comparison, the form used by Metro Mobility to determine eligibility for its transportation services asks directly about both physical and mental impairments.

²⁹ The department also used MTM to coordinate access transportation in the Twin Cities area prior to July 2009.

The broker has followed DHS's informal guidance when making special transportation eligibility decisions.

However, we found that:

- **There was no evidence that conflicts of interest have affected the broker's decisions regarding special transportation eligibility.**

We examined a sample of special transportation assessments conducted from January 2007 through June 2010 and concluded that MTM consistently followed DHS's informal guidance in making eligibility decisions. In addition, we found no systemic differences between eligibility decisions made for recipients outside the Twin Cities area (where no conflict of interest could exist) and recipients within the Twin Cities area.³⁰

Further, MTM and DHS staff told us that MTM has frequently consulted department staff about issues related to special transportation eligibility, and e-mails and meeting notes show that regular communication has occurred. Although we question whether the criteria MTM uses exactly match those outlined in state law, DHS developed the criteria, not MTM. Similarly, although we found that MTM's records were insufficient to fully evaluate special transportation eligibility practices, DHS has not asked MTM for more complete records.

Finally, some advocates have charged that DHS and MTM frequently deny special transportation to applicants but reverse their decisions to avoid losing when applicants file formal appeals. We did not find evidence to support this claim. Of the 117 appeals related to special transportation filed from April 2008 through September 2010, only 8 were resolved before a hearing took place. The department does not record why appeals are dismissed; some or all of these dismissals may have been due to applicants withdrawing their appeals rather than DHS reversing its stance.

Furthermore, we found that:

- **Medical Assistance recipients denied special transportation have filed relatively few appeals with the Department of Human Services.**

As stated earlier, DHS paid MTM for nearly 4,900 eligibility assessments from January 2009 through June 2010. The company denied special transportation in about one-third of the cases. During the same time period, MA recipients denied special transportation filed 83 appeals, and administrative law judges reversed the department's denials 40 percent of the time. Appeals judges' decisions overturning special transportation denials usually cited one of three reasons: (1) the recipient's impairment was more severe than MTM had found; (2) no appropriate access transportation was available in the recipient's area; or (3) the person usually accompanying the recipient could not provide "driver-assisted services" or the accompanying person did not always attend appointments.

³⁰ Because MTM coordinates access transportation trips within the Twin Cities area only, it would gain no advantage from funneling additional MA recipients to access transportation services outside the Twin Cities area.

Assessment Frequency and Length of Eligibility

Some policy makers and transportation providers have questioned the frequency with which MA recipients must undergo eligibility assessments for special transportation. State law and DHS's contract with MTM provide general guidance regarding the frequency of assessments.

The Legislature has specifically directed DHS to avoid frequent reassessments for special transportation eligibility. In 2007, it said that eligibility assessments "must not be performed more than semiannually on any individual, unless the individual's circumstances have sufficiently changed."³¹ In 2010, it changed "semiannually" to "annually."³² While the law gives DHS the discretion to initiate eligibility assessments more often, the statutory language anticipates that frequent assessments will be the exception, not the rule.

In addition, DHS's contract with MTM requires that special transportation certifications "generally parallel the time given for Social Security Insurance Disability redeterminations as outlined in 20 CFR 416.990."³³ Under these provisions, reassessments occur (1) between 6 and 18 months if the recipient is expected to improve, (2) at least once every 3 years for recipients with a disability not considered permanent but whose improvement cannot be accurately estimated, and (3) no more frequently than once every 5 years for those with a permanent disability.³⁴

When the broker approves a request for special transportation, it also specifies how long that approval will last.

Because recipients need new assessments to receive special transportation once their previous eligibility periods expire, assessment frequency is linked to the length of eligibility periods. If eligibility periods are short, recipients must be reassessed more frequently to continue using special transportation. Conversely, if eligibility periods are long, recipients will not need reassessments—but some recipients may receive costly special transportation for longer than they need it. Statutory language does not directly address the length of eligibility periods except for stretcher transportation, for which recipients are "presumed to maintain that level of need" until otherwise determined by DHS, or for six months, whichever is sooner.³⁵

We found that:

- **The Department of Human Services has frequently limited Medical Assistance recipients' eligibility for special transportation to extremely short time periods.**

Although MTM's *Operations Manual* states that special transportation approval periods will be "at least 6 months or up to 7 years," DHS and MTM have agreed

³¹ *Laws of Minnesota* 2007, chapter 147, art. 5, sec. 7.

³² *Laws of Minnesota* First Special Session 2010, chapter 1, art. 16, sec. 4.

³³ Department of Human Services, *Contract #436466*, II. H13(b).

³⁴ 20 CFR 416.990(d) (2010).

³⁵ *Minnesota Statutes* 2010, 256B.04, subd. 14a.

on procedures that limit the duration of eligibility for many MA recipients to time periods much shorter than six months.³⁶ As shown in Table 2.1, eligibility lasted for only a single day for about 40 percent of ambulatory and wheelchair approvals. MTM granted eligibility periods of 181 days or more in only 36 percent of ambulatory and wheelchair approvals and only 1 percent of stretcher approvals.

Table 2.1: Percentage of Special Transportation Eligibility Approvals by Length of Eligibility Period and Type of Eligibility, July 2007-June 2010

Type of Eligibility	Length of Eligibility Period			
	1 day	2 to 180 days	181 days to 7 years	7 years or more
Ambulatory	42%	14%	36%	7%
Wheelchair	38	17	36	9
Stretcher	87	11	1	0

NOTES: Data are based on 10,457 eligibility approvals for 7,400 unique Medical Assistance recipients. Because the Department of Human Services' data are incomplete, this table likely understates the percentage of special transportation eligibility periods of short duration, particularly in earlier years. Seven years was defined as 2,525 days or more in order to capture instances where the person entering the time span rounded to the nearest month. Rows may not sum to 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Department of Human Services data.

However, special transportation eligibility for many MA recipients lasts only a single day.

Due to the high cost of stretcher transportation, DHS has been particularly aggressive in limiting eligibility periods for this level of service. The department requires that MTM preapprove each stretcher trip separately to ensure that a recipient is unable to use less expensive services. As a result, over 90 percent of stretcher special transportation approvals from January 2009 through June 2010 were limited to a single day. Stretcher eligibility periods lasting six months or more were very rare.

According to DHS, certification for special transportation and the length of the eligibility period should be based on medical necessity. If a recipient's medical condition justifying special transportation is not expected to last for a year, then MTM should not grant eligibility for a year. Consequently, some recipients require new special transportation assessments to take another trip within weeks of a previous approval, despite the statutory language saying that such reassessments should only occur if "circumstances have sufficiently changed."³⁷ The department's perspective is that the expiration of the eligibility period indicates that circumstances have changed.

³⁶ Medical Transportation Management, *Operations Manual* (St. Louis, MO, 2009), 21.

³⁷ *Minnesota Statutes* 2010, 256B.04, subd. 14a.

When a recipient with a recent but now expired approval requests additional eligibility for another special transportation trip, MTM may conduct an entirely new eligibility assessment for which it charges the department. In other instances, MTM may simply update the recipient’s previous certification to include a new time period without charging DHS. The department has not provided MTM with any written guidelines that describe when billing is appropriate; rather, the choice appears to be at MTM’s discretion.

Because many recipients do not request an additional special transportation certification shortly after being approved, short eligibility periods cause a relatively small number of special transportation applicants to need additional reassessments in less than six months. As shown in Table 2.2, in about 12 percent of the determinations made from January 2009 through June 2010, the recipient had been approved for special transportation less than 180 days previously. However, because MTM did not record the level of service each applicant sought, some recipients assessed twice may have requested a more costly level of special transportation (for example, a recipient already eligible for ambulatory service may have requested wheelchair service).

Table 2.2: Special Transportation Eligibility Assessments by Length of Time since Previous Approval, January 2009-June 2010

Time Since Previous Approval	Number	Percentage of Total	Percentage Paid for by DHS
3 days to 30 days	254	5%	93%
31 days to 180 days	363	7	93
181 days or more	1,749	33	88
No previous approval	2,950	55	92
Total	5,316	100%	91%

A small number of MA recipients have had to reapply for special transportation within weeks of an earlier approval.

NOTES: Data include 486 assessments appearing in Medical Transportation Management (MTM) records for which the Department of Human Services (DHS) recorded no payment. However, data do not include 59 assessments DHS paid for during this time period that do not appear in MTM’s records (because we could not determine from DHS’s data alone whether the assessments resulted in approvals or denials). We also excluded 1,396 assessments appearing in MTM’s records that took place less than three days after a previous approval. Most of these likely represent double-counting of single assessments; only 3 percent were paid for by DHS.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Because DHS does not keep complete records regarding special transportation approvals, it is difficult to determine whether its practice of limiting eligibility periods has actually been effective in managing special transportation costs. Shorter approval periods may reduce the likelihood that recipients receive more costly transportation services than they need. However, the department’s current contract with MTM calls for DHS to pay \$35 for each special transportation eligibility assessment. As shown earlier in Table 1.8, the difference in cost between special transportation trips and similar access transportation trips is

In some cases, it makes sense to tightly limit how long MA recipients can receive special transportation without being reassessed, but in other cases it does not.

frequently less than \$10.³⁸ If a recipient's medical condition improves and he or she no longer needs ambulatory or wheelchair special transportation, it costs more to reassess the recipient and deny eligibility than it would to simply allow the recipient to take an additional trip or two at special transportation rates. Further, an early reassessment of a recipient whose condition has *not* improved represents an unnecessary expense.³⁹

Because stretcher transportation is much more expensive than other options, requiring frequent reassessments of eligibility for stretcher transportation is more likely to lower overall costs than reassessments for other forms of special transportation—particularly if longer distances are involved. For example, as shown earlier in Table 1.8, the difference in cost between a 20 mile stretcher trip and a 20 mile wheelchair special transportation trip is \$73. Thus, even if most reassessments did not change recipients' special transportation status, the savings in the minority of cases where they did change the status could justify the additional assessment costs.

Cost-effectiveness, though, is not the only criterion by which to assess DHS's actions limiting eligibility periods. Because special transportation is designed to serve recipients who are unable to use any other form of transportation, individuals who apply for special transportation status are often struggling with severe physical or mental health issues. For this population, the need to undergo repeated assessments to determine their eligibility for special transportation may be a significant burden.

RECOMMENDATIONS

Generally speaking, the evidence that we examined suggests that most MA recipients have been able to get to or from medical appointments using access or special transportation (or without assistance). The difficulties with eligibility criteria and approval periods that we describe above have likely affected a small proportion of MA recipients seeking transportation. Nonetheless, we believe some changes are necessary to simplify Minnesota's medical nonemergency transportation system, reduce unnecessary duplication, and improve services and accountability.

RECOMMENDATION

The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 Legislature.

³⁸ This calculation excludes administrative charges paid by some counties to contractors who arrange access transportation trips. In the Twin Cities area, this fee is currently \$5.54 per trip.

³⁹ In practice, MTM sometimes does not bill the state for early reassessments of individuals whose condition has not changed.

Administrative structures for access and special transportation should be unified and simplified.

Minnesota's current approach to providing transportation to MA recipients is needlessly complicated. Although the two categories of service that the state uses (access and special transportation) are sometimes offered by the same providers and used by the same recipients, each category has different eligibility determination processes, scheduling arrangements, billing procedures, and oversight mechanisms. Additionally, recipients' needs are not fixed; some recipients with serious health concerns move back and forth between the two categories as their health needs change. Consolidating access and special transportation into a single administrative structure would lessen confusion, enhance coordination, and improve accountability. It would also make it easier to standardize data collection so that program performance can be evaluated and improved over time.

Separate special transportation arrangements have been in place in Minnesota for over three decades. Moving to a consolidated structure would not be easy and would require careful planning. A single structure could either require counties to take on additional special transportation responsibilities or DHS to take on additional access transportation responsibilities. Both state and local administrators would have to estimate how their costs would change and determine how to pay for any expected increases. Additionally, the definition of special transportation is used in other parts of state law, for example, in sections governing Metro Mobility, and potential statutory changes would need to be examined to prevent unintended effects on other programs.

RECOMMENDATION

As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable.

The Department of Human Services' administrative law judges have reached different conclusions when interpreting the eligibility criteria for special transportation outlined in statute. Specifically, it is unclear whether recipients who live in communities where appropriate access transportation is not available are eligible for special transportation. The Legislature should clarify its intent, bearing in mind that either approach has drawbacks. If recipients in these circumstances are considered eligible for special transportation, then special transportation providers in areas with low competition will have little incentive to also offer access transportation and costs may increase. If these recipients are not considered eligible, some rural counties may have difficulty finding appropriate transportation for some disabled recipients, particularly for longer trips.

RECOMMENDATION

The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation.

State law regarding special transportation eligibility criteria, assessment frequency, and approval periods needs to be clarified.

Policies regarding the frequency of assessments and the length of special transportation eligibility periods involve tradeoffs. Shorter eligibility time frames and more frequent assessments increase both inconvenience for recipients and assessment costs. However, they could lower transportation costs because recipients may be less likely to receive more costly levels of service than they need.

Although the Legislature has made a policy choice regarding assessment frequency, statutes do not directly address the length of eligibility periods. The department and MTM have granted very short eligibility periods to many recipients, a practice that appears inconsistent with the Legislature's desire for fewer assessments. While we are uncomfortable with how DHS has interpreted the statutory language, we agree that the law is vague. The department should propose replacement statutory language that more clearly reflects its current practices and seek the Legislature's endorsement of its approach.

In reviewing DHS's proposal, the Legislature should consider that limiting DHS's ability to reassess MA recipients may constrain the department's ability to control costs. We noted in Chapter 1 that some recipients take as many as 100 nonemergency transportation trips a year. When a recipient's health could plausibly change, it becomes increasingly cost-effective to spend money on an additional assessment as more trips are taken. Further, because the cost of a stretcher trip is much higher than any other type of nonemergency transportation, frequently reassessing eligibility for stretcher transportation also enhances DHS's ability to control costs.

However, in our view, DHS's practice of limiting many ambulatory and wheelchair eligibility periods to a single day errs too far in the other direction. Though a small number of individuals have needed reassessments within weeks of a previous approval, those reassessments represent unnecessary costs to the state and unnecessary inconvenience to recipients.

Very short eligibility periods are also inconsistent with MTM's contract, which requires the company to set eligibility periods in conformance with Social Security Disability guidelines. The department has not provided MTM with formal instructions describing when eligibility periods should deviate from the six-month minimum indicated by these guidelines, nor has it made such instructions available to recipients, transportation providers, and other interested parties.

RECOMMENDATION

The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changed.

In our discussions with transportation providers, recipient advocates, county officials, and other interested parties, we found a substantial amount of misinformation about how special transportation eligibility is determined and how access and special transportation differ from one another. While special

transportation is a small part of a much more complex MA program, it has been the subject of disproportionate scrutiny. The Legislature has made repeated changes to laws relating to special transportation.

We believe that the lack of clear information and the close scrutiny of DHS's administration of special transportation are related. Department staff told us that outside interests have sometimes mischaracterized DHS's actions. However, DHS has rarely published materials that actually describe how it administers medical nonemergency transportation. The department's ad hoc approach to program administration has meant that decisions are made and implemented behind the scenes. The department should increase transparency by publishing documentation that clarifies its special transportation eligibility process and explains changes so that recipients, advocates, providers, and legislators can better understand its policies and practices.

The department needs to make its policies and decision making more transparent to the public.

RECOMMENDATION

The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow.

Setting clear expectations is a prerequisite for effective accountability procedures. Our review led us to conclude that MTM had generally implemented DHS's directives. However, we found it surprisingly difficult to figure out what those directives were in the first place.

The department should routinely provide clear written directions to MTM about its implementation of department policies. Providing written materials would also improve overall transparency; such letters or other formal documents could be readily reviewed by interested parties such as transportation providers and disability advocates. The department should also routinely update its contract when actions outlined in the contract are substantially changed or are no longer required.

MANAGEMENT ISSUES

As we pointed out in Chapter 1, the federal government allows states considerable flexibility in designing their medical nonemergency transportation programs. This chapter addresses a number of concerns that legislators and other interested parties have raised about medical nonemergency transportation, including the use of brokers, state oversight practices, and recipient satisfaction.

BROKERING

Over the last several years, states have increasingly moved from operating their transportation programs themselves to contracting for such services. In fact:

- **Since the mid-1990s, the federal government has encouraged states to contract with “brokers” to manage medical nonemergency transportation for Medicaid recipients.**

The term “broker” refers to an entity that takes requests for trips and then distributes the trips among service providers.¹ Brokers act as intermediaries between Medicaid recipients and transportation providers and between providers and the state Medicaid agency.

Federal Requirements

When states choose to use brokers to coordinate transportation, the federal government requires that the brokers be selected through a competitive procurement process and that the programs be cost-effective.² State contracts must require that brokers: (1) have oversight procedures in place to monitor Medicaid recipient access and complaints; (2) use transportation personnel who are licensed, qualified, competent, and courteous; and (3) comply with federal requirements related to prohibitions on referrals and conflicts of interest.³ Additionally, states must perform regular auditing and oversight of brokers to ensure that Medicaid recipients have access to quality transportation services.

The primary purpose of a broker is to coordinate services in a cost-efficient and effective manner. The federal government’s preference for brokers grew out of

Brokers take trip requests and distribute them among transportation providers.

¹ Transportation Research Board, *Transit Agency Participation in Medicaid Transportation Programs* (Washington, DC, 2006), 4.

² 42 CFR 440.170(a)(4) (2010). Also, see U.S. Department of Human Services, Centers for Medicare & Medicaid Services, letter to State Medicaid Directors, March 31, 2006.

³ 42 CFR 440.170(a)(4) (2010).

Widespread fraud and abuse prompted the federal government to encourage states to use brokers.

widespread fraud and abuse by both transportation providers and recipients, costing states and the federal government millions of dollars.⁴ According to various studies, brokers can reduce or control costs by: (1) ensuring that recipients receive the most appropriate and least costly type of transportation, (2) decreasing average trip length, (3) coordinating trips and riders, (4) obtaining competitive bids from service providers, and (5) discouraging provider and recipient fraud and abuse.⁵ In addition, brokers can simplify the transportation process for recipients and help ensure more consistent decision making. States using brokers generally report an increase in the number of trips provided but a reduction in cost per trip, although the rigor of the different studies varies.⁶

However, even well-designed broker programs can have disadvantages—disadvantages that must be weighed against brokers’ abilities to control costs. First, state administrative costs may increase since, without a broker, transportation services would likely be provided locally as part of a county’s overall Medicaid program. Also, states using brokers must monitor brokers’ performance, which may add costs. Second, administrative costs for this single service may be too high to find economies of scale for programs providing a relatively low number of trips. Third, brokers may offer recipients less choice regarding the type of transportation or which transportation provider to use. Fourth, brokers unfamiliar with local environments or human services providers may be less efficient than local agencies when trying to coordinate Medicaid transportation with transportation services for other groups.

Other States

After reviewing relevant studies and talking with officials in several states, we found that:

- **Most states use one or more brokers to administer at least a portion of their medical nonemergency transportation programs.**

As shown in Table 3.1, at least 40 states and the District of Columbia either (1) used a broker for at least a portion of their Medicaid population in 2010 or (2) are planning to use one in 2011. Although states frequently use brokers to provide transportation for Medicaid recipients under a fee-for-service system, many states also use them for recipients in managed care plans.⁷

⁴ U.S. Department of Health and Human Services, *Controlling Medicaid Non-Emergency Transportation Costs* (Washington, DC, April 1997).

⁵ For example, see The Hilltop Institute, *Non-Emergency Medical Transportation (NEMT) Study Report* (Baltimore, MD, September 26, 2008); and Joint Legislative Committee on Performance Evaluation and Expenditure Review, *A Review of the Mississippi Division of Medicaid’s Non-Emergency Transportation Program* (Jackson, MS, January 7, 2008).

⁶ For example, see Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, May 2004); and Public Policy Center, *Iowa Medicaid Non-Emergency Medical Transportation System Review and Options for Improvements* (Iowa City, IA: University of Iowa, September 30, 2008).

⁷ In some states, transportation is carved out of managed health care plans with services coordinated by a broker rather than the health plans.

Table 3.1: Use of Brokers Nationwide, 2011

States Using One or More Brokers

Alaska	Missouri
Arkansas	Montana
Colorado	Nebraska
Connecticut	Nevada
Delaware	New Jersey
District of Columbia	New Mexico
Florida	New York
Georgia	North Carolina
Idaho	Oklahoma
Illinois	Oregon
Indiana	Pennsylvania
Iowa	Rhode Island
Kansas	South Carolina
Kentucky	Tennessee
Louisiana	Utah
Maine	Vermont
Maryland	Virginia
Massachusetts	Washington
MINNESOTA	Wisconsin
Mississippi	West Virginia

States Not Using a Broker

Alabama	North Dakota
Arizona	Ohio
California	South Dakota
Hawaii	Texas
New Hampshire	West Virginia

NOTES: Not all the states that we have classified as having brokers administer those programs at the state level. In some states, individual counties or groups of counties administer the brokerage programs. Illinois only uses a broker to determine eligibility for transportation assistance.

SOURCE: Office of the Legislative Auditor, analysis of various reports and studies.

Some states use a single broker statewide; others use brokers on a regional or county basis.

Brokers come in varying sizes, with differing functions and levels of responsibility. They can be for-profit companies, not-for-profit agencies, or units of government such as transit authorities. Also, brokers can operate on a statewide, regional, or county basis—or any combination thereof. These differences make it difficult to compare the effectiveness of states’ experiences using brokers.

States also use a variety of methods to pay their brokers, as shown in Table 3.2. Each type of payment method comes with its own set of service-related incentives, and no method is clearly superior to another. In theory, the type of payment method used should reflect state priorities, with oversight mechanisms built into contracts to guard against the disincentives inherent in the respective payment method adopted.

Table 3.2: Types of Payment Methods States Use to Pay Brokers, 2011

Method 1: Fixed Amount per Medicaid Recipient	Fee is based on a set amount per Medicaid recipient or enrollee in the geographic area covered.
Method 2: Maximum Total Amount	Broker earns a set amount of money during the life of the contract.
Method 3: Flat Amount per Trip by Type of Trip	Broker is paid a fixed amount for each type of trip provided, with fees generally higher for trips using taxi-style vehicles and lower for trips using common carriers such as buses and cars.
Method 4: Flat Amount per Trip	Broker is paid a fixed amount for each trip provided, regardless of the type of transportation used.
Method 5: Administrative Fee	Broker is paid a flat administrative fee for each trip provided, plus an additional amount to specifically reimburse transportation providers' costs.

SOURCE: Office of the Legislative Auditor.

Different payment methods create incentives for brokers to control costs or limit access.

Payment methods 1 and 2 limit the total amount of money paid to brokers. Under both methods, brokers are paid a lump sum of money out of which they must cover their own costs and those of transportation providers. Studies suggest that these types of payment methods are the most cost-effective because they provide a direct incentive for brokers to reduce costs in order to maximize their profits.⁸ Another advantage is that total costs are predictable. However, these payment methods provide incentives for brokers to inappropriately deny services or shift recipients to cheaper, but less appropriate, types of transportation.

Methods 3 and 4 are based on the number of trips brokers arrange. Brokers are paid on a per trip basis and, as with methods 1 and 2, they must use their per trip fees to cover both their costs and those of transportation providers. These payment methods provide brokers with an incentive to reduce per trip costs but not the number of trips provided. They also offer states less budget predictability than methods that limit total payments and, if certain types of transportation are more profitable than others, brokers have an incentive to assign recipients to the more profitable types of transportation.

Finally, under method 5, brokers are paid an administrative fee for each completed trip, plus they are reimbursed for the amounts paid to transportation providers. This method provides little incentive for brokers to control the number of trips or miles driven or to ensure that the least costly but most appropriate type of transportation is provided. On the other hand, with reduced

⁸ For example, see The Lewin Group, *MO HealthNet NEMT Review Final Report* (Falls Church, VA, February 25, 2010); and Legislative Research Commission, *Human Service Transportation Delivery: System Faces Quality, Coordination, and Utilization Challenges* (Frankfort, KY, May 2004).

pressure to limit costs, recipients may be more likely to receive better, but more costly, services.

We looked at the payment methods used by states and found that:

- **Most states with brokers use payment systems that limit what brokers can earn for coordinating medical nonemergency transportation.**

Of the 19 states for which we have data, 11 paid brokers a flat amount per Medicaid enrollee (method 1), 6 paid a set administrative fee per trip plus the direct cost of transportation provider reimbursement (method 5), and 2 paid a fixed total amount (Method 2). Some states in the early phases of brokering told us that, although they are currently paying (or plan to pay) their brokers an administrative fee per completed trip, they want to switch to a method that limits total payments after their programs collect enough baseline data to set those amounts.

Minnesota

Although states vary widely in how they organize and administer their broker programs, we found that:

- **Minnesota is similar to most other states in that a private, for-profit company has been used to coordinate medical nonemergency transportation for at least a portion of its Medicaid population.**

In Minnesota, a for-profit broker, Medical Transportation Management, Inc. (MTM), has been used to deliver portions of the state's access transportation program since mid-2004. From July 2004 through June 2009, DHS contracted with MTM to: (1) establish a network of transportation providers, (2) determine recipient eligibility, (3) schedule trips, and (4) monitor transportation providers and recipients in 11 counties in the Twin Cities area.⁹ In May 2009, however, the Legislature prohibited the department from brokering access transportation.¹⁰ Subsequently, beginning in July 2009, counties in the Twin Cities area have jointly contracted with MTM to continue brokering their access transportation programs.¹¹

Since 2004, the department's contracts with MTM have required the company to determine eligibility for special transportation statewide. The contracts also

A for-profit company has brokered access transportation in the Twin Cities area since 2004.

⁹ Minnesota Department of Human Services and Medical Transportation Management, *Contract #432723*, as amended, June 15, 2004-June 30, 2006; and Minnesota Department of Human Services and Medical Transportation Management, *Contract #436466*, as amended, July 1, 2006-June 31, 2011.

¹⁰ *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 34.

¹¹ Anoka County and Medical Transportation Management, *Contract #09-2142*, as amended, June 23, 2009-June 31, 2010; and Hennepin County and Medical Transportation Management, *Contract #A100838*, July 1, 2010-December 30, 2011. For the most part, the Twin Cities area counties have contracted for the same access transportation services previously specified in DHS's contract.

Brokering arrangements in Minnesota have changed several times in the last decade, due in part to legislative actions.

required MTM to broker special transportation in the Twin Cities area, which it did from October 2006 through January 2008. However, the 2007 Legislature prohibited DHS from brokering special transportation.¹² Consequently, since February 2008, MA recipients in the Twin Cities area who are eligible for special transportation have scheduled their own rides—just as recipients in outstate counties have done.

Table 3.3 lists major changes in how Minnesota’s medical nonemergency transportation program has been administered since 2004. As shown, most program changes over the last several years have occurred in the Twin Cities area.

Table 3.3: Major Administrative Changes in Medical Nonemergency Transportation, 2004-2010

June 2004	Department of Human Services (DHS) contracts with a broker (Medical Transportation Management, Inc. [MTM]) for select services
July 2004	MTM brokers access transportation across seven Twin Cities area counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington)
February 2005	MTM determines eligibility for special transportation statewide MTM extends access transportation brokering to four additional counties (Chisago, Isanti, Sherburne, and Wright)
October 2006	MTM brokers special transportation in 11-county Twin Cities area, but participation is optional
January 2007	MTM brokers special transportation in 11-county Twin Cities area, and participation is mandatory
February 2008	DHS prohibited from brokering special transportation; MTM stops brokering the services in the Twin Cities area, but continues to determine special transportation eligibility statewide
July 2009	DHS prohibited from brokering access transportation; Anoka County contracts with MTM to jointly broker access transportation across 11 Twin Cities area counties
August 2009	Wright County drops out of the 11-county contract with MTM
February 2010	Carver and Scott counties drop out of the 10-county contract with MTM
July 2010	Hennepin County contracts with MTM to jointly broker access transportation across eight Twin Cities area counties

SOURCES: Office of the Legislative Auditor, analysis of contracts and Department of Human Services and Medical Transportation Management, Inc., data.

We looked at the payment methods used in Minnesota and found that:

- **Over the last several years, a variety of methods have been used to pay a broker to coordinate medical nonemergency transportation in the Twin Cities area.**

According to the terms of its first contract, DHS agreed to pay MTM an administrative fee, but capped what MTM could earn at a fixed amount (a

¹² *Laws of Minnesota* 2007, chapter 147, art. 5, sec. 6.

combination of methods 5 and 2) for the first two years of brokering.¹³ The department switched to paying a flat amount per completed trip (method 4) for the first three years of its second contract.¹⁴ When the Twin Cities area counties contracted with MTM in July 2009, they paid the company a fixed amount (method 2) the first year, but switched to paying an administrative fee per completed trip plus reimbursement for transportation providers' costs (method 5) in mid-2010.¹⁵ According to officials in Hennepin County, which took the lead in negotiating the latest contract with MTM, the county wanted to emphasize participation as opposed to cost control. Hence, it favored a payment method that did not contain financial incentives for MTM to deny trips to eligible MA recipients.

Impact of Brokering

Lack of data limits the extent to which we can measure the broker's impact on medical nonemergency transportation in Minnesota. Specifically, neither DHS nor counties tracked the type or amount of trips provided in the Twin Cities area before brokering began in July 2004. Consequently, we cannot compare the types of trips provided before and after MTM began brokering access transportation. Likewise, we cannot compare the costs of administering nonemergency transportation before and after brokering because counties have not tracked their administrative expenses for the program. Finally, lack of data about trips provided in outstate Minnesota prevents us from comparing counties that use brokers with those that do not. Nevertheless, we were able to examine certain ways brokering has affected program costs, participation, and service levels.

Lack of data limited our ability to measure how brokering has affected overall costs for nonemergency transportation.

Cost Savings

In this section we examine how using a broker has affected medical nonemergency transportation costs. Overall, we found that:

- **Brokering has reduced certain medical nonemergency transportation costs, although total savings are unclear.**

We identified three ways in which using a broker has helped reduce spending: tightening special transportation eligibility, controlling reimbursable trip miles, and making greater use of the lower-cost service levels for taxi-style vehicles.

First, as we discussed in Chapter 2, the Legislature began tightening special transportation eligibility in 2003 by making DHS, not physicians, primarily

¹³ Department of Human Services, *Contract #432723*, II. A. Although DHS agreed to pay MTM an administrative fee of \$4.39 per completed trip, total contract costs were capped at about \$1.6 million and \$1.7 million for fiscal years 2005 and 2006, respectively. These amounts include other tasks assigned to MTM such as determining eligibility for special transportation and specifically authorizing access transportation trips over 30 miles.

¹⁴ Department of Human Services, *Contract #436466*, various payment charts attached to the contract and subsequent amendments.

¹⁵ Anoka County, *Contract #09-2142*; and Hennepin County, *Contract #A100838*.

Using a broker in the Twin Cities area has saved money because MA recipients have used less costly forms of transportation.

responsible for determining eligibility.¹⁶ The following year, the department hired MTM to make special transportation eligibility determinations on a statewide basis. Subsequently, there was a shift in trips from special transportation to less costly access transportation. As we discussed in Chapter 1, the number of special transportation trips was cut in half between fiscal years 2003 and 2006, going from about 855,000 to 417,000. During the same time period, we estimate that the number of access transportation trips increased by about 400,000 in the Twin Cities area, and spending data suggest that trips in outstate Minnesota also increased.¹⁷

The shift in trips from special to access transportation appears to partially explain the reduction in average cost per trip in the Twin Cities area over the last decade that we described in Chapter 1. For example, in 2007, allowable payments to providers for special transportation trips in the Twin Cities area would have been \$6.50 less per trip using access transportation rather than special transportation. Even considering the additional administrative fee for access transportation (currently \$5.54 per trip), switching rides to access transportation saved money. If all of the reduction in special transportation trips (about 438,000) were shifted to access transportation, we estimate that the shift is saving about \$400,000 per year.¹⁸

Second, using a broker to schedule special transportation trips reduced costs because MTM specified, in advance, the number of miles that providers would be reimbursed per trip. When MTM brokered special transportation in the Twin Cities area (October 2006 through January 2008), it used computerized mapping to determine trip distance rather than special transportation provider logs, which were used before and after the brokering period. From October 2006 through January 2008, special transportation trips averaged 8.2 miles per trip, compared with 9.8 miles the year before and 9.4 miles the year after this period. At a cost of \$1.30 to \$1.35 per mile for the most common types of special transportation, controlling mileage appears to have saved between \$1.50 and \$2.20 per trip. We estimate that this mileage reduction saved between \$400,000 and \$600,000 per year.

Third, brokering helped decrease costs by arranging less costly types of appropriate transportation.¹⁹ MTM has reduced access transportation costs over

¹⁶ *Laws of Minnesota* First Special Session 2003, chapter 14, art. 12, sec. 36.

¹⁷ Although we do not have trip data for outstate counties, their access transportation spending increased from \$4.7 million to \$8.6 million between fiscal years 2003 and 2006.

¹⁸ We based this estimate on detailed special transportation trip data for 2007 for the Twin Cities area, where about 356,000 of the total reduction in special transportation trips occurred. Lacking detailed trip data for outstate Minnesota, we assumed that savings per trip in outstate Minnesota were the same as in the Twin Cities area. Our estimate includes the reduced payments made to providers under access transportation as well as administrative fees (currently \$5.54 per trip) for conducting the additional access transportation trips. We further assumed that the reduction in administrative costs for DHS to process special transportation payments offset the additional administrative cost to conduct special transportation eligibility determinations, which has averaged about \$113,000 per year over the past six years.

¹⁹ Again, data limitations hampered our ability to fully address this issue. For example, data on the type of access trips provided are not available prior to fiscal year 2005—the year MTM began brokering access transportation in the Twin Cities area.

time by increasing the proportion of taxi-style, curb-to-curb trips provided and decreasing the more expensive door-to-door trips. As we showed in Chapter 1, the percentage of wheelchair trips that provided curb-to-curb service increased from 18 to 74 percent between fiscal years 2005 and 2010. The corresponding increase for ambulatory trips was from 88 to 95 percent. Curb-to-curb service costs \$2 less per trip than door-to-door service for ambulatory trips and \$3 less for wheelchair trips. We estimate that the increased use of curb-to-curb trips saved about \$140,000 to \$200,000 in fiscal year 2010.

Taxi-style trips increased at a faster rate than other types of access transportation in the Twin Cities area. Between fiscal years 2005 (MTM's first year of brokering access transportation) and 2010, the number of access transportation trips climbed from about 424,000 to 853,000. Most of this growth was handled by using taxi-style vehicles rather than public transit or mileage reimbursement. During this time period, the number of taxi-style trips increased by 356,000, or 84 percent of the total growth. One likely reason for the increased use of taxi-style vehicles was likely to accommodate the shift from special transportation, which generally served a population that required a higher level of service.

In terms of administrative costs, we compared the compensation MTM received for brokering access transportation in the Twin Cities area before and after the Twin Cities area counties took responsibility for access transportation. We found that:

- **Counties in the Twin Cities area paid the broker less in administrative fees for fiscal year 2010 than the Department of Human Services had the previous fiscal year.**

The Twin Cities area counties paid MTM \$4.4 million in fiscal year 2010, or about \$5.70 per trip; they are paying MTM \$5.54 per trip for fiscal year 2011. In comparison, in fiscal year 2009, DHS paid MTM a flat fee of \$22.14 per trip to cover both MTM's payments to providers and its own administrative costs. After subtracting MTM's payments to providers, we estimate that MTM's administrative compensation was about \$6.7 million, or \$8.30 per trip.

MTM's high compensation rate for fiscal year 2009 is partly due to certain actions that DHS took when MTM started and stopped brokering special transportation. When the company began brokering special transportation in October 2006, DHS raised the flat fee it paid MTM per completed trip from \$18.06 to \$21.24, about \$3 per trip.²⁰ The increase was meant to compensate MTM for the higher rates paid to special transportation providers. However, when MTM stopped brokering special transportation in February 2008, DHS lowered the fee from \$21.24 to \$20.31, only about \$1 per trip. In addition, DHS increased the rate paid to MTM by 9.1 percent for trips occurring after June 30, 2008, to account for cost-of-living changes.²¹ These increases were made even though the payment rates for providers increased only slightly during this time period. Together, we estimate that these changes increased MTM's

After Twin Cities area counties took over contracting with the broker, they paid the broker about \$2 million less in administrative fees than DHS had the previous year.

²⁰ Department of Human Services, *Contract #436466*, Amendment 3.

²¹ *Ibid.* We discuss these changes in greater detail later in this chapter.

administrative compensation from about \$5.00 to \$8.30 per trip, an increase of 66 percent.

Other Effects

As noted earlier, research suggests that brokering may have other benefits that affect costs, including greater control over fraud and abuse, competitive bidding, and trip coordination.²² Regarding fraud and abuse, DHS's contract with MTM required the broker to implement procedures to guard against fraudulent activity on the part of transportation providers and recipients.²³ For example, MTM had to develop a quality control program for providers that included on-site monitoring and collecting certain performance-related data.²⁴ The department hoped to use this information to ultimately contract with fewer, high-quality providers. To help ensure that MA recipients had access to services, DHS invited all eligible transportation providers to contract with MTM when the department began using a broker in 2004.

The broker has also helped in monitoring the quality of transportation services and controlling for fraud and abuse.

Although we did not specifically examine MTM's activities in this area, we noted that the broker has randomly reviewed a small percentage of transportation providers' trip logs each month to check compliance with documentation and driver requirements. MTM staff have also randomly observed providers as they pick up and drop off MA recipients at their destinations and have watched recipients go into their medical appointments. Over the last several years, MTM has forwarded a few cases of possible fraud or abuse to DHS's Surveillance and Integrity Review Section for further investigation.²⁵ Also, as we discuss later in this chapter, MTM has used its consumer complaint system to help improve services for recipients.²⁶

On the other hand, we found that:

- **Minnesota has not used two other ways to reduce costs—obtaining competitive bids from transportation providers and coordinating trips among riders.**

One of MTM's responsibilities (under both its contract with the Twin Cities area counties and its previous contracts with DHS) is to develop a network of access transportation providers. The department's contract gave MTM the authority to negotiate individual reimbursement rates with providers to help ensure that the

²² For example, see U.S. Department of Health and Human Services, *Controlling Medicaid Non-Emergency Transportation Costs* (Washington, DC, April 1997).

²³ Department of Human Services, *Contract #436466*, II. E, I, J.

²⁴ *Ibid.*

²⁵ Surveillance and Integrity Review Section (SIRS) is DHS's post-payment review function for all Medicaid programs paid through the department's Medicaid management information system.

²⁶ In addition, some of the broker's up-front activities that we discussed previously are designed to help prevent fraud and abuse, for example, by acting as a transportation gatekeeper and specifying trip length in advance when scheduling rides with transportation providers.

least costly and most appropriate transportation services were provided.²⁷ However, MTM never utilized this strategy, opting instead to reimburse providers at the maximum rates allowed.²⁸ Further, the department never directed MTM to use this tool to help control costs.

According to the research literature, using a broker should make it easier to coordinate transportation trips—both among MA recipients (such as scheduling two or more MA recipients on a single trip) and between transportation programs for MA recipients and other transportation programs (such as Metro Mobility or a county-operated transportation program for senior citizens or veterans).²⁹ Furthermore, MTM’s contracts have traditionally contained language encouraging the broker to work with other agencies.

In practice, however, few MA trips are coordinated—either among MA recipients or across programs. A major obstacle is that Minnesota gives MA recipients the ability to choose which transportation provider to use. When recipients have a preference for one provider over another, MTM must honor that request, if possible. According to MTM staff, 50 to 75 percent of MA recipients state a preference for a particular service provider. Thus, MTM’s ability to save money for the state by using the same provider to deliver multiple riders to one clinic at a time (providers receive a flat rate for the first passenger and lesser amounts for additional riders) is limited.³⁰ MTM noted that the transportation providers it uses may serve clients from other programs and providers may be able to coordinate rides and riders. However, this does not affect the reimbursement rates that DHS pays them.

Furthermore, we found that:

- **Medicaid requirements make it difficult for the broker to use paratransit systems such as Metro Mobility to transport Medical Assistance recipients to health-related appointments.**

It costs the state more to use Metro Mobility to transport MA recipients than it does to use medical nonemergency transportation providers.

The Americans with Disabilities Act (ADA) requires transit systems that receive federal funds to operate paratransit services.³¹ Paratransit consists of services complementary to fixed route transit (for example, Metro Mobility) for individuals with physical or cognitive impairments that prevent them from safely using fixed route transit either some or all of the time. In 2009, paratransit accounted for less than 2 percent of access transportation trips in the Twin Cities area; paratransit represented about 3 percent of access transportation spending in outstate Minnesota.

²⁷ Department of Human Services, *Contract #438466*, II. A3(m). Also, see Hennepin County, *Contract #A100838*, Exhibit A3.2.6.

²⁸ As we discuss later in this chapter, MTM actually negotiated a reimbursement rate for wheelchair door-to-door service that was beyond the maximum set by DHS.

²⁹ For example, see Legislative Research Commission, *Human Service Transportation Delivery*.

³⁰ According to MTM, Minnesota is considerably more liberal than most other states in terms of recipient choice.

³¹ 42 U.S.C. §§12131-12165 (2010).

Medical Assistance recipients in the Twin Cities area are generally not referred to paratransit partly because Metro Mobility, as with paratransit nationwide, is heavily subsidized by the state. Metro Mobility trips cost, on average, about \$25.50 per passenger in 2008, but riders, including MA recipients, pay only \$2.50-\$3.50 each.³² Consequently, state and federal government subsidies were about \$22.30 per passenger in 2008.³³ In comparison, costs per trip for taxi-style vehicles in the Twin Cities area ranged from \$20.31 to \$22.14 in 2008, with the federal government picking up about half the cost. Medicaid regulations do not allow states to use Medicaid funds to reimburse individual transportation providers transporting Medicaid recipients at a higher rate than the general public or human service agencies would pay for such services.³⁴ In addition, Metro Mobility officials told us that Metro Mobility is kept busy meeting the demands for ADA service.

No Shows

Some transportation providers have questioned whether the broker has requested and received reimbursement for “no shows.” No shows are trips that were scheduled but never completed because MA recipients were not at designated pick-up sites when transportation providers arrived.

One reason for transportation providers’ concern is a 2007 investigation by the Department of Human Services’ Surveillance and Integrity Review Section (SIRS) that found MTM improperly received nearly \$84,000 in payments for trips that were not completed.³⁵ The department examined payments made during the first two years of its contract with MTM (July 2004-June 2006). According to DHS and MTM staff, the problem was essentially one of timing that has since been addressed. MTM returned the \$84,000 and revised its management information system so it could identify and return reimbursements made by DHS for uncompleted trips, which it has periodically done over the last few years.

Contrary to claims from some transportation providers, DHS did not pay the broker when MA recipients did not show up for scheduled trips.

To investigate the no-show issue more closely, we requested data on all trips scheduled for a one-week period in March 2010 from the ten largest transportation providers, which accounted for about two-thirds of all access trips in the Twin Cities area. Specifically, we asked providers to tell us, for each trip scheduled, whether the trip was completed, cancelled, or a no show.³⁶ Three providers did not track no shows or were unable to provide data; the seven remaining providers reported a total of 196 no shows during this time period.

³² Metropolitan Council, *Twin Cities Transit System 2009 Performance Evaluation* (St. Paul, March 2010), 43.

³³ *Ibid.* State government pays for most of Metro Mobility’s per passenger subsidy.

³⁴ 42 CFR 440.170(a)(4)(ii)(B)(4)(iii) (2010).

³⁵ Minnesota Department of Human Services, “Notice of Agency Action-Medical Transportation Management PID #854649500,” June 12, 2007. These particular uncompleted trips were cancelled trips, which, along with no shows, are not eligible for reimbursement.

³⁶ We also asked for trip identification numbers so that we could match trips with data from DHS’s and MTM’s databases.

We examined DHS's payment records for each of the recipients who did not show up for their scheduled ride and found that:

- **There was no evidence that MTM improperly collected payments for no-show trips.**

The department's trip-by-trip payment records show that DHS did not make any payments for the nearly 200 no-show trips reported by the seven large transportation providers for a week in March 2010.

Some transportation providers were also concerned that MTM data understate the no-show problem. Transportation providers find no shows particularly irksome because the federal government does not allow states to use Medicaid funds to pay providers for miles driven when no passengers are in their vehicles. Providers waste time and money when MA recipients fail to show for scheduled trips. Although MTM has reported overall no-show rates ranging from 1 to 3 percent over the last several years, some transportation providers claimed that rates are substantially higher.³⁷ We found that:

- **Transportation provider data indicate no-show rates averaging about 4 percent, which is higher than the rate reported by MTM, but lower than interest group claims.**

The no-show rates reported by the seven providers ranged from 1 to 9 percent. Although these rates are higher than those shown by MTM, they are not as high as the 30 percent no-show rates sometimes cited by interest groups.

As part of its contract, DHS required MTM to develop a no-show policy to limit or deal with no shows (this provision is also in MTM's contract with the Twin Cities area counties).³⁸ To counteract no shows under DHS's contract, MTM encouraged transportation providers to call recipients to confirm trips beforehand. Although MTM was required to inform callers who had two or more no shows that a third no show could result in future denials for taxi-style vehicles, it has rarely done so. MTM and the eight Twin Cities area counties are currently exploring alternative options concerning no shows.

STATE OVERSIGHT

Although MA recipients receiving transportation assistance do not obtain those services directly from DHS, the department is ultimately responsible for ensuring that eligible recipients receive appropriate, cost-effective services.³⁹ To this end, we found that:

³⁷ Medical Transportation Management, *Monthly Reports* (St. Louis, MO).

³⁸ Department of Human Services, *Contract #436466*, II. N2(o); and Hennepin County, *Contract #A100838*, 3.2.10.

³⁹ Minnesota Department of Human Services, *Title XIX State Plan, 3.1(c)(1) Assurance of Transportation* (St. Paul, undated).

- **The Department of Human Services provides little oversight of medical nonemergency transportation services statewide.**

To some extent, the program’s administrative structure makes consistent oversight of medical nonemergency transportation difficult. As noted earlier, the state has set up two separate transportation categories (access and special), and each category is administered differently. Furthermore, DHS’s data collection efforts vary—both across and within the two categories. For example, the department collects more detailed information on access transportation from the 8 Twin Cities area counties than from the 79 outstate counties.⁴⁰ Also, DHS does very little systematic checking to make sure that the data submitted from any county are accurate or even reasonable. The department requires special transportation providers to submit more detailed data about the rides they provide—more data than it requires from counties regarding their access transportation programs.

Data collection and staffing issues at DHS have hindered effective oversight of the nonemergency transportation program.

Limited staff resources at the department have also made oversight difficult. For the last several years, DHS has employed only one full-time staff person (plus a part-time supervisor) to monitor transportation statewide. The staff person currently overseeing the program has been employed in that capacity approximately three years; the staff person previously in that position is no longer with the department. Hence, there is limited historical knowledge or documentation about program operations prior to 2008.⁴¹

Access Transportation

As noted previously, from July 2004 through June 2009, DHS contracted with a broker (MTM) to provide access transportation in the 11 county Twin Cities area. In the remaining 76 counties, the counties themselves were responsible for administering the services as they saw fit. Overall, we found DHS’s oversight of access transportation—regardless of how it was provided—lacking.

Twin Cities Area Counties

To assess how well DHS oversaw access transportation when it contracted with a broker, we examined the department’s contractual arrangements with MTM. As noted earlier, the federal government requires that states using brokers have specific operational standards related to vehicle safety, staff competency, timeliness, access, licensing, and grievances.⁴² Because it is important that Medicaid recipients arrive at medical appointments in a timely manner, the federal government also requires DHS to regularly audit the timeliness of transportation provided through the broker. Overall, we found that:

⁴⁰ The department does not require the Twin Cities area counties to submit more detailed data; they simply do because the department’s former contract with MTM—and the counties current contract—require MTM to collect more detailed data.

⁴¹ Several states with brokers, including Kansas, Kentucky, South Carolina, and Virginia, employ two to seven staff to monitor their brokers, and these states generally provide fewer transportation trips each year than does Minnesota. See The Lewin Group, *MO HealthNet NEMT Review*.

⁴² 42 CFR 440.170(a)(4) (2010).

- **The Department of Human Services’ most recent contract with its broker set forth numerous oversight mechanisms, including performance standards.**

For example, MTM had to submit various weekly, monthly, quarterly, and yearly reports related to local operations and annual reports regarding company finances. The department’s contract allowed the department to reduce its payments to MTM for unsatisfactory performance regarding timely report submission, staffing levels, and performance goals for call center telephone abandonment rates, caller time spent on hold, customer satisfaction, and complaint rates.⁴³ It also laid out measurable performance objectives for MTM, including a requirement that transportation providers arrive to pick up recipients within 15 minutes of their scheduled arrival times.⁴⁴ For the most part, the department relied on MTM to monitor recipients and transportation providers and report results back to the department.

Despite the presence of these monitoring tools, we found that:

- **The Department of Human Services did not implement a formal quality assurance program to monitor its broker.**

For the most part, department oversight of MTM consisted largely of informal communication and frequent meetings with MTM staff to discuss areas of mutual concern. The department did not consistently enforce contract reporting requirements that would have enabled policy makers to better track performance. For example, the department’s contract required MTM to submit annual transportation reports beginning in fiscal year 2006, but when we asked DHS for copies of those reports, it could only locate the 2008 final report.⁴⁵ The department provided a draft report for 2007 and the report that DHS said was for 2006 was written by the department, not MTM, in March 2005—more than a year prior to its due date.⁴⁶ MTM did not complete a report for 2009, nor did DHS ask for one.

Other elements of the contract were likewise unenforced. As we discussed earlier, MTM determines whether MA recipients are eligible for special transportation and certifies their eligibility for a specific length of time. According to contract language, MTM is to make special transportation certifications that “generally parallel the time frames given for Social Security Insurance Disability redeterminations.”⁴⁷ The contract also requires MTM to submit data monthly to DHS on the number and disposition of special

Department oversight of its broker has been largely informal.

⁴³ Department of Human Services, *Contract #436466*, IV. The “call center” is MTM’s main telephone number that MA recipients call to schedule rides. Abandonment rates measure the extent to which callers hang up due to busy signals or being placed on hold.

⁴⁴ *Ibid.*, II. E1.

⁴⁵ *Ibid.*, II. K1(d).

⁴⁶ *Ibid.* The department’s contract with MTM required it to submit a draft annual report within 60 days after the end of each fiscal year, with a final report due within 30 days following receipt of the department’s comments.

⁴⁷ *Ibid.*, II. H13(b).

transportation assessments performed. However, despite concerns expressed by legislators and others about the frequency with which recipients were being reassessed, DHS did not enforce contract requirements regarding eligibility time frames. Likewise, DHS did not require MTM to report all required data regarding eligibility decisions, including the number of approvals and denials by the level of special transportation (ambulatory, wheelchair, or stretcher) requested.

Similarly, although MTM was responsible for monitoring transportation provider pick-up, delivery, and waiting times from July 2006 through July 2009, and DHS wrote related performance measures into its contract with MTM, DHS never required the broker to develop and implement a reliable system to collect such information, nor did the department regularly audit the timeliness of transportation provided. Finally, DHS did not periodically verify a sample of MTM's documentation to ensure that MA recipients were receiving appropriate services or that data submitted were accurate or reasonable.⁴⁸

We noted earlier that DHS's contract with MTM allowed the department to reduce its payments to MTM if the company did not meet certain performance goals. However, DHS never exercised this option despite MTM's failure to submit annual reports in a timely fashion. Similarly, monthly reports that MTM submitted to DHS show that the broker consistently had problems meeting its performance goal related to call center abandonment rates, but the department never reduced its payments or set a more appropriate call abandonment goal.

Although we focused our review of DHS's oversight in relation to its second contract (July 2006 through August 2011) with MTM, the department failed to enforce one key provision in its first contract. We found that:

- **In fiscal year 2006, the Department of Human Services paid its broker about \$1 million more than the amount agreed to in the contract.**

The terms of DHS's initial contract with MTM called for the department to pay MTM a \$4.39 administrative fee for each access transportation trip completed. The contract capped the total amount that MTM could earn for fiscal years 2005 and 2006 at \$1.6 and \$1.7 million, respectively. According to contract language, administrative costs would be "monitored monthly by the STATE so as not to exceed the total compensation for administrative services in each state fiscal year."⁴⁹ However, DHS paid MTM \$1.7 million in fiscal year 2005 and \$2.7 million in fiscal year 2006. Department officials told us that MTM had to add staff to meet the unanticipated increase in the demand for services, and the department agreed to pay more than the amount shown in their contract. The department, however, never amended its contract with MTM. The following

⁴⁸ Many states that use brokers monitor them by auditing the broker's records, including data related to prior authorization for services, proof of medical necessity, appropriate routes taken, and verification of recipients' medical appointments. See U.S. Department of Health and Human Services, *Memorandum Report: Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services* (Washington, DC, May 2009), 6-7.

⁴⁹ Department of Human Services, *Contract #432723*, II. A1.

The department failed to enforce key provisions of its contract with the broker.

fiscal year DHS removed the payment caps from the contract and began paying its broker a flat amount per completed trip, combining MTM's administrative costs with transportation providers' reimbursements. Department staff told us that they did so partly because some people made negative comments about paying MTM over \$4 a completed ride for its administrative costs without fully understanding the time and work involved in doing so.

We also found that:

- **The Department of Human Services frequently amended its contract with the broker to increase payment rates, even though provider reimbursement rates remained fairly stable.**

Table 3.4 shows how the rates DHS paid to MTM have changed over time. Access transportation provider reimbursement rates have remained fairly stable, increasing only \$.05 for every mile traveled over the first five miles since July 2004. In contrast, DHS increased what it agreed to pay MTM for each completed access transportation trip 23 percent from fiscal years 2006 through 2009.⁵⁰

As we noted earlier in this chapter, DHS paid MTM substantially more in administrative fees for brokering access transportation than the Twin Cities area counties paid MTM for essentially the same services. Furthermore, we found that:

- **In fiscal year 2009, the Department of Human Services overpaid its broker by about \$1.5 million when the department gave the broker an inappropriate cost-of-living adjustment.**

There are three reasons why we think DHS paid MTM too much in fiscal year 2009. First, as noted earlier, when MTM began brokering special transportation in October 2006, DHS increased the flat fee it paid MTM about \$3 per trip.⁵¹ This was meant to offset the higher reimbursement rates paid to special transportation providers. However, when MTM stopped brokering special transportation in February 2008, DHS lowered the flat fee about \$1 per trip, thereby giving MTM a \$2 rate increase.

Second, DHS then increased MTM's new payment rate by 9.1 percent for trips occurring after June 30, 2008, to account for a cost-of-living change.⁵² This adjustment further increased MTM's compensation by \$1.83 per trip. We think it was unwise to build a cost-of-living adjustment into MTM's contract at a time when provider payments, MTM's principal expense, were controlled by DHS and changed little during this period. In fact, the average amount that MTM paid to providers per trip increased only 2 percent between fiscal years 2007 and 2009.

⁵⁰ Since July 2004, DHS has increased MTM's payment rate for determining eligibility for special transportation 277 percent. With the exception of stretcher rates (which have nearly doubled), base reimbursement rates paid to special transportation providers have declined from \$0.50 to \$1.00 since July 2004.

⁵¹ Department of Human Services, *Contract #436466*, Amendment 3.

⁵² *Ibid.*

Table 3.4: Department of Human Services' Payment Rates to MTM for Brokering Selected Transportation Services, Fiscal Years 2005-2010

Date	Payment Rate
July 2004	\$4.39 administrative fee per completed trip, up to a maximum of \$1.6 million. MTM reimbursed separately for transportation providers' costs. \$9.29 per Level I Level of Need Assessment \$31.00 per Level II Level of Need Assessment
July 2005	\$4.39 administrative fee per completed trip, up to a maximum of \$1.7 million. MTM reimbursed separately for transportation providers' costs. \$9.29 per Level I Level of Need Assessment \$31.00 per Level II Level of Need Assessment
July 2006	\$18.06 per completed trip, including transportation providers' costs, in seven-county area; \$19.30 in four-county area. \$25 per Level I Level of Need Assessment \$75 per Level II Level of Need Assessment
October 2006	\$21.09 per completed trip, including transportation providers' costs, in seven-county area; \$25.51 in four-county area \$25 per Level I Level of Need Assessment \$75 per Level II Level of Need Assessment
July 2007	\$21.24 per completed trip, including transportation providers' costs, in seven-county area; \$25.66 in four-county area
February 2008	\$20.31 per completed trip, including transportation providers' costs, in 11-county area \$25 per Level I Level of Need Assessment \$75 per Level II Level of Need Assessment
July 2008	\$22.14 per completed trip, including transportation providers' costs in the 11-county area
July 2009	\$35 per Level I Level of Need Assessment \$75 per Level II Level of Need Assessment

NOTES: Except for the period from October 2006 to February 2008, completed trips refer to access transportation trips only. From October 2006 to February 2008, completed trips include both access and special transportation trips. The seven-county area covers Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. The four-county area covers Chisago, Isanti, Sherburne, and Wright counties.

SOURCES: Office of the Legislative Auditor, analysis of contracts and Department of Human Services and Medical Transportation Management data.

Third, DHS's decision to base the cost-of-living adjustment on the transportation component of the Consumer Price Index was inappropriate. The transportation component is a volatile measure because it is heavily influenced by the cost of fuel, especially for the time period on which DHS based its adjustment. The department's rate adjustment to MTM did not extend to transportation providers who are actually responsible for transporting recipients and are, thus, more affected by fuel prices. In carrying out its administrative responsibilities, MTM incurs few if any costs attributable to actually driving MA recipients to and from medical appointments. We estimate that the cost-of living adjustment increased MTM's administrative compensation by \$1.5 million.

Finally, weak oversight by DHS allowed the broker—and ultimately the department—to pay some transportation providers at a slightly higher rate than permitted by department policy. As noted earlier, DHS sets the maximum reimbursement rates paid for taxi-style vehicles, and most counties pay these providers the maximum allowed. However, we found that:

- **Through the broker, the Department of Human Services has reimbursed some taxi-style providers at a slightly higher rate than its reimbursement policy allows.**

In its January 2010 bulletin to counties, the department indicated that the maximum rate counties could pay access transportation providers for wheelchair door-to-door service was \$15 for the first five miles plus \$1.45 per mile thereafter—rates that had not changed for several years.⁵³ However, MTM negotiated a slightly higher base rate for trips in the Twin Cities area—\$16 rather than \$15.⁵⁴ According to department staff, MTM was concerned that it would have problems finding transportation providers willing to transport recipients in wheelchairs for a base rate of \$15. However, MTM did so without seeking approval from DHS. Because DHS does not routinely examine a sample of claims submitted from the broker or counties, the department was unaware that MTM was billing for the higher amount.

The department was unaware that the broker was reimbursing some transportation providers at a higher rate than DHS’s policy allows.

We find the need to increase reimbursement rates for Twin Cities area providers somewhat perplexing given the problems many outstate counties have finding providers willing to provide access transportation to their MA recipients. Furthermore, the Legislature has traditionally recognized problems involved in providing services in outstate counties where recipients generally have to travel long distances to receive services. For example, since 2009, the Legislature has specified slightly higher rates for special transportation providers serving MA recipients in “rural” and “super-rural” counties than providers serving other, less rural counties.⁵⁵

Finally, we noted that DHS made mistakes in drafting contract language. For example, when the department amended its contract with MTM in February 2009, it neglected to specify MTM’s payment rate for brokering access transportation.⁵⁶ The department made a somewhat similar mistake a few months later when it failed to incorporate the payment rates it had intended to pay MTM for special transportation eligibility assessments. Department staff told us that they had meant to pay \$30 per assessment rather than the \$35 specified in contract amendments.⁵⁷

⁵³ Minnesota Department of Human Services, *Access Transportation Services (ATS) Information*, Bulletin #10-21-02 (St. Paul, January 13, 2010), 6.

⁵⁴ Medical Transportation Management, Inc., *Minnesota Schedule A to Medical Transportation Services Agreement*, July 1, 2009.

⁵⁵ *Laws of Minnesota* 2009, chapter 79, art. 5, sec. 32.

⁵⁶ Department of Human Services, *Contract #436466*, Amendments 3-5.

⁵⁷ *Ibid.*, Amendments 6-7. As we discuss later in this chapter, MTM was not aware that the rate had increased to \$35 and was only billing DHS \$30 per assessment.

Overall, we found several problems with DHS's oversight of its broker, but we have not made any recommendations specifically related to the department's former contracts with MTM for access transportation. As we noted earlier, the Legislature prohibited DHS from using a broker for access transportation, and DHS severed its contractual arrangements with MTM regarding access transportation.

Outstate Counties

We also looked at DHS's oversight of counties' access transportation programs and found that:

- **The Department of Human Services has exercised little oversight of access transportation provided through counties.**

The department requires counties to file annual plans that outline how they will provide access transportation. The plans are written on department templates and many provide little insight into how services are provided or how counties monitor services. The department did not require counties to file an updated plan for 2010. According to staff, DHS allowed counties to simply extend their previous plans instead of submitting new ones pending the outcome of a federal audit that may result in counties having to change how they file for reimbursement.⁵⁸

Furthermore:

- **The Department of Human Services collects almost no statewide data on access transportation participation, and data collected independently by outstate counties are sketchy at best.**

The department only requires counties to submit total spending by types of transportation to receive reimbursement. Consequently, DHS cannot accurately determine the number of individuals receiving access transportation in outstate Minnesota, the number of trips provided, or average costs per trip. Furthermore, the department does not routinely check the accuracy or reasonableness of the cost data that counties do submit. Department staff told us that they have no idea whether counties are adhering to DHS's policy regarding maximum reimbursement rates for transportation providers.

We asked county human services directors how they have monitored their access transportation programs. We found that county activities vary widely. Most outstate directors told us that they monitor informally, for example, through complaints and routine meetings with their providers. Few outstate counties tabulate data related to total participants, trips, and costs.

⁵⁸ The federal government does a comprehensive check once every three years to determine whether DHS is paying Medicaid claims, including transportation services, properly. Results from the latest Payment Error Rate Measurement audit, commonly referred to as PERM, were due late 2010. In conducting the review, federal auditors expressed concern over counties sending in large "group" reimbursement claims rather than individual claims for transportation reimbursement.

Due partly to lax oversight, until January 2010, DHS failed to enforce federal requirements that prohibit states from using Medicaid funds to pay for no-load miles.⁵⁹ No-load miles refer to the miles transportation providers must travel with their vehicles empty to arrive at or return from pick-up or drop-off sites. In our survey of county human services directors, 56 of the 73 outstate respondents reported being reimbursed by DHS before January 2010 for compensating volunteer drivers for no-load miles.

At the same time, we found that:

- **Failing to reimburse transportation providers for no-load miles creates a substantial burden for outstate counties.**

Transportation providers serving Minnesota's more rural areas often must drive substantial distances without recipients in their vehicle to arrive at pick-up sites or return from drop-off sites. In our survey of human services directors, 67 percent of outstate respondents strongly agreed that "the lack of state reimbursement for 'no-load' miles (when a public assistance recipient is not in the vehicle) causes problems in our county." An additional 10 percent agreed with the statement. Seventy percent of outstate directors reported difficulty in finding either for-profit or volunteer providers to transport MA recipients to medical facilities. When we asked generally what changes should be made to improve access transportation services, over half of the respondents cited the lack of reimbursement for no-load miles.

The federal government only allows states to use federal Medicaid funds to pay providers for miles traveled when a recipient is in the vehicle.⁶⁰ This restriction applies to both for-profit transportation companies and volunteer drivers. As a result, states must use different payment approaches to compensate providers in rural areas. For example, states can increase the amount paid per loaded mile to help offset the cost of no-load miles. States may also pay separately for no-load miles using non-Medicaid funds.

In Minnesota, neither of these approaches is used. Under current DHS policy, the department does not make additional funding available to help pay for no-load miles. According to DHS administrators, they have proposed increasing the per-mile amount paid to volunteers, but counties have balked because volunteers would then earn taxable income.

Until 2010, DHS did not enforce federal rules that prohibit using Medicaid funds to pay volunteers for certain types of mileage.

⁵⁹ Department of Human Services, *Access Transportation Services (ATS) Information*, 4.

⁶⁰ Verlon Johnson, Associate Regional Administrator, Center for Medicare & Medicaid Services, letter to Brian Osberg, State Medicaid Director, Minnesota Department of Human Services, May 28, 2010.

RECOMMENDATION

The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments.

The department's January 2010 reassertion of the prohibition on payments for no-load miles was received by many counties as an unexpected cost shift from the state to counties. Because DHS had not previously made any effort to deny reimbursements for no-load miles, many rural counties had used state and federal funds to compensate their volunteer drivers.

In rural areas, volunteers must often travel long distances to reach or return from rider pick-up and drop-off sites.

We agree with counties that it is unrealistic to ask volunteer drivers to pay out-of-pocket for long-distance travel. The department should allow counties to increase the compensation paid to volunteer drivers so that more of their actual expenses can be covered. One approach would be to increase the per-mile amount for loaded miles (this is the approach recommended by the federal Centers for Medicare and Medicaid Services).⁶¹ Another approach might be to treat volunteer drivers as independent contractors instead of volunteers. MTM staff told us that they have done this in other states where the company brokers transportation services.

It is not clear why counties would object to DHS's proposal to increase mileage rates for volunteers. While it is possible that this strategy could discourage volunteers by increasing the complexity of their tax returns, simply eliminating payments for no-load miles has already been shown to discourage volunteers. The department could perhaps develop information handouts or publish information on its Web site to explain how volunteers should report reimbursement income on their tax returns.

Special Transportation

As we discussed in Chapters 1 and 2, counties are not involved in providing or overseeing special transportation—MTM determines eligibility at recipients' (or their representatives') request, recipients schedule their own rides, and transportation providers file reimbursement claims with DHS. From October 2006 through January 2008, the department contracted with MTM to broker special transportation in the 11-county Twin Cities area. As part of its contract, MTM monitored recipients and transportation providers in the same manner that it monitored access transportation. When the Legislature prohibited DHS from brokering special transportation in 2008, MTM's direct oversight responsibilities ceased. Since that time, we found that:

- **The Department of Human Services has not routinely monitored special transportation, although it has recently conducted several special investigations.**

⁶¹*Ibid.*

For the most part, DHS has relied on its Surveillance and Integrity Review Section (SIRS) or MTM to periodically monitor individual special transportation providers, as the need arises. In the last two years, however, department staff have examined specific issues within special transportation more closely. For example, DHS has contracted with MTM to help it determine whether reimbursement claims for special transportation were reasonable in terms of the miles driven and whether transportation providers were obtaining written documentation from health care providers as required by law.⁶² The department reviewed reimbursement claims for nearly 18,200 trips provided between February and July 2008.⁶³ It found that most reimbursement claims were for trips of a reasonable length. About 71 percent of the claims submitted were for trips less than or within one or two miles of what DHS determined to be the proper mileage. However, 16 percent of trips were three or more miles above DHS's determination of proper mileage; an additional 13 percent did not contain enough information (which providers are required to keep) about the trip for the department to verify mileage. Lack of required signatures was a greater problem. Transportation providers either failed to obtain any signature from the health care provider or the signature was inadequate for about half of the trips.

The department also recently contracted with MTM to help it examine whether special transportation providers were complying with state law that allows MA recipients living in nursing homes to automatically qualify for special transportation.⁶⁴ Because there is sometimes a time lag in updating recipients' files regarding place of residence, DHS had allowed special transportation providers to transport some recipients even though the department's management information system did not show them as residing in a nursing home. The department analyzed thousands of trips made between October 2008 and July 2010. After finding more than \$500,000 in provider payments for transporting MA recipients who were not living in nursing homes or eligible for special transportation, DHS retracted its practice that allowed providers to bypass certain controls built into the reimbursement system in Fall 2010. The department began collecting payments from some providers who were improperly reimbursed, and staff are pursuing payments from others.

The department recently found it had made more than \$500,000 in improper payments to some special transportation providers.

On the other hand, despite poor monitoring by DHS, we found that:

- **There is no evidence that the broker has acted contrary to Department of Human Services' directions in carrying out the company's special transportation responsibilities.**

In fact, we found instances where MTM failed to charge DHS the full amount they were allowed. For example, when DHS and MTM amended their contract in mid-2009, the reimbursement rate for special transportation eligibility

⁶² Department of Human Services, *Contract #436466*, Amendments 5-7. When transporting Medicaid recipients to health-related services, statutes require special transportation providers to obtain written documentation from health care providers indicating the time recipients arrived for their appointments. See *Minnesota Statutes* 2010, 256B.0625, subd. 16(3)(b).

⁶³ Transportation providers submitted sufficient documentation for the department to review 86 percent of the claims filed.

⁶⁴ Department of Human Services, *Contract #436466*, Amendments 5-7.

Effective monitoring and evaluation are impossible without accurate data.

determinations increased from \$25 to \$35 per assessment.⁶⁵ However, MTM only billed DHS \$30 per assessment. Also, as noted in Chapter 2, although MTM can perform Level II eligibility determinations and bill DHS \$75 for each, it has instead set up an internal reconsideration process for which it does not charge the department.

Data Problems

Given state and county budget problems, we think that policy makers need better information about the cost-effectiveness of transportation assistance statewide. Our evaluation was hampered by an overall lack of consistent, comparable, and reasonable data collected from counties and service providers across the state, which made it impossible to compare the cost-effectiveness of the various administrative structures in place. Improved data would give legislators and county officials better knowledge about how MA recipients are being served and would enable counties to measure their effectiveness and efficiency in relation to other counties.

RECOMMENDATION

The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data.

We think that DHS should routinely collect information such as the number of unique participants, trips by type of transportation, and costs per trip on a statewide basis, regardless of how programs are administered. In addition, DHS should ensure that its broker routinely submits more complete data on the number and type of special transportation eligibility determinations that it makes, including the number approved and disapproved by type of transportation requested. Furthermore, the department should periodically audit or check the accuracy and reasonableness of data submitted by counties as well as its broker. Routinely sampling a number of reimbursement requests would also help prevent costly mistakes on the department's part. As we noted earlier, there have been periods of time where the department was reimbursing certain transportation providers more than what the department thought it was paying them.

CUSTOMER SATISFACTION

Measuring customer satisfaction with transportation services can provide useful information to policy makers, government regulators, brokers, and transportation providers. This section looks at two separate measures of customer satisfaction, including complaints and customer satisfaction surveys.

⁶⁵ *Ibid.*, Amendment 6.

Complaints

Earlier in this chapter, we noted that the federal government requires states using brokers to have oversight procedures in place to monitor Medicaid recipient access and complaints. MTM’s previous contract with DHS and its current contract with the eight Twin Cities area counties require that MTM establish a complaint process regarding access transportation, which it has done.⁶⁶ We examined complaints filed with MTM over the last several years and found that:

- **Judging by the number and type of complaints filed, Medical Assistance recipients eligible for access transportation in the Twin Cities area are fairly satisfied with services.**

Table 3.5 shows the number of complaints that MTM has received over time compared with the number of trips scheduled. As shown, MTM has received, on average, less than 1 complaint for every 100 trips scheduled over the last several years. Furthermore, the percentage of trips with complaints has declined since July 2007.

Over the last several years, the broker has received less than 1 complaint for every 100 trips scheduled in the Twin Cities area.

Table 3.5: Scheduled Trips with Complaints, Twin Cities Area, Fiscal Years 2008-2010

	Number of Complaints	Number of Trips Requested	Percentage of Trips with Complaints
July 2007-December 2007	747	640,785	.12%
January 2008-June 2008	633	555,674	.11
July 2008-December 2008	406	521,424	.08
January 2009-June 2009	404	550,221	.07
July 2009-December 2009	444	560,682	.08
January 2010-July 2010	412	557,939	.07

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Comparable data are not available prior to July 2007.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Table 3.6 shows the subject matter of complaints over time. Recipients most frequently complained about timeliness, no shows, and unprofessional behavior on the part of transportation providers. Although MTM experienced an increase in the percentage of complaints involving its own operations in the first six months after the Twin Cities area counties assumed contract management in July 2009, its share of total complaints has since dropped to about 13 percent. In response to most complaints, MTM “reeducates” transportation providers by reminding them of their responsibilities, most often regarding pick-up

⁶⁶ A 2009 survey of state Medicaid agencies found that most states report using multiple techniques, including complaint investigations, to monitor the performance of their brokers. See Department of Health and Human Services, *Fraud and Abuse Safeguards*, 5-6.

requirements. MTM also uses its complaint system to routinely monitor individual transportation providers. Providers whose passengers are less satisfied may be subject to greater scrutiny by MTM and may be assigned fewer trips or dropped altogether.

Table 3.6: Percentage of Complaints by Subject Area, Twin Cities Area, Fiscal Years 2008-2010

Subject Area	7/2007- 12/2007	1/2008- 6/2008	7/2008- 12/2008	1/2009- 6/2009	7/2009- 12/2009	1/2010- 6/2010
Provider no-show	34%	32%	27%	28%	20%	25%
Provider timeliness	36	31	34	32	36	33
Quality of provider service	6	5	4	3	2	2
Driver behavior	13	18	18	23	23	27
MTM service	5	11	17	14	19	13
Miscellaneous	6	4	0	0	0	0

NOTES: The Twin Cities area covers from 8 to 11 counties, depending on the year. The counties include: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright. Comparable data are not available prior to July 2007. Columns may not total 100 due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Medical Transportation Management data.

Assessing customer satisfaction through complaints is much more difficult in outstate counties. We found that:

- **Outstate counties generally report receiving few complaints about their access transportation programs.**

The Department of Human Services does not require counties to establish complaint systems as part of their access transportation programs. In our survey of county human services directors, we asked directors about the average number of complaints they received from MA recipients as well as transportation providers. Most respondents were unsure about the number of complaints received or they reported fewer than ten complaints a year from either recipients or providers. Many directors reported receiving more complaints from transportation providers once DHS required counties to stop using Medicaid dollars to pay volunteers for no-load miles.

On the other hand, we found that:

- **Medical Assistance recipients who receive special transportation do not have access to a formal complaint system when they have service-related problems.**

It is not entirely clear where special transportation recipients should go if they have problems related to timeliness or driver assistance. There are a number of possible options, but none are clearly responsible for service-related problems: (1) MTM, which determines whether recipients are eligible for special transportation (and has an appeals process for eligibility), (2) DHS, which pays

It is unclear where MA recipients dissatisfied with special transportation services should complain.

transportation providers and is ultimately responsible for program oversight, (3) county financial aid workers who help people as they apply for public assistance, or (4) MnDOT, which is responsible for certifying special transportation providers.⁶⁷

RECOMMENDATION

The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation.

Complaints can be a useful tool for measuring the performance of special transportation providers. Currently, MA recipients experiencing problems regarding late pick-ups, no shows, or driver assistance can change service providers, but transportation options are limited in some parts of the state. Because MnDOT already has a complaint system in place for issues related to certification, DHS could forward certification-related issues to MnDOT. Likewise, when MnDOT receives a complaint from an MA recipient that is outside its purview, the department could forward that complaint to DHS. The Department of Human Services should also require that special transportation providers notify MA recipients of complaint procedures when they transport them. It should also require that its broker advise recipients of such procedures when it determines that MA recipients are eligible for special transportation.

User Surveys

Although a potentially important tool for monitoring the performance of MTM as well as service providers, we found that:

- **The Department of Human Services did not specifically require its broker to survey Medical Assistance recipients regarding their access transportation experiences.**

In DHS's fiscal year 2006-2009 contract with MTM, the only reference to a rider survey was in the performance standards section of the contract, which allowed DHS to deduct nine points if "customer satisfaction as measured by the monthly random survey" did not exceed 90 percent overall and 93 percent for call center

⁶⁷ While MnDOT has a complaint process in place, its authority is limited to driver, vehicle, or provider certification issues and does not extend to timeliness or driver assistance issues. *Minnesota Statutes* 2010, 174.30, subd. 9(b), requires that MnDOT prepare a biennial report for the Legislature on each complaint received and investigated. The first report showed the department receiving three complaints over a six-month period. See Minnesota Department of Transportation, *Report to the Legislature Regarding Special Transportation Service Complaints* (St. Paul, January 15, 2009).

operations.⁶⁸ The current contract MTM has with the Twin Cities area counties likewise does not specifically require MTM to conduct rider surveys (although Hennepin County staff told us they expect MTM to do so). Hennepin County officials told us that the county is planning to survey recipients about their experiences as part of its contract oversight responsibilities. Doing so will also allow the county to collect data specific to each of the participating counties; MTM's current survey procedures do not collect data concerning respondents' county of residence, level of service provided, type of transportation taken, or the transportation provider used.

Although not specifically required to do so, MTM has been surveying a sample of MA recipients who have received access transportation from taxi-style providers for the last several years. Medical Assistance recipients who use public transit or who drive themselves are excluded. Recipients are telephoned and asked to answer 12 brief questions about their transportation experience that cover areas such as the call intake process, driver and vehicle assessment, and timeliness.

We reviewed MTM's customer satisfaction surveys for access transportation and found that:

- **Methodological problems in the way the broker's customer satisfaction survey is conducted may bias results.**

Most notably, MTM excludes from its survey all MA recipients who receive transportation to psychiatrists, psychologists, counselors, social workers, and other mental health providers or to dialysis appointments. Such trips make up nearly one-third of the total taxi-style trips provided.⁶⁹ Because this is such a large portion of total trips and because transportation providers and MTM staff could potentially treat recipients with mental health concerns differently than individuals with physical health concerns, omitting these groups could significantly bias survey results.

MTM staff suggested that DHS had instructed them to exclude these populations several years ago, but they were unable to provide any documentation. Department staff could not confirm or deny MTM's comment, reflecting staff turnover and lack of documentation at the department. Current DHS staff were unaware that recipients receiving transportation to mental health providers and dialysis appointments were not represented in the survey results reported by MTM.

The broker's customer satisfaction surveys show high approval, but too many people are excluded from the surveys.

⁶⁸ Department of Human Services, *Contract #436466*, IV. B1d(iii). The contract did require MTM to develop an *Operations Manual* to detail its procedures for scheduling and delivering services. Although the contract lists numerous topics to be covered, it does not refer to customer surveys. Nevertheless, MTM's manual states that "at least 5 percent of all trips are randomly selected for a follow up customer satisfaction survey." See Medical Transportation Management, *Operations Manual* (St. Louis, MO, 2009), 19.

⁶⁹ Excluding certain groups of recipients is contrary to MTM's *Operations Manual*, which says that at least 5 percent of all trips will be randomly selected for follow up. See MTM, *Operations Manual*, 19.

Despite its methodological shortcomings:

- **The broker's customer surveys suggest high levels of satisfaction with access transportation in the Twin Cities area.**

The recipients that were surveyed were overwhelmingly pleased with the services they received. Between January 2008 and June 2010, well over 90 percent of respondents interviewed answered "yes" to questions such as "Was your call answered promptly?" "Was your trip scheduled while you were on the phone?" "Was the driver's conduct professional and courteous?" and "Did you arrive to your appointment on time?"

RECOMMENDATION

To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation.

The current method of choosing a sample of recipients for MTM's customer satisfaction survey appears to be an artifact of a long-forgotten decision. Neither MTM nor DHS could provide a reason why recipients receiving transportation to mental health and dialysis appointments are excluded from MTM's surveys. We can think of no valid reason for excluding these groups. All recipients receiving taxi-style transportation through MTM should have an equal chance of being included.

For a short time, DHS contracted with MTM to survey MA recipients receiving special transportation statewide.⁷⁰ However, this proved too difficult because, unlike access transportation trips, DHS does not know whether a special transportation trip has occurred until the provider submits a bill. Providers have up to a year to bill DHS for special transportation trips. Unless a provider has submitted its bills relatively quickly, the trips often occurred too far in the past for recipients to remember them accurately (particularly if they had taken more than one trip). Although DHS limited its surveys to providers that had sent in bills quickly, surveying individuals served only by certain providers could clearly bias results. The department concluded that the information it was receiving from the special transportation surveys was not sufficiently valuable to continue them. In the surveys that were conducted, recipients were generally positive about their special transportation experiences.

⁷⁰ Department of Human Services, Contract #436466, Amendments 6-7.

List of Recommendations

- The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 Legislature. (p. 32)
- As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable. (p. 33)
- The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation. (p. 33)
- The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changed. (p. 34)
- The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow. (p. 35)
- The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments. (p. 58)
- The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data. (p. 60)
- The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation. (p. 63)
- To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation. (p. 65)



Minnesota Department of **Human Services**

January 24, 2011

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

The enclosed material is the Department of Human Services response to the findings and recommendations included in the draft audit report titled Medical Nonemergency Transportation issued in January 2011. It is our understanding that our response will be published in the Office of the Legislative Auditor's final audit report.

The Department of Human Services policy is to follow up on all audit findings to evaluate the progress being made to resolve them. Progress is monitored until full resolution has occurred. If you have any further questions, please contact Gary L. Johnson, Acting Internal Audit Director, at (651) 431-3623.

Sincerely,

Lucinda E. Jesson
Commissioner

Enclosure

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

Audit Finding #1

Minnesota has two separate administrative structures for nonemergency transportation, “access” and “special,” that are duplicative and confusing.

Audit Recommendation #1-1

The Legislature should direct the Department of Human Services, in consultation with counties and other stakeholders, to develop a proposal to create a single administrative structure for the medical nonemergency transportation program and present that proposal to the 2012 legislature.

Department Response #1-1

The Department agrees with the finding and recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 1/1/2012

Audit Recommendation #1-2

As long as special transportation remains a separate service, the Legislature should specify in law whether special transportation status should be granted when appropriate access transportation is unavailable.

Department Response #1-2

The Department agrees with this recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #2

Through its broker, DHS has frequently limited recipients’ eligibility for “special” transportation to very short time periods—often one day—which is inconsistent with contract language.

Audit Recommendation #2

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

The Department of Human Services should propose statutory changes to address the frequency of eligibility assessments and the length of time Medical Assistance recipients are eligible for special transportation.

Department Response #2

The Department agrees with this finding and recommendation. We are prepared to assist with the development of a legislative proposal and will assist in the execution of that proposal.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #3

The Department of Human Services administers key elements of “special” transportation (which offers the most costly and highest levels of services) in an ad hoc fashion without using rulemaking procedures, developing formal policies, or notifying the public about changes in practice.

Recommendation #3-1

The Department of Human Services should routinely publish its special transportation eligibility policies and seek comment from interested parties before new policies are implemented or significantly changes.

Department Response #3-1

The Department agrees with this finding and recommendation. We will work to improve communication of existing policies, and provide better opportunities for stakeholders to participate in the development of new policies or significant changes in existing policies.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 4/1/2011

Recommendation #3-2

The Department of Human Services should provide more explicit guidance to its contractor regarding its special transportation duties and should adjust its contract to better reflect practices the department wants the company to follow.

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

Department Response #3-2

The Department agrees with this recommendation. We will work to improve communications with our contractor. We will review current contract requirements, adherence to those requirements and add any additional duties or contract changes that may be necessary.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 4/1/2011

Auditing Finding #4

Failing to reimburse transportation providers for “no-load” miles creates a substantial burden for outstate counties.

Audit Recommendation #4

The Department of Human Services should develop alternative reimbursement methods to help compensate volunteers for no-load miles when transporting Medical Assistance recipients to or from health-related appointments.

Department Response #4

The Department agrees with this finding and recommendation. The non-payment of no-load miles has been of great concern for counties. We will work with counties to find the best solution, and are prepared to assist with a possible legislative proposal to address the no-load issue.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Auditing Finding #5

The Department of Human Services’ oversight of nonemergency transportation has been weak, and it collects very little data on the program statewide.

Audit Recommendation #5

The Department of Human Services should identify key performance measures to assess the cost-effectiveness of medical nonemergency transportation statewide and then collect, audit, and periodically report these data.

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

Department Response #5

The Department agrees with this finding and recommendation. Currently, most counties bill access transportation in aggregate, so we do not have the detailed data necessary to generate accurate reports on key performance measures. Special transportation services are currently billed in sufficient detail to assess key performance measures. We are working with counties and other stakeholders to use a more standardized billing process for access transportation services that will enable the Department to gather relevant metrics. Our goal will be to generate consistent, reliable data that enables us to better measure and report the performance and cost effectiveness of all medical nonemergency transportation statewide.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #6

Medical Assistance recipients who receive special transportation do not have access to a formal complaint system when they have service-related problems.

Audit Recommendation #6

The Department of Human Services should develop a statewide complaint system for Medical Assistance recipients using special transportation.

Department Response #6

The Department agrees with this finding and recommendation. A formal complaint system, when used in conjunction with the Department's or contractor's ability to sanction a provider up to and including removal from the program or provider network, would be a positive adjustment to the special transportation service process. We will work with counties and other stakeholders to develop a formal complaint process.

Person Responsible: Jeff Schiff HSMM Division Director
Estimated Completion Date: 7/1/2011

Audit Finding #7

The Department of Human Services did not specifically require its broker to survey Medical Assistance recipients regarding their access transportation experiences.

Department of Human Services
Response to Medical Nonemergency Transportation Report
January 24, 2011

Audit Recommendation #7

To help ensure unbiased results, the broker should base its customer satisfaction surveys on a sample of recipients that is representative of all those receiving taxi-style access transportation.

Department Response #7

The Department agrees with this finding and recommendation. Satisfaction surveys should include all recipients served by the metro contract. We will work with contractors and stakeholders to expand their surveys to include all recipients.

Person Responsible:	Jeff Schiff HSMM Division Director
Estimated Completion Date:	07/01/2011

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Civil Commitment of Sex Offenders, February 2011

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Pesticide Regulation, March 2006

Criminal Justice

Public Defender System, February 2010
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Substance Abuse Treatment, February 2006
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Managing Local Government Computer Systems: A Best Practices Review, April 2002
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