**New York State Office of the State Comptroller**
Thomas P. DiNapoli

Division of State Government Accountability

# Appropriateness of Payments to Transportation Management Contractors and Providers

## Medicaid Program
## Department of Health

Report 2016-S-67 December 2017

# Executive Summary

## Purpose

To determine whether the Department of Health (Department) made improper Medicaid payments for transportation services. The audit covered the period January 1, 2013 through December 31, 2016.

## Background

Federal regulations require the State Medicaid program to provide transportation to medically necessary services for those recipients who are unable to obtain transportation on their own. In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health care services. As part of this initiative, in January 2012, the Department began the process of removing non-emergency transportation services from the mainstream Medicaid managed care benefit package and transferring these services to the Medicaid fee-for-service program (in which Medicaid reimburses providers directly for services rendered). In addition, this initiative transferred the responsibility of managing transportation services from local social services districts to the Department, which contracted with private transportation managers to manage such services and evaluate requests for prior authorization of non-emergency transportation services. As of December 2015, all non-emergency transportation services that were previously covered by mainstream managed care were covered under fee-for-service and all prior authorization requests for these services were handled by two transportation managers. From January 1, 2013 to December 31, 2016, the two transportation managers were reimbursed nearly $180 million for transportation management services, and Medicaid fee-for-service payments to transportation providers for non-emergency transportation services totaled approximately $1.6 billion.

## Key Findings

- The Department reimburses transportation managers monthly based on the number of Medicaid recipients who are eligible for non-emergency fee-for-service transportation services. We identified flaws in the Department's methodology for determining the number of monthly Medicaid recipients. We determined that recipients from nine Medicaid coverage groups were incorrectly included in the Department's monthly calculations because the coverage groups do not actually cover Medicaid non-emergency transportation services. The inclusion of these coverage groups resulted in an over-reporting by the Department of 8.3 million recipients cumulatively between January 2013 and December 2016. This resulted in overpayments to the transportation managers of over $6.2 million. In response to our audit, the Department promptly implemented corrective actions in January 2017 to exclude these coverage groups from the monthly recipient counts. We estimated this will save the Medicaid program $7.6 million over the next five years.
- We identified two taxi companies that did not maintain the required documentation to support their transportation claims. One taxi company did not maintain the proper records for any trips prior to 2016, which accounted for $2.4 million in Medicaid payments. The other taxi company admitted it overbilled Medicaid for tolls after we requested records supporting the tolls. As a result of our audit, the taxi company self-reported the matter to the Office of the Medicaid

Inspector General for corrective action. During our audit period, the provider billed Medicaid $169,893 for tolls.

- We also determined that four Advanced Life Support First Responder (ALSFR) providers were inappropriately enrolled in Medicaid, and received a total of $162,401 in inappropriate payments.

## Key Recommendations

- Recover the $6.2 million in contract overpayments to the transportation managers for the period January 2013 to December 2016 and ensure that the nine Medicaid coverage groups are excluded from the monthly recipient counts that are used to pay transportation managers.
- Review the Medicaid payments made to the two taxi providers and recover any improper payments as warranted.
- Take the necessary corrective steps regarding the four ALSFR providers' future participation in the Medicaid program, and take steps to ensure that ALSFR companies are not enrolled as Medicaid providers.

## Other Related Audits/Reports of Interest

Department of Health: Medicaid Claims Processing Activity October 1, 2015 Through March 31, 2016 (2015-S-74)

Department of Health: Program Oversight and Monitoring of the Maximus Contract for the New York State of Health (Insurance Marketplace) Customer Service Center (2015-S-80)

# State of New York
# Office of the State Comptroller

## Division of State Government Accountability

December 15, 2017

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
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Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Appropriateness of Payments to Transportation Management Contractors and Providers*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Office of the State Comptroller*
*Division of State Government Accountability*

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# Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State's Department of Health (Department). For the fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million recipients and Medicaid claim costs totaled about $58 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs; the State funded about 29 percent; and the localities (the City of New York and counties) funded the remaining 15.7 percent.

Medicaid claims are processed and paid by an automated system called eMedNY. The eMedNY system uses recipient coverage groups to identify whether individuals have full Medicaid benefits or limited Medicaid coverage (e.g., some individuals may be limited to inpatient services only and others may be limited to Medicaid payments of Medicare coinsurances and deductibles). When eMedNY processes claims, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and whether the amounts claimed for reimbursement are appropriate. Specifically, some edits verify the eligibility of the Medicaid recipient, others verify the eligibility of the medical service, and still others verify the appropriateness of the amount billed for the service.

For Medicaid recipients who need medical services but don't have a means of travel to obtain the necessary care, federal regulations require that transportation be provided to them. Reimbursement for medically necessary transportation, both emergency and non-emergency, for Medicaid recipients is available to lawfully authorized transportation providers.

Non-emergency transportation can include ambulance, ambulette, taxi, and group transports. Typically, all non-emergency medical transportation, excluding transportation approved by Medicare, requires authorization before transportation expenses are incurred. Prior authorization is a determination that payment for a specific mode of transportation is essential in order for a recipient to obtain necessary medical care and services and that the mode of transportation is the most medically adequate and least costly.

In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health care services. As part of this initiative, beginning January 2012, the Department began the process of removing non-emergency transportation services from the mainstream Medicaid managed care benefit package. As of December 2015, all non-emergency transportation services that were previously covered by mainstream Medicaid managed care were covered by Medicaid fee-for-service (under fee-for-service, Medicaid pays providers directly for each Medicaid-eligible service rendered to Medicaid recipients). In addition, this initiative transferred the responsibility of managing transportation services from local social services districts to the Department, which contracted with private transportation managers to manage such services and evaluate requests for prior authorization of non-emergency transportation services.

The Department has contracted with two transportation managers to manage the non-emergency medical transportation program statewide: LogistiCare Solutions, LLC and Medical Answering Services, LLC. The contracts require the transportation managers to: confirm recipients' eligibility, assess the appropriateness of the request, confirm trip details (e.g., origin and destination addresses), authorize the trip, and determine the most medically appropriate mode of transportation. The transportation managers then assign approved trips to Medicaid-enrolled transportation providers.

Transportation managers are reimbursed for program management costs based on the monthly volume of Medicaid recipients who are eligible to receive non-emergency fee-for-service transportation, at the monthly fee amount per eligible recipient stipulated in the contract. From January 1, 2013 to December 31, 2016, the Department reimbursed the transportation managers a total of nearly $180 million for management services: $124 million to LogistiCare Solutions for services in New York City and Long Island; and $54.9 million to Medical Answering Services for services in the Finger Lakes, Hudson Valley, and northern and western New York regions. In addition, during this period, Medicaid fee-for-service payments to transportation providers totaled approximately $1.6 billion for non-emergency transportation services.

# Audit Findings and Recommendations

We determined that flaws in the Department's methodology for calculating the monthly transportation management payments improperly included certain recipient coverage groups, resulting in more than $6.2 million in overpayments to the transportation managers between January 2013 and December 2016. As a result of our audit, in January 2017, the Department changed its processes to ensure that certain coverage groups are excluded from the monthly recipient count. We estimate that the Department's corrective action will result in cost savings of $7.6 million over the next five years.

We also identified two providers of taxi services that did not maintain sufficient supporting documentation for certain claims totaling about $2.6 million and four providers that were inappropriately enrolled in Medicaid, resulting in $162,401 in inappropriate payments.

## Contract Payments to Transportation Managers

Each month the Department determines the volume of Medicaid recipients who are eligible to receive non-emergency fee-for-service transportation, which is then multiplied by the fee amount per eligible recipient for each region to determine the monthly contract payment amounts. Transportation managers receive the recipient counts from the Department and then submit an invoice to the Department for payment.

In order to determine the appropriateness of payments made to the transportation managers, we reviewed the Department's methodology for calculating the monthly volume of eligible recipients. With assistance from the Department, we determined that the monthly recipient counts incorrectly included recipients from nine Medicaid coverage groups with limited or provisional benefits that do not include Medicaid non-emergency transportation services (e.g., coverage is for inpatient services only, family planning services only, or Medicare coinsurances and deductibles only; or coverage in which recipients must meet a spend down of excess income prior to becoming eligible for Medicaid benefits). As a result, between January 2013 and December 2016, the Department over-reported its monthly count by a total of 8.3 million recipients, accounting for a total overpayment to the transportation managers of approximately $6.2 million.

During the course of our audit, officials stated that, because of their uncertainty regarding the appropriateness of certain coverage groups, a decision was made to reimburse the transportation managers according to the total volume of Medicaid recipients and allow for only obvious exceptions, such as those enrolled in managed long-term care plans. However, we note that for each of the nine coverage codes in question, Medicaid does not allow for a fee-for-service payment for non-emergency transportation services, and therefore the Department's decision was flawed.

For example, the coverage group that includes only the payment of recipients' Medicare deductibles and coinsurances for Medicare-approved services has a corresponding eMedNY system edit that would reject transportation claims unless Medicare approved the service (when Medicare is

responsible for approving transportation services, transportation managers are not required to approve or manage those services). Nevertheless, between January 2013 and December 2016, the Department paid the transportation managers about $4 million for an estimated 5.3 million recipients in this coverage group.

We concluded that the $6.2 million in payments to the transportation managers was not in accordance with the transportation management contracts, and the Department should seek recoveries from the contractors. As a result of our audit, the Department and the Office of the Medicaid Inspector General (OMIG) agreed to review and recover any improper payments.

Additionally, in January 2017, the Department updated its processes for calculating the monthly volume of recipients eligible for non-emergency transportation. The nine coverage groups we identified are now properly removed from the monthly counts. As a result of the Department's corrective action, we estimate potential cost savings over the next five years of $7.6 million.

## Recommendations

1. Ensure that the nine Medicaid coverage groups continue to be excluded from the monthly recipient counts that are used as the basis for paying transportation managers.

2. Review and recover the $6.2 million in contract overpayments to the transportation managers for the period January 2013 to December 2016.

3. Review and recover contract payments to the transportation managers for ineligible coverage groups for the period prior to the scope of this audit, as warranted.

## Other Matters

### *Insufficient Supporting Documentation at Taxi Providers*

According to the New York State Medicaid program's Transportation Policy Guidelines (Guidelines), "transportation providers will be reimbursed only when contemporaneous, complete, acceptable, verifiable records are available upon request to the State in connection with an audit, investigation or inquiry." Specific supporting documentation that is required includes the following:

- Medicaid recipient's name and Medicaid identification number;
- Date of transport;
- Trip origination and time of pick-up;
- Trip destination and time of drop-off;
- Vehicle license plate number;
- The driver's license number and full printed name and signature; and
- Attestation from the driver that the trip was completed.

This documentation is required for every leg of a trip, and must be maintained for a period of six years following the date of payment. If any of the required information is incomplete or deemed unacceptable or false, any relevant paid reimbursement will be recouped, and the provider may be subject to other statutory or regulatory liability, financial damages, and sanctions. The guidelines also specifically note that driver/vehicle manifests or dispatch sheets, prior authorizations by an approved official with subsequent checkmarks, or prior authorization rosters are not considered acceptable documentation.

Additionally, if a provider determines through self-review, compliance programs, or internal controls that it has been overpaid by Medicaid, the provider can self-disclose the overpayments with OMIG. Providers that identify that they received reimbursement to which they are not entitled must disclose the parameters of the problem, the cause, and its potential Medicaid financial impact in accordance with the self-disclosure guidelines.

In order to determine if transportation providers were adhering to Medicaid's record-keeping policy, we conducted site visits and record reviews. We judgmentally selected providers based on the likelihood that a trip did not actually occur as well as the possibility that a provider did not claim the appropriate payment amount.

We identified a provider that did not maintain sufficient supporting documentation for its transportation trips prior to 2016. Officials at this provider stated that prior to receiving the *Medicaid Update* publication from the Department in 2016, they were not aware of the specific record-keeping requirements. Instead of maintaining the required detailed trip logs, they printed the Medical Answering Services trip roster and hand-wrote the driver's initials or name next to each assignment as attestation of the completed trip. Per Department regulations, this is not acceptable supporting documentation. This provider was reimbursed $2.4 million for the period of August 18, 2014 to December 31, 2015. We note that the Department's record-keeping requirements were clearly explained in the Medicaid provider manual since at least 2013.

We also identified a provider that overbilled the Department for tolls. Per Department policy, the Medicaid program will reimburse transportation providers only for the actual costs incurred while transporting a Medicaid recipient. In response to our request for supporting documentation for claims for tolls, the provider determined that it was overpaid for tolls and subsequently self-disclosed the matter with OMIG. The provider stated that it billed the Department for tolls based on the cash toll rate instead of the discounted amount that the provider actually paid through its E-ZPass account. During our audit period (January 1, 2013 to December 31, 2016), the provider billed Medicaid a total of $169,893 for tolls. As of the end of the audit fieldwork, the amount of the overpayment had not yet been determined by OMIG.

### *Incorrect Provider Enrollments*

Emergency transportation services are provided without regard to the recipient's ability to pay, and therefore no prior authorization is required. In order to receive Medicaid reimbursement for emergency transportation services, a provider must be enrolled as an ambulance company and hold a valid ambulance service operating certificate issued by the Department. Ambulance companies are certified to provide either Basic Life Support (BLS) or Advanced Life Support (ALS)

services. BLS services include an array of emergency procedures needed to ensure a person's immediate survival, including CPR, control of bleeding, treatment of shock and poisoning, stabilization of injuries and/or wounds, and basic first aid. ALS services are a higher level of emergency medical care, which may include defibrillation, airway management, and use of drugs and medications.

Some BLS-certified providers maintain contracts with Advanced Life Support First Responders (ALSFRs), which enable the BLS providers to accommodate emergency situations that require ALS services. However, ALSFRs are not permitted to enroll in and submit claims to Medicaid.

Within the Department, the Bureau of Emergency Medical Services (Bureau) is responsible for certifying ambulance providers and maintaining ambulance certification records. The Bureau maintains a database with information about all ambulance providers, including whether a company provides ALS or BLS services or is an ALSFR. One distinction made on the certificates issued by the Bureau is whether the service provider is an ambulance company or an ALSFR. However, neither the database nor the certificates are provided to or requested by the Medicaid Transportation Policy Unit (Transportation Unit) to ensure proper Medicaid billings (i.e., that ALSFRs do not enroll in or submit claims to Medicaid).

We compared the list of certified ambulance companies and ALSFRs as maintained by the Bureau with information in the Medicaid Data Warehouse to determine if providers were appropriately billing Medicaid for BLS and ALS services. We identified four ALSFR providers that were improperly enrolled in Medicaid and were paid a total of $162,401 by Medicaid from January 1, 2013 to December 31, 2016. In response to this finding, Transportation Unit officials agreed these providers should not be enrolled in or billing the Medicaid program. Officials informed us that the Transportation Unit would coordinate with the Bureau of Provider Enrollment, which is responsible for approving providers for Medicaid enrollment, to determine the appropriateness of the four providers' continued enrollment and to ensure that ALSFR providers are not enrolled in Medicaid in the future.

## Recommendations

4. Determine the appropriateness of the $2.4 million in Medicaid payments to the provider with unsupported transportation claims for the period August 18, 2014 to December 31, 2015 and recover overpayments as warranted.

5. Ensure the inappropriate payments to the provider for tolls are recovered through the self-disclosure process.

6. Determine the appropriateness of the $162,401 in Medicaid payments to the four ALSFR providers and recover overpayments as warranted.

7. Review the enrollment status of the four ALSFR providers and take the necessary corrective steps regarding their future participation in the Medicaid program.

8. Take steps to ensure that ALSFRs are not enrolled as Medicaid providers.

# Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department made improper Medicaid payments for transportation services. The audit covered the period January 1, 2013 through December 31, 2016.

To accomplish our audit objective, we interviewed officials from the Department, examined the Department's relevant Medicaid policies and procedures, and reviewed applicable federal and State laws, rules, and regulations. We reviewed the Department's contracts with Medical Answering Services and LogistiCare Solutions. We assessed the Department's internal controls as they related to our audit objective. We used the Medicaid Data Warehouse and the Medicaid claims processing system (eMedNY) to identify transportation providers and recipients receiving transportation services. We extracted and analyzed paid Medicaid claims and tested medical records supporting provider claims for reimbursement. Additionally, we shared our methodology with, and provided data and findings to, the Department and OMIG officials during the audit for their review.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

# Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

# Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

# Contributors to This Report

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## Vision

A team of accountability experts respected for providing information that decision makers value.

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To improve government operations by conducting independent audits, reviews, and evaluations of New York State and New York City taxpayer-financed programs.

# Agency Comments

NEW YORK STATE OF OPPORTUNITY. Department of Health

**ANDREW M. CUOMO**
Governor

**HOWARD A. ZUCKER, M.D., J.D.**
Commissioner

**SALLY DRESLIN, M.S., R.N.**
Executive Deputy Commissioner

September 13, 2017

Ms. Andrea Inman, Audit Director
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Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2016-S-67 entitled, "Appropriateness of Payments to Transportation Management Contractors and Providers."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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# Department of Health
# Comments on the
# Office of the State Comptroller's
# Draft Audit Report 2016-S-67 entitled,
# Appropriateness of Payments to Transportation Management Contractors and Providers

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-67 entitled, "Appropriateness of Payments to Transportation Management Contractors and Providers."

**Background**

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

**Recommendation #1**

Ensure that the nine Medicaid coverage groups continue to be excluded from the monthly recipient counts that are used as the basis for paying transportation managers.

**Response #1**

This recommendation has been addressed. Prior to the OSC preliminary audit findings, the Department was in the process of examining which coverage codes should be included in the Standard Query Language (SQL) that determines the monthly enrollee eligibility report due to uncertainties some of the codes presented. The Department identified nine coverage codes that were included in error. These coverage codes were excluded from the monthly enrollee counts effective January 2017. The Office of the State Comptroller (OSC), during its review, confirmed that the nine coverage codes identified in their preliminary audit findings were included on the Department's exclusion list. The exclusion of these codes was a permanent change to the SQL that generates the monthly enrollee eligibility report.

* Comment 1

**Recommendation #2**

Review and recover the $6.2 million in contract overpayments to the transportation managers for the period January 2013 to December 2016.

*See State Comptroller's Comments, page 19.

**Response #2**

The Department and OMIG will work collaboratively to review payments and take any appropriate action.

As previously indicated to OSC, before this audit began the Department's Bureau of Medicaid Transportation was examining the issue of determining which Medicaid coverage codes were appropriate to include in the structured query language that is used to generate the monthly eligibility reports. Because of the uncertainties presented by some of the codes, a decision was made to reimburse its Medicaid transportation managers per an inclusive volume of enrollees likely to be eligible for Fee-for-Service (FFS) transportation, while accounting for clearly determined exclusions such as those enrollees in Managed Long Term Care. This decision helped ensure that the Department could fulfill the MRT and Medicaid Administration Reform transportation management directives, and successfully achieve their important savings initiatives.

**Recommendation #3**

Review and recover contract payments to the transportation managers for ineligible coverage groups for the period prior to the scope of this audit, as warranted.

**Response #3**

The Department disagrees with this recommendation. A Department review of coverage codes related to contract payments made prior to the scope of this audit, back to 2011, to both previous and current transportation managers, would be difficult and cumbersome to adequately conduct, particularly due to the complexities associated with the transportation management start-up process. This administrative takeover from the 62 counties included a phased-in approach of specific counties at different time periods within the different contractual regions, and the carving out of managed care enrollees into FFS management during different time periods. Also, the Department likely may not be able to reconstruct the payment logic used to determine the enrollee volume for the initial management contracts.

* Comment 2

Furthermore, the awarded transportation management contractors developed their procurement bids and resulting infrastructure, that achieved significant Medicaid savings for the state, based on the Department's enrollment projections. These projections may have included the coverage codes referenced in this audit, and may have been eliminated from the payment calculation by the Department in January 2017.

**Recommendation #4**

Determine the appropriateness of the $2.4 million in Medicaid payments to the provider with unsupported transportation claims for the period August 18, 2014 to December 31, 2015 and recover overpayments as warranted.

**Response #4**

The Department will research claims submitted by the provider identified in this report, and will consult with OMIG to determine whether recoupment is necessary for the claims identified. OMIG will pursue recovery of any payment determined to be inappropriate.

Transportation providers will be reimbursed only when contemporaneous, complete, acceptable, and verifiable records are available to the State, upon request, in connection with an audit, investigation or inquiry. Non-Emergency Medical Transportation providers are required to document every leg of the trip with acceptable trip verification which includes: the Medicaid enrollee's name, date of transport, origination and destination of trip along with the time of pick up and drop off, vehicle license plate number, and driver's license plate number. Effective March 1, 2016, the record keeping requirements were updated to include the driver's signature and an attestation from the driver that the trip was completed. A driver or vehicle dispatch sheet, a prior authorization with checkmarks, an authorization roster, or an attendance log from a day program is not considered acceptable supporting documentation for the trip. A printed Medical Answering Services roster with initials or names next to each trip would not meet the Departments record keeping requirements.

**Recommendation #5**

Ensure the inappropriate payments to the provider for tolls are recovered through the self-disclosure process.

**Response #5**

OMIG will review and pursue recovery of any payments determined to be inappropriate.

**Recommendation #6**

Determine the appropriateness of the $162,401 in Medicaid payments to the four ALSFR providers and recover overpayments as warranted.

**Response #6**

Advanced Life Support First Response (ALSFR) only providers are not permitted to enroll and bill the Medicaid program. The Department's Medicaid Transportation Policy Unit will work with the Department's Bureau of Provider Enrollment and OMIG to determine the appropriateness of the payments to the four identified providers, and OMIG will pursue recovery of any inappropriate payments.

**Recommendation #7**

Review the enrollment status of the four ALSFR providers and take the necessary corrective steps regarding their future participation in the Medicaid program.

**Response #7**

In conjunction with the Department, OMIG will review the four providers, and take appropriate action if necessary regarding the enrollment status of these providers in the Medicaid program.

**Recommendation #8**

Take steps to ensure that ALSFRs are not enrolled as Medicaid providers.

**Response #8**

The Department's Medicaid Transportation Policy Unit has worked with the Department's Bureau of Emergency Medical Services and the Bureau of Provider Enrollment to create a process to verify that ambulance companies applying to become Medicaid Providers are not ALSFR-only. Provider Enrollment has expanded the ambulance enrollment procedures to identify the type of certificate held by the enrolling ambulance company and deny any ALSFR-only ambulances. Additionally, all enrollment staff that handle ambulance enrollment have been trained with examples on the difference between an ambulance certificate and an ALSFR-only certificate. The changes in the enrollment process should eliminate improper enrollment of ALFSR-only ambulance companies.

# State Comptroller's Comments

1. The Department's response is misleading. Prior to issuing our preliminary audit findings, we provided Department officials with information that specified the needed improvements to the methodology the Department used to determine Medicaid recipients eligible for non-emergency fee-for-service transportation. In fact, as indicated on page 7 of our audit report, Department officials stated that, because of their uncertainty regarding the appropriateness of certain coverage groups, the Department decided to reimburse transportation managers according to the total volume of Medicaid recipients and allow for only obvious exceptions, such as recipients enrolled in managed long-term care plans. Furthermore, it was not until after we provided Department officials, in January 2017, with a list of specific Medicaid coverage groups we believed should not be included in their methodology that the Department excluded the coverage codes from the Structured Query Language. We are pleased the Department took the steps necessary to fix its computer programs used to calculate the monthly volume of Medicaid recipients eligible for non-emergency transportation. Left unaddressed, these errors would have caused additional overpayments to the Department's transportation management contractors in the future.
2. On page 1 of the Department's response, officials acknowledge that the nine coverage codes in question were included in error, and on page 2 indicate they will work with OMIG to review the overpayments we identified that occurred during the scope of this audit (January 1, 2013 through December 31, 2016) and take appropriate action. As stated on page 8 of our audit report, in January 2017 the Department updated its processes for calculating the monthly volume of recipients eligible for non-emergency transportation and removed the nine coverage groups from the monthly counts. We commend the Department for promptly correcting these errors. We believe the Department can realize further recoveries if it and OMIG review the contract payments to transportation managers for ineligible coverage groups for the period prior to the scope of this audit. Given the current fiscal stress on state Medicaid programs, we strongly urge the Department to reconsider and review contract payments made during the period we did not review, and recover overpayments as warranted.