Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

LOUISIANA DID NOT ALWAYS COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CLAIMS SUBMITTED FOR THE NONEMERGENCY MEDICAL TRANSPORTATION PROGRAM

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Office of Inspector General

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EXECUTIVE SUMMARY

During the period April 1, 2013, through March 31, 2014, Louisiana claimed at least $1.2 million for unallowable Federal Medicaid payments for nonemergency medical transportation services.

WHY WE DID THIS REVIEW

Federal regulations require each State to ensure that Medicaid beneficiaries have necessary transportation to and from medical providers. During the period April 1, 2013, through March 31, 2014, the Louisiana Department of Health and Hospitals (State agency) claimed $20.6 million for payments to nonemergency medical transportation (NEMT) providers. Prior Office of Inspector General reviews have found that States' claims for NEMT services were not always in accordance with Federal and State requirements.

The objective of this review was to determine whether the State agency claimed Federal Medicaid reimbursement for NEMT services claims submitted by transportation providers in Louisiana in accordance with certain Federal and State requirements.

BACKGROUND

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Federal regulations require each State to ensure that Medicaid beneficiaries have transportation to and from medical providers and to describe in its State plan the methods that the State will use to meet this requirement. The regulations define transportation expenses as costs for transportation that the State deems necessary to secure medical examinations and treatment for beneficiaries. The State agency reports expenditures of funds for NEMT services on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64 report). The amounts reported on the CMS-64 report must be actual expenditures and supported by documentation.

HOW WE CONDUCTED THIS REVIEW

For our review, we selected the 10 ambulance and 10 nonambulance providers with the highest claim amounts. In total, these providers submitted 68,268 claims totaling $13 million during the period April 1, 2013, through March 31, 2014. We reviewed a stratified random sample of 120 claims. The $13 million claimed by the 20 providers was 63 percent of the $20.6 million claimed for services in our audit period. We obtained claim information from the State agency. We obtained and reviewed documentation from each transportation provider to determine whether the claim met certain Federal and State requirements. We also reconciled the expenditures reported on the State agency's CMS-64 report to supporting documentation.

WHAT WE FOUND

During the period April 1, 2013, through March 31, 2014, the State agency claimed Federal Medicaid reimbursement for some NEMT services claims submitted by transportation providers that did not comply with certain Federal and State requirements. Of the 120 NEMT claims in our sample, the State agency properly claimed Medicaid reimbursement for 83 claims. However, the remaining 37 claims contained services that did not comply with certain Federal and State regulations. Of the 37 claims, 14 contained more than 1 deficiency:

- For 22 claims, the provider did not provide documentation to support the NEMT services.
- For 21 claims, the beneficiary did not receive a Medicaid-covered health care service on the transportation date.
- For eight claims, the rate paid did not match the approved rate for the services provided.
- For one claim, the beneficiary canceled the transportation request before receiving the service.

The claims for unallowable services were made because the State agency's policies and procedures for overseeing the Medicaid program did not ensure that providers complied with Federal and State requirements for documenting and claiming NEMT services. On the basis of our sample results, we estimated that the State agency submitted at least 13,917 improper NEMT claims and received at least $1,064,312 in improper Federal Medicaid reimbursement.

In addition, the State agency did not have adequate support for $278,771 ($182,623 Federal share) of costs claimed on the CMS-64 report. The lack of support occurred because the State agency did not have adequate controls in place to monitor the reporting of expenditures claimed for NEMT services.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $1,246,935 to the Federal Government: $1,064,312 for improper claims and $182,623 for costs claimed without adequate support;
- strengthen its policies and procedures to ensure that providers:
    - keep records that are necessary to document the services provided,
    - provide transportation services only to beneficiaries receiving Medicaid-covered services,
    - submit claims that match approved rates, and
    - do not submit claims for cancelled trips; and

- strengthen its controls over its process for reporting expenditures claimed for NEMT services.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not agree with parts of our finding on unallowable claims and described actions that it has taken in response to our finding on inadequate support of costs claimed. Regarding the unallowable claims, the State agency did not agree with the sections on beneficiaries receiving a Medicaid-covered service on the date of transportation and paid rates not matching approved rates for a provided service. The State agency stated that CMS had advised it to provide transportation to medically necessary Medicare-covered services for beneficiaries with dual Medicaid and Medicare eligibility. The State agency also stated that the issue we identified with rates was because of its use of negotiated rates and that mileage was not the only factor in the rates paid.

We did not determine whether the beneficiaries that did not receive a Medicaid-covered service on the date of transportation service had received a Medicare-covered service. However, the State Medicaid plan specifies that transportation for Medicaid-covered services is allowable. The State agency may work with CMS to determine the allowability of any claims we identified as deficient. In addition, we used rate schedules provided by the State agency to determine that the State agency did not pay providers based on approved rates. The State agency did not provide any additional documentation to support its determination that any of the claims we identified as deficient actually complied with requirements. Thus, we maintain that our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Federal regulations require each State to ensure that Medicaid beneficiaries have necessary transportation to and from medical providers (42 CFR § 431.53). During the period April 1, 2013, through March 31, 2014, the Louisiana Department of Health and Hospitals (State agency) claimed $20.6 million for payments to nonemergency medical transportation (NEMT) providers. Prior Office of Inspector General reviews have found that States' claims for NEMT services were not always in accordance with Federal and State requirements. Appendix A lists Office of Inspector General reports related to NEMT.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for NEMT services claims submitted by transportation providers in Louisiana in accordance with certain Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Federal regulations require each State to ensure that Medicaid beneficiaries have transportation to and from medical providers and to describe in its State plan the methods that the State will use to meet this requirement (42 CFR § 431.53). Federal regulations define transportation expenses as costs for transportation that the State deems necessary to secure medical examinations and treatment for beneficiaries (42 CFR § 440.170(a)(1)).

Louisiana's Nonemergency Medical Transportation Program

In Louisiana, the State agency administers the NEMT program. This program provides transportation to eligible Medicaid beneficiaries. Participants are eligible to receive transportation when no other means of transportation is available and a medical necessity exists.

The State agency entered into provider agreements with NEMT service providers. Each agreement specified the parish or parishes where the provider was eligible to provide services. The State agency's contractor for dispatch services receives requests for transportation and provides nonambulance providers with an authorization number. The authorization number specifies the Medicaid recipient, by name and identification number, and the category of service.

Providers must include the authorization number on each claim to receive payment for the service.

State Requirements

The NEMT program includes reasonable transportation of a prior-authorized medical transportation program recipient to and/or from a prior-authorized health care facility where health care needs will be met. The NEMT program does not cover transportation of individuals to services that are not covered by the applicable State or Federal medical assistance program under which the recipient qualifies.

HOW WE CONDUCTED THIS REVIEW

For our review, we selected the 10 ambulance and 10 nonambulance providers with the highest claim amounts. In total, these providers submitted 68,268 claims totaling $13 million during the period April 1, 2013, through March 31, 2014. We reviewed a stratified random sample of 120 claims. The $13 million claimed by the 20 providers was 63 percent of the $20.6 million claimed for services in our audit period. We obtained claim information from the State agency. We obtained and reviewed documentation from each transportation provider to determine whether the claim met certain Federal and State requirements.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology, Appendix C contains the details on our statistical sampling methodology, Appendix D contains our sample results and estimates, Appendix E contains the details on Federal and State requirements related to NEMT, and Appendix F summarizes the deficiencies for each sampled claim.

FINDINGS

During the period April 1, 2013, through March 31, 2014, the State agency claimed Federal Medicaid reimbursement for some NEMT services claims submitted by transportation providers that did not comply with certain Federal and State requirements. Of the 120 NEMT claims in our random sample, the State agency properly claimed Medicaid reimbursement for 83 claims. However, the remaining 37 claims contained services that did not comply with Federal and State regulations. Of the 37 claims, 14 contained more than 1 deficiency:

- For 22 claims, the provider did not provide documentation to support the NEMT services.
- For 21 claims, the beneficiary did not receive a Medicaid-covered health care service on the transportation date.

- For eight claims, the rate paid did not match the approved rate for the services provided.

- For one claim, the beneficiary canceled the transportation request before receiving the service.

The claims for unallowable services were made because the State agency's policies and procedures for overseeing the Medicaid program did not ensure that providers complied with Federal and State requirements for documenting and claiming NEMT services. On the basis of our sample results, we estimated that the State agency submitted at least 13,917 improper NEMT claims and received at least $1,064,312 in improper Federal Medicaid reimbursement.

In addition, the State agency did not have adequate support for $278,771 ($182,623 Federal share) of costs claimed on the CMS-64 report. The lack of support occurred because the State agency did not have adequate controls in place to monitor the reporting of expenditures claimed for NEMT services.

THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT FOR UNALLOWABLE CLAIMS

Providers Did Not Document Transportation Services

State plans are required to "provide for agreements with every person or institution providing services under which such person or institution agrees (A) to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan and (B) to furnish the State agency or the Secretary [of the U.S. Department of Health and Human Services] with such information ... as the State agency or the Secretary may from time to time request."[1]

For 22 claims, the providers did not provide documentation to support the service on the NEMT service claim.

Beneficiaries Did Not Receive a Medicaid-Covered Service on the Date of Transportation

According to State regulations, an NEMT service is eligible for Medicaid payment when the transportation service is essential for the beneficiary to obtain necessary medical care and when that medical care is covered under the Medicaid program (State Medicaid plan, Attachment 3.1-A, Item 24.a, page 4).

The State agency claimed reimbursement for 21 transportation claims with dates of service for beneficiaries who did not receive a Medicaid-covered health care service. For the 21 claims, the State Medicaid Management Information System (MMIS) did not have claims data to verify that a Medicaid-covered health care service was provided on the transportation date.

[1] The Social Security Act § 1902(a)(27).

The Rates Paid Did Not Match Approved Rates for the Services Provided

The State plan categorizes the types of services available. The State agency established rates for each category, which may vary based on mileage or the origination and destination parishes. In addition, the State agency negotiated rates for monthly capitation payments with individual providers[2] (State Medicaid plan, Attachment 4.19-B, Item 24.a, page 3).

The State agency claimed reimbursement for eight transportation claims that did not match approved rates for the services provided. For five claims, the State agency paid providers for transportation between parishes that did not have an approved rate. For example, the State agency paid a provider $147 for a round trip between Winn and LaSalle parishes. However, because the rate schedule did not have a rate that covered the provider for those parishes, the payment should have been $18.32, based on a round trip of 51 miles. For three of the eight claims, providers claimed more miles than supported by available documentation.

A Beneficiary Did Not Receive a Transportation Service

The State Medicaid plan limits transportation to Medicaid beneficiaries being taken to and from providers rendering Medicaid-covered services.[3]

For one claim, the provider requested payment and the State agency paid for a transportation service the provider did not provide. The driver noted the cancellation in the driver's log; however, the provider did not reconcile the driver's log with the approved client list before submitting the claim.

THE STATE AGENCY CLAIMED FEDERAL REIMBURSEMENT WITHOUT ADEQUATE SUPPORTING DOCUMENTATION

In addition, the State agency did not have adequate support for $278,771 ($182,623 Federal share) in costs claimed on the CMS-64 report. The State agency used a series of reports to calculate the costs submitted on the CMS-64 report. However, for the quarter ending June 30, 2013, an employee incorrectly added $278,771 to the reported amount. The inadequate support occurred because the State agency did not have adequate controls in place to monitor the reporting of expenditures claimed for NEMT services.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,246,935 to the Federal Government: $1,064,312 for improper claims and $182,623 for costs claimed without adequate support;

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[2] The capitated rates are for recurring services, such as dialysis, and are based on the level of service, the number of trips per week, and required mileage.

[3] State Medicaid plan, Attachment 3.1-D, page 4.

- strengthen its policies and procedures to ensure that providers:
    - keep records that are necessary to document the services provided,
    - provide transportation services only to beneficiaries receiving Medicaid-covered services,
    - submit claims that match approved rates, and
    - do not submit claims for cancelled trips; and
- strengthen its controls over its process for reporting expenditures claimed for NEMT services.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not agree with parts of our finding on unallowable claims and described actions that it has taken in response to our finding on inadequate support of costs claimed. Regarding the unallowable claims, the State agency did not agree with the sections on beneficiaries receiving a Medicaid-covered service on the date of transportation and paid rates not matching approved rates for a provided service. The State agency stated that CMS had advised it to provide transportation to medically necessary Medicare-covered services for beneficiaries with dual Medicaid and Medicare eligibility. The State agency also stated that the issue we identified with rates was because of its use of negotiated rates and that mileage was not the only factor in the rates paid.

We did not determine whether the beneficiaries that did not receive a Medicaid-covered service on the date of transportation service had received a Medicare-covered service. However, the State Medicaid plan specifies that transportation for Medicaid-covered services is allowable. The State agency may work with CMS to determine the allowability of any claims we identified as deficient. In addition, we used rate schedules provided by the State agency to determine that the State agency did not pay providers based on approved rates. The State agency did not provide any additional documentation to support its determination that any of the claims we identified as deficient actually complied with requirements. Thus, we maintain that our findings and recommendations are valid. The State agency's comments are included in their entirety as Appendix G.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Improper Payments for Medicaid Nonemergency Medical Transportation

Report Title	Report Number	Date Issued
North Carolina Improperly Claimed Federal Reimbursement for Some Medicaid Nonemergency Transportation Services	A-04-15-04037	11/18/2016
New Jersey Did Not Adequately Oversee Its Medicaid Nonemergency Medical Transportation Brokerage Program	A-02-14-01001	7/5/2016
California Claimed Medicaid Reimbursement for Certain Nonemergency Medical Transportation Services in Los Angeles County Billed as Exempt From Prior Authorization That Did Not Comply With Federal and State Requirements	A-09-13-02054	3/30/2015
California Claimed Medicaid Reimbursement for Some Nonemergency Medical Transportation Services That Did Not Comply With Federal and State Requirements	A-09-13-02033	1/23/2015
Texas Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program	A-06-12-00053	10/20/2014
California Claimed Medicaid Reimbursement for Some Nonemergency Medical Transportation Services in Los Angeles County That Did Not Comply With Federal and State Requirements	A-09-12-02083	6/24/2014

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From the 68,268 claims for 10 ambulance and 10 nonambulance providers totaling $13 million that the State agency claimed for Federal reimbursement during the period April 1, 2013, to March 31, 2014, we reviewed a random sample of 120 claims. The $13 million claimed by the providers was 63 percent of the $20.6 million claimed for our audit period.

We did not assess the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our review of internal controls to those applicable to our audit objective. In addition, the scope of our audit did not require us to review the medical necessity of the transportation services.

We conducted fieldwork from January 2015 through June 2016 at the State agency's offices in Baton Rouge, Louisiana, and at the business offices of transportation providers located throughout Louisiana.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws and regulations related to Medicaid transportation services;
- interviewed State agency officials regarding beneficiaries' eligibility for transportation services, prior authorization and scheduling of services, and the claims process;
- reconciled the State agency's claims for transportation services on the CMS-64 report with supporting documentation for the quarters ending June 30, 2013, September 30, 2013, December 31, 2013, and March 31, 2014;
- interviewed providers regarding policies and procedures used to record, modify, cancel, audit, and claim transportation services;
- selected a stratified random sample of 120 claims (Appendix C) for transportation services submitted by 10 nonambulance and 10 ambulance providers for which we:
    - obtained the claim information from the State agency;
    - reviewed the providers' documentation on the beneficiary, origination and destination addresses, prior authorizations, and the driver and vehicle used;
    - reviewed the payments to providers to determine whether the rates paid were in accordance with the approved State rate for the type of service and the dropoff and pickup locations; and

- analyzed claims data from the State MMIS to help determine whether each beneficiary obtained a Medicaid-covered health care service on the date of the transportation service;

- used the results of the sample to estimate the unallowable Federal Medicaid reimbursement (Appendix D); and

- discussed our results with the State agency on August 9, 2016.

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicaid claims paid to 10 nonambulance and 10 ambulance providers with the highest payments for contractor demand-response services claimed for Federal reimbursement during the period April 1, 2013, through March 31, 2014.

SAMPLING FRAME

The sampling frame consisted of 68,268 claims paid to 10 nonambulance and 10 ambulance providers totaling $12,985,339.

SAMPLE UNIT

The sample unit was an individual Medicaid claim for transportation services paid by the State NEMT program.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into four strata, two for nonambulance providers and two for ambulance providers, based on cost thresholds.

SAMPLE SIZE

We selected a sample size of 120 paid Medicaid claims, 30 per stratum.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 30 random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to appraise the sample results. We estimated the total number of unallowable claims and the value of overpayments at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

Stratum	Sampling Frame Size	Value of Frame[4]	Sample Size	Value of Sample	Number of Unallowable Sampled Claims	Value of Unallowable Sampled Claims (Federal Share)
1	20,808	$847,433	30	$1,368	17	$408
2	8,120	2,534,349	30	9,059	17	3,776
3	35,612	6,161,364	30	5,153	1	103
4	3,728	3,442,193	30	23,496	2	368
Total	**68,268**	**$12,985,339**	**120**	**$39,076**	**37**	**$4,655**

Table 2: Estimates of Unallowable Claims (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

	Number of Unallowable Claims	Value of Overpayments
Point estimate	17,828	$1,473,299
Lower limit	13,917	$1,064,312
Upper limit	21,740	$1,882,287

[4] We did not determine the Federal share for the value of the sample frame.

APPENDIX E: FEDERAL AND STATE REGULATIONS FOR NONEMERGENCY MEDICAL TRANSPORTATION

FEDERAL REGULATIONS

According to section 1902(a)(27) of the Social Security Act, a State plan must require that providers of services maintain records to fully disclose the extent of services provided to Medicaid beneficiaries.

Each State is required to ensure necessary transportation for Medicaid beneficiaries to and from providers and to describe in its State plan the methods that the State will use to meet this requirement (42 CFR § 431.53).

Transportation includes expenses for transportation and related expenses determined to be necessary by the State Medicaid agency to secure medical examinations and treatment for a beneficiary (42 CFR § 440.170).

STATE REGULATIONS

The State Medicaid plan states that "it is the policy of the Medicaid Program to provide all non-emergency transportation for recipients to receive essential medically necessary care through providers in the normal trade area and none outside the normal trade area" (State Medicaid plan, Attachment 3.1-A, Item 24.a, page 3).

APPENDIX F: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Table 3: Office of Inspector General Review Determinations for Sampled Claims

Description of Deficiencies

1	Provider did not document transportation service
2	Medicaid eligible medical service was not provided
3	Rate paid was not valid
4	Beneficiary did not receive transportation service

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
1	0	0	0	0	0
2	1	0	0	0	1
3	0	1	0	0	1
4	1	0	0	0	1
5	1	0	0	0	1
6	0	1	1	0	2
7	0	0	0	0	0
8	0	0	0	0	0
9	0	1	0	0	1
10	1	0	0	0	1
11	0	0	0	0	0
12	0	1	0	0	1
13	1	0	0	0	1
14	0	0	0	0	0
15	0	0	1	0	1
16	0	0	0	0	0
17	0	0	0	0	0
18	1	1	0	0	2
19	0	1	1	0	2
20	1	1	0	1	3
21	0	0	0	0	0
22	1	0	0	0	1
23	0	1	1	0	2
24	0	0	0	0	0
25	0	0	0	0	0
26	1	0	0	0	1
27	0	0	0	0	0
28	0	0	0	0	0
29	0	1	1	0	2
30	0	0	0	0	0
31	0	0	0	0	0
32	1	1	0	0	2
33	0	1	0	0	1
34	0	0	0	0	0
35	1	1	0	0	2
36	0	0	0	0	0
37	0	0	0	0	0
38	1	1	0	0	2
39	0	0	0	0	0
40	0	0	0	0	0
41	1	0	0	0	1
42	1	1	0	1	2

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
43	1	0	0	0	1
44	1	1	0	0	2
45	0	0	1	0	1
46	1	1	0	0	2
47	1	0	0	0	1
48	0	1	0	0	1
49	1	0	0	0	1
50	0	0	0	0	0
51	1	1	0	0	2
52	0	0	0	0	0
53	0	0	0	0	0
54	0	0	0	0	0
55	1	1	0	0	2
56	0	0	0	0	0
57	0	0	0	0	0
58	0	0	0	0	0
59	0	0	1	0	1
60	1	0	0	0	1
61	0	0	0	0	0
62	0	0	0	0	0
63	0	0	0	0	0
64	0	1	0	0	1
65	0	0	0	0	0
66	0	0	0	0	0
67	0	0	0	0	0
68	0	0	0	0	0
69	0	0	0	0	0
70	0	0	0	0	0
71	0	0	0	0	0
72	0	0	0	0	0
73	0	0	0	0	0
74	0	0	0	0	0
75	0	0	0	0	0
76	0	0	0	0	0
77	0	0	0	0	0
78	0	0	0	0	0
79	0	0	0	0	0
80	0	0	0	0	0
81	0	0	0	0	0
82	0	0	0	0	0
83	0	0	0	0	0
84	0	0	0	0	0
85	0	0	0	0	0
86	0	0	0	0	0
87	0	0	0	0	0
88	0	0	0	0	0
89	0	0	0	0	0
90	0	0	0	0	0
91	0	0	0	0	0
92	0	0	0	0	0
93	0	0	0	0	0
94	0	0	0	0	0

Sample Claim	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
95	0	0	0	0	0
96	0	0	0	0	0
96	0	0	0	0	0
97	0	0	0	0	0
98	0	0	0	0	0
99	0	0	0	0	0
100	0	1	0	0	1
101	0	0	1	0	1
102	0	0	0	0	0
103	0	0	0	0	0
104	0	0	0	0	0
105	0	0	0	0	0
106	0	0	0	0	0
107	0	0	0	0	0
108	0	0	0	0	0
109	0	0	0	0	0
110	0	0	0	0	0
111	0	0	0	0	0
112	0	0	0	0	0
113	0	0	0	0	0
114	0	0	0	0	0
115	0	0	0	0	0
116	0	0	0	0	0
117	0	0	0	0	0
118	0	0	0	0	0
119	0	0	0	0	0
120	0	0	0	0	0
Category Totals	**22**	**21**	**8**	**1**	**52**
37 Claims With Deficiencies					

APPENDIX G: STATE AGENCY COMMENTS

John Bel Edwards
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State of Louisiana
Louisiana Department of Health
Bureau of Health Services Financing

November 29, 2016

Patricia Wheeler
Regional Inspector General
HHS/OIG/OAS
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: OIG Audit # A-06-15-00019

Dear Ms. Wheeler,

The Louisiana Department of Health (LDH) appreciates this opportunity to respond to the OIG audit report relative to nonemergency transportation in the Louisiana Medicaid program. LDH staff has reviewed the OIG's findings and related documents and has provided a response for each finding below.

Finding: Providers did not document transportation services.

Response: LDH requires this documentation be maintained by the provider. After a post pay review, LDH will recoup the funds for this violation. Medicaid has previously facilitated stakeholder meetings to reinforce compliance with this requirement. As of 12/1/15, non-emergency medical transportation (NEMT) is included in managed care and the five (5) managed care organizations (MCO) are responsible for enforcing the applicable Medicaid policy. LDH staff began monitoring each plan in July of 2016 and requires plans to submit corrective action plans when a deficiency is found.

Finding: Beneficiaries did not receive a Medicaid-covered service on the date of transportation.

Response: LDH does not agree with this finding. Many Medicaid recipients who receive NEMT services are dually eligible with Medicare and Medicaid, with Medicare being their primary insurer. CMS has specifically stated that if the recipient qualifies for NEMT, the state is responsible for transportation to medically necessary services covered by the recipient's Medicare coverage. In these cases, there will be no claim in the State's MMIS system. The NEMT claims would need to be compared to the Medicare claims system. In 2008, LDH was reminded by our CMS state liaison, [redacted] of this federal requirement. LDH approved our sub-contractors to provide transportation based on this guidance from our federal agency.

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Office of Inspector General Note—The deleted text has been redacted because it is personally identifiable information.

Finding: The rates paid did not match approved rates for the services provided.

Response: LDH does not agree with this finding. Based on documents provided by the OIG, the claims were paid for procedure code Z5178. This code is approved in our state plan as a negotiated rate code. We use this code when it is difficult to find a provider for transportation. Mileage is not the only factor in setting this rate; rather, availability and willingness of providers factor into the negotiated rate. If no provider is willing, LDH or its subcontractor must negotiate/pay higher rates to make sure the recipient is transported to their medical appointment. This is a standard practice amongst all state Medicaid programs to ensure transportation services.

Finding: A beneficiary did not receive a transportation service.

Response: LDH requires a service to be provided in order to receive reimbursement. After a post pay review, LDH will recoup the funds for this violation. As of 12/1/15, non-emergency medical transportation (NEMT) is included in managed care and the five (5) managed care organizations (MCO) are responsible for enforcing the applicable Medicaid policy. LDH staff began monitoring each plan in July of 2016 and requires plans to submit corrective action plans when a deficiency is found.

Finding: The state agency claimed federal reimbursement without adequate supporting documentation.

Response: The LDH Fiscal office has implemented new procedures relative to CMS 64 reporting that includes a second level review of support documentation for the quarterly reports. In addition, additional staff have been assigned to the federal reporting team that is responsible for preparing the CMS 64 each quarter.

LDH understands its responsibility to implement controls to ensure that paid claims are appropriate and authorized. In order to augment the payment controls, LDH performs post pay reviews to ensure services billed were actually provided and appropriately documented. If deficiencies are discovered, a procedure is available to recover funds that were paid for undocumented or unauthorized claims. Now that NEMT is provided through the managed care plans, LDH staff perform quarterly reviews to ensure compliance with these regulations. Staff will work closely with the MCOs to strengthen the enforcement of the NEMT policies.

If you have any questions or need additional information, please contact Randy Davidson, Medicaid Program Manager, at 225.342.6116.

Sincerely,

Jen Steele
Medicaid Director