DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 13 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Rhode Island's Medicaid Nonemergency Transportation Costs for March 1, 2004, Through May 31, 2005 (A-01-06-00007)

Attached is an advance copy of our final report on Medicaid nonemergency transportation (NET) costs claimed by the Rhode Island Department of Human Services (the State agency). We will issue this report to the State agency within 5 business days.

Federal regulations (42 CFR § 431.53) require each State to ensure that Medicaid recipients have necessary transportation to and from medical providers and to describe the methods that the State will use to meet this requirement in its State plan. In Rhode Island, the State agency partners with the Rhode Island Public Transit Authority (RIPTA) to provide NET for Medicaid-eligible Rhode Island residents enrolled in either of the State's two managed care insurance programs. Through this partnership, RIPTA provides Medicaid beneficiaries with monthly bus passes that enable the beneficiaries to access transportation to and from medical services, including visits to doctors, hospitals, and pharmacies.

Our objective was to determine whether the State agency claimed NET costs for the period March 1, 2004, through May 31, 2005, that complied with Federal and State requirements.

The State agency did not claim Medicaid NET costs in accordance with Federal and State requirements. Specifically, the State agency's purchase of monthly bus passes was not cost effective based on beneficiaries' use of medical services. From March 2004 through May 2005, bus pass recipients averaged 1.5 medical services per month for months in which they received a pass. The less costly purchase of 10-ride bus passes could have saved at least $9.8 million ($4.9 million Federal share) during our 15-month audit period. The State agency incurred these excessive costs because it did not consider utilization data in determining whether monthly bus passes were a cost-effective means of providing NET to State Medicaid beneficiaries.

In addition, the State agency's claim included the costs of approximately 8,700 bus passes for beneficiaries of two non-Medicaid State programs. As a result, the State agency overstated its claim for NET costs by $386,452 ($193,226 Federal share). These unallowable NET costs were due to the State agency's lack of sufficient policies and procedures to ensure that it allocated costs to the appropriate program.

We recommended that the State agency:

- either refund $4.9 million (Federal share) for NET costs claimed for monthly bus passes from March 2004 through May 2005 or provide documentation to show that the monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries;

- refund $193,226 (Federal share) in unallowable NET costs claimed for beneficiaries of two non-Medicaid State programs;

- in the absence of documentation demonstrating that monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries, review NET costs for bus passes reimbursed after our audit period, recalculate the State agency's claim based on Medicaid beneficiaries' use of medical services and the purchase of 10-ride bus passes, and refund to the Federal Government NET costs reimbursed in excess of the recalculated amount; and

- establish policies and procedures, including utilization reviews, to ensure that it complies with Federal requirements and the State plan for claiming NET costs that are reasonable, allocable, and cost effective.

In its written comments on our draft report, the State agency agreed with our second recommendation but disagreed with the other recommendations. We maintain that our findings and recommendations are correct and need no modification.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-06-00007 in all correspondence.

Attachment

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

MAR 20 2008

Report Number: A-01-06-00007

Mr. Lee D. Grossi
Acting Secretary
Rhode Island Executive Office of Health and Human Services
74 West Road
Cranston, Rhode Island 02920

Dear Mr. Grossi:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Rhode Island's Medicaid Nonemergency Transportation Costs for March 1, 2004, Through May 31, 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through e-mail at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-06-00007 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RHODE ISLAND'S MEDICAID NONEMERGENCY TRANSPORTATION COSTS FOR MARCH 1, 2004, THROUGH MAY 31, 2005

Daniel R. Levinson
Inspector General

March 2008
A-01-06-00007

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

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

The Rhode Island Department of Human Services (the State agency) administers the nonemergency transportation (NET) program, and the Rhode Island Public Transit Authority (RIPTA) provides mass transit service within the State. RIPTA and the State agency have partnered to provide NET for Medicaid-eligible Rhode Island residents enrolled in either of the State's two managed care insurance programs. Through this partnership, RIPTA provides Medicaid beneficiaries with monthly bus passes that enable the beneficiaries to access transportation to and from medical services, including visits to doctors, hospitals, and pharmacies.

OBJECTIVE

Our objective was to determine whether the State agency claimed NET costs for the period March 1, 2004, through May 31, 2005, that complied with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not claim Medicaid NET costs in accordance with Federal and State requirements. Specifically, the State agency's purchase of monthly bus passes was not cost effective based on beneficiaries' use of medical services. From March 2004 through May 2005, bus pass recipients averaged 1.5 medical services per month for months in which they received a pass. The less costly purchase of 10-ride bus passes could have saved at least $9.8 million ($4.9 million Federal share) during our 15-month audit period. The State agency incurred these excessive costs because it did not consider utilization data in determining whether monthly bus passes were a cost-effective means of providing NET to State Medicaid beneficiaries.

In addition, the State agency's claim included the costs of approximately 8,700 bus passes for beneficiaries of two non-Medicaid State programs. As a result, the State agency overstated its claim for NET costs by $386,452 ($193,226 Federal share). These unallowable NET costs were due to the State agency's lack of sufficient policies and procedures to ensure that it allocated costs to the appropriate program.

RECOMMENDATIONS

We recommend that the State agency:

- either refund $4.9 million (Federal share) for NET costs claimed for monthly bus passes from March 2004 through May 2005 or provide documentation to show that the monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries;

- refund $193,226 (Federal share) in unallowable NET costs claimed for beneficiaries of two non-Medicaid State programs;

- in the absence of documentation demonstrating that monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries, review NET costs for bus passes reimbursed after our audit period, recalculate the State agency's claim based on Medicaid beneficiaries' use of medical services and the purchase of 10-ride bus passes, and refund to the Federal Government NET costs reimbursed in excess of the recalculated amount; and

- establish policies and procedures, including utilization reviews, to ensure that it complies with Federal requirements and the State plan for claiming NET costs that are reasonable, allocable, and cost effective.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its comments on our draft report, the State agency agreed with our second recommendation but disagreed with the other recommendations. The State agency presented several rationales to support its position that its use of the bus pass distribution system for providing NET was cost effective and that it had adequate policies and procedures to ensure that its claim for NET costs complied with Federal requirements and the State plan.

We disagree with the State agency's assertions that it achieved cost effectiveness through the use of the bus pass distribution system for providing NET and that it had adequate policies and procedures in place. The State agency provided no evidence to justify the 187-percent increase in cost to the Medicaid program—from $4.3 million in 2003 to $12.3 million in 2005—that resulted from the change in the way the State calculated NET costs. Nothing in the State agency's response has caused us to alter our recommendations.

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INTRODUCTION

BACKGROUND

Medicaid and the Nonemergency Transportation Program

Pursuant to Title XIX of the Social Security Act (the Act), 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 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 (42 CFR § 431.53) require each State to ensure that Medicaid recipients have necessary transportation to and from medical providers and to describe the methods that the State will use to meet this requirement in its State plan. Federal regulations (42 CFR § 440.170) define transportation as expenses for transportation that the State deems necessary to secure medical examinations and treatment for Medicaid recipients.

Rhode Island Nonemergency Transportation Program

The Rhode Island Department of Human Services (the State agency) administers the Medicaid program in Rhode Island. The State agency provides medical services to most eligible Medicaid recipients through managed care organizations (MCO). The State agency separately contracts with the Rhode Island Public Transit Authority (RIPTA), which services the entire State, to provide nonemergency transportation (NET) to ensure that Medicaid beneficiaries have access to medical services, including visits to doctors, hospitals, and pharmacies. Through this contract, RIPTA provides monthly bus passes to Medicaid beneficiaries. Beneficiaries collect the passes at major supermarkets throughout the State by presenting a Medicaid card to verify their eligibility.

Before March 2004, the State agency made a monthly capitated payment of $2.79 to RIPTA for each beneficiary enrolled in one of the State's Medicaid MCOs and claimed Federal Medicaid reimbursement for these expenses in the form of Medicaid program costs. In March 2004, the State agency contracted with RIPTA to provide NET to Medicaid beneficiaries through monthly bus passes. The State agency paid RIPTA $44 for each pass and claimed these expenses as administrative costs. This change in payment resulted in Medicaid NET program costs increasing 187 percent, from $4.3 million in 2003 to $12.3 million in 2005, while the number of Medicaid beneficiaries enrolled in the State Medicaid MCOs increased only 5 percent.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed NET costs for the period March 1, 2004, through May 31, 2005, that complied with Federal and State requirements.

Scope

We reviewed NET costs totaling $14,808,904 ($7,404,452 Federal share) that the State agency claimed from March 1, 2004, through May 31, 2005.

We recalculated costs to determine whether the State agency's purchase of monthly bus passes was cost effective when compared to 10-ride passes called RIPTIKs. However, we did not (1) compare modes of transportation to determine whether another mode of transportation was even more cost effective or (2) ensure that the pass was appropriate to the individual's needs and personal situation.

The objective of our review did not require an understanding or assessment of the State agency's complete internal control structure. Accordingly, we limited our consideration to those controls related to the State agency's process for determining NET costs.

We performed our fieldwork at the State agency in Cranston, Rhode Island, from April 2006 to June 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance and the CMS-approved State plan;
- reviewed audit work performed by the Rhode Island Office of the Auditor General;
- interviewed officials from CMS, the State agency, and the State's Medicaid MCOs;
- reconciled the State agency's Medicaid administrative claim for NET for the period March 1, 2004, through May 31, 2005, on the Form CMS-64, "Quarterly Medical Statement of Expenditures for the Medical Assistance Program," to supporting documentation;
- reviewed the State agency's process for determining NET and the results of a State agency study to support the cost effectiveness of its process;
- analyzed the MCO monthly data on beneficiaries' use of medical services and the State agency's data showing those individuals who received a bus pass (Appendix A);

- recalculated the State agency's claim using RIPTIKs, priced at either $11.25 or $13.50 each, to provide NET based on beneficiaries' use of medical services (Appendix B); and

- compared the cost of providing NET using monthly bus passes with the cost of providing NET using RIPTIKs, based on beneficiaries' use of services.

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not claim Medicaid NET costs in accordance with Federal and State requirements. Specifically, the State agency's purchase of monthly bus passes was not cost effective based on beneficiaries' use of medical services. From March 2004 through May 2005, bus pass recipients averaged 1.5 medical services per month for months in which they received a pass. The less costly purchase of 10-ride bus passes could have saved at least $9.8 million ($4.9 million Federal share) during our 15-month audit period. The State agency incurred these excessive costs because it did not consider utilization data in determining whether monthly bus passes were a cost-effective means of providing NET to State Medicaid beneficiaries.

In addition, the State agency's claim included the costs of approximately 8,700 bus passes for beneficiaries of two non-Medicaid State programs. As a result, the State agency overstated its claim for NET costs by $386,452 ($193,226 Federal share). These unallowable NET costs were due to the State agency's lack of sufficient policies and procedures to ensure that it allocated costs to the appropriate program.

FEDERAL AND STATE REQUIREMENTS

Federal Law

Section 1903(a)(7) of the Act permits Federal reimbursement for the cost of a Medicaid activity if it is necessary for the proper and efficient administration of the State plan.

Federal Circular

Office of Management and Budget Circular A-87, Attachment A, section C.1.a, provides that costs must be necessary and reasonable to be allowable under Federal awards. Section C.3.a provides that a cost is allocable to a program "if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received."

Letter to State Medicaid Directors

CMS's letter to State Medicaid Directors, issued December 26, 1996, clarifies the allowability of State expenditures for bus passes used to ensure transportation for Medicaid-eligible individuals to providers of covered services. The letter establishes conditions that States are subject to when claiming Federal financial participation for administrative costs of their Medicaid NET programs. One of these conditions is that States must ensure that the purchase is cost effective. The letter recommends ensuring cost effectiveness by (1) comparing payment methods, (2) comparing modes of transportation, and (3) ensuring that the pass is appropriate to the individual's needs and personal situation. Specifically, the letter states that "a State should first determine the most cost-effective method of paying for bus transportation."

State Plan

Attachment 3.1-D of the State plan, approved January 16, 2002, provides that the State agency will ensure necessary transportation of recipients using the following guidelines:

> Requests for transportation received from recipients will be evaluated on an individual basis to assure that each individual has access to transportation as indicated by his particular combination of medical need, geographic location, and appropriate source of care with due consideration to sources of transportation available to the individual without charge to the individual or agency.

STATE AGENCY'S CLAIM FOR NONEMERGENCY TRANSPORTATION COSTS

The State agency did not claim its Medicaid NET costs in accordance with Federal and State requirements. Specifically, the State agency's purchase of monthly bus passes was not cost effective. In addition, its claim included the costs of approximately 8,700 bus passes for beneficiaries of non-Medicaid State programs.

Monthly Bus Passes Not Cost Effective

The State agency's purchase of monthly bus passes was not cost effective. Specifically, Medicaid beneficiaries' use of medical services did not justify the purchase of monthly bus passes.

From March 2004 through May 2005, bus pass recipients averaged 1.5 medical services per month for months in which they received a pass. In addition, 23 percent of these recipients did not have any medical services requiring NET in a given month. Applying the MCO data on Medicaid beneficiaries' use of medical services, we evaluated the cost of providing NET using 10-ride RIPTIKs and determined that 74 percent of individuals could have had their monthly NET needs met with no more than one RIPTIK, and 92 percent with no more than two RIPTIKs.

As a result, the amount that the State agency spent during our audit period for providing NET by purchasing monthly passes at $44 each was significantly higher than the total cost that we

calculated of providing NET by purchasing RIPTIKs, priced at $11.25 before February 2005 and $13.50 afterward. Purchasing RIPTIKs based on beneficiaries' use of medical services could have reduced the State agency's costs by at least $9.8 million ($4.9 million Federal share) during our 15-month audit period. Moreover, our calculation of the $9.8 million did not account for the additional cost savings from RIPTIKs that would occur if riders used any unused rides in future months.[1]

The State agency did not consider utilization data in determining whether monthly bus passes were a cost-effective means of providing NET to Rhode Island Medicaid beneficiaries. Although the State agency had conducted a study comparing the cost effectiveness of monthly bus passes with that of taxi rides for providing NET, the State agency did not compare the cost effectiveness of the monthly pass with that of the less expensive 10-ride RIPTIK.

Monthly Bus Passes for Beneficiaries of Non-Medicaid Programs

From March through December 2004, the State agency claimed NET costs totaling $386,452 ($193,226 Federal share) for beneficiaries of two non-Medicaid State programs. Specifically, the State agency claimed the costs of 8,783 bus passes that were for beneficiaries of Rhode Island's RIte Start and Immigration programs.[2] As a result, the State agency claimed $386,452 ($193,226 Federal share) in NET costs that should not have been claimed as Medicaid administrative costs. The table below shows the costs claimed under each program.

Table: Transportation Costs Claimed in Two Non-Medicaid Programs

Program	Number of Bus Passes	Amount Claimed	Federal Share
RIte Start	2,639	$116,116	$58,058
Immigration	6,144	270,336	135,168
Total	**8,783**	**$386,452**	**$193,226**

These errors occurred because the State agency did not have sufficient policies and procedures to ensure that costs were allocated to the appropriate program.

[1]RIPTIKs, unlike monthly bus passes, do not expire after 30 days.

[2]RIte Start is a State program that receives Federal funding through the State Children's Health Insurance Program for providing bus passes to its beneficiaries. Immigration, which covers noncitizens within specific income guidelines, is a State program that receives no Medicaid funding.

RECOMMENDATIONS

We recommend that the State agency:

- either refund $4.9 million (Federal share) for NET costs claimed for monthly bus passes from March 2004 through May 2005 or provide documentation to show that the monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries;

- refund $193,226 (Federal share) in unallowable NET costs claimed for beneficiaries of two non-Medicaid State programs;

- in the absence of documentation demonstrating that monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries, review NET costs for bus passes reimbursed after our audit period, recalculate the State agency's claim based on Medicaid beneficiaries' use of medical services and the purchase of 10-ride bus passes, and refund to the Federal Government NET costs reimbursed in excess of the recalculated amount; and

- establish policies and procedures, including utilization reviews, to ensure that it complies with Federal requirements and the State plan for claiming NET costs that are reasonable, allocable, and cost effective.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

In its comments on our draft report, the State agency agreed with our second recommendation but disagreed with our other three recommendations. We summarize and respond to the State agency's specific comments regarding these four recommendations below.

Recommendation 1

State Agency's Comments

The State agency maintained that its use of the bus pass distribution system provided cost-effective NET to ensure that Medicaid beneficiaries had sufficient and timely access to anticipated medical services. The State agency said that, in using monthly bus passes to provide NET, it was simply continuing the very system it had in place for 10 years but was now claiming Federal participation at the administrative rate rather than at the higher Federal Medicaid Assistance Percentage rate.

The State agency presented the following reasons for disagreeing with this recommendation:

- The State agency claimed that the 1996 State Medicaid Directors letter is not binding because it is not Federal policy. The State agency asserted that this letter was the basis

for our recalculation. The State agency also said that it was unaware of the State Medicaid Directors letter until CMS brought the letter to its attention in November 2004.

- The State agency said that RIPTIKS were not a more cost-effective alternative because they were not available to beneficiaries through the distribution system that was in place. The State agency maintained that the RIPTIKs that we used in our recalculation were "a hypothetical lower-cost alternative for which there is not a distribution system." Thus, the State agency does not believe that our recalculation based on RIPTIKs was reasonable or valid.

- The State agency maintained that its comparison of monthly bus passes with taxis was valid and demonstrated cost effectiveness. Specifically, it said that it had "completed a cost-effective comparison between bus passes and the only other option that was available—taxis—and determined that bus passes were more cost-effective." It further noted that "[t]he subject State Medicaid Directors letter is explicit that comparisons to other modes of transportation such as taxis are valid."

Office of Inspector General's Response

We disagree with the State agency's assertion that it achieved cost effectiveness through the use of the bus pass distribution system for providing NET, and nothing in the State agency's response has caused us to alter our conclusions or recommendation. The State agency provided no evidence to justify the 187-percent increase in cost to the Medicaid program—from $4.3 million in 2003 to $12.3 million in 2005—that resulted from the change in the way the State calculated NET costs.

In response to the State agency's specific reasons for disagreeing with this recommendation, we note the following:

- The State Medicaid Directors letter is CMS's interpretation of a Federal statute that governs the allowability of costs under the Medicaid program. The HHS Departmental Appeals Board has repeatedly held that a Federal agency's interpretation of a statue that it is responsible for implementing is entitled to deference so long as the interpretation is reasonable and the grantee had adequate notice of that interpretation.

  Section 1903(a)(7) of the Act and the Office of Management and Budget Circular A-87 were the bases for our finding. We referenced the State Medicaid Directors letter because it provides further interpretation from CMS on the allowability, as a Medicaid administrative cost, of State expenditures for bus passes used to ensure transportation for Medicaid-eligible individuals to providers of covered services.

  The State agency had adequate opportunity to familiarize itself with the State Medicaid Directors letter before CMS brought the letter to its attention in November 2004. The State Medicaid Directors letter was distributed to all State Medicaid Directors in 1996 and has been publicly available since that time.

- According to RIPTA, both RIPTIKs and monthly bus passes were available to the general public for purchase at supermarkets—the distribution points for monthly passes for Medicaid beneficiaries—during our audit period. Thus, the State agency could have used the same RIPTA distribution system that it used to provide eligible beneficiaries with monthly passes to provide these same individuals with RIPTIKs.

- Although the State agency conducted a study to establish that bus passes were more cost effective than taxis, the State agency did not determine the most cost-effective method of paying for bus transportation, as the State Medicaid Directors letter requires.

Recommendation 2

State Agency's Comments

The State agency agreed to refund $193,226 (Federal share) in unallowable NET costs claimed for beneficiaries of two non-Medicaid State programs. It stated that it had adjusted its CMS-64 for the quarter ending March 2007 after we brought the error to its attention.

Office of Inspector General's Response

CMS told us that it was unable to determine whether the State agency had appropriately adjusted its CMS-64 for the quarter ending March 2007 because the State agency had not submitted the refund as a prior period adjustment.

Recommendation 3

State Agency's Comments

The State agency said that it "is willing to discuss moving prospectively to a system in which RIPTIKs as opposed to an unlimited monthly bus pass is used . . . . [and] to set a target date at which time the use of RIPTIKs would become effective so long as the State is not required to recalculate the cost of monthly passes issued prior to that target date."

Office of Inspector General's Response

The State agency did not address the refund of the difference between NET costs reimbursed and the costs associated with the purchase of RIPTIKs. Our position on this matter is unchanged.

Recommendation 4

State Agency's Comments

The State agency maintained that "Since August of 1994, the State has had in place a method for determining the need for NEMT [NET]. That method, accepted by HCFA [Health Care Financing Administration, which became CMS] and CMS, is self-declaration by a beneficiary

who is eligible for enrollment in the State's Medicaid managed care program of the need for a bus pass."

Office of Inspector General's Response

The State agency did not provide evidence that it had established policies and procedures to ensure that it complies with Federal regulations and the State plan in claiming NET costs. A self-declaration from a beneficiary may meet the requirement for a needs assessment. However, a utilization review is also necessary to ensure that Medicaid expenditures for NET are cost efficient. The importance of a valid needs assessment and utilization review is evidenced by the 187-percent increase in NET costs in Rhode Island between 2003 and 2005 and by the 23 percent of beneficiaries who did not have any medical services in a month when they received a bus pass. Nothing in the State agency's response has caused us to alter our recommendation.

We have included the State agency's comments in their entirety as Appendix C.

APPENDIXES

METHODS USED IN OFFICE OF INSPECTOR GENERAL'S RECALCULATIONS OF COSTS OF PROVIDING NONEMERGENCY TRANSPORTATION USING RIPTIKS

To determine the cost of using RIPTIKs for nonemergency transportation (NET):

1. We analyzed the Rhode Island Department of Human Services' (the State agency) monthly data showing those individuals who received a bus pass from March 1, 2004, through May 31, 2005.

2. We analyzed the managed care organization's monthly data on beneficiaries' use of medical services from March 1, 2004, through May 31, 2005. We followed the methodology that the State used in its cost study for determining which medical services required NET. For example, the State agency assumed that pharmacy and nonemergency hospital outpatient services required NET, while home health and hospice did not.

3. We determined the number of RIPTIKs needed.

   - We based our determination on beneficiaries' use of medical services.

   - We assumed that every eligible household member would travel to each medical service. Therefore, we allowed at least one RIPTIK for each eligible member of the household for every month if at least one Medicaid eligible member of the household received a medical service. However, if no eligible household member received a medical service in a month, we did not allow any RIPTIKs for that month.

4. We multiplied the number of RIPTIKs needed by the cost of RIPTIKs during the month when each beneficiary received medical services. We did not account for the additional cost savings from RIPTIKs that would occur if riders used any unused rides in future months.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES' NONEMERGENCY TRANSPORTATION CALCULATIONS AND OFFICE OF INSPECTOR GENERAL'S RECALCULATIONS

Month	A Monthly Passes Issued by RIPTA	B State Agency Monthly Pass Price	C State Agency NET (A × B)	D RIPTIKS Needed	E RIPTIK Price	F Recalculated NET (D x E)	G Total Overpayment (C - F)	H Federal Share of Overpayment (G × 50% FMAP)
March 2004	20,235	$44.00	$890,340	25,611	$11.25	$288,124	$602,216	$301,108
April 2004	20,774	44.00	914,056	24,421	11.25	274,736	639,320	319,660
May 2004	21,062	44.00	926,728	24,680	11.25	277,650	649,078	324,539
June 2004	21,138	44.00	930,072	24,575	11.25	276,469	653,603	326,801
July 2004	19,886	44.00	874,984	21,849	11.25	245,801	629,183	314,591
August 2004	20,038	44.00	881,672	23,255	11.25	261,619	620,053	310,027
September 2004	22,641	44.00	996,204	26,775	11.25	301,219	694,985	347,493
October 2004	23,015	44.00	1,012,660	28,011	11.25	315,124	697,536	348,768
November 2004	22,846	44.00	1,005,224	26,947	11.25	303,154	702,070	351,035
December 2004	22,169	44.00	975,436	25,946	11.25	291,892	683,544	341,772
January 2005	22,268	44.00	979,792	26,111	11.25	293,749	686,043	343,022
February 2005	22,597	44.00	994,268	25,008	13.50	337,608	656,660	328,330
March 2005	22,516	44.00	990,704	28,477	13.50	384,440	606,264	303,132
April 2005	23,385	44.00	1,028,940	28,127	13.50	379,714	649,226	324,613
May 2005	23,170	44.00	1,019,480	28,907	13.50	390,244	629,236	314,618
Total	**327,740**		**$14,420,560**	**388,700**		**$4,621,543**	**$9,799,017**	**$4,899,509**

RIPTA = Rhode Island Public Transit Authority

FMAP = Federal Medical Assistance Percentage

APPENDIX B

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Executive Office of Health & Human Services
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December 17, 2007

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203

Subject: Draft Report No. A-01-06-00007

Dear Mr. Armstrong:

We appreciate the opportunity to comment on the November 26, 2007 draft of Report No. A-01-06-00007 titled *Review of Rhode Island's Medicaid Nonemergency Transportation Costs for March 2004, Through May 31, 2005.* Before we comment on the report's findings and recommendations, we believe it to be extremely important to provide a history of the State of Rhode Island's claiming for costs that are the subject of this review. It should be noted that this essential context for the State's claiming was previously provided to the Office of the Inspector General (OIG) in a more expanded form by letter on November 6, 2006. It should also be noted that this was also provided to the Centers for Medicare & Medicaid Services (CMS) prior to its provision to the OIG, when CMS initiated its financial review of the subject claims.

1. History of Non-Emergency Medical Transportation (NEMT) in Rhode Island

The State of Rhode Island has worked closely with CMS and its predecessor organization, the Health Care Financing Administration (HCFA), for more than a decade regarding non-emergency medical transportation for Medical Assistance (MA) recipients in the State of Rhode Island. The State believes it important to the context of the administrative cost review by the OIG to describe the history of the State's provision of bus passes and claiming for them under Title XIX of the Social Security Act.

> The State's interest in providing bus passes to Medicaid-eligible individuals coincided with the conceptual development of the State's Medicaid managed care program, RIte Care.

In the November 1, 1993 letter from HCFA approving the Section 1115 demonstration for RIte Care, HCFA waived the Section 1902(a)(10)(B) amount, duration, and scope of services requirements to "enable the State to modify the Medicaid benefit package and to permit coverage of benefits for the demonstration which are not covered for the non-demonstration population." So it came to be that monthly RIPTA bus passes were included as a *benefit* under RIte Care when enrollment began in August 1994.

There are two types of non-emergency medical transportation provided – bus passes and other (e.g., taxicab and para-transit). Such transportation was deemed to be an important component in the design of the State's Section 1115 Medicaid waiver demonstration project (No. 11-W-00004/1), RIte Care, which has had as an explicit goal from the beginning to improve access to care for beneficiaries. Lack of transportation was identified to be a major factor impeding timely access to appropriate health care for beneficiaries.

Effective July 1, 1996, DHS began contracting directly with RIPTA for NEMT. In addition, certain "cooperation requirements" for the Health Plans were stipulated in the *RIte Care Health Plan Contract.* The benefit, itself, was described in this latter document in the "Enhanced Services" section of the agreement – services not covered under the Rhode Island Medicaid State Plan, but covered under the Section 1115 waiver. HCFA prior-approved these agreements, which have been cited as a "best practice" among transportation advocates.[1]

After the June 14, 2002 *Final Rule* was promulgated implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA), a dialogue began between DHS and the CMS Region I office about the agreement between DHS and RIPTA. This was initiated by John Young, Associate Director of DHS in a May 9, 2003 e-mail to the CMS Region I office. Specifically, Mr. Young's communication stated:

> "This is a request from RIPTA for capitation adjustment going into FY2004. As presented, the factors compound to a net 5.77% increase, which is consistent with the inflation factor applied to the health care contracts going into next year. Please advise if you need any more information, so that we can preare (sic) the contract documents."

CMS responded by e-mail to Mr. Young on May 19, 2003 as follows:

> "As I mentioned to you the other day, as the contract is considered to be a type of managed care contract, it must meet the requirements of the new Medicaid Managed care regulations. I have attached a working paper that I am using to determine if there are some other options."

Among the "other options" in the working paper was to "consider the service administrative and not a medical benefit".

[1] Kulkarni, M. *Fact Sheet: Medicaid Transportation Services*, National Health Law Project, June 2000..

The dialogue culminated with the State's submission of a January 29, 2004 letter to Bruce Greenstein, then Associate Regional Administrator of CMS, from John Young that stated:

> "Based on conversation and advice from CMS staff, I am writing to inform the Centers for Medicare and Medicaid Services (CMS) of an impending change in the RIte Care program, effective March 1, 2004. The change concerns the method by which RIte Care has covered the provision of non-emergency transportation as an in-plan benefit . . . Effective March 1, 2004, Rhode Island will cease covering non-emergency medical transportation for the foreseeable future as an optional medical expense under RIte Care. However, the State will continue to ensure such non-emergency medical transportation is available for RIte Care enrollees as an administrative expense, an option afforded the States. DHS will amend its agreement with RIPTA, providing payment to RIPTA for bus passes issued to eligible RIte Care enrollees. In making this program change, the state recognizes that the Federal Medical Assistance percentage (FMAP) for non-emergency medical transportation will be at the rate of 50 percent, consistent with the match for administrative expense."

In a telephone conversation between Mr. Greenstein and Mr. Young on February 27, 2004, Mr. Young confirmed that CMS would not oppose this change in methods. Accordingly, the State proceeded with the steps necessary to affect this change.

When the State received Deferral No. RI/2204/3/E/01/ADM from the CMS Region I office by letter dated November 12, 2004, it was only then that the State became aware that, from CMS' perspective, the State might be expected to do more than just change the claiming method from a roughly 54 percent Federal match to a 50 percent Federal match. It was only in the course of the deferral that CMS brought up a December 26, 1996 *State Medicaid Director Letter* (SMDL). The State was unaware of the existence of the subject SMDL until it was referenced by CMS in the first of three rounds of questions the State was required by CMS to address pertaining to the deferral. The State immediately sought to obtain the subject SMDL, and went on-line to the CMS Website to do so at: http://www.cms.hhs.govv/states/letters, CMS' then central repository for such guidance that had been issued by CMS. The subject SMDL was not listed there and still is not listed in CMS' new repository at

http://www.cms.hhs.gov/SMDL/SHO/list.asp?filtertype=none&datefiltertype=&datefilterinterval=&keyword=&intNumPerPage=10&cmdFilterList=Show+Items .

Upon request, we were able to obtain it from the CMS Region I office toward the end of June 2005.

This SMDL was never referenced by CMS during any discussions or communications over more than a year's period of time while the State was working on implementing the now present arrangements with RIPTA as a Medicaid administrative cost. Given the

State's long history of the subject arrangements with RIPTA, the State operated under the belief that it was simply changing Medicaid claiming methods at a lower Federal Medical Assistance Percentage (FMAP).

2. State Comments on the OIG's Methodology

There are three basic underpinnings to the OIG's methodology for this review:

- Costs for NEMT must be incurred on behalf of individuals who are Medicaid eligible
- Costs incurred must be cost-effective
- A beneficiary-specific needs assessment should have been made for each Medicaid-eligible individual for whom claims are made

The State's comments on each of these underpinnings are addressed separately below.

2.1 Costs for NEMT Must Be Incurred on Behalf of Individuals Who Are Medicaid Eligible

The State concurs. However, in the findings section of the report the OIG noted that the State made claims for some individuals who were not Medicaid eligible. This was an inadvertent error on the part of the State and was adjusted on the CMS-64 for the quarter ending March, 2007 after it was brought to the State's attention by the OIG.

2.2. Costs Incurred Must Be Cost-Effective

The OIG's basis for this methodological underpinning is the December 26, 1996 SMDL. Page 4 of the draft report states:

> "The letter **recommends** ensuring cost effectiveness by (1) comparing payment methods, (2) comparing modes of transportation, and (3) ensuring that the pass is appropriate to the individual's needs and personal situation. Specifically, the letter states that 'a state **should** first determine the most cost-effective method of paying for bus transportation.'" (emphasis added)

The State does not believe that this is Federal "policy." In fact, no SMDL is "policy" as stated[2] by CMS as follows:

> "The State Medicaid Director letter is used to provide States with guidance and clarification on current information pertaining to Medicaid policy and Medicaid

[2] See: http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage

> data issues. The intent of these letters **is not to establish policy**, but to ensure consistency and better serve the States." (emphasis added)

The State completed a cost-effective comparison between bus passes and the only other NEMT option that was available – taxis - and determined that bus passes were more cost-effective.

2.3 A Beneficiary-Specific Needs Assessment Should Have Been Made for Each Medicaid-Eligible Individual for Whom Claims Are Made

The December 26, 1996 SMDL states in this regard:

> "Under this requirement States **should** establish some process or test for determining whether a bus pass is reasonable for particular individuals." (emphasis added)

The State **did** establish a process that a bus pass is reasonable for particular individuals. The State did this in August 1994, when enrollment in RIte Care began. That process, adopted with the full knowledge and acceptance of the, then, HCFA, was a self-declaration by a RIte Care-eligible individual as part of the RIte Care application that a monthly bus pass was needed in order to obtain medical services for which the individual was eligible. It should also be noted that RIte Care-participating Health Plans determine on an individual basis whether another mode of transportation (e.g., taxi) is required by a RIte Care-eligible individual in order to obtain needed medical services. These facts were communicated in writing to both CMS and the OIG during their respective reviews.

3. State Comments on the OIG's Findings

The OIG had two principal findings in the draft report of this review:

- Monthly bus passes are not cost-effective
- Monthly bus passes for beneficiaries of non-Medicaid programs

The State's comments on each of these findings are presented separately below.

3.1 Monthly Bus Passes Are Not Cost-Effective

The OIG stated in the draft report "23 percent of these recipients did not have any medical services requiring NET in a given month." That some beneficiaries who received a monthly bus pass did not receive medical services in a given month should not be surprising. The bus pass program was designed from the very beginning to be "prospective" in order to facilitate beneficiary access to needed services, if and when they might be needed. Determining cost-effectiveness on a "retrospective basis" does not sufficiently calculate the value of providing access to NEMT in a timely fashion for sick

and urgent visits. In order to ensure **sufficient and timely access to anticipated** medical services, it is imperative that recipients be given access to cost-effective NEMT which the State achieved through the use of the bus pass distribution system. The Federal Government was well aware of this from the time of pre-waiver approval and continued to be aware of it and accepted it. At no time during the more than one-year period while the shift claiming of bus passes from a service benefit to an administrative cost was under discussion did CMS even once raise that this might no longer be acceptable – and still has not.

Second, the OIG stated:

> "Purchasing RIPTIKs based on beneficiaries' use of medical services could have reduced the State agency's costs by at least $9.8 million ($4.9 million Federal share) during our 15-month audit period."

RIPTIKs is a 10-ride bus packet and the OIG further stated with regard to RIPTIKs that "74 percent of individuals could have had their monthly NET needs met with no more than one RIPTIK, and 92 percent with no more than two RIPTIKS." In theory, that is true. However, RIPTIKs were **not** available to beneficiaries through the distribution system in place. Only "unlimited monthly bus passes" were available which the State plainly made explicit to HCFA on October 18, 1993 and have remained in place since then with both HCFA's and CMS' knowledge and concurrence. Once again, the State was simply continuing the very system it had in place for 10 years but was going to be claiming it at the lower administrative match. At no time during the more than one-year period while the shift in claiming of bus passes from a service benefit to an administrative cost was under discussion did CMS raise that issuance of monthly bus passes might no longer be acceptable. In addition, nowhere in the subject SMDL does the State see where it would be required to make comparisons to something for which there is no distribution system in place.

On page 5 of the draft report, the OIG made reference to a State "study" of cost-effectiveness using taxis as the basis of comparison to a monthly bus pass (as opposed to a comparison to RIPTIKs). That "study" was done in response to questions arising during CMS' financial review, and demonstrated cost-effectiveness on that basis. The subject SMDL is explicit that comparisons to other modes of transportation such as taxis are valid.

3.2 Monthly Bus Passes for Beneficiaries of Non-Medicaid Programs

As noted above, the State inadvertently claimed bus pass costs in error for some beneficiaries not eligible for Federal matching. This error was adjusted on the CMS-64 for the quarter ending March, 2007 after it was brought to the State's attention by the OIG.

4. State Comments on Recommendations

The OIG had four recommendations in the draft report. The State's comments on each of these recommendations are addressed separately below.

4.1 Either refund $4.9 million (Federal share) for NET costs claimed for monthly bus passes from March 2004 through May 2005 or provide documentation to show that the monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries

First, the State does not believe the subject SMDL is binding. Second, the State does not believe that recalculating claims based on something that does not exist in reality (i.e., a hypothetical lower-cost alternative for which there is not a distribution system) is reasonable or valid. Third, the State believes that, even if it conceded it was obligated to demonstrate cost-effectiveness, which it does not, the comparison to taxis is valid and demonstrated cost-effectiveness

4.2 Refund $193,226 (Federal share) in unallowable NET costs claimed for beneficiaries of two non-Medicaid State programs

As noted above, this inadvertent error was adjusted on the CMS-64 for the quarter ending March, 2007 after it was brought to the State's attention by the OIG.

4.3 In the absence of documentation demonstrating that monthly bus passes were the most cost-effective means of providing NET to Medicaid beneficiaries, review NET costs for bus passes reimbursed after our audit period, recalculate the State agency's claim based on Medicaid beneficiaries' use of medical services and the purchase of 10-ride bus passes, and refund to the Federal Government NET costs reimbursed in excess of the recalculated amount

In July 2007, RIPTA began offering new electronic "e-fare" cards and "e-RIPTIKS". RIPTA has also improved the distribution system to make these e-fare and e-RIPTIKS available at local grocery stores, along with the monthly bus passes (which have also been converted to electronic format). The State is willing to discuss moving prospectively to a system in which RIPTIKs as opposed to an unlimited monthly bus pass is used. As part of this discussion, the State is willing to set a target date at which time the use of RIPTIKs would become effective so long as the State is not required to recalculate the cost of monthly passes issued prior to that target date. This acknowledges that considerable work including, for example, computer system changes, policy changes, beneficiary notifications, etc. would need to be undertaken to accomplish this.

4.4 Establish policies and procedures, including periodic needs assessments and utilization reviews, to ensure that it complies with Federal requirements and the State plan for claiming NET costs that are reasonable, allocable, and cost effective

Since August of 1994, the State has had in place a method for determining the need for NEMT. That method, accepted by HCFA and CMS, is self-declaration by a beneficiary who is eligible for enrollment in the State's Medicaid managed care program of the need for a bus pass. In addition, those individuals who believe they require NEMT other than a bus pass (e.g., taxi) in order to obtain needed Medicaid-covered services must obtain the prior approval of the Medicaid managed care organization (MCO) in which they are enrolled.

As we have stated in previous correspondence, creation of a NEMT brokerage system in Rhode Island will involve significant new administrative expense and effort: computer system changes, policy changes, beneficiary notifications, and creation of a pass distribution system. In addition to representing a de facto barrier to members' ability to access needed services, we believe that these new costs are out of scale to the control issues attendant on NEMT, and are themselves not cost effective.

We would hope that the foregoing addresses the issues raised by the OIG. Thank you.

Sincerely,

Lee D. Grossi

Lee D. Grossi
Acting Secretary
Executive Office of Health and Human Services
State of Rhode Island

LDG/co
cc: Gary Alexander, Director
RI Department of Human Services

John R. Young, Deputy Director
RI Department of Human Services