

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Controlling Medicaid Non-Emergency
Transportation Costs**



JUNE GIBBS BROWN
Inspector General

April 1997
OEI-04-95-00140

OFFICE OF INSPECTOR GENERAL

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OEI's Atlanta Regional Office prepared this report under the direction of Jesse J. Flowers, Regional Inspector General, and Christopher Koehler, Deputy Regional Inspector General. Principal OEI staff included:

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To obtain a copy of this report, call the Atlanta Regional Office at 404-730-9452.

EXECUTIVE SUMMARY

PURPOSE

To identify and describe effective practices for controlling non-emergency transportation costs in the Medicaid program.

BACKGROUND

The U.S. Health Care Financing Administration estimated that nationally non-emergency transportation costs increased 10 percent per year from 1990 until 1995. Some individual States reported that their non-emergency transportation costs increased substantially more. For example, one State reported a 250 percent increase in 4 years, another a 230 percent increase in only one year, and another a 136 percent increase in two years.

We used a case study method to identify and describe practices for controlling Medicaid non-emergency transportation costs. We selected programs in Miami, Florida; Philadelphia, Pennsylvania; Louisiana, and Washington for review. Various experts recommended these Medicaid programs for case study because they were unique cost saving programs, and had significantly reduced or maintained low non-emergency transportation costs over several years.

FINDINGS

Selected case study programs reported significant savings from controlling non-emergency transportation costs.

Each of the four programs we studied reported that savings can result from controlling non-emergency transportation costs. For example, Louisiana reported reductions in non-emergency transportation costs of \$52 million in 1 year. Miami, Florida claims to have decreased average Medicaid non-emergency transportation costs per beneficiary from \$630 per month to \$30 per month in two years. Washington State and Philadelphia, Pennsylvania reported increases of less than 8 percent per year during an 8 year period.

Case study programs focused control efforts on the kinds of fraud and abuse which were most likely to occur:

- people who have other means of transportation,
- unnecessary trips,
- excessive claims, and
- trips claimed, but not made by providers.

Case study programs also reduced non-emergency transportation costs by using least costly transportation.

Each program we surveyed used the least costly mode of non-emergency transportation available. Even in instances where the freedom of choice provision of the Medicaid law applied, States offered beneficiaries a choice among the lowest cost providers. The freedom of choice provision of the Medicaid law states that beneficiaries have a right to choose their provider of services.

States that claimed Federal reimbursement for non-emergency transportation as an administrative expense did not have to adhere to the freedom of choice provision. In addition, States can obtain a waiver of the freedom of choice provision from the Health Care Financing Administration.

Using brokers may help control costs.

Our case study programs use brokers as intermediaries to assure that transportation is necessary. Such brokers have a contractual incentive to control costs.

RECOMMENDATIONS

We recommend that HCFA advise States of opportunities to establish controls to reduce costs for non-emergency transportation. Most States could adopt practices similar to those used by the case study programs described in this report. We cannot accurately estimate the precise amount that could be saved. However, this is a program with over \$1 billion in expenditures. If all States adopted practices similar to those used by the case study programs, substantial savings could be achieved.

AGENCY COMMENTS

The HCFA Administrator concurred with our recommendations. He stated that the report recommendations are consistent with existing HCFA activities. The HCFA established a Non-Emergency Transportation Technical Advisory Group comprised of State and Federal Medicaid staff. The group is currently developing recommendations for HCFA and the Executive Committee of the National Association of State Medicaid Directors on a wide range of issues, including those in our report. He believes that their recommendations will facilitate the changes we seek.

The Principal Deputy Assistant Secretary for Planning and Evaluation (ASPE) also concurred with our recommendations.

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INTRODUCTION

PURPOSE

To identify and describe effective practices for controlling non-emergency transportation costs in the Medicaid program.

BACKGROUND

Medicaid Non-Emergency Transportation Services

Federal regulation 42 CFR 431.53 requires all States that receive Federal Medicaid funds to assure transportation for Medicaid beneficiaries to and from medical appointments. A description of the method of providing transportation must be included in State Medicaid plans.

The way in which States manage non-emergency transportation services varies. Some States use regional offices while others use local agencies. An increasingly popular way to manage non-emergency transportation is through contracts with separate entities, commonly referred to as brokers.

States can elect to claim Federal reimbursement for Medicaid non-emergency transportation as either an optional medical or administrative expense. There are three major distinctions between claiming non-emergency transportation as an optional medical expense versus an administrative expense. First, States that claim non-emergency transportation services as an optional medical expense are required to make direct payments to transportation providers. In contrast, States that claim non-emergency transportation as an administrative expense may pay a broker who, in turn, pays the transportation provider.

Second, States that claim non-emergency transportation services as an optional medical expense are reimbursed for transportation expenses at a State's Federal financial participation rate for medical expenses--50 to 83 percent of their medical expenses. States that claim non-emergency transportation services as an administrative expense are always reimbursed at the administrative rate of 50 percent of their administrative expenses.

Third, States that claim non-emergency transportation as an optional medical expense must give beneficiaries a right to choose their provider of services. The right to choose a transportation provider is granted by a provision of the Medicaid law referred to as freedom of choice. States that claim non-emergency transportation as an administrative expense do not have to give beneficiaries a choice of transportation providers.

Rising Costs of Non-Emergency Transportation Services

The Health Care Financing Administration (HCFA) estimates that non-emergency transportation expenditures total 1 percent of all Medicaid program costs, or about \$1 billion in 1995. The HCFA also estimated that nationally non-emergency transportation costs increased 10 percent per year from 1990 until 1995¹.

Some individual States reported that their non-emergency transportation costs increased substantially more. For example, Louisiana costs increased from \$20 million in 1990 to \$72 million in 1994--a 250 percent increase in 4 years. Georgia's expenditures increased from \$3 million in 1993 to \$10 million in 1994--a 230 percent increase in only one year. Indiana's costs increased from \$19 million in 1990 to \$45 million in 1992--a 136 percent increase in two years.

States report that fraud and abuse by providers and beneficiaries contributes to the increased costs. The major types of fraud and abuse reported include providers billing Medicaid for more miles than they actually provide, providers billing Medicaid for trips they did not provide, and beneficiaries using Medicaid transportation when they have other means of transportation to a medical appointment. Other problems such as unnecessary trips and use of the most costly mode of transportation have also contributed to the increasing cost of non-emergency transportation.

Increasing costs and allegations of fraud and abuse have led some members of the Congress to consider eliminating non-emergency transportation as a covered Medicaid service.

In addition, HCFA has been concerned about the increasing non-emergency transportation cost. In November 1994, HCFA created a Medicaid Transportation Technical Advisory Group to identify ways to more efficiently and effectively provide Medicaid transportation services. The technical advisory group includes Federal and State members who meet regularly.

Finally, States are seeking ways to reduce non-emergency transportation costs. They have an ever increasing number of Medicaid beneficiaries placing demands on their already strained budgets. Therefore, States are analyzing their programs to identify more cost efficient ways to provide non-emergency transportation. Likewise, States are intensifying their scrutiny of non-emergency transportation claims.

¹HCFA can only estimate the percent increase because they do not collect cost data from States specifically for non-emergency transportation.

SCOPE AND METHODOLOGY

We used a case study method to identify and describe practices for controlling Medicaid non-emergency transportation costs. We selected programs in Miami, Florida; Philadelphia, Pennsylvania; Louisiana, and Washington for review².

In selecting four programs for case study, we consulted with various experts on non-emergency transportation. We consulted with HCFA, the American Public Welfare Association (APWA), and Ecosometrics, Inc. Ecosometrics completed a national study on non-emergency transportation for HCFA in 1994. The experts recommended these Medicaid programs for case study because they were unique cost saving programs, and had significantly reduced or maintained low non-emergency transportation costs over several years. We also consulted with HCFA's Technical Advisory Group for Medicaid transportation to identify pertinent issues to consider in our study.

We conducted on-site visits to each selected program. We interviewed program officials and staff using a standardized discussion guide. We also reviewed applicable program policies, procedures, and records.

We obtained savings data directly from the case study programs. We did not independently verify the data, and we limited our discussion to those practices that the case study programs reported were effective. We did not collect administrative costs of the practices States used. Use of the case study method does not enable us to generalize how much other programs can save by adopting our study results or what their administrative costs would be. But, the study results can provide insight to States on effective practices to develop and improve their non-emergency transportation programs.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

²The Miami metropolitan area includes Monroe and Dade counties. Philadelphia includes Philadelphia county.

FINDINGS

CASE STUDY PROGRAMS REPORTED SIGNIFICANT SAVINGS THROUGH CONTROLLING NON-EMERGENCY TRANSPORTATION COSTS

Each of the four Medicaid programs we inspected reported that they had operated cost effective non-emergency transportation programs in recent years. Two of the four reported significant reductions in their non-emergency transportation cost. The remaining two reported constantly keeping non-emergency transportation cost low.

The two Medicaid programs that reported significant reductions in non-emergency transportation costs are Louisiana and Miami, Florida.

In 1991, non-emergency transportation costs in Louisiana were \$20 million. By the end of 1994, the costs had increased to \$70 million--a 250 percent increase in 4 years. To detect and prevent fraudulent and abusive practices in non-emergency transportation, Louisiana implemented program controls in 1994. The Louisiana legislature supported the State Medicaid agency's actions to implement such controls. Further, to ensure that controls were enforced, the legislature reduced funding for Medicaid transportation to \$28 million in Fiscal Year 1995. As a result, Louisiana reduced non-emergency transportation costs from \$72 million in 1994 to \$18 million in 1995. This was a \$54 million decrease in 1 year.

Miami, Florida substantially reduced its non-emergency transportation cost in a similar manner. In 1993, non-emergency transportation cost the Miami, Florida Medicaid program \$630 per beneficiary per month. By the end of 1995, non-emergency transportation costs per beneficiary had decreased to \$30 per month. During the 3 year period, the Miami, Florida Medicaid staff reported saving over \$6 million. According to the Miami program administrator, their Medicaid budget would have increased by \$6 million during this time period had they not been able to reduce the costs of non-emergency transportation.

The two Medicaid programs that reported constantly keeping non-emergency transportation costs low are the State of Washington and Philadelphia, Pennsylvania. Both Washington State, and Philadelphia, Pennsylvania Medicaid staffs said they have had program controls in place to prevent fraudulent and abusive practices in non-emergency transportation for the last 8 years.

Washington reported that in 1985 their costs for non-emergency transportation was about \$4 million. In 1993, their non-emergency transportation cost had increased to only \$15 million--an \$11 million increase in 8 years.

Similarly, Philadelphia, Pennsylvania reported non-emergency transportation cost of about \$10 million in Fiscal Year 1986. In Fiscal Year 1994, the cost had increased to \$14 million--a \$4 million increase in 8 years.

CASE STUDY PROGRAMS FOCUSED CONTROL EFFORTS ON THE KINDS OF FRAUD AND ABUSE WHICH WERE MOST LIKELY TO OCCUR

People Who Have Other Means of Transportation

According to HCFA regulations, persons who have other means of transportation are not eligible for Medicaid transportation. States should use all available sources of free transportation services, such as relatives and friends, before authorizing non-emergency transportation payments.

The four Medicaid programs we inspected each had controls to verify that Medicaid beneficiaries had no other means of transportation. For example, each of the four programs used transportation brokers to manage non-emergency transportation for Medicaid beneficiaries. When a beneficiary contacts a broker for non-emergency transportation, the broker makes several tests before authorizing non-emergency transportation. The broker checks computerized beneficiary records to verify that they are eligible for Medicaid services.

When a beneficiary calls for transportation, the broker asks a series of questions designed to ascertain whether or not beneficiaries have access to other transportation. Computerized software programs are designed to prompt broker personnel on the types of questions to ask. For example, a broker might ask questions such as the following. How do you usually get to the grocery store? Do you live with other people, and do the other people have a car? Have you contacted your friends and relatives for help in getting to your medical appointment? When such controls indicate that a beneficiary does have access to other transportation, non-emergency transportation is denied. The beneficiary is advised to use those sources.

Three of the four Medicaid programs we inspected screen for such information each time a beneficiary asks for help with transportation. The other program screens for such information during a beneficiary's initial request for transportation. Thereafter, the broker assumes that a beneficiary's status has not changed unless the beneficiary presents new information.

Unnecessary Trips and Excessive Claims

The four programs we inspected had implemented controls to prevent payment of claims for unnecessary trips and excessive claims. Three of the four programs used trip sheets to match against authorized trips. One program used an authorization control number to match against authorized trips.

Use Of Trip Sheets: The Miami, Florida, Philadelphia, Pennsylvania and Washington State Medicaid programs used trip sheets to help prevent unauthorized trips. A trip sheet is a record that brokers require providers to keep. It shows beneficiary name and address, destination address, beginning and ending odometer reading, and pick-up

and drop-off times. The trip sheet is either submitted with a claim, or serves as the actual claim for payment.

The Medicaid programs we inspected used trip sheets to identify providers who bill Medicaid for unauthorized trips. When a Medicaid beneficiary calls to obtain non-emergency transportation, a broker either authorizes or denies the trip. If the trip is authorized, it is added to a computerized list of authorized trips. When a provider submits the trip sheet and claim for payment, the broker matches it to the list of authorized trips. If it does not match, payment is denied.

Trip sheets are also used to detect providers who bill for more miles than they actually provide. Before paying a claim, brokers examine odometer readings on the trip sheets to assure that providers do not bill for excessive mileage.

The Medicaid programs admitted that it is difficult to precisely verify mileage from one destination to another. However, their brokers told us that the trip sheets are reviewed by staff who know the geographic area. Further, by repeatedly reviewing trip sheets, the staff become familiar with the distance from one destination to another. In instances where the distance appears excessive, the provider is questioned and the payment may be adjusted. One broker in Washington State is experimenting with a computer program that actually calculates the mileage from one destination to another. Then they can compare the mileage on provider claims to that calculated by the computer.

Use Of Prior Authorization Numbers: Louisiana prevents payment for unauthorized trips by assigning a unique prior authorization number to each authorized trip. When a trip is authorized, the broker gives a transportation provider a prior authorization number. The broker then sends all prior authorization numbers to the claims payment center. When a provider submits a claim for payment, the claim must show the prior authorization number. The payment center matches the prior authorization number on the claim to the prior authorization number assigned by the broker. If the prior authorization numbers do not match, the claim will not be paid.

Trips Not Provided

All of the Medicaid programs we inspected have established controls to identify unethical providers who bill for trips not provided. The Medicaid programs required brokers to routinely call a random sample of medical providers to verify that patients received medical care on the same day that trips were authorized.

To illustrate, one broker in Washington State verified 15 percent of the trips each day by calling medical providers. In instances where the appropriate medical providers did not have a record of a beneficiary receiving a medical service, the broker was required to deny payment, or in instances where payment had already been made, initiate action to recover it. Usually, this involved sending a letter to the non-emergency transportation provider demanding reimbursement of the payment.

The brokers for the Miami, Florida program operate a similar control. The broker had a listing of health providers that they call regularly to verify that beneficiaries had and kept medical appointments. The health providers they called were family health centers, mental health agencies, and AIDS programs.

CASE STUDY PROGRAMS ALSO REDUCED NON-EMERGENCY TRANSPORTATION COSTS BY USING LEAST COSTLY TRANSPORTATION

According to HCFA regulations, States must use the least costly means of transportation when multiple methods exist. All of the programs we inspected adhered to the policy. Each program had established criteria for determining the least costly mode of non-emergency transportation. The criteria, in priority order, was to authorize non-emergency transportation from (1) family and friends who are willing to provide non-emergency transportation for reimbursement, (2) available public transportation, (3) available non-profit providers, and (4) available for-profit providers. Non-profit and for-profit providers are typically vans and taxis. Vans equipped to provide rides to wheelchair bound beneficiaries are usually reimbursed at a higher rate.

Typically, when a beneficiary calls a broker for transportation, the broker will ask the beneficiary if they have family or friends that can provide the transportation or if they live on a bus line. If not, the broker will ask them to choose between available non-profit providers. For-profit providers will only be used when non-profit providers are not available.

The following two examples illustrate the need for using the least costly transportation. Prior to 1994, Louisiana largely used the more costly modes of transportation. In 1994, an audit of Louisiana's program showed that for-profit providers received 99.6 percent of all non-emergency transportation reimbursements in 1993. This is the highest cost type of provider. The audit further stated that most unnecessary non-emergency transportation cost resulted from using the most costly sources of non-emergency transportation. Following the audit, Louisiana started determining the least costly mode of transportation before authorizing non-emergency transportation. As a result of this and other program changes, non-emergency transportation costs decreased from \$72 million in 1994 to \$18 million in 1995--a \$54 million decrease in one year.

Likewise, in 1993 the Miami, Florida program reduced its non-emergency transportation costs by using the least costly method of transportation. Miami, Florida began a program, referred to as the Metropass program. Under Metropass, public transportation bus passes are issued by the State to Medicaid beneficiaries for non-emergency transportation.

The Metropass program targets beneficiaries who have three or more medical appointments a month. Three appointments would normally cost the program \$90 whereas, a monthly bus pass only costs \$30. In instances where such transportation

was not readily available or accessible for beneficiaries, other forms of transportation was authorized.

Freedom of Choice Provision does not have to limit States ability to use least costly transportation

The freedom of choice provision of the Medicaid law states that beneficiaries have a right to chose their provider of services when Federal reimbursement for Medicaid services are claimed as a medical expense. Therefore, States that claim non-emergency transportation as an optional medical expense must adhere to the freedom of choice provision.

Two of our selected Medicaid programs, Miami, Florida, and Louisiana, claim Federal reimbursement for non-emergency transportation as an optional medical expense. Both programs demonstrated that adhering to the freedom of choice provision does not limit their ability to use low cost transportation.

Freedom of choice does not require a State to provide transportation at unusual or exceptional costs to meet a recipient's personal choice of provider. Louisiana and Miami, Florida used this exception to the freedom of choice provision to use low cost transportation and reduce their non-emergency transportation costs. To illustrate, Louisiana offers beneficiaries a choice, however, the choice is among the lowest cost providers. A beneficiary in Louisiana would have to choose among a non-profit provider before choosing among a for-profit provider.

In Miami, Florida, a beneficiary must use public transportation if it is most cost effective for the Medicaid program. They cannot use a for-profit or non-profit provider if public transportation is available in their area. Again, the Medicaid beneficiary has a choice, but they still must use the lowest cost transportation available.

States can limit freedom of choice by claiming Federal reimbursement for non-emergency transportation as an administrative expense

Two of our selected Medicaid programs, Philadelphia, Pennsylvania and Washington, chose to claim Federal reimbursement for non-emergency transportation as an administrative expense. Both programs do not have to adhere to the freedom of choice provision. They can reduce costs by contracting with only low cost providers. They can choose the type of transportation and the transportation providers who will provide the services.

However, the extent of potential savings from claiming non-emergency transportation as an administrative expense may or may not offset future losses in Federal revenue. For example, Louisiana chose to treat non-emergency transportation as an optional medical expense because they receive a Federal matching rate of 75 percent for medical services. If they changed the way they treat non-emergency transportation to

an administrative expense, they would only receive a Federal matching rate of 50 percent. Therefore, Louisiana may or may not realize significant savings by claiming non-emergency transportation as an administrative expense.

In contrast, Philadelphia, Pennsylvania and Washington State's Federal matching rates for Medicaid medical services are 56 percent and 54 percent, respectively. By choosing to treat non-emergency transportation as an administrative expense, they receive a 50 percent Federal matching rate which is only slightly lower than their Federal matching rate for medical services. These Medicaid programs believe the loss in Federal matching funds is offset by savings in program costs.

States can obtain a waiver of the freedom of choice provision to have greater flexibility in using least costly transportation

States that claim Federal reimbursement for non-emergency transportation as an optional medical expense can also reduce costs by obtaining a waiver of the freedom of choice provision. By obtaining a freedom of choice waiver, States are not required to give beneficiaries a right to choose their provider of transportation services. Such programs can choose what types of transportation they will provide and who will provide transportation service to Medicaid beneficiaries. A freedom of choice waiver allows Medicaid programs to control costs by having more flexibility to contract with low-cost non-emergency transportation providers, while maintaining their higher Federal matching rate.

According to HCFA, only three States currently have a freedom of choice waiver. The freedom of choice waiver is contingent upon Federal approval. Medicaid programs must demonstrate that their transportation methods do not limit beneficiary accessibility to Medicaid services.

USING BROKERS MAY HELP CONTROL COSTS

The four Medicaid programs we inspected used brokers to help manage their non-emergency transportation programs³. Brokers are contractors who may be private or public organizations. The Medicaid programs we inspected contracted with one or several brokers who managed non-emergency transportation on a regional or county basis. Medicaid staffs in the four programs we inspected told us brokers can help control costs. The brokers, they said, have a contractual obligation to keep costs at a specified level--an incentive to control cost.

Washington State, for example, reported significant cost savings from using brokers. In 1990, Washington Medicaid staff compared non-emergency transportation costs against what it would have cost under a pre-broker system in 1988. The comparison

³In Louisiana, the brokers are referred to as dispatch offices.

showed that given the same number of trips, non-emergency transportation would have cost \$3.7 million more under the pre-broker system in 1988.

Major Advantages of Using Brokers

Staff of the four programs we inspected cited several advantages to using brokers to manage non-emergency transportation. First, brokers are intermediaries to assure that transportation is necessary. The four Medicaid programs we inspected used brokers to schedule appointments for trips. They require Medicaid beneficiaries to schedule non-emergency transportation through a broker rather than a transportation provider. By scheduling trip appointments through brokers, they assure that trips requested by beneficiaries are necessary before giving approval and scheduling the trip with a provider. In contrast, when a beneficiary asks a provider directly for non-emergency transportation, unethical providers have an opportunity to provide the transportation whether or not it is needed. Further, unethical providers may solicit transportation business from beneficiaries who do not need it.

Second, brokers who manage non-emergency transportation at local levels typically know the transportation resources, conditions, and beneficiary needs.

Third, brokers usually have expertise in providing transportation services. They can use their experience to determine the most cost-effective mode of transportation. Many brokers are social service agencies that have experience in arranging trips. For example, the Philadelphia broker existed many years as a volunteer transportation organization.

Fourth, brokers have flexibility to develop cost-saving ways of providing transportation. For example, a broker in Washington State is developing a system by which they give beneficiaries gas vouchers, and gas stations bill the broker.

Major Disadvantage of Using Brokers

Staff at the four programs we inspected cited one potential disadvantage of using brokers to manage non-emergency transportation. They noted that some brokers may also be in the transportation business, or have relatives and close friends in the business. In such instances, an unethical broker has an opportunity to assign non-emergency transportation business to their own company, or that of a friend or relative. If so, the non-emergency transportation provider may not be the least costly provider. Only one non-emergency Medicaid transportation program we inspected said they had experienced this problem to a great extent. In this instance, the Medicaid program staff said they resolved the problem by immediately discontinuing use of the abusive brokers involved. The other three Medicaid programs we inspected said they had not experienced this problem to any great extent.

RECOMMENDATIONS

We recommend that HCFA advise States of opportunities to reduce expenditures for non-emergency transportation. Specifically, to

- focus efforts and establish controls on the kinds of fraud and abuse which are most likely to occur,
- use least costly transportation, and
- use brokers where appropriate to help manage non-emergency transportation.

We also recommend that HCFA advise States of their options for using less costly transportation methods. Two of the States we surveyed demonstrated that opportunities exist to use less costly transportation methods while still adhering to the freedom of choice provision. States can avoid constraints of the freedom of choice provision by electing to claim Federal reimbursement for non-emergency transportation as an administrative expense. In addition, States can get a waiver of the freedom of choice provision.

Most States could adopt practices similar to those used by the case study programs described in this report. We cannot accurately estimate the precise amount that could be saved because we did not independently verify the savings data, we did not collect administrative cost data for the case study programs, and we do not know what progress other States have made in controlling costs. However, this is a program with over \$1 billion in expenditures. If all States adopted practices similar to those used by the case study programs, we believe substantial savings could be achieved.

AGENCY COMMENTS

The HCFA Administrator concurred with our recommendations. He stated that the report recommendations are consistent with existing HCFA activities. The HCFA established a Non-Emergency Transportation Technical Advisory Group comprised of State and Federal Medicaid staff. The group is currently developing recommendations for HCFA and the Executive Committee of the National Association of State Medicaid Directors on a wide range of issues, including those in our report. He believes that their recommendations will facilitate changes we seek.

In response to HCFA's technical comments, we made appropriate revisions to the report.

The Principal Deputy Assistant Secretary for Planning and Evaluation (ASPE) conditionally concurred with our recommendations. In the draft report, we roughly estimated that if all States adopted practices similar to our case study programs, the Medicaid program could save \$100 million per year. The ASPE comments challenged the accuracy of this estimate and recommended that it not be included in the report. We agree that this was, at best, a rough estimate. We had only intended to illustrate in broad terms the potential for savings. We removed the savings estimate of \$100 million and substituted general language indicating the potential for savings.

The full text of HCFA and ASPE comments are provided in Appendix A.

APPENDIX A

AGENCY COMMENTS ON THE DRAFT REPORT



The Administrator
Washington, D.C. 20201

DATE: FEB 13 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Controlling Medicaid Non-Emergency Transportation Costs," (OEI-04-95-00140)

We reviewed the above-referenced report that describes effective practices for controlling non-emergency transportation costs in the Medicaid program. The report recommendations are consistent with existing Health Care Financing Administration (HCFA) activities that have already been initiated in this area. HCFA established a Non-Emergency Transportation (NET) Technical Advisory Group (TAG) comprised of state and Federal Medicaid staff. The TAG is currently developing recommendations to HCFA and the Executive Committee of the National Association of State Medicaid Directors that will address a wide range of issues, including those in the subject report. We believe the findings of this group will be the ideal instrument to facilitate the necessary changes we all seek. Our detailed comments are attached.

Thank you for the opportunity to review and comment on this report.

Attachment

IG	_____
EAIG	_____
SAIG	_____
PDIG	_____
DIG-AS	_____
DIG-EC	_____
DIG-EI	_____
DIG-OI	_____
DIG-MP	_____
AIG-LC	_____
OGC/IG	_____
ExecSec	_____
Date Sent	2/20

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Health Care Financing Administration (HCFA)
Comments on Office of Inspector General (OIG) Draft Report:
“Controlling Medicaid Non-Emergency Transportation (NET) Costs.”
(OEI-04-95-00140)

OIG Recommendations

- o HCFA should advise states of opportunities to reduce expenditures for non-emergency transportation.
- o HCFA should advise states of their options for using less costly transportation methods.

HCFA Response

HCFA concurs. The report recommendations are consistent with existing HCFA activities that have already been initiated in this area. HCFA worked with the states to ensure the positive developments outlined below.

In 1994, HCFA created the Non-Emergency Transportation (NET) Technical Advisory Group (TAG) to find cost-effective and efficient ways to provide transportation services under Medicaid and to address the wide range of transportation-related issues that impact Medicaid. The TAG's membership is comprised of 10 state members from each of the HCFA regions. Currently, the TAG is preparing a comprehensive report with recommendations to HCFA and the Executive Committee of the National Association of State Medicaid Directors that will address a wide range of issues, including those discussed in the OIG report. We believe the findings of this group of experts will be the ideal instrument to facilitate the necessary changes we all seek. The work is scheduled for completion by the end of June 1997.

In recognition of the need to give states flexibility to provide access to needed medical care, the Federal statute permits Medicaid transportation services to be provided as either an administrative activity or an optional covered medical service. In an effort to provide clarification to states and others, HCFA discussed the policies associated with the provision of transportation services under Medicaid in different forums, both written and verbal, including onsite assistance. During several annual State Medicaid Directors' conferences, HCFA sponsored a workshop for states to share the workings of their NET programs with others.

Page 2

We agree with the report recommendation regarding the use of brokers as a means to help manage NET expenditures. Additionally, we believe it would be helpful to accompany the recommendation with a reminder of the alternative approaches to be aware of when claiming these costs for Federal matching purposes.

General and Technical Comments

Federal Medical Assistance Percentage (FMAP) - On page 1 of the OIG report, in the second to last paragraph, the report refers to the FMAP rate as ranging from 50 to 80 percent. We suggest the report reference section 1905(b) of the Social Security Act, which indicates that the extreme limits for the FMAP range from 50 to 83 percent.

We recommend consistency between paragraph 3 on page 4, and paragraph 4 on page 7; i.e., show the savings as either \$52 million or \$54 million, whichever is correct.



FEB 21 1997

To: June Gibbs Brown
Inspector General

From: David F. Garrison
Principal Deputy Assistant Secretary
for Planning and Evaluation

Subject: OIG Draft Report: "Controlling Medicaid Non-Emergency
Transportation Costs -- *CONDITIONAL CONCURRENCE*

DEI-0495-00140

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
SAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EC	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
AIG-LC	<input type="checkbox"/>
OGC/IG	<input type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	<u>2/25</u>

Thank you for the opportunity to review this draft report. The strategies undertaken in the case study states to control non-emergency transportation costs in Medicaid are of interest and should certainly be shared with the other states.

I concur with the IG's report with one condition. The estimate of potential annual savings of \$100 million if all states reduced their costs by 10 percent is not well-grounded and is probably excessive. This reference should be omitted so as to avoid unrealistic expectations for Medicaid savings in this area. My criticism of the estimate is based on the following considerations:

- It is unrealistic to expect 10-percent cost reductions in every state, on an annual basis. It is more likely that some states may be able to achieve significant savings in the first year or years that they institute new cost-control measures, rather than on a continuous basis. Depending on circumstances and state practices, other states may not be able to achieve significant savings.
- Relatedly, the \$100 million estimate assumes savings in the case study states as well as the others, even though the case study states have probably already achieved most of the cost-reducing effect of their practices.
- Although the case study states were chosen for their exemplary accomplishments, other states may also have practices in effect currently to control their Medicaid spending on non-emergency transportation. To the extent that this is so, the estimate is overstated.
- The report (page 3) offers several caveats about the savings data obtained from the case study states, such as the fact that the data were not validated independently and do not reflect administrative costs incurred by the study states. In light of these limitations, the savings reported in the study states do not provide a sturdy foundation for the national annual estimate.

If you have any questions, please contact Julia Paradise, of my staff, at 690-6476

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