DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 28 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Stuart Wright /S/
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: "Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services," OEI-06-07-00320

This memorandum report provides information about the safeguards that State Medicaid agencies use to prevent and detect Medicaid nonemergency medical transportation (NEMT) fraud and abuse. It also identifies the numbers, types, and outcomes of NEMT fraud and abuse cases that State Medicaid Fraud Control Units (MFCU) investigated in recent years.[1] Federal regulations (42 CFR § 431.53) require each State to ensure that Medicaid beneficiaries have necessary transportation to and from medical providers and to describe, in its State plan, the methods that the State will use to meet this requirement. The Office of Inspector General (OIG) and other entities have identified significant vulnerabilities to fraud and abuse in State NEMT programs.[2] To safeguard against fraud and abuse, Federal regulations (42 CFR § 455.13) require that each State Medicaid agency establish methods for identifying and investigating suspected fraud and abuse cases and referring them to law enforcement.

In a survey of State Medicaid agencies, we found that most States concentrate their safeguard activities on screening providers, requiring prior approval for services, and implementing methods to prevent and detect improper payments. Further, the 29 States that use contracted transportation brokers (hereinafter referred to as "brokers") to administer their NEMT benefit reported using multiple techniques to monitor brokers, including complaint investigation, periodic contract renewal, and broker reporting requirements. State MFCUs provided data indicating that they

[1] A MFCU is a single identifiable entity of State government, annually certified by the Secretary of the Department of Health and Human Services (HHS), that conducts a statewide program for the investigation and prosecution of health care providers that defraud the Medicaid program. Social Security Act §1903(q), 42 U.S.C. 1396b(q).

[2] "Review of Wisconsin's Non-Emergency Medical Transportation Costs for Services Provided by American United Taxicab, Inc. for January 1 Through December 31, 2005," August 4, 2008, A-05-08-00040; Government of the District of Columbia, Office of the Inspector General, "Audit of the Maintenance of Medical Necessity Forms for Non-Emergency Transportation of Medicaid Recipients," September 29, 2006, 05-2-18HC(b); Missouri State Auditor, "Controlling Costs For Medical Equipment and Transportation," October 2005, 2005-73.

investigated a combined total of 509 NEMT fraud and abuse cases from 2004 to 2006, with the most common types involving billing for services not rendered and unspecified overbilling.[3]

BACKGROUND

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund 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.[4] Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to 42 CFR § 440.170, the transportation benefit includes transportation expenses and related travel expenses deemed necessary by the State Medicaid agency to secure medical examinations and treatment for a beneficiary. Examples of modes of transportation that States authorize include ambulances; specialized motor vehicles (e.g., wheelchair-accessible vans); and common carriers (e.g., taxis, personal vehicles, and public transportation).

The Deficit Reduction Act of 2005 gave States the option to "[establish] a non-emergency medical transportation brokerage program in order to more cost-effectively provide" transportation for Medicaid beneficiaries.[5] The statute requires that brokers:

- be selected through competitive bidding;
- have oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;
- be subject to regular auditing and oversight by the States; and
- comply with all prohibitions on referrals and conflicts of interest established by the Secretary of HHS.

Beyond these requirements, States have considerable discretion regarding what services they contract with brokers to provide and how they oversee brokers. For example, States may choose to use brokers in only limited geographic locations, such as metropolitan areas, or they may use brokers to handle all aspects of NEMT services statewide.

Fraud and Abuse Safeguards

Federal regulations require that each State Medicaid agency establish a program integrity (PI) program that includes methods for identifying and investigating suspected fraud and abuse cases and referring them to law enforcement.[6] States must also take action to investigate and resolve

[3] The "unspecified overbilling" category of fraud cases were reported by State MFCUs as overbilling cases without further detail.

[4] The State plan is a comprehensive written statement submitted by the State Medicaid agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with all applicable laws, regulations, and official issuances (42 CFR § 430.10).

[5] P.L. No. 109-171 § 6083(a)(3), adding § 1902(a)(70) to the Social Security Act, effective February 8, 2006.

[6] 42 CFR § 455.13.

cases involving overpayments, including recovery of overpayments made to providers.[7] If a State detects evidence of potential provider fraud, it must refer such a case to the State MFCU or other appropriate law enforcement agency, such as a local district attorney.[8] The MFCU is responsible for reviewing the referrals it receives from the State Medicaid agency and other sources to determine whether the issues involved merit criminal and/or civil investigation. Although States must meet Federal requirements, they have flexibility in the design and execution of their Medicaid PI programs. States that use brokers to administer and safeguard NEMT may also include mechanisms for oversight of those brokers.

Recent reports regarding fraud and abuse in State NEMT programs highlight some of the types of fraud and abuse and the importance of effective PI activities. For example, an OIG report found that 18 of 100 sample NEMT claims submitted by a taxicab company in Wisconsin in 2005 were paid inappropriately for NEMT services on dates when beneficiaries did not receive Medicaid services.[9] OIG estimated that almost $700,000 in improper NEMT claims for the year could be attributed to the single provider. A report issued by the District of Columbia Office of Inspector General found that the program's failure to maintain medical necessity forms for over $16 million in NEMT services or to perform any onsite visits or reviews constituted "a serious breach of basic internal controls."[10] Likewise, a report issued by the Missouri State Auditor found that the broker hired to arrange NEMT services for beneficiaries failed to arrange the most appropriate mode of transportation and acted to maximize its own profit.[11]

METHODOLOGY

Scope

For this memorandum report, we examined all 50 States and the District of Columbia (hereinafter referred to as "States") to identify their safeguards to prevent and detect NEMT fraud and abuse. We also examined the numbers, types, and outcomes of fraud and abuse cases that State MFCUs investigated from 2004 to 2006.

Data Collection and Analysis

We obtained written responses from all State Medicaid agencies regarding their NEMT program operations and the safeguards in place at the time of their responses (i.e., July to November 2007). States provided documentation to support their written responses, and we conducted followup as necessary to clarify information reported.

We obtained information regarding 2004–2006 NEMT fraud and abuse cases from 49 State MFCUs. Regarding the remaining two States, the Idaho MFCU was created in 2007 and,

---

[7] 42 CFR § 455.16.

[8] 42 CFR §§ 455.15 and 455.21.

[9] "Review of Wisconsin's Non-Emergency Medical Transportation Costs for Services Provided by American United Taxicab, Inc. for January 1 Through December 31, 2005," August 4, 2008, A-05-08-00040.

[10] Government of the District of Columbia, Office of the Inspector General, "Audit of the Maintenance of Medical Necessity Forms for Non-Emergency Transportation of Medicaid Recipients," September 29, 2006, 05-2-18HC(b).

[11] Missouri State Auditor, "Controlling Costs For Medical Equipment and Transportation," October 2005, 2005-73.

therefore, did not investigate any cases from 2004 to 2006 and North Dakota does not operate a federally supported MFCU.

We analyzed information reported by State Medicaid agencies and MFCUs to identify:
- States' fraud and abuse safeguards for NEMT services;
- States' use of brokers and States' activities for oversight of these brokers; and
- numbers, types, and outcomes of NEMT fraud and abuse cases investigated by State MFCUs from 2004 to 2006.

Limitations
This report relies on information reported by State Medicaid agencies and MFCUs, which we did not independently verify. Further, determining the extent to which States and/or their contractors actually implemented reported safeguards and oversight activities was beyond the scope of the study.

Standards
This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency (now Council of the Inspectors General on Integrity and Efficiency).

RESULTS

States Reported Focusing Medicaid Nonemergency Medical Transportation Safeguards on Screening Providers, Requiring Prior Approval of Services, and Implementing Methods To Prevent and Detect Improper Billing

All States reported conducting a variety of safeguard activities to protect against fraud and abuse of NEMT services. However, most States and their brokers concentrate their safeguard activities on three areas: screening providers, requiring prior approval for services, and implementing methods to prevent and detect improper billing. Depending upon the State, responsibility for conducting these activities lies with the State Medicaid agency itself, other State agencies, brokers, or some combination of these entities.

Screening Providers. Forty-five States reported conducting NEMT provider-screening activities in 2007 to safeguard their NEMT programs from fraud and abuse. The remaining six States did not enroll NEMT providers. All 45 States that enroll NEMT providers check applicant information against the OIG list of excluded providers, and 43 States require transportation providers to disclose relevant prior criminal convictions.[12] (See Table 1.)

[12] OIG maintains a list of all individuals and entities currently excluded under various legal authorities from participation in Federal health care programs.

Table 1: Provider-Screening Activities of States That Enrolled Medicaid Nonemergency Medical Transportation Providers

Safeguard	Number of States	Percentage of States That Enrolled Providers (n=45)
Check for exclusion from Federal health care programs	45	100%
Require disclosure of criminal convictions	43	95%
Require special license, certification, or training	38	84%
Check driving records	32	71%
Conduct onsite visits	30	67%
Conduct criminal background checks	28	62%
Require periodic provider reenrollment	24	53%

Source: OIG analysis of survey responses and documents submitted by State Medicaid agencies in 2007.

Thirty-eight States require providers to obtain specific licenses or certifications, including drivers' licenses, vehicle inspections, or certifications for operating passenger transportation vehicles. Additionally, 10 of these 38 States require special licensure and/or training, such as defensive driving, first aid and cardiopulmonary resuscitation, passenger assistance, special needs assistance, and others. Thirty-two States check the driving records of NEMT providers, and 30 States conduct site visits to verify the legitimacy of providers. Site visits include both random and targeted inspections of provider locations by State agencies and/or brokers. Twenty-eight States require NEMT providers to submit to criminal background checks. Twenty-four States require providers to periodically reenroll, which typically involves some combination of completing new applications, updating driving record checks, conducting new criminal background checks, and/or renewing professional licenses and certifications.

Requiring Prior Approval. Forty-six States reported that they require beneficiaries to obtain prior approval before using some or all NEMT services. The five remaining States do not require prior approval. Prior approval typically involves verification of the beneficiary's Medicaid eligibility, the medical necessity of the trip, and the beneficiary's lack of alternative transportation options. Thirty-one of the forty-six States require prior approval for all NEMT services, although these States may authorize "standing orders" for certain types of recurring trips, e.g., trips to and from dialysis treatment. The remaining 15 of the 46 States require prior approval for only certain NEMT services. A common approach among these States is to have lists of "standard" NEMT services that do not require prior approval. A beneficiary must seek prior approval only when transportation needs differ from the standard list. For example, in one State, a beneficiary's trip to a Medicaid-covered physician's office does not require prior approval, whereas prior approval is required for trips out of the State; trips exceeding certain mileage limits (e.g., 50 miles); and trips requiring food, lodging, or unusual transportation modes (such as air ambulance).

Implementing Methods To Prevent and Detect Improper Billing. Fifty States reported implementing one or more methods to prevent and detect improper billing.[13] (See Table 2.) Forty States reported operating public hotlines for beneficiaries or others to either pass along fraud and

[13] State Medicaid agency officials from the one remaining State reported that its NEMT program relies on a capitated payment to its transportation broker that shifts much of the risk of improper NEMT payments from the State to the broker.

abuse tips or make complaints about NEMT providers or services. States direct complaints to PI staff or contractors for further investigation. Depending upon the State, investigations may include unannounced audits, medical record reviews, referral to the MFCU, or other action. Thirty-six States reported conducting reviews of randomly selected NEMT claims after payment has been made and/or all claims submitted by specific providers. Such reviews may occur periodically (e.g., monthly) or only in response to a complaint. Claims reviews can result in requests for further records from transportation providers or further audits.

Table 2: Methods To Prevent and Detect Medicaid Nonemergency Medical Transportation Improper Billing

Method	Number of States	Percentage of States (n=51)
Fraud or complaint hotline	40	78%
Claims review	36	71%
Data analysis and monitoring	35	69%
Prepayment edits	23	45%

Source: OIG analysis of survey responses and documents submitted by State Medicaid agencies in 2007.

Another common fraud and abuse detection method, reported by 35 States, involves analysis of claims data. Data analysis methods include simple comparisons between physician billings and charges as well as more sophisticated data mining. For example, use of computer algorithms enables States to monitor an individual provider's billing patterns and usage trends over time. These algorithms can repeat certain claims analysis routines for each provider or each claim and flag those that meet predetermined criteria for suspicious activity or inappropriate billing, such as a surge in a provider's billing or reimbursement. If data analysis uncovers aberrant patterns or suspected fraud and abuse activity, State Medicaid agencies or their brokers can conduct further audits or refer the case to the MFCU for investigation. Finally, 23 States reported using prepayment edits specifically designed to process NEMT claims. Prepayment edits are automated programs that check multiple elements of each claim for specific inconsistencies or errors that, if present, trigger the denial of the claim. For example, a State using a prepayment edit might deny a NEMT claim because the beneficiary did not receive any other Medicaid services on the same day.

The 29 States That Used Brokers Reported Using Complaint Investigations, Reporting Requirements, Contract Renewal, and Other Techniques To Oversee Brokers

Twenty-nine States reported that brokers administered all or part of their NEMT programs at the time of the States' responses in 2007. The remaining 22 States did not use brokers, but 4 of these States were in various stages of developing brokerage programs. Of the 29 States using brokers, 25 States estimated that brokers provided at least half of their NEMT services and the 4 remaining States estimated that brokers provided less than half of their NEMT services. The primary services that States contracted with brokers to provide include screening and enrolling providers, arranging NEMT services for beneficiaries, processing NEMT claims, tracking and reporting NEMT usage to the States, conducting PI activities, and vetting prior approval requests.

States reported using multiple techniques to ensure that brokers administered NEMT services appropriately and helped to safeguard the programs from fraud and abuse as required by the States.

(See Table 3.) All 29 States reported using at least three of the seven oversight activities listed in Table 3. For example, 26 States reported that they investigate complaints made by beneficiaries or others about their NEMT services. Twenty-five States required their brokers to periodically, e.g., quarterly, report to the State Medicaid agencies administrative data, such as the numbers of hotline telephone calls and complaints received, the number of trips provided, and certain details about each trip. Twenty-five States also periodically renew their broker contracts, giving them the opportunity to evaluate broker performance and rebid the contracts if necessary. Twenty States reported that their staffs conduct onsite reviews of brokers, which included random audits of claims data, inspection of vehicles, and monitoring of call center activity. Twenty-one States reported using information generated through complaint hotlines to monitor brokers. Finally, 19 States reported service trip verification activities that include audits of a wide range of broker records, such as records of prior authorization, proof of medical necessity, appropriate routes taken, verification of beneficiaries' medical appointments, and other records.

Table 3: Oversight Mechanisms of Twenty-nine States That Use Medicaid Nonemergency Medical Transportation Brokers

Oversight Mechanism	Number of States	Percentage of States That Use Brokers (n=29)
Complaint investigation	26	90%
Regular reporting requirements	25	86%
Periodic contract renewal	25	86%
Beneficiary satisfaction survey	23	79%
Complaint hotline	21	72%
Onsite broker review	20	69%
Service trip verification	19	66%

Source: OIG analysis of survey responses and documents submitted by State Medicaid agencies in 2007.

State Medicaid Fraud Control Units Reported Investigating 509 Medicaid Nonemergency Medical Transportation Fraud and Abuse Cases of Various Types From 2004 to 2006

State MFCUs provided data regarding the types and outcomes of their NEMT fraud and abuse investigations from 2004 to 2006. Forty-two MFCUs reported a total of 509 NEMT fraud and abuse cases, two States did not operate MFCUs during this period, and the remaining seven MFCUs did not report any NEMT fraud and abuse cases. These seven MFCUs indicated that NEMT fraud was not tracked separately from other types of Medicaid fraud and, therefore, could not be distinctly reported.

The cases investigated by MFCUs from 2004 through 2006 included a variety of types of fraud and abuse. The two most common types involved provider billing fraud, including billing for services not rendered (104 cases) and unspecified overbilling (93). Other common types included upcoding (57), undocumented or forged documentation (32), billing for excess mileage (31), and nonmedical use of NEMT services (25). Table 4 contains examples of these and other frequently reported types of fraud and abuse involving providers.

Of the 509 cases reported by State MFCUs, 371 (73 percent) were closed and the remaining 138 cases (27 percent) were open at the time the MFCUs submitted data to OIG during the second half of 2007. States either reported that open cases were under active investigation or provided no further detail about the status of open cases.

Table 4: Types of Medicaid Nonemergency Medical Transportation Provider Fraud and Abuse Cases Investigated by State Medicaid Fraud Control Units

Fraud and Abuse Type and Examples	Number of Cases
Billing for Services Not Rendered • Billing for trips that never actually occurred. • Billing for an additional attendant (i.e., a beneficiary caretaker) when none was provided.	104
Unspecified Overbilling • Engaging in deceptive billing practices to receive excess payment. • Misrepresenting invalid trips and services to receive excess payment.	93
Upcoding • Billing for an attendant when one was not necessary. • Billing for an ambulance when a less expensive form of transportation could have been used. • Billing for nonambulatory support services when the beneficiary was ambulatory.	57
Undocumented Trips and/or Forged Documents • Missing and forged supporting documentation of trips, including transportation provider trip logs, signed certificates of medical necessity, and signed transportation vouchers.	32
Billing for Excess Mileage • Billing for a 30-mile trip when a 15-mile trip was actually taken.	31
Nonmedical Use of NEMT Services • Billing for services when taking a beneficiary to pick up groceries or run other errands.	25
Billing Without a License and/or Using Unauthorized Providers • Providing services through unauthorized personnel. In these cases, NEMT providers might be unlicensed, have bad driving histories, have failed drug tests, or have been convicted of felonies.	23
Double Billing for the Same Service • Submitting two claims for the same service by changing the service date on one of the claims.	21
Kickbacks • Providing free rides for nursing home providers to gain the business of the Medicaid beneficiaries who live there. • Paying beneficiaries to use a particular service. • Paying anyone who has influence over beneficiaries' use of services, including caseworkers, nursing home or hospital transportation coordinators, dialysis center employees, and rehabilitation center employees.	19
Ineligible or Deceased Beneficiary • Inappropriately providing rides to the family members of beneficiaries. • Billing Medicaid for services for deceased beneficiaries.	15
Patient Abuse or Neglect • Physically or sexually abusing beneficiaries. • Leaving beneficiaries unattended or deserting them. • Not picking up beneficiaries in a timely manner, resulting in missed appointments.	9
Notes: • Ninety additional cases did not fit meaningfully into the fraud and abuse types listed above. • The numbers of cases do not sum to 509 because some involved circumstances that fit into more than one fraud and abuse type.	

Source: OIG analysis of fraud and abuse case information submitted by State MFCUs in 2007.

The outcomes of the closed cases are listed in Table 5. Among the 371 closed cases, 150 (40 percent) were reported by MFCUs as dismissed because the allegations were unsubstantiated after investigation. Another 68 cases (18 percent) were investigated and closed without prosecution, typically because there was insufficient evidence for prosecution. Forty-three of the 371 closed cases (12 percent) resulted in criminal convictions. In 37 cases (10 percent), the parties agreed to civil settlements; typically in these cases, defendants reimbursed Medicaid for disallowed expenses but avoided criminal conviction. Outcomes for the remaining cases either were not reported to OIG by the MFCUs (54 cases), resulted in referral to separate law enforcement agencies (10 cases), or did not fit into any of the other categories (9 cases).

Table 5: Outcomes of Closed Medicaid Nonemergency Medical Transportation Fraud Cases Investigated by State Medicaid Fraud Control Units From 2004 to 2006

Outcome	Number of Cases	Percentage of Closed Cases (n=371)
Allegations unsubstantiated	150	40%
Cases not prosecuted	68	18%
Convictions	43	12%
Civil settlements reached	37	10%
Outcomes not reported by MFCUs	54	15%
Referred to other law enforcement agencies	10	3%
Other	9	2%

Source: OIG analysis of fraud and abuse case information submitted by State MFCUs in 2007.

CONCLUSION

This memorandum report provides information that CMS may find useful in its oversight of the Medicaid program. All State Medicaid agencies reported multiple NEMT fraud and abuse safeguards, particularly screening providers, requiring prior approval of services, and implementing methods to detect and prevent improper billing. Twenty-nine States contracted with brokers and most frequently reported using complaint investigations, reporting requirements, and periodic contract renewals to oversee their brokers. Despite these measures, NEMT fraud and abuse has been and may continue to be a problem across States, with State MFCUs reporting that they investigated 509 NEMT fraud cases from 2004 to 2006. Billing for services not rendered and unspecified overbilling were the most common NEMT fraud and abuse cases investigated by MFCUs.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-07-00320 in all correspondence.