

**New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor**

**Department of Human Services
Division of Medical Assistance and Health Services
Transportation Broker Services Contract - Utilization**

July 1, 2014 to June 30, 2017

**Stephen M. Eells
State Auditor**

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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Transportation Broker Services Contract – Utilization for the period of July 1, 2014 to June 30, 2017. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells
State Auditor
March 28, 2018

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), Transportation Broker Services Contract – Utilization for the period July 1, 2014 to June 30, 2017. Our audit included financial activities accounted for in the state’s General Fund. The U.S. Department of Health and Human Services, Office of Inspector General issued a report on the Medicaid Nonemergency Medical Transportation Brokerage program in July 2016. That report found the division did not provide adequate oversight of the program to ensure vehicles used to transport beneficiaries met state standards, drivers were licensed and qualified, prior authorizations were obtained for beneficiaries requiring mobility assistance vehicles, and transportation providers maintained required insurance coverage. These requirements, which involve monitoring broker performance, were excluded from the scope of our audit to avoid duplication of effort. This is the second of two reports regarding the Transportation Broker Services contract. Our first report, released on March 30 2017, found the contract’s capitation rates, although compliant with the contract terms, were not reasonable when compared to the direct transportation costs. This report can be found at <http://www.njleg.state.nj.us/legislativepub/Auditor/545916.pdf>.

The Transportation Broker Services contract established a sole provider (broker) responsible for arranging non-emergent transportation services for Medicaid recipients in all counties through its provider network. The division is responsible for monitoring the contract and for oversight of the fiscal agent responsible for receiving and maintaining encounter claims submitted by the broker. Annual expenditures under the contract were \$171.7 million, \$177.9 million, and \$180.9 million in fiscal years 2015, 2016, and 2017, respectively, and provided services to 135,000 of the approximately 1.67 million Medicaid recipients. Expenditures are partially reimbursed by the federal government.

Objectives

The objective of our audit was to determine whether the division’s procedures for administering and managing the Transportation Broker Services contract were adequate.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. 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.

In preparation for our testing, we studied legislation, the administrative code, and the Transportation Broker Services contract. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing of financial transactions. We also reviewed financial trends and interviewed agency personnel to obtain an understanding of the program and the internal controls.

Statistical and nonstatistical sampling approaches were used. Our samples of financial transactions were designed to provide a conclusion on our audit objective as well as internal controls and compliance. Documentation relating to the costs reviewed was received directly from the agency or the broker, or was derived through queries of the agency's shared data warehouse. Sample populations were sorted and transactions were judgmentally and randomly selected for testing.

Conclusions

We found the division's procedures for administering and managing the Transportation Broker Services contract should be improved. Specifically, our review found the division's procedures for assessing liquidated damages, providing mileage reimbursements to individuals who transport Medicaid recipients, and processing the monthly capitation fees need to be strengthened to reduce costs.

As part of our testing, we noted transactions associated with two Medicaid recipients that may affect their program eligibility. These cases will be referred to the Division of Criminal Justice for their review.

Background

The division has contracted with a transportation broker (broker) to provide non-emergency medical transportation services to Medicaid recipients. The five-year contract, which began in July 2009 and has received multiple extensions and capitation rate adjustments, recently expired on August 31, 2017. The Department of the Treasury, Division of Purchase and Property, on behalf of the division, awarded the new contract to the same broker effective September 1, 2017. Pursuant to both contracts, the broker is paid a set monthly fee, called a capitation, for each eligible Medicaid recipient and submits detailed claim information (encounter claims) to the state's fiscal agent for review. The monthly capitation rate of \$9.04 remained unchanged during our audit period, and was decreased to \$8.68 with the implementation of the new contract. In April 2013, the division amended the contract to impose its ability to sanction the broker if it did not meet certain agreed upon service levels. These sanctions, called liquidated damages, were implemented in an effort to encourage and improve overall service performance.

Liquidated Damages

Procedures for assessing liquidated damages need to be strengthened to promote better performance from the broker.

The division can assess liquidated damages against the broker for failure to meet any of the 12 performance standards defined in the contract in an effort to promote improved performance. Liquidated damages for the period July 2014 to June 2017 totaled \$904,750 or approximately \$25,000 per month (0.17% of monthly capitation). Capitation payments paid to the broker are offset by any liquidated damages assessed by the division.

The broker sends monthly reports to the division which summarize actual service levels for 12 performance standards. The data contained in the reports is then used by the division to calculate potential liquidated damages for each of the performance standards. The division, however, does not review or verify the broker's performance data contained in the monthly reports and the data is simply accepted as accurate. Our detailed review of liquidated damages assessed by the division in calendar year 2016 noted the following.

- The contract established a Vehicle Safety standard which recommends the broker inspect the vehicles of 25 percent of the providers every three months and all providers at least once during a twelve-month period. Liquidated damages of up to \$10,000 can be assessed annually by the division if the vehicle inspection rate drops below 95 percent. Our review of 132 service providers who were active for all of calendar years 2015 and 2016 disclosed that 26 went four or more quarters without an inspection by the broker, and the average time between inspections for these 26 providers was more than 17 months. The division, however, has not assessed any liquidated damages for this standard and could have in calendar years 2015 and 2016 had it reviewed the inspection data submitted by the broker.
- The contract includes a Member Complaints standard for which the broker is assessed liquidated damages of at least \$7,500 per month if greater than one percent of recipients file a complaint. The broker, however, receives the complaints directly and reports the results to the division monthly as previously mentioned. Our review found the broker was not assessed any damages in calendar year 2016 as recipient complaints were reported to be less than one percent each month. We conducted a random survey of Medicaid recipients who used the transportation services during the period January 1, 2017 to May 24, 2017. Of the 250 surveys mailed we received 46 responses. Eleven of the 46 responses (23.9%) noted at least one instance where a provider didn't show up for their scheduled pickup, and 19 responses (41.3%) indicated they had submitted a complaint to the broker. According to the broker, all reported no-show incidents are registered as complaints by the broker. An independent third party should receive, catalogue, and report recipient complaints as the broker could under-report actual complaints to avoid liquidated damages.
- The methodology contained in the broker's contract for calculating liquidated damages for on-time performance and provider no-shows was not properly followed by the broker,

resulting in liquidated damages being under-assessed by at least \$100,000 in 2016 for these two standards collectively.

- We reviewed the data utilized by the division to calculate the monthly liquidated damages for ten of the performance standards in calendar year 2016. Of the 120 data sets we reviewed, we found five instances where the data used by the division did not match the data in the broker's corresponding monthly reports. Although none of these instances had a monetary effect on the liquidated damages assessed, the risk still exists that the division could miscalculate liquidated damages by not accurately transferring the monthly data.

Our review also found that the penalties established in the contract for liquidated damages may not be sufficient to encourage or promote better performance. For example, the broker was assessed the maximum damages allowable, \$15,000 per month, for the provider no-show standard in 34 of the 36 months we reviewed from July 2014 to June 2017. The maximum penalty is assessed when providers fail to show up for greater than .06 percent of unduplicated gross trips (net authorized trips, excluding cancelled or denied trips) in a month. For calendar year 2016, providers averaged approximately 520,375 unduplicated gross trips per month. Our detailed review of calendar years 2015 and 2016 found that providers actually failed to show up for greater than .10 percent of the scheduled trips in 12 of the 24 months. The damages assessed do not appear to provide adequate incentive for the broker to improve provider performance for this standard.

Recommendation

We recommend the division implement procedures to review and verify the data received from the broker prior to assessing liquidated damages each month. The division should also comply with all contract requirements and properly follow the methodology contained in the contract for assessing liquidated damages. In addition, recipient complaints should be received and catalogued by a third party. Finally, the division should consider increasing the maximum amount that can be assessed against each performance standard to promote better broker performance.



Mileage Reimbursements

Controls over mileage reimbursements need to be strengthened to avoid improper payments and reduce costs.

The transportation broker services contract provides a mileage reimbursement of 50 cents per mile to individuals who transport Medicaid recipients to or from a Medicaid-covered service. These drivers are usually friends or family members of the recipients and are not part of a contracted provider's staff. Recipients who have an available vehicle and are able to drive themselves are not entitled to a mileage reimbursement. During calendar year 2016, there were

2,419 individual drivers who were reimbursed a total of \$2,901,952. These costs are covered under the capitation paid to the broker and are recorded by the division as encounter claims in support of the broker's direct transportation costs.

We reviewed the two drivers with the largest total mileage reimbursements in calendar year 2016 and found they were predominantly transporting two or more recipients to the same destination at the same time. Although the contract requires the broker to limit excessive multi-loading, it does not specify a lower reimbursement rate for multi-load trips. As a result, these drivers were reimbursed as though they provided separate trips for each recipient and for more miles than they actually drove. We recalculated the calendar year 2016 total mileage reimbursement for these two drivers based on the farthest recipient transported each trip and noted the following discrepancy.

2016 Mileage Reimbursements			
	Actual Paid	Audit Calculation*	Difference
Driver 1	\$ 49,298.00	\$ 18,129.50	\$ 31,168.50
Driver 2	\$ 23,338.00	\$ 10,041.00	\$ 13,297.00

*The audit calculation of 2016 mileage reimbursements represents the cost incurred to transport only the recipient who traveled the farthest in each multi-load trip.

The division could have saved over \$44,000 in 2016 for these two drivers alone if the reimbursements were based on the actual miles driven for each multi-load trip.

An additional review of calendar year 2016 mileage reimbursement claims provided by the broker disclosed 5,998 claims totaling \$83,236 where the recipients appear to have been reimbursed for driving themselves to a medical appointment. This includes 3,844 instances where the driver and rider names were an exact match and 2,154 instances where the driver and rider names were an exact match except for a middle initial missing from either the rider or driver data. Instances of similar names with suffix differences (Jr., Sr., etc.) were excluded from these totals. A further analysis of the 5,998 claims disclosed that the driver's home address matched the recipient's pickup or drop off location on 2,131 reimbursements totaling \$25,125. As previously mentioned, recipients who drive themselves to a medical appointment are not entitled to a mileage reimbursement.

Currently, the encounter data received from the broker for mileage reimbursements is not sufficient to allow for a proper review. The data does not include the driver's name and therefore the division has no mechanism in place to identify improper payments.

In addition, we randomly selected a sample of 127 mileage reimbursements in calendar year 2016 to determine if a Medicaid-covered service was provided to the recipient on the same day. We found that 12 of the 127 trips (9.4 percent) could not be traced to a corresponding medical

claim or encounter. During our testing, we noted that 56 of the 127 reimbursements were associated with a recipient enrolled in sub-capitated treatment services such as dialysis or clinics. With these types of services, the division is billed only once, and the recipient may receive the service multiple times during the claim's designated period. If a mileage reimbursement claim fell within a sub-capitated claim's service period, we did not count it as an exception. Based on our test results, we estimate that 23,029 claims, or approximately \$274,000 of the calendar year 2016 mileage reimbursements were unsupported by a medical claim for the same day of the trip. A similar test of transportation services provided by the contracted providers resulted in an exception rate of only 3.2 percent for the same day of the trip.

Recommendation

We recommend that the division modify the contract and limit mileage reimbursements for multi-load trips to the actual distance traveled. We further recommend the division require the broker to submit detailed encounter data for mileage reimbursements. This data should include the driver's name so that these claims can be adequately monitored. The division should also implement procedures or system edits to ensure mileage reimbursements are supported by a Medicaid-covered service on the date of transportation.



Duplicate Capitation Payments

The monthly capitation fee was paid multiple times for some Medicaid recipients.

The broker is paid a set monthly capitation fee for each eligible Medicaid recipient. Our review of capitation payments from July 2014 through August 2017 disclosed 14,058 duplicate payments totaling \$127,084. The division paid the monthly capitation fee two or more times for some recipients resulting in overpayments totaling approximately \$336,000 dating back to July 2009.

Each month, the division provides the broker with a list of all current Medicaid recipients. This list is used to generate the capitation payment. There are circumstances for which a recipient may have more than one identification number due to eligibility for different programs. The division has implemented procedures to link these multiple eligibility segments for the same recipient on the state's New Jersey Medicaid Management Information System. Once multiple segments are linked to one recipient, however, there are no procedures in place to review prior capitation fees paid and recover overpayments.

Recommendation

We recommend the division implement procedures to periodically review monthly capitation payments for duplication and recover improper payments.



Denied Encounter Claims

Procedures for monitoring the program's direct transportation expenses need to be strengthened.

The current transportation broker services contract, effective September 1, 2017, requires the actual direct transportation expenses of the program to be, at a minimum, 80 percent of capitation paid. If the 80 percent threshold is not met, the division may recover excess capitation paid. In order to monitor the expense ratio, the division is required to audit the broker's profit and loss statements semi-annually. As part of its review, the division must be able to reconcile paid amounts from the encounter claims submitted through the state's fiscal agent to within 98 percent of paid claim amounts reported in the broker's profit and loss statements.

The New Jersey Medicaid Management Information System (NJMMIS) is utilized by the state's fiscal agent to review and validate encounter claims submitted by the broker. Our review of transportation encounter claims disclosed the division denied encounter claims totaling \$5.2 million, \$6.3 million, and \$19.9 million in fiscal years 2015 through 2017, respectively. One system edit in NJMMIS was responsible for denying \$29 million (92%) of the \$31.4 million encounter claims that were denied over the three-year period. These valid claims were erroneously denied because of a field in NJMMIS which contains a date that is subsequent to the date the encounter data was received. Until these denied claims are properly accounted for, the division will not be able to reconcile encounter claims to within 98 percent of the broker's profit and loss statements as required by the contract. Without a proper reconciliation, the division will not be able to verify if the broker is meeting the 80 percent threshold.

Recommendation

We recommend the division revise the NJMMIS edits to ensure that valid encounter claims are not denied, thereby enabling the division to reconcile encounter claims to the broker's profit and loss statements.





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CAROLE JOHNSON
Acting Commissioner

March 20, 2018

Mr. John J. Termyna
Assistant State Auditor
Office of Legislative Services
125 South Warren Street
PO Box 067
Trenton, NJ 08625

Dear Mr. Termyna:

The Department of Human Services is in receipt of a draft audit report issued by your office titled "**Department of Human Services' (The Department) Division of Medical Assistance and Health Services (DMAHS), Transportation Broker Services Contract – Utilization**". The objective of the audit was to determine whether DMAHS' procedures for administering and managing the Transportation Broker Services contract were adequate.

We agree with the overall conclusion that the Division's procedures for administering and managing the Transportation Broker Services Contract should be improved. The Division has already taken a number of steps in this regard. Our responses to the individual findings and recommendations are as follows:

Recommendation

We recommend the Division implement procedures to review and verify the data received from the broker prior to assessing liquidated damages each month. The Division should also comply with all contract requirements and properly follow the methodology contained in the contract for assessing liquidated damages. In addition, recipient complaints should be received and catalogued by a third party. Finally, the Division should consider increasing the maximum amount that can be assessed against each performance standard to promote better broker performance.

Response

Toward the end of the previous contract, the Division initiated an on-site monitoring unit which we intend to expand. Currently, there is a staff of five (5) dedicated to monitoring the Non-Emergency Medical Transportation (NEMT) program including the twelve (12) performance standards defined within the contract. There are plans to add an additional two (2) staff to the function. The responsibilities of this monitoring unit include: verifying

the data received from the broker; compliance with contract requirements; and monitoring recipients complaints. Furthermore, the Division's External Quality Review Organization (EQRO) will be reviewing complaints and contacting recipients directly. While we agree that the contract penalties are important to enforce the contract, when necessary, we also believe in implementing additional strategies to promote meeting performance standards under the contract. The Division has worked with the broker on multiple improvement strategies that will directly impact performance measures under the contract. An example of this is a global positioning system (GPS) which was initiated prior to the end of the last contract but is now contractually required in all vehicles. This system has successfully resolved consumer disputes in many cases. The Division has successfully addressed other criticisms of the program in the new contract including requiring additional vehicle safety requirements, ongoing customer satisfaction surveys and the clarification of complaint monitoring and reporting. It is also important to note the NEMT broker is voluntarily credentialed by the Utilization Review Accreditation Commission (URAC). The Division relies on this accreditation review as part of its monitoring activities. The Division will continue to work with the NEMT broker to address performance issues as they arise.

Recommendation

We recommend that the Division modify the contract and limit mileage reimbursements for multi-load trips to the actual distance traveled. We further recommend the Division require the broker to submit detailed encounter data for mileage reimbursements. This data should include the driver's name so that these claims can be adequately monitored. The Division should also implement procedures or system edits to ensure mileage reimbursements are supported by a Medicaid covered service on the date of transportation.

Response

The auditors are correct in their observations regarding mileage reimbursement. As a result, the broker will begin to track drivers and limit mileage payment for multi-load situations. Currently, mileage reimbursement is restricted to challenging cases which often incur incentive payments to complete. We, however, believe there are savings realized by the broker and the Medicaid program through reduction of direct and indirect costs by using mileage reimbursement to meet consumer demand. This will result in increased client satisfaction while reducing the need for the broker to pay a contracted provider the load fee for each individual in addition to the mileage.

As for verification of a Medicaid covered service, HIPAA regulations prohibit the broker from asking the nature of the appointment. Therefore, the broker is limited to verifying that the request is to an address that houses a medical provider. However, the Department does recognize the importance of this finding and has already begun efforts to compile lists of the addresses of known, non-eligible services and comparing the request for services to these addresses.

Responsibility for verification of a matching service will be given to the State Monitoring Unit (SMU) that can verify if a matching service was billed to NJ FamilyCare. The SMU

Mr. John J. Termyna
March 20, 2018
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will notify the broker of suspected abusers of this service and will limit their access to mileage reimbursement.

Recommendation

We recommend the Division implement procedures to periodically review monthly capitation payments for duplication and recover improper payments.

Response

The Department agrees and has been working with its fiscal agent to reduce duplicate payments across all capitation payments including NEMT.

Recommendation

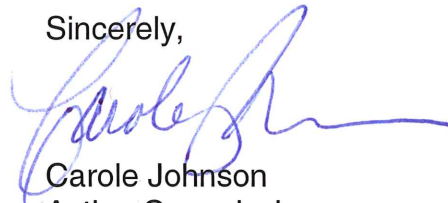
Procedures for monitoring the program's direct transportation expenses need to be strengthened.

Response

Issues related to the submission of complete and correct encounter data are being addressed to ensure claims meet the 98% threshold required under the contract. This will enable the Department to monitor direct costs and ensure the broker is utilizing at least 80% of the capitation rate for direct costs. Failure to do so will result in recovery and a change in the capitation rate.

If you have any questions or require additional information, please contact Christopher Bailey at (609) 984-5382 or Richard Hurd at (609) 588-2550.

Sincerely,



Carole Johnson
Acting Commissioner

CJ:02

C: Christopher Bailey
Meghan Davey
Richard Hurd
Mark Talbot