MAA Mississippi Ambulance Alliance

July 25, 2018

Mr. Drew Snyder, Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Dear Mr. Snyder:

I am writing to you on behalf of the Mississippi Ambulance Alliance with respect to your letter of June 29, 2018 (attached).

As we understand this, the Division of Medicaid has asked CMS for approval of an amendment to the Medicaid State Plan that would require non-emergency ambulance and other transportation providers to bill long-term care facilities for ambulance and other non-emergency transportation of facility residents. The facility would then list the non-emergency transportation costs on the facility's cost report.

We are requesting that the Division of Medicaid delay implementation of this change, for at least 90 days, due to the numerous questions and concerns that have arisen, which include but are not limited to the following:

- When a somewhat similar plan was implemented in Ohio a few years ago, it was nothing short of a major disaster for all concerned, including Medicaid patients. We would be happy to provide you with more details on the subject, but we know that the facilities often refused to pay the ambulance providers causing a problem with access to care; ambulance companies refusing to transport Medicaid patients from certain facilities; the largest ambulance company in the state going bankrupt and out of business as a direct result of the change; etc. Ohio Medicaid ultimately realized the error and stopped the program, but not before major damage resulted.
- Implementation requires the transportation providers and facilities to enter into contracts, but that process can not begin until after various questions as to implementation are answered.
- Contracts between transportation providers and facilities will take time because of legal questions that need to be resolved. Even once those questions are resolved, the parties still need to draft contracts and have them approved.
- Ambulance providers need time to train their staff internally to make the necessary changes, e.g. when to go through MTM versus the facility, which transports are billed at certain rates, etc.
- As far as we know, CMS has not yet approved the State Plan Amendment.

- Ambulance and other transportation providers have not been notified of the proposed change.
- The letter does not indicate that ambulance providers are included.
- The letter does not indicate the rates to be paid to the transportation providers.
- Provision must be made for prompt payment by the facilities, with penalties if they do not comply.
- An appeals process is necessary for denials, i.e. when the facility claims they are not responsible for transportation charges.
- There must be some oversight by Medicaid that forces the facilities to pay the transportation providers and the time limits in which they must pay. If there is no oversight by a state agency, ambulance and transportation providers will not be paid or will not be paid timely, which will result in transportation providers either refusing to transport Medicaid patients or going broke. The transportation providers can not under any circumstances be left in a position of having to bring litigation in order to be paid. If that happens - - as it did in Ohio - - transportation providers will refuse to transport Medicaid patients from certain facilities, potentially leaving facilities and geographic areas with no access to transportation.
- Software changes may be needed.

In addition, many questions have arisen which need to be answered before the ambulance providers and facilities can proceed. A few of those are as follows:

- Will the facility be reimbursed by Medicaid the same amount charged by the ambulance or other non-emergency transportation provider?
- How soon after the facility is billed will it be reimbursed?
- What is the rate to be paid the transportation providers? Is it the current Medicaid rate or a rate that must be negotiated by the facility and transportation provider?
- Are all Medicaid patients in the facility included or are there categories of Medicaid patients that are excluded?
- Which transports are included? For example, if a facility in-patient has an emergency, is transported to a hospital and is admitted as an in-patient, are they still considered a resident of the long term care facility when they are discharged from the hospital? Are repetitive patients (e.g. dialysis, wound care, chemo and radiation therapy) included as the responsibility of the facility?
- Which facilities will this cover? For example, is it only long term care facilities that contract with Medicaid? Does this include assisted living facilities? Inpatient hospices? Inpatient hospitals that have nursing home beds? And how will the transportation providers know which patients in which facilities are included in this proposal?
- Can the patients be billed for non-covered services?
- Can the patients be billed if the patient or their family, rather than the facility, requests the transportation?

- Will there be a prior authorization requirement and, if so, is the facility required to obtain it?

Please note, the above concerns and questions need to be addressed before implementation of this change. Otherwise you will have total chaos with facilities claiming they are not responsible for transports, disputes as to the amounts to be paid, which trips/patients are included, delayed payments, etc. which will lead to transportation providers going broke and not being able to provide access to transportation. If you think this will not happen, you need to research what happened in Ohio when the above concerns were ignored.

Our industry stands ready to help you in any way we can to get this implemented correctly.

Sincerely,

Wade N. Spruill, Jr.

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June 27, 2018

Mr. Drew Snyder, Director
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Via: Margaret.Wilson@medicaid.ms.gov

Re: Proposed State Plan Amendment (SPA) 18-0010

Dear Mr. Snyder:

As the financial and reimbursement advisor to numerous long term care (LTC) providers in the State, we wish to offer our perspective on changes proposed by the Division of Medicaid in the Mississippi State Plan Amendment (SPA) 18-0010. We trust the Division will consider the following comments in a thoughtful manner.

Historically, the Division of Medicaid has paid for a majority of non-emergency transport services provided to nursing facility residents through either the Ambulance program or the Non-Emergency Transport (NET) program. Pursuant to the aforementioned proposed SPA, the Division proposes to transfer this financial obligation to nursing homes and other long term care providers.

Attachment 4.19-D of the State Plan encompasses the reimbursement guidelines for long term care providers. Specifically, Chapter 3 of Attachment 4.19-D states "the intent of the Division of Medicaid to reimburse nursing facilities a rate that is adequate for an efficiently and economically operated facility." With this in mind, the Division has consistently provided interim rate adjustments to account for such mandates imposed on long term care providers. Examples of rate adjustments born out of such mandates include changes in provider assessments and minimum wage increases. We expect the Division to follow historical precedence in this case as well. Interim rate adjustments to LTC provider per diem rates would ensure LTC providers are compensated for these mandated cost increases in order to comply with Attachment 4.19-D. Failure to provide these payment adjustments would constitute a unilateral de-obligation for such services by the State. It would simultaneously mandate that long term care providers provide and pay for these services without timely reimbursement from Medicaid.

Furthermore, because long term care providers were not provided advance notice from the Division concerning their intentions to make such changes, providers have already finalized budgets for the current and coming year. Such sudden and unfunded mandates would serve only to destabilize the industry and put patient access at risk.

In light of the aforementioned, should the Division choose to pursue CMS approval of SPA 18-0010, we posit that necessary rate adjustments to LTC providers would be warranted to account for the resulting financial obligation shift to LTC providers.

We appreciate your thoughtful consideration of these comments.

Sincerely,

HORNE LLP

W. Shane Hariel, CPA
Partner, Healthcare Services

Enclosure

WSH/kp