

**TESTIMONY BEFORE THE PUBLIC SAFETY COMMITTEE
TODD PORTER, CHAIRMAN
NOVEMBER 27, 2007**

Chairman Porter, members of the Public Safety Committee, I am Maggie Anderson, Director of the Division of Medical Services for the Department of Human Services. I appear before you to provide information regarding your study of the Emergency Medical Services System.

Medicaid Rates for Ambulance Services

In addition to the inflationary increases provided to all providers during the 2005 Legislative Assembly, an appropriation (Total Funds \$170,940, of which \$60,000 were General Funds) was provided for Medicaid reimbursement to Ambulance providers. The intent of the funds was to target 50 percent toward the base ground rates and 50 percent toward the base air rates. The Department worked with Ambulance providers and allocated the funds accordingly.

During the 2007 Legislative Session, additional funds were again provided for Medicaid reimbursement to Ambulance providers (Total Funds of \$347,029, of which \$125,000 were General Funds). The intent of the funds was to address ground ambulance rates, particularly mileage reimbursement. The Department held several meetings with the North Dakota EMS Association and adopted their proposals for changes to the fee schedule. The changes were effective July 1, 2007.

Attachment A shows the rates prior to the enhancement, the rates with the enhancement, and the enhanced rates with the four percent

inflationary increase approved for all providers by the 2007 Legislative Assembly. In addition, Attachment A shows what the fee schedule will be after the five percent inflationary increase on July 1, 2008.

Attachment B takes the analysis one step further with a comparison of the Medicaid fee schedule (effective July 1, 2008) to the current Medicare rates. As you can see, based on Calendar Year 2006 utilization data, increasing the Medicaid rates to the Medicare rates for Ambulance Services would require approximately \$1 million, of which approximately \$353,000 would be General Funds.

Processing Medicaid Ambulance Claims

The 2005 Legislative Assembly adopted House Bill 1206, which created a Medicaid Provider Appeals process and amended an existing section of Century Code related to the review of Medicaid Ambulance Claims. The Medicaid Provider Appeals process affords providers the opportunity to request a "second" review of the claim/documentation. This second review MUST be conducted by staff who were not involved in the original decision on the claim. If the provider disagrees with the second decision made, they have the option of appealing the decision to the district court. Since implementation, the appeals process has been used 135 times. Of those appeals, 86 have been submitted by Ambulance providers and 49 by other providers. Of the appeals submitted, 43 percent have been upheld (this number also includes 26 appeals considered untimely or not appealable) and 55 percent have been overturned. Two percent are currently in progress. As you can see from the data, the majority of the appeals are from Ambulance providers. It was early Calendar Year 2007 when a significant influx of Ambulance provider appeals was noted.

Department staff met several times with Ambulance Providers and the North Dakota EMS Association to discuss the volume of appeals. These meetings lead to a better understanding of Ambulance Service protocols and the various sets of rules under which the services must operate.

While the number of appeals has significantly decreased, I expect there to be continued discussions and decisions surrounding NDCC 50-24.1-15 (adopted April 2005) which states "... A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the pre-hospital emergency medical services were not medically necessary or that a medical emergency did not exist." The term "medical necessity" is a cornerstone of utilization review in Medicaid; therefore, adopting a method different from the other utilization review conducted by the Department has been a learning process for our medical and administrative staff.

Status of the Claims Backlog

Why are there so many claims in the backlog?

As you know, the 2007 Legislature appropriated funds to develop and implement a new Medicaid Management Information System (MMIS). The primary reasons for developing a new system are the inability to easily modify the current system and because the system is fragile. Minor policy changes often involve prolonged and complicated "hard coding" that require extensive resources and often lead to additional problems.

In the last year, there have been two federal changes that have resulted in the majority of the problems with the current MMIS. First, Medicare changed the processes by which they submit claims for the dual-eligibles

(those that qualify for both Medicare and Medicaid) to states. The Medicare modifications have led to delays in receipt and processing of the Medicare/Medicaid claims and, we have recently identified that some of the claims have not reached our system.

Second, the National Provider Identification was required to be in production in May 2007. This was a significant change to the MMIS and has also resulted in thousands of claims suspending or being rejected.

What has been done to address the backlog?

Medical Services has been authorizing overtime for staff for over a year, in an effort to process claims in a timely basis.

When it was evident that the voluntary overtime was not reducing the backlog fast enough, Medical Services began mandatory overtime in September. In addition, DHS-Information Technology Services also authorized overtime for the data entry staff.

The extra efforts of both the data entry and claims staff are resulting in the processing of additional claims; however, because of the large volume of claims in suspense, it is evident that a larger, more concerted effort is warranted. Therefore, Medical Services is in the process of adding six additional temporary staff and we will continue to monitor their status until we can reduce the backlog and sustain the suspended claims at an appropriate level.

What has the Department done to assure cash flow to providers?

The Department is monitoring the claims backlog on a weekly basis and in recognition of the significant number of suspended claims, we have issued payouts (advances) to providers in the past several months. We will continue to arrange for these payouts until the backlog is reduced. Providers are encouraged to contact our office if they are having specific cash flow issues.

The Department recognizes the importance of reducing the backlog to a manageable volume. We are committed to continuing our efforts to ensure the claims are processed as quickly as possible.

This concludes my testimony. I would be happy to address any questions that you may have.