June 4, 2018

Chairman Burke, Vice Chair Beagle, and Ranking Member Tavares, and members of the Senate Health, Human Services, and Medicaid Committee, thank you for the opportunity to testify on Senate Bill 218 (SB 218).

I am Richard Whipple, Regional Director for American Medical Response (AMR), the nation's largest private ambulance company. We currently operate in 40 states and the District of Columbia, collectively transport over 4.8 million patients annually and employ over 28,000 people across the nation. I personally am responsible for business units in Ohio, Michigan and Indiana. In Ohio alone, AMR collectively transported over 100,000 patients in 2017.

While AMR supports efforts across the country to reduce waste, fraud and abuse, it is my belief that Senate Bill 218 will not impact these areas in a meaningful way and will not result in the outcome intended by the bill sponsors. The genesis of this effort seems to have resulted from a report produced by State Auditor Dave Yost titled, "Promoting Integrity in Ohio's Medicaid Program." Mr. Yost states in his report that **since 2012**, there have been **20 convictions** for fraud in the transportation sector, representing **only 1.2%** of providers for an amount that represents only **3.1% of the total Medicaid fraud** (report attached).

The requirement of a $50,000 surety bond, along with other provisions of SB 218 will not move the needle on the issue of waste, fraud and abuse, and potentially force reputable providers to reduce participation in transporting Medicaid patients entirely. This would have the unintended consequences of reducing service availability to this patient population. This is particularly true for those completing wheelchair transports.

The Medicaid level of reimbursement for both ambulance and wheelchair transportation is already far below most reputable service providers' cost to operate. Add in the ever-burdening and ever-changing rules and regulation of brokered Medicaid, and there becomes a tipping point by which it is no longer in a service provider's interest to continue completing these transport requests. This will only serve to further burden the hospital systems and delay moving patients in a timely fashion.

In AMR's Ohio division, we know that for all modes of Medicaid transportation in 2017 – wheelchair and ambulance – and for all levels of service, Medicaid only covered **43.6% of overall costs per transport**. Providers rely on other business, better reimbursed segments of the patient population and health system contracts to provide adequate revenues to offset the losses incurred by inadequate Medicaid reimbursement. This is not a sustainable model.

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Lastly, it occurs to me that if by the Auditor's own information only 1.2% of transport providers are causing the waste, fraud and abuse, then SB 218 would be onerous to 98.8% of all other providers. Does this really seem like a reasonable legislative approach?

I appreciate the opportunity to have provided this testimony, and welcome the opportunity to discuss further if necessary. I urge the members to oppose SB 218 and to engage the leaders of medical transportation in the state to develop a comprehensive, sustainable and functional Medicaid system that would include appropriate and meaningful provisions of accountability. AMR and other reputable Ohio service providers who are members of the American Ambulance Association have a long-standing history of helping find solutions on a federal level, and I'm confident will be willing to work with legislators to develop a common-sense approach for Ohio.

Respectfully,

Richard Whipple
Regional Director

RNW: attachment

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Promoting Integrity in Ohio's Medicaid Program

- Currently there are 92,000 Medicaid providers in Ohio. Transportation and Home Health Medicaid Providers make up:
  - 16% of all providers
  - 84% of fraud convictions
  - $20 million in ordered repayment since 2012
  - $50 million in monetary penalties
  - Only 5% is recovered
- Providers being overpaid are typically un-certified in specific areas, and lack basic documentation of the services they provide to their clients. This leads to providers fraudulently billing Medicaid for services not rendered.

Preventive Measures

- ***Surety Bonds:***
  - Requiring high-risk providers to provide a surety bond to the Department of Medicaid would allow the state to recoup losses from fraud and overpayment.
  - This bill requires all Medicaid transportation providers and home health agencies to hold a $50,000 surety bond. Independent home health aides who have been sanctioned or terminated in the past 5 years will be required to provide a surety bond for 3 consecutive years.
  - States including Florida, Texas, Indiana, and New York, have utilized this approach. The concept was also proposed in HB 12 of the 129th General Assembly, which was sponsored by then-Representative Barbara Sears.
- ***Requiring Continuing Education***
  - Some Medicaid providers lack awareness of the documentation, licensing, and certification they are expected to provide. Because of this, they often improperly bill Medicaid.
  - Providers' agreements filed with the Department of Medicaid state that they have read and understand each of these requirements, however there is no way to ensure their continued understanding and compliance.

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- This bill would require specific training for home health and transportation providers, and make completion of the training a prerequisite for provider approval by the Department.

Attorney General Medicaid Fraud Data

	Convictions	% of Providers	% of total fraud	Ordered Penalties
Home Health	**520**	**15.1**	**81.1**	**$45,449,250.79**
Transportation	**20**	**1.2**	**3.1%**	**$4,194,346.11**

Total Medicaid Fraud

Convictions	641
Ordered Monetary Penalties	$301,424,794.43

Auditor of State Medicaid Audits

	Number of Examinations	Amount of Improper Medicaid Payment
Home Health Agency	**17**	**$12,583,153**
Home Health Independent Provider	**33**	**$2,356,268**
Medical Transportation	**30**	**$7,988,540**

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