Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

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TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Assembly Bill 874/Senate Bill 826: Reimbursement for Ambulance Services under the Medical Assistance Program

2021 Assembly Bill 874 and Senate Bill 826 are identical bills that would make two changes to reimbursement paid under the Medical Assistance (MA) program for ambulance services. Both changes create new mechanisms that would increase federal matching funds claimed by the state, resulting in increased reimbursement without increased GPR spending.

AB 874 was introduced on January 18, 2022, and referred to the Assembly Committee on Local Government. The Committee held a public hearing on February 2, 2022. Subsequently, the author introduced Assembly Amendment 1 to clarify the classification of certain ambulance providers. On February 8, 2022, the Committee adopted AA 1 on a vote of nine to zero and recommended the bill for passage, as amended, by a vote of nine to zero. On February 15, 2022, the author introduced Assembly Amendment 2, allowing the Department of Health Services to expend funds for certain administrative costs.

SB 826 was introduced on January 6, 2022, and referred to the Senate Committee on Health. Two amendments to SB 826 have been introduced. Senate Amendment 1 to SB 826 is identical to Assembly Amendment 2 to AB 874, and Senate Amendment 2 to SB 826 is identical to Assembly Amendment 1 to AB 874. The Committee held a public hearing for SB 826 on February 17, 2022.

BACKGROUND

Under current law, MA reimburses public and private ambulance providers for services rendered to individuals enrolled in the program. Payments are generally based on the intensity of services provided, as well as the type of vehicle used. In addition to the base payment rate, providers are reimbursed for mileage and for certain consumable supplies. As with most MA services, the state receives federal matching funds covering approximately 60% of these expenditures.

Currently, approximately 75% of reimbursements for ambulance services are paid to private ambulance companies that contract with local governments to provide services. The remaining 25% of services are delivered by public, government-owned ambulance services, such as fire departments that provide emergency medical services (EMS). Under current law, the Department of Health Services (DHS) makes supplemental payments to local governments with public ambulance departments, based on the number of ambulance trips made for MA beneficiaries. DHS adjusts the per-trip rate such that the supplemental payments total $5 million annually. As with other supplemental payments made under MA, the state is eligible to claim federal matching funds for these payments as well, again covering approximately 60% of the cost.

This supplement, however has no net effect on local governments or their EMS departments. Under provisions establishing the supplement, the Department of Revenue is required to reduce each municipality's shared revenue payment (under the county and municipal aid program) by an amount equal to the supplement that it receives. Although the local governments or EMS departments do not benefit from the supplement program, the state benefits from this arrangement since the supplement is partially paid with federal funds (approximately $3 million FED and $2 million GPR) while the offsetting $5 million shared revenue reduction is entirely GPR. That is, the state saves approximately $3 million GPR from this transaction.

SUMMARY OF THE BILL

Assembly Bill 874/Senate Bill 826 would make two separate changes to MA reimbursement for ambulance services, one that applies only to publically-owned providers and one that applies only to private providers.

For public providers, the bill would require DHS to implement a program to allow local governments to claim federal matching funds for certain local government costs attributable to MA patients that exceed the MA reimbursement they receive for ground emergency medical transportation. The federal Centers for Medicare and Medicaid Services (CMS) refers to such claims as certified public expenditures (CPE). The Department would be required to submit a Medicaid state plan amendment to CMS for approval and, if approved, make supplemental reimbursements to public ambulance providers in an amount equal to the federal matching funds. If CMS does not approve the state plan amendment, the Department would not pay the supplement.

For many public ambulance providers, the costs attributable to providing services to MA patients are greater than the reimbursement they receive. The CPE program would give public ambulance providers the option of documenting these unreimbursed costs and certifying to the state their total costs attributable to MA patients. DHS would then claim federal matching funds for the amount by which these public expenditures exceed the MA reimbursement, including payments under the $5 million supplement, the provider received. The bill requires DHS to pass through to the public ambulance provider the full amount of federal matching funds received.

Wisconsin's MA program currently uses the CPE model of reimbursement for several services where a local government agency is the certified provider of the service, including school-based services, county mental health services, and county-operated nursing homes. Several other states,

including California, Florida, Indiana, and Massachusetts, have implemented CPE programs for ambulance services. As approved by federal regulators, these other states' CPE programs generally limit the total costs that can be claimed for federal matching to the average rate that would be paid by private insurers for the same service (the average commercial rate, or ACR).

Federal regulations limit CPE programs to public, government-owned ambulance services. For private ambulance providers, the bill would create a new provider assessment (commonly known as a "provider tax") on private ambulance providers, create a new segregated fund to receive the assessment revenue, and direct DHS to use the assessment revenue, along with associated federal matching funds, to supplement MA reimbursement paid to private ambulance providers.

The assessment would be a uniform percentage of every private ambulance provider's net patient revenues from emergency ambulance transports. Federal regulations limit provider assessments to 6% or less of net patient revenues. The bill would require that the assessment rate be set within one quarter of a percentage point of this federal maximum, thus between 5.75% and 6.0%. For the purposes of this provision, "emergency ambulance transport" would be defined as: (a) each ground emergency transport that requires the delivery of life support services, including basic life support or advanced life support, by an emergency medical transponder or emergency medical services practitioner at any practice level; or (b) any other ambulance transport that is designated by the Department to be subject to the assessment.

Private ambulance providers would be required to pay the assessment in a manner determined by the Department, acting in consultation with the Professional Ambulance Association of Wisconsin, or its successor organization, but no more frequently than on a quarterly basis. The Department would be required to allow an ambulance provider to make a delayed payment if the provider is unable to make a payment by the due date established for payments.

The bill would create an ambulance service provider trust fund to receive assessment revenue and would create a SEG appropriation from the fund for making supplemental reimbursement payments to private ambulance providers and to health maintenance organizations (HMOs), for eligible services delivered through an MA HMO. The supplemental reimbursement would be eligible for federal matching funds, at the standard federal matching rates, meaning that every $1 of assessment revenue paid back to providers would generate approximately $1.50 in new federal matching funds. Federal regulations place certain limits on the use of provider assessment revenues, including a prohibition against the state distributing the funds in a way that guarantees that the providers are held harmless for the amount of the tax that they pay.

The Department would be required to submit a Medicaid state plan amendment or any other approval that is required to CMS to implement the assessment and supplement provisions, and would be prohibited from levying the assessment until it has obtained federal approval.

The MA program currently uses provider assessments for hospitals and nursing homes, although the methods of assessment and provisions for making additional reimbursement payments vary.

ASSEMBLY AMENDMENT 1/ SENATE AMENDMENT 2

Assembly Amendment 1 and Senate Amendment 2 would clarify that the CPE provision, not the provider assessment, would apply to any ambulance provider owned by a municipality or group of municipalities, regardless of whether that provider is organized as a nonprofit corporation.

ASSEMBLY AMENDMENT 2/SENATE AMENDMENT 1

Assembly Amendment 2 and Senate Amendment 1 would modify the ambulance service provider trust fund SEG appropriation to specify that it may also be used for the administration of the ambulance service provider fee.

FISCAL EFFECT

The primary state fiscal effect of the certified public expenditure provision would be to increase FED expenditures by the amount of the matching funds received for CPE claims. It is not possible to develop a reliable estimate of the amount of federal matching funds that would be claimed by local governments because public ambulance providers do not currently report their costs and revenues. In addition, it is uncertain how many providers would choose to submit CPE claims.

In addition to this direct fiscal effect, the state could incur costs associated with implementing and administering the program. DHS would need to prepare and submit to CMS a state plan amendment, a process which typically requires months to a year. Once approved, DHS staff or contracted agencies would need to collect, validate, and submit to CMS data on each participating local government's expenditures, and determine the appropriate claim amount. DHS estimates that contracting for these administrative functions would cost $163,200 all funds ($81,600 GPR and $81,600 FED) per year. The bill would not provide funding for DHS to administer the CPE program, so any such costs would have to be absorbed by the Department using existing sources of administrative funding.

The provisions of the bill creating the assessment and supplement for private ambulance providers would have the direct fiscal effects of increasing FED expenditures and creating revenue and expenditures in a new SEG trust fund for ambulance service providers. It is difficult to estimate the scale of these effects as well, as ambulance providers do not currently report their net patient revenues publically. As a point of comparison, a similar provision recently enacted in Massachusetts is expected to generate assessment revenue of approximately $27 million annually. However, that state's population and its market for ambulance services is likely sufficiently different from Wisconsin's that this estimate should only be used to get a general sense of the magnitude of the fiscal effect of the proposal.

The Department also estimates that, to secure federal approval for both the CPE program and the supplement for private providers, they will need to contract to collect data on private payments to calculate the average commercial rate (ACR) and demonstrate that supplemental payments are below this threshold each year. They estimate annual costs of $129,600 all funds ($64,800 GPR and $64,800 FED) to determine the ACR.

As in the case of the CPE, it is likely that the state would incur further costs to implement the assessment and supplement, including to obtain federal approval and make changes to provider payment systems. The Department estimates these one-time costs at $800,000 all funds ($200,000 GPR and $600,000 FED).

It is also likely that DHS would need to contract for the ongoing administration of the assessment. The Department estimates that they would need to establish an administrative contract including the collection of information on provider revenues necessary to determine each providers' liability under the assessment, at an annual cost of $500,000 all funds ($250,000 GPR and $250,000 FED). Until it was repealed in 2017, the Department of Revenue administered a similar assessment levied on ambulatory surgical centers, and retained five percent of revenues for administrative costs. Likewise, DHS currently collects annual assessments on hospitals' gross patient revenues, the administration of which is funded with a portion of revenues collected from the assessments.

Under the bill, any costs for implementation and administration would have to be absorbed within DHS's existing administrative appropriations for the current biennium. However, Assembly Amendment 2/Senate Amendment 1, introduced on February 15, 2022, would amend the bill to permit DHS to expend revenue collected under the assessment for administrative costs of the assessment.

Prepared by: Carl Plant