

RIDER 74 ANALYSIS

Ambulance Services Transportation Funding

**As Required by the 2014-15 General Appropriations Act
(Article II, Health and Human Services Commission, Rider 74,
S.B. 1, 83rd Legislature, Regular Session, 2013)**

**Health and Human Services Commission
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Introduction

The 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 74), required that the Health and Human Services Commission (HHSC) analyze opportunities to leverage local funds expended for emergency transport services for the purpose of enhancing ambulance services payments.

***Ambulance Services Transportation Funding.** It is the intent of the Legislature that out of funds appropriated above in Strategy B.3.1, Medicaid Contracts and Administration, the Health and Human Services Commission conducts a thorough analysis, inclusive of funding mechanisms used in other states, of opportunities to leverage local funds expended for emergency transport services for the purpose of enhancing ambulance transport systems. The commission shall submit the results of their findings with potential funding mechanism options to the Legislative Budget Board no later than December 1, 2014.*

Review of Other States

HHSC reviewed other states' Medicaid supplemental payment programs for ambulance services, and determined that the only state that has such a program approved as part of its Medicaid State Plan is Louisiana. On June 4, 2012, the Centers for Medicare and Medicaid Services (CMS) approved a Louisiana upper payment limit (UPL) supplemental payment program via a state plan amendment (SPA) for emergency medical transportation services rendered by Louisiana land and air ambulance providers (SPA LA 11-23). Based on the approved SPA, local governments in Louisiana are able to put up the non-federal share of payments for contracted ambulance providers in order to increase the overall Medicaid payments available to those providers. Governmental entities located in large urban areas are eligible to be reimbursed at 100 percent of the provider's average commercial rate under the program and all other providers are eligible for reimbursement at 80 percent of that level.

Replacement of Texas' UPL Payments with Uncompensated Care Payments

Prior to late 2011, Texas had a number of UPL programs authorized as part of its Medicaid state plan, including for public and private hospitals, public physician groups, public dental groups, and public ambulance providers. In December 2011, CMS approved a five year 1115 demonstration waiver, the Texas Healthcare Transformation and Quality Improvement Program, to expand Medicaid managed care statewide while converting the funds from these historic UPL programs and managed care savings into two funding pools - an Uncompensated Care (UC) pool and a Delivery System Reform Incentive Payment (DSRIP) pool. Once healthcare services are included in managed care capitation rates, they are no longer eligible for UPL payments because the managed care rates must be actuarially sound and all-inclusive; states are not allowed to make direct payments to providers outside of the managed care capitation rates unless authorized through a waiver such as the 1115 waiver. The UC pool replaced the UPL programs under a

different methodology to help offset uncompensated care costs for the same groups that had previously been eligible for UPL payments.

Under the waiver, which runs through September 30, 2016, the UC pool is capped at a certain amount each demonstration year (DY) – ranging from \$3.9 billion in DY2 to \$3.1 billion in DY 5. Eligible providers submit UC applications to HHSC, and receive a share of the pool amount based on their level of uncompensated care to Medicaid and low-income uninsured individuals. If there is not enough money in the pool to cover all eligible UC for a given year, then all eligible providers take a proportional reduction (a "haircut") to their payments. Such a haircut was necessary in DY 2, which ended September 30, 2013, and as the UC pool declines in size over the final three years of the demonstration period, HHSC presumes that larger UC haircuts likely will be required for DY 3-5 (i.e., providers will receive payments that offset a lower percentage of their eligible UC). The non-federal share of UC payments comes from intergovernmental transfers (IGT) from public entities, including counties and hospital districts.

Issues with Adding Private Ambulance Providers to Texas' UC Programs

Given that Texas no longer has UPL programs, if Texas were to request a supplemental payment program for non-public ambulance providers, it would need to request a waiver amendment to allow payments to these providers through the UC pool in the 1115 waiver. However, recent events indicate that it may be challenging to get federal approval of an additional supplemental payment program for non-public Medicaid providers.

State Medicaid Director Letter regarding Provider-Related Donations

On May 9, 2014, CMS issued a letter to State Medicaid Directors, SMD #14-0004, regarding provider-related donations under the Medicaid program. In this letter, CMS expressed new concerns and guidance related to impermissible provider-related donations (donations from private providers to IGT entities) in situations in which public entities put up the non-federal share of funds for supplemental payments to private Medicaid providers. The letter discusses arrangements that generally involve Medicaid supplemental payments (e.g. UPL, UC) or special add-ons to the base payment rate that are contingent upon or otherwise related to agreements between government and private entities under which the private entities assume obligations to provide donated services or other transfers of value as directed in the arrangements. The guidance went beyond previous CMS guidance on this topic, stating that "Regardless of the expressed intent of providers and governmental entities, when there is an effective return of some, or all, of the donation to the private provider through Medicaid supplemental payments, a hold harmless arrangement (i.e., an impermissible provider-related donation) exists". Based on discussions with CMS staff, CMS appears to believe that if a private provider receives IGT to support a supplemental Medicaid payment and then provides care that otherwise may have been provided by the public IGT entity (even if the public entity does not have a statutory obligation to provide those services), the provision of those services may constitute an impermissible provider-related donation. While CMS approved private provider UPL arrangements in Texas and Louisiana in the past, it appears there will be greater scrutiny of such programs going forward based on the May 9, 2014, guidance letter.

Deferral of Private Hospital UC Payments

On September 24, 2014, CMS issued a deferral of private hospital UC payments in three regions in Texas based on a financial management review of those geographic areas. The deferral has potential statewide implications for private hospital UC and DSRIP payments, so HHSC is working diligently with the affected Texas stakeholders to urge CMS to lift the deferral as soon as possible. HHSC does not believe that the arrangements under the UC or DSRIP program constitute impermissible donations, and will work to make that case to CMS strongly. HHSC learned from CMS in early December 2014 that CMS intends to lift the current deferral soon in order to work with Texas in the coming year to resolve CMS concerns related to Texas' financing of UC and DSRIP payments for private hospitals.

Limited Funding Available Under Current UC Pool

If Texas seeks to add UC for private ambulance providers, HHSC would need to request additional funds be added to the UC pool in order to not reduce payments to the provider-types currently eligible for UC payments (public and private hospitals, and public physician groups, dental groups, and ambulance providers). In light of CMS' guidance in the May 2014 SMD letter, it seems unlikely that CMS would approve additional UC pool funds for private ambulance providers in Texas at this time. If CMS does not approve additional UC pool funds for private ambulance providers, but allows them to participate in UC, which also seems unlikely at this time, then UC payments to the currently eligible providers would have to be reduced to allow for payments to private ambulance providers. Spreading the existing UC pool over a larger population of providers is an undesirable option given that the pool is getting smaller each year while the UC burden in Texas is not declining.

Conclusion

HHSC recommends waiting until the September 2014 CMS deferral of private hospital UC payments is resolved before making a final decision regarding the pursuit of UC payments for private ambulance providers. Delaying a decision until the deferral is resolved will help inform the likelihood of Texas getting approval of a similar program for private ambulance providers and will also inform how such a program should be structured to conform to recent federal guidance. Given the various issues discussed above, a logical time to request a waiver amendment to add IGT-supported UC payments for private ambulance providers would be upon submission of the waiver renewal request to be effective October 1, 2016.