SENATE BILL REPORT
ESSB 6534

As of January 29, 2020

Title: An act relating to an ambulance transport quality assurance fee.

Brief Description: Creating an ambulance transport quality assurance fee.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senator Cleveland).

Brief History:
Committee Activity: Health & Long Term Care: 1/29/20.

Brief Summary of Engrossed First Substitute Bill

- Establishes an ambulance transport quality assurance fee program for Medicaid-funded emergency ambulance transports provided by private ambulance transport providers.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: LeighBeth Merrick (786-7445)

Background: Medicaid-Funded Emergency Medical Transportation. The Health Care Authority (HCA) currently reimburses providers for emergency medical transportation on a fee-for-service basis. Providers are reimbursed for emergency medical transportation for ambulance transportation, during which the client receives needed emergency medical services en route to an appropriate medical facility. This includes ambulance transportation between medical facilities. Services rendered may include either basic or advanced life support services. Providers are also reimbursed for mileage and tolls or fees, such as parking, incurred during transporting the client. Nonemergency transportation is reimbursed when the client must be transported by stretcher or gurney for medical safety reasons, or must have medical attention from trained medical personnel available en route.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

In 2015, the Legislature established the Ground Emergency Medical Transportation (GEMT) program to provide supplemental payments to qualified publicly owned or operated ground emergency medical transportation providers. The supplemental payments are used to cover the funding gap between a provider's actual costs per transport and the allowable amount received from Washington Apple Health (Medicaid) and any other sources of reimbursement.

Provider Assessments. Health care provider-related charges, such as assessments, fees, or taxes, have been used in some states to help fund the costs of the Medicaid program. Under federal rules, these provider-related charges include any mandatory payment where at least 85 percent of the burden falls on health care providers. States collect funds from health care providers and pay them back as Medicaid payments. States use these provider-related payments to claim federal matching funds. Federal laws requires health care provider-related assessments, fees, and taxes be broad-based, uniform, and in compliance with hold harmless provisions. To be broad-based and uniform, they must be applied to all providers of the same class and be imposed at the same rate to each provider in that class. If a provider-related assessment, fee, or tax is not broad-based or uniform, these provisions may be waived if the assessment, fee, or tax is generally redistributive. The hold harmless provision may not be waived.

Summary of Engrossed First Substitute Bill: Quality Assurance Fee Program. The program only applies to private ambulance transport providers (providers). Each provider is required to submit certain data to HCA. HCA must calculate the quality assurance fee based on transport and gross receipts data they receive from the providers. The providers are required to pay the fee for each emergency ambulance transport. In return, HCA uses the fees collected to draw down federal match and apply an add-on to Medicaid rates for providers of emergency ambulance transports. The program is conditional upon a number of items, including approval from the Centers for Medicare and Medicaid Services (CMS). HCA is authorized to adopt rules to implement the program. The program expires July 1, 2024.

Data Collection. HCA must establish the form and schedule for providers to report the required data to HCA. On or after August 15, 2020, the provider must report the number of emergency ambulance transports by payer type and the annual gross receipts for the state fiscal year ending June 30, 2020. On or after the 45th day of each state fiscal quarter, beginning with the state fiscal quarter ending September 30, 2020, the provider must report the number of emergency ambulance transports by payer type for each state fiscal quarter. On or after the 45th day after the end of each state fiscal year, the provider must report the annual gross receipts for the state fiscal year. HCA may impose a civil penalty of $100 per day against a provider that fails to report the data within the required timeframes. HCA must deposit any collected civil penalties into the program's fund.

Fee Assessment. Beginning July 1, 2021, HCA must annually calculate the fee rate. Each provider must quarterly pay the fee based on the provider's number of emergency ambulance transports in the second quarter preceding the state fiscal quarter for which the fee is assessed. For fiscal year 2022, the fee rate is calculated by multiplying the projected total annual gross receipts of all providers by 5 percent and dividing its product by the projected total annual ambulance transports by all providers for the state fiscal year. For fiscal year 2023 and onward, the fee rate is calculated by a ratio, the numerator is the sum of the product of the projected aggregate fee schedule amount and the effective state medical assistance percentage and HCA's costs related to administering the program, and the denominator is the projected total annual emergency ambulance transports by all providers. HCA must adjust the fee rate so the available fee amount is approximately equal to the aggregate fee schedule if the projected or available fee amount exceed or is less than the actual or projected aggregate fee schedule amount by more than 1 percent.

HCA must quarterly send each provider an assessment notice no later than 30 days prior to the beginning of the applicable state fiscal quarter, and no later than 30 days before the payment is due. HCA must establish the fee payment due dates, but it must not be earlier than 15 days after the beginning of the applicable state fiscal quarter. HCA must assess interest on fees not paid on the due date and deposit the interest into the program's fund. If the fee payment is more than 60 days overdue, HCA may deduct the unpaid fee and interest owed from any Medicaid reimbursements owed to the provider.

The program's fund is known as the ambulance transport fund and is in the custody of the state treasury. The fund must retain its interest and must only be used to receive and disburse funds in accordance with the program.

Add-on. Beginning July 1, 2021, Medicaid reimbursement for provider's emergency ambulance transports must be increased by applying an add-on. The add-on must be calculated by June 15, 2021 and must remain the same for future state fiscal years. The addon is the quotient of the available fee amount projected by HCA by June 15, 2020 for the 2021-2022 state fiscal year, divided by the total Medicaid emergency ambulance transports projected by HCA by June 15, 2021 for the 2021-2022 state fiscal year. The add-on must only be funded from the fees and interest earned on the fees, and federal reimbursement or other related federal funds.

Centers for Medicare and Medicaid Services Approval. HCA must request CMS approval to implement the program and is authorized to modify the program as necessary to obtain CMS approval. The fee must only be assessed and collected for quarters in which the add-on is paid. If CMS approval is delayed, HCA may assess the amount the provider would be required to pay if the program was approved, but the provider is not required to pay the fee until the program is approved.

Conditions. Implementation of the program is conditional upon:

- CMS program approval and providing federal match;
- the state not reducing its fee-for-service reimbursement for ambulance transport providers;
- the state not delegating responsibility to pay for ambulance transports to managed care organizations, prepaid inpatient, or ambulatory health plans; and
- the program not prohibiting the GEMT reimbursement program.

Appropriation: None.

Fiscal Note: Requested on January 21, 2020.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony: PRO: This bill has been in front of the Legislature for a number of years, and stakeholders worked over the interim to refine the proposal. Medicaid rates for ambulances have not increased since 2006. Washington's rate is one of the lowest rates in the country. Meanwhile, providers costs such as fuel, health care for employees, minimum wage, medications and equipment have gone through the roof. The rate does not cover the costs. The program is funded by provider imposed fees and federal match, and will not cost the state any money. The bill will ensure people have access to high quality EMS. Both labor and employers agree on this bill because it will help fund a living wage for employees. We have legal analysis that indicates the program will have zero impact on GEMT. California received CMS approval for a similar proposal, and we have agree to language that will offer reassurances to GEMT providers.

Persons Testifying: PRO: Senator Annette Cleveland, Prime Sponsor; Mary Keefe, Teamsters Local 174; Timia Olsen, AMR; Chris Clem, Olympic Ambulance; Jason Sorrick, American Medical Response / VP of Gov Relations; Paul Priest, AMR / Eastern Washington Manager.

Persons Signed In To Testify But Not Testifying: PRO: Liz Brown, Teamsters Local 174; Patricia Seib, Seattle Children's Hospital; Mike Andrews, Wa Ambulance Association; Amy Anderson, Association of WA Business.

OTHER: MaryAnne Lindeblad, HealthCare Authority.