
Response to Medicaid Reimbursement Impacts - Legislative Report

Background

During the 2015 Legislative Session S.B. 172 (Emergency Medical Services Amendments) passed creating an assessment on ambulance service providers. House Bill 7, Item 25 requires the Bureau of EMS and Preparedness to present this report.

The amendment allows ambulance providers to be assessed by the Utah Department of Health (UDOH) on every patient transport to create a state Medicaid fund. This new fund is used to create matching funds for Federal Medicaid payments. State matching funds allow licensed ambulance providers to collect the current base rate as determined by the UDOH for a patient transport. Past ambulance reimbursements from Medicaid were approximately \$142.72 per patient transport. **The base rate as of July 1, 2016 for ambulance patient transport was \$707.00, which means a Medicaid patient prior to the amendment would have received a payout of \$142.72 and now using current base rates, this same patient transport will receive a payout of \$707.00.** It is also possible that some ambulance providers may pay out more in assessments to create the state fund than they receive back in total payouts by the enhanced Medicaid payments if they do not transport a sufficient number of Medicaid patients or if they fail to bill Medicaid.

Historically, licensed ambulance providers have subsidized through a “cost-shift” of Medicaid patient transports by charging more to non-Medicaid patients. Fixed and variable costs of licensed ambulance providers were used by the UDOH to establish “just and reasonable” rates as required in UCA Title 26-8a-403(1). This caused increasing pressure to increase base rates to offset Medicaid transport losses. The new Medicaid reimbursement procedure has reduced the need to substantially increase overall base ambulance rates.

Data

Fiscal reports submitted to the state by all licensed ambulance providers for 2016 indicated that a small increase of 0.5% to the base rate would be needed to maintain fiscal viability for an average ambulance provider. Past years have traditionally have shown the need for a 1% to 3% increases.

Medicaid data for the six month period prior to the implementation of S.B 172 (January 1, 2015 to June 30, 2015) ranged in monthly payouts to ambulance providers in the aggregate from \$197,787 to \$250,095. The Medicaid data for the six month period after the implementation of S.B. 172 (July 1, 2015 to December 31, 2015) ranged in monthly payouts to ambulance providers in the aggregate from \$822,827 to \$1,022,499.

Conclusion

Early aggregated data suggests that improved Medicaid reimbursements have alleviated the need for “cost-shifting” and allowed ambulance services to cover costs of Medicaid transports. Collected fiscal data from ambulance providers using current survey questions will be refined to validate the actual impacts in future years. A baseline year has been established; however, the fiscal trends need to be monitored to ensure accurate assessment and to ensure no harming of ambulance providers in areas where Medicaid reimbursements are a small percentage of their billable patient transports.