Emergency Medical Services (EMS) Revenue Maximization Initiative Feasibility Study & Recommendations Report

Kansas Emergency Medical Services Association (KEMSA)

December 30, 2016
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I. EXECUTIVE SUMMARY

Over the past year, the leadership and members of the Kansas Emergency Medical Services Association (KEMSA) have worked with Public Consulting Group, Inc. (PCG) to complete a feasibility study assessing various methodologies to increase Medicaid revenues for member providers and benefit the entire community of emergency medical service providers serving the State of Kansas. This final feasibility study and recommendations report represents the culmination of that effort.

Medicaid reimbursement rates for Emergency Medical Services (EMS), and in particular emergency medical transportation, lag behind commercial insurance rates, and are not generally adequate to meet the costs of serving the Medicaid-eligible population. Supplemental payments may be made to EMS providers up to the Upper Payment Limit (UPL), but states must establish methodologies both to determine this UPL, and to adequately fund the state share of such supplemental payments. There are many factors to consider, but in states across the country, well-designed EMS revenue maximization initiatives have successfully generated significant incremental revenues for the EMS provider community at no additional cost to the state or its taxpayers. This is achieved by leveraging the existing reimbursement programs approved by the federal Centers for Medicare and Medicaid Services (CMS) and administered by the state Medicaid agency. Each of the program options have been available for decades and widely utilized by a variety of other healthcare service providers including hospitals, nursing homes, and physician practices. Implementation of a successful and sustainable EMS revenue maximization initiative is independent of Medicaid expansion.

The diversity of different models to determine and match funding up to the UPL means that there is no simple one-size-fits-all approach to EMS revenue maximization. For this reason, a feasibility study is a critical step in the planning and development of a program for a particular state. A CPE program designed for Texas or a provider assessment program that serves Missouri may not function in the best interest of Kansas’ provider community. Each state make-up is different; provider mix, payer mix, and political climate are just a few of the unique attributes that must guide program design and implementation. As a national leader in the development and implementation of revenue maximization projects for EMS providers, PCG’s role in the feasibility study was to work with KEMSA to accumulate and analyze the appropriate data in order to determine a supplemental payment model which will maximize provider reimbursement while minimizing unnecessary burden on the provider community.

PCG has experience working with state Medicaid agencies and EMS providers across the country, including Florida, Massachusetts, Oklahoma, and Texas, in order to develop and implement EMS revenue enhancement initiatives. Through the implementation of revenue enhancement initiatives, PCG has helped generate over $135 million in net revenue for EMS providers in Texas over a period of five fiscal years. A similar initiative in Massachusetts is anticipated to generate as much as $10 million annually.

The report that follows captures the results of the statewide provider survey undertaken by PCG and KEMSA, and presents the results of the analysis performed by PCG using the provider-submitted data as well as state Medicaid statistics and analytical models drawn from our national experience. The report also outlines various revenue maximization options and evaluates them in light of the current national landscape and the findings of our Kansas-specific survey of provider metrics and other program conditions. We appreciate the opportunity to assist KEMSA in this important first step of identifying the
optimal EMS revenue maximization strategy and look forward to the opportunity to guide implementation efforts alongside the Kansas EMS provider community.

II. PROGRAM APPROACHES & NATIONAL LANDSCAPE

The feasibility study focused on three primary options that can be used to fund increases in Medicaid reimbursement for EMS providers:

1. Certified Public Expenditure (CPE)
2. Intergovernmental Transfer (IGT)
3. Provider Assessment

Each of these methodologies represents a different way to create the “state share” necessary to draw down additional Federal Financial Participation (FFP), up to a limit determined by either Medicaid charges or the cost of delivering Medicaid services. The federal government will match state funds disbursed to support Medicaid services, and by finding alternative methods to subsidize the state share, additional funding can be obtained through supplemental payment programs. All three methods involve passing funds from individual providers up to the state level, in order to trigger additional federal funds when they are disbursed.

EMS Revenue Maximization Process

Federal rules provide regulatory justification for all three options, but the design and implementation processes for each approaches are vastly different. In a Certified Public Expenditure (CPE) methodology, expenditures already made in support of Medicaid services can be documented and certified as “state share,” and are then matched by federal funds in a cost settlement process. However, this opportunity is only available for publically supported providers whose ongoing expenditures can be characterized as costs to the state government.

The second option involves intergovernmental transfer (IGT) to fund the state share of additional supplemental payments in order to bring total reimbursement up to the calculated cost of providing Medicaid services. A new discrete payment is made by the state to each provider, with the state share funded out of the IGT and the federal drawdown triggered by this payment. This methodology is preferred when Medicaid services are paid through a managed care service delivery system.

The final option is a provider assessment, wherein the state levies a tax on providers that is used to finance the state share. Although providers cannot be guaranteed that their payments received will
directly correspond to the state share paid, in general, a carefully-constructed model will make providers whole. The table below summarizes the differences between the three approaches:

### EMS Revenue Maximization Approaches

<table>
<thead>
<tr>
<th>APPROACH</th>
<th>Certified Public Expenditure (CPE)</th>
<th>Intergovernmental Transfer (IGT)</th>
<th>Provider Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the solution?</strong></td>
<td>For Medicaid services paid on a Medicaid Fee-For-Service (FFS) basis, eligible participating providers may receive a cost settlement payment through a Certified Public Expenditure (CPE) program.</td>
<td>For Medicaid services paid through a managed care service delivery system, increased payments are made through managed care contracts equivalent to the cost settlement payments received within Medicaid FFS.</td>
<td>For private providers, an option for generating additional Medicaid revenues involves establishing rate increases through an assessment on the state’s providers to draw down additional federal matching funds. Funds raised through such assessments cycle back to providers in the form of rate increases.</td>
</tr>
</tbody>
</table>
| **What is the general process behind the solution?** | • Work with stakeholders to design and develop an EMS CPE.  
• Submit a State Plan Amendment (SPA)  
• Develop a cost reporting tool and establish the payment mechanism.  
• Prepare and submit annual cost reports.  
• Perform desk reviews to ensure compliance.  
• Draw down additional federal funds to disburse lump-sum supplemental payment to each provider. | • Engage stakeholders to conduct increased payment modeling.  
• Establish contractual language for program participation.  
• Modify MCO contracts to establish minimum payments.  
• Determine incremental payments on a prospective basis.  
• On a scheduled basis (monthly or quarterly), determine IGT required based on Medicaid enrollment by MCO. | • Establish a stakeholder group to explore opportunity and define expectations.  
• Perform provider assessment modeling analysis.  
• Define assessment rate(s) and providers subject to assessment.  
• Facilitate CMS review and approval.  
• Pass legislation and implement assessment.  
• Use assessment to draw down federal funds.  
• Utilize additional federal funds to increase Medicaid rates for all providers. |
<table>
<thead>
<tr>
<th>APPROACH</th>
<th>Certified Public Expenditure (CPE)</th>
<th>Intergovernmental Transfer (IGT)</th>
<th>Provider Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who benefits the most from each approach?</td>
<td>Governmental providers with higher Medicaid FFS payer mix</td>
<td>Governmental providers with higher Medicaid Managed Care payer mix</td>
<td>All providers (governmental or private) with a higher Medicaid payer mix</td>
</tr>
<tr>
<td>What is the effect on the state budget?</td>
<td>There is no expenditure from the general fund required to finance any of these EMS revenue maximization solutions. To cover the costs of facilitating the program, the state Medicaid agency may opt to collect an administrative fee from the nonfederal share.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regardless of which program is selected, it will be necessary to collaborate closely with the Kansas Department of Health & Environment (KDHE) to determine the specifics of program design, cost calculations, and implementation. All three options rely on calculating the overall cost of delivering Medicaid services, and the details of this cost reporting process must be decided between the state, CMS, and providers. KDHE and stakeholders from the provider community will also need to work closely with CMS to iron out reimbursement processes and ensure that the program is compliant with all federal regulations.

Below are descriptions of how each program option could look from a Kansas perspective:

**Option 1: Certified Public Expenditure (CPE)**

Federal regulations at 42 CFR 447.300 and Section 1902(a)(30) of the Social Security Act allow states to establish alternative payment methodologies including supplemental payment and CPE methodologies. The state must provide a rationale to validate providing these payments as supplemental funds rather than by directly updating Medicaid rates. For this reason, a program that supports public entities and reflects actual expenditures by the state through CPE can be more persuasive to CMS. Public entities (as defined at 42 CFR 433.50) are eligible to participate in a CPE reimbursement methodology.

In order to take advantage of the opportunity presented by a CPE reimbursement methodology for EMS, governmental providers would need to engage KDHE in the process. KDHE, as the single state agency for the Medicaid program, would need to submit and gain CMS approval of a State Plan Amendment (SPA) that defines the CPE reimbursement methodology. In this effort, KDHE would be able to point to similar EMS Supplemental Payment Programs already approved in California, Massachusetts, and Texas, among others. Operationally, the implementation of this program would not require any changes to the current activities of public providers, with the exception of the completion of an annual Medicaid cost report as required and defined in the SPA submitted by KDHE to CMS. Certification of public
expenditures demonstrates the costs that were already incurred, and these costs are reported by the state Medicaid agency on the CMS-64 Quarterly Expense Report.

Key to the CPE Initiative is that it is only available to public providers; depending on the provider mix and political climate in a given state, states are sometimes reluctant to move forward with a program that excludes all private providers. However, public providers typically serve as the safety net and commonly provide a higher percentage of services to Medicaid recipients and the uninsured. Another critical factor is that CPE reimbursement is only a viable solution for Fee-for-Service reimbursement. Therefore, states with a payer mix tilted more heavily towards managed care services will not be able to receive the benefit of CPE reimbursement for the majority of services.

In Kansas, PCG found that approximately 85% of providers are governmental or quasi-governmental providers. However, because the current payer mix heavily favors managed care (almost 97% of charges are Managed Care), a CPE methodology would not currently produce the maximum benefit for Kansas providers. A waiver exception, similar to the 1115 waiver currently used in Texas (see below), could allow for compensation for not only managed care services, but also uncompensated care costs; however, the administrative burden involved in passing a waiver is greater than a simple SPA, and with recent changes in the approach of CMS to such exceptions, the future of such waiver programs is unclear.

CPE programs have been the most widely used approach to increase Medicaid reimbursement for EMS providers. There are at least five states that currently offer a CPE program, and several other states that are considering the development of a CPE. Programs in Texas and California are described below.

### Case Study: Texas

In 2006, PCG partnered with Austin-Travis County EMS and the State of Texas Health and Human Services Commission (HHSC) to develop the Ambulance Supplemental Payment Program. While the program initially applied only to Medicaid FFS claims, the revenue potential expanded to Medicaid MCO and Uninsured (uncompensated care) with inclusion of EMS in the Medicaid 1115 Waiver beginning in March 2012. The 1115 Waiver is set to expire December 2017, and the future of the ASPP in Texas is unclear at this time.

As much as 95% of the supplemental payments have been tied to Medicaid MCO and Uninsured. Supplemental payments for the FY15 reporting period totaled more than $70 million for 46 providers. Current enrollment in the program includes more than 70 providers.
Case Study: California

California’s Ground Emergency Medical Transportation (GEMT) Program, enacted on October 2, 2011, provides supplemental reimbursement up to the allowable costs of services for governmental providers that provide GEMT services to Medi-Cal beneficiaries. Eligible GEMT providers must certify to the State the total CPE for providing GEMT services.

A unique aspect of California’s GEMT is the eligibility of governmental providers that provide first response services but contract with private ambulance companies for transports. Highlighting the effect of differing interpretation of federal guidelines, a provider that similarly serves as a contracting agent in Texas would be excluded from participation.

Although reimbursement is limited to Medicaid FFS claims, the California GEMT has generated significant new funding due to the fact that reimbursement is based on costs rather than the lesser of costs or charges (as has been traditional). From SFY 2010-11 to SFY 2014-15, the GEMT has generated a total of $85 million for 104 providers in five fiscal years. Another 56 providers have been identified as eligible to participate but do no currently participate.

Option 2: Intergovernmental Transfer (IGT)

As states have seen a shift in the Medicaid payer mix from FFS to MCO, IGTs have become a more popular vehicle to the enhancement of revenues. Public providers, as defined in 42 CFR 433.50, are able to voluntarily transfer (IGT) public dollars to the state Medicaid agency. These funds can then be used to reimburse providers, serving as state share to trigger additional federal funding.

The key to this methodology is assuring that funds are properly passed through to providers. Unlike direct Fee-for-Service reimbursement, supplemental funds do not flow directly to the entity providing the IGT, but must be passed through a managed care entity, and are paid out on a different basis than traditional Fee-for-Service payments. Incremental funding must be incorporated into enhanced Medicaid MCO capitation rates, which then MCOs pass on to eligible providers. This approach requires working with MCOs to modify MCO contracts to establish enhanced Medicaid payment levels. Coordination of MCO agreements would be led by the state Medicaid agency.

Capitation payments would be enhanced by amounts actuarially equivalent to the supplemental Fee-for-Service payments that would have been available for eligible providers in a Fee-for-Service environment, to the extent permissible under federal law. This requires the same cost reporting process that would be applied in a CPE methodology (described below), as the process is to determine “what would have been” under that alternate supplemental payment architecture.

Intergovernmental transfers can only be funded by public (governmental) agencies, and for this reason, IGT programs are often, like CPE initiatives, limited to public providers only. However, recently in Louisiana, Medicaid agencies and EMS provider associations have been able to cooperate in order to generate additional revenues for both public and private providers. In this methodology, an independent provider organization (generally managed or incorporated under a statewide EMS provider association) is used for pass-through and distribution of funds. Public entities across the state would enter into a contractual agreement to pay the independent provider organization their portion of the state share,
sufficient to cover all providers. The provider organization would collect payments and submit the total state share to the Medicaid agency. The Medicaid agency would use the state share to pull down federal funds and pass these new funds back to the independent provider organization. The provider organization would then be responsible for directing increased payments to providers. Typically, these payments reflect costs or utilization, but rate increases for public providers are enhanced in relation to private providers in order to make them whole for the additional funds provided in IGT.

### Case Study: Louisiana

Louisiana’s supplemental payment program for emergency ambulance services became effective September 2011. The Louisiana model is unique in that private providers also receive additional reimbursement if they are enrolled Medicaid providers.

Political subdivisions throughout the state contribute their share of the IGT to the Louisiana Ambulance Alliance (LAA), a nonprofit corporation separate and distinct from the state. The LAA pools the funds and submits the IGT funds to the Louisiana Department of Health and Hospitals (DHH). DHH then uses these funds to draw down FFP. Large urban governmental (LUG) providers, IGT contributors, receive enhanced payments up to 100% of the provider’s average commercial rate, and all other ambulance service providers receive reimbursement up to 80% of the provider’s average commercial rate.

### Option 3: Provider Assessment

While states finance their Medicaid programs through a variety of sources, including income, sales, and property taxes, a key source of additional revenue for many states is derived from assessments on health care providers. All but one state (Alaska) imposed some type of provider assessment on at least one category of health care providers in FY14.

Provider assessments generate revenue to support state Medicaid programs, using funds raised through the assessment to draw down additional federal matching funds. Commonly, a portion of the funds is utilized to provide rate increases to providers to ensure continued access to services for Medicaid recipients. In addition, generated funds are leveraged to drive specific programmatic and/or policy goals, such as improved quality in the delivery of services. Given the gap between the costs of providing ambulatory services and Medicaid payments, a provider assessment can be used to generate significant additional revenues for states to alleviate budget shortfalls that might otherwise result in cuts to Medicaid rates. In this way, a provider assessment is distinct from the other two options, in that it does not support a supplemental payment program—it supports higher Medicaid rates in the first place.

States have some flexibility in the design of a Provider Assessment Initiative, provided that it adheres to applicable federal rules and regulations. As shown in the following table, state Medicaid agencies have three primary options for implementation of a provider assessment.
**Provider Assessment Options**

<table>
<thead>
<tr>
<th>Type of Assessment</th>
<th>Assessment Description &amp; Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Broad based and uniform</strong></td>
<td>A broad based and uniform assessment results in the state Medicaid agency taxing all providers at the same assessment rate within a class of services. For the purposes of a Provider Assessment Initiative for EMS agencies, a broad based assessment would result in all EMS agencies being assessed at the same rate.</td>
</tr>
<tr>
<td><strong>Broad based and uniformity waived</strong></td>
<td>When Medicaid agencies waive the broad based provision of the federal regulation, it results in certain types of providers being exempted from the provider assessment. In the case of hospital provider assessments, some states opt to exclude stand-alone psychiatric and long-term care hospitals from assessment, while the remaining or non-waived hospitals are assessed at the same rate. Should KDHE decide to pursue this model, it would be necessary to conduct modeling to identify EMS agencies that might be excluded from this initiative.</td>
</tr>
<tr>
<td><strong>Broad based waived, but uniform</strong></td>
<td>In this scenario, Medicaid agencies waive the uniformity provision of the federal regulation and assess or tax providers at different rates up to and/or including the exemption of certain providers within a permissible class.</td>
</tr>
</tbody>
</table>

In order for provider assessment revenues to serve as the state share, the tax must meet the criteria for one of the three above types. Provided that this requirement is met, states can structure the assessment and any related payment increases to providers to align with their overall goals of market efficiency and provider accountability.

In principle, states are flexible to structure and pass on rate increases as they see fit. However, in practice, state Medicaid agencies will frequently use a cost reporting methodology to set rates and determine the scope of the assessment. While any enhanced rate structure will result in “winners” and “losers” within the provider community, a cost reporting methodology that informs the rate structure can be used to devise a plan that compensates providers in a manner proportionate to their costs and to their contribution to the assessment. An independent provider association, as described above, can serve as an intermediary to support these goals as well.
**Case Study: Missouri**

The Missouri Ambulance Reimbursement Allowance was passed and signed into law in 2009. Through Missouri EMS Agent Corporation (MoEMSAC), a nonprofit entity independent from the state, providers submit gross receipt surveys are assessed a “provider tax.” Tax rates have been phased in slowly and now stand at 4.44%. The ARA assessment funds are pooled and used to draw down additional federal matching funds.

Taxes and new monies are funneled through MoEMSAC, the “provider’s agent,” making it possible to redistribute the new funds in a manner that prevents an adverse impact on low volume MoHealthNet providers. Additional revenues totaling around $15 million on an annual basis have been used to fund enhanced payments for mileage and base rates.

**Cost Reporting Methodologies**

As noted above, whichever option is selected to support reimbursement, operation of the program will require a methodology to calculate the cost to providers in supporting Medicaid services. PCG would assist providers in capturing all of the cost and statistical data to prepare the annual cost report required to support the claim for additional federal reimbursement (or determine the scope of an assessment). The approved methodology for such cost reporting is to determine the overall cost of delivering services, then use an allocation statistic of Medicaid services as a portion of total services to allocate a Medicaid-specific cost.

CMS requires that provider costs related to fire suppression and service delivery are properly identified and excluded from the medical costs of paramedics on fire apparatus when calculating Medicaid eligible costs. Utilizing Computer-Aided Dispatch (CAD) data, PCG has developed approved allocation methodologies that differentiate the allowable medical costs that can be claimed for reimbursement and the unallowable fire costs that must be excluded from the cost reports. In this manner, a CPE allows fire-based providers to receive additional reimbursement for first responder services.

Regardless of how the program is implemented, it will be necessary to collect relevant cost and charge data for each provider. While this information is typically collected via Excel cost reports, PCG has determined that this approach to reporting can create unnecessary administrative burden and can result in additional challenges with regards to compliance. Even with annual trainings, providers that are not as experienced in Excel can struggle to understand how to accurately complete cost reports. Excel-based cost reports can often create confusion as to what needs to be entered and how this data is incorporated into the calculation of the cost settlement. This can limit the benefits of the program, leading to some providers choosing not to participate due to the efforts required to complete the annual cost report.

One alternative to the Excel cost report is a web-based cost reporting application that providers will be able to use to input necessary charge, expenditure, revenue, and other statistical information necessary to prepare and submit cost reports. Drawing from extensive experience in EMS data analyses as well as best practice solutions gained over a 30-year span of Medicare and Medicaid cost reporting for a variety of healthcare providers, PCG has developed a customizable solution that makes cost reporting easier for all EMS providers. A significant advantage with PCG’s system is its ability to perform real-time validation
checks for quality assurance and accuracy. The system takes the guess work out of reporting and facilitates compliance.

Many providers may not realize the risk they bear when submitting and receiving reimbursement for their cost report. State or federal audit findings can arise as a result of a provider’s lack of understanding of federal cost accounting, cost allocation, and allowable cost procedures. A recommended best practice of any cost reporting-based initiative is to require a mandatory desk review of all provider cost reports following submission to the state Medicaid agency.

Administrative oversight requirements from the state Medicaid agency would usually require a program manager and a team of two or three part-time data analysts to pull Medicaid billing reports and conduct desk reviews. Because each provider only submits one cost report and receives one lump-sum payment on an annual basis, there is little need to hire additional full-time employees to maintain such a program. The desk review and subsequent payment processes usually occur over a three to six-month period and do not require year-round full-time management.

III. KANSAS FEASIBILITY: PROJECT SUMMARY & RECOMMENDATIONS

Objective

The objective of the feasibility study is to provide KEMSA and other stakeholders the opportunity to understand the outcomes of three primary approaches – 1) Certified Public Expenditure (CPE), 2) Intergovernmental Transfer (IGT), and 3) Provider Assessment – to EMS revenue maximization in order to evaluate applicability of these approaches to Kansas.

One of the primary sub-objectives that led to the feasibility study was the impetus that KEMSA placed on including all types of providers in the discussion. In order to promote the goal of inclusion of all stakeholders, KEMSA formed a diverse task force from all six regions representing various models and sizes of ambulance providers. Services represented in the task force included fire-based, hospital-based, and stand-alone ground and air EMS providers with a mix of public, private, volunteer, and nonprofit statuses.

KEMSA and PCG understand that the provider community must understand both the benefit and the nuances of the options in order to obtain their buy-in and acceptance. A transparent feasibility study is the first step in the effort to achieve this goal and to build a unified commitment of a single plan to KDHE and other state leadership.

Methodology

In this initial phase of the project, PCG conducted market analysis of the various approaches in order to better understand the national landscape. PCG then collected and analyzed data pertinent to EMS transports, charges and payments from payers, and cost data in order to determine the fiscal impact of each initiative on EMS agencies. Sources of data included Medicaid paid claims data provided by KDHE and providers’ self-reported claims and expenditure data collected via survey tool. Other sources or information have included Kansas Board of Emergency Medical Services and the KEMSA task force on EMS revenue maximization.
**Market Analysis**

One of the first steps in the feasibility study included reaching out to states that have existing EMS revenue maximization programs in order to gather qualitative and quantitative statistics relating a program’s success. After identifying the states with current projects, PCG developed a survey to gather pertinent information including the number of participating/non-participating providers, the revenue generated, the administrative costs to the state, and any risks/challenges associated with the program.

**Fiscal Impact Analysis**

In collaboration with the KEMSA task force, PCG developed an Excel survey tool to collect provider information including transport, charge, and payment data for each procedure code and payer type for the two recent state fiscal years, 2014 and 2015. PCG kicked off the data collection process with providers at the 2016 KEMSA Conference and Expo in August 2016, a critical opportunity to connect with billing professionals and service directors across the state.

Following the conference, PCG distributed data requests via email and the KEMSA website. Subsequent outreach to obtain data from providers included multiple rounds of email reminders and more than 100 logged calls to providers from PCG staff. In addition, members of the KEMSA task force were called to action to work directly with providers in their region to return the data requests. PCG also hosted four informational sessions via webinar to provide support to providers that had questions regarding the data requests.

The goal throughout the process was to collect as much data as possible in order to accurately measure the effects of the three program approaches. Without the data from providers, it would be impossible to obtain billing information for all payers. Additionally, PCG worked with KDHE to obtain Medicaid billing information by provider and by transport. The state’s database was used as a quality check against a provider’s self-reported Medicaid charges and payments.

**Findings & Recommendations**

In examining the provider mix in the state, we found that the provider community was dominated by city and county services. Governmental and quasi-governmental services comprised more than 85% of the total provider population. The set of providers that we labeled as governmental included some nonprofit and volunteer services, but the ultimate determination of private/public status depends on whether or not each provider has taxing authority or direct access to tax revenues. When we received survey results, we found that many of the service providers that identified as nonprofit or volunteer were quasi-governmental in nature and likely received city or county funding. This is important as it potentially opens the door to their participation in both CPE and IGT programs if KDHE and CMS deem these providers to be public entities.

Of the approximately 165 ambulance service providers statewide, our data collection efforts netted 54 returns. As shown in the table below, providers of varying sizes and organization type responded.
With approximately 33% of providers submitting revenue data for the feasibility study, we were unable to conduct statistically reliable modeling for a provider assessment. In our experience in other states, we have seen how difficult it can be to accurately extrapolate results based on such a limited percentage of providers. Furthermore, it draws additional attention to the administrative efforts that it would take to gain federal approval and administer an ongoing assessment program when a majority of providers are not able to easily report revenue and utilization data. We have seen that this is less of an issue for hospitals and other provider types that are already accustomed to the annual reporting requirements of Medicare cost reports. The ambulance industry is highly fragmented, comprised of providers with data management and billing systems that can be either sophisticated or dated. As the industry works toward building a common reporting model in the coming years, data collection from all providers should be less of a limitation to provider assessment programs.

The Medicaid paid claims data provided by KDHE also proved to be valuable in examining the opportunity of an EMS revenue maximization initiative. We centered our analysis on the mileage and base codes for both air and ground services. In looking at the two most recent fiscal years of 2014 and 2015, we saw four payers. As shown in the table below, Medicaid FFS payments accounted for a little more than 2.4% of total payments, while the three Medicaid MCO payers made up the remaining 97.6%.

### Medicaid Paid Claims Data, State Fiscal Year 2014 & 2015

<table>
<thead>
<tr>
<th>Payer</th>
<th>SFY2014</th>
<th>SFY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments</td>
<td>Percentage</td>
</tr>
<tr>
<td>MEDICAID FEE FOR SERVICE</td>
<td>$ 110,988</td>
<td>2.21%</td>
</tr>
<tr>
<td>AMERIGROUP</td>
<td>$ 1,783,246</td>
<td>35.45%</td>
</tr>
<tr>
<td>SUNFLOWER STATE HEALTH PLAN</td>
<td>$ 1,520,031</td>
<td>30.22%</td>
</tr>
<tr>
<td>UNITEDHEALTHCARE COMMUNITY PLAN</td>
<td>$ 1,616,095</td>
<td>32.13%</td>
</tr>
<tr>
<td>Total</td>
<td>$ 5,030,360</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Source: Kansas Department of Health & Environment

In order to assess the potential of CPE and IGT opportunities, we utilized data from provider and state sources. The provider data was used as a tool to determine expenditures. We found that for these providers, estimated costs were just slightly higher than the billed charges. Because we did not have expenditures for all providers, we assumed costs using this statewide average of billed charges.

For the remaining analysis, we focused efforts on ground services for a number of reasons. Air and ground services are distinct classes of providers with dissimilar cost, charge, and payment structures. While a majority of ground service providers are public agencies, most, if not all, air service providers are
private, for profit entities. Private air service providers would be prohibited from participating in a CPE and they are unable to submit IGT payments.

We considered the potential of new federal revenues using upper payment limits including Medicare, costs, and the lesser of costs or charges. Through modeling, we found that using costs as the driver was the optimal approach, approximately 4% more beneficial than using charges. Costs are also typically an easier standard for CMS to accept, as costs are verifiable through auditable cost reporting processes and charges may be viewed as an unsubstantiated or arbitrary amount.

We found that the opportunity for a CPE for governmental providers is limited due to sparse Medicaid FFS claims. The total benefit of the CPE to the governmental providers would be capped between $200,000 and $250,000 annually. Considering that this amount is spread out over almost 70 providers, the cost-benefit ratio would be too high for most to participate. Sedgwick County, with an estimated settlement of $70,000, is projected to receive the greatest benefit from a CPE. Wyandotte County is a distant second with around $30,000.

### Revenue Potential for CPE (Medicaid FFS) Option

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current Payments</th>
<th>Estimated New Federal Revenues</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Public</td>
<td>$113,638</td>
<td>$250,451</td>
<td>120%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$113,638</strong></td>
<td><strong>$250,451</strong></td>
<td><strong>120%</strong></td>
</tr>
</tbody>
</table>

A CPE would be beneficial for a few large governmental providers but is not viewed as a meaningful long-term solution for the provider community. The IGT option would be the preferred approach, as it allows providers to capture additional revenues for services provided through managed care. Using IGT funds to support additional payments to be passed through the state’s three MCO payers or an independent provider association has the potential to provide as much as $9 million annually in new federal revenues for both public and private ground providers.

### Revenue Potential for IGT (Medicaid MCO) Option

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Current Payments</th>
<th>IGT Required to Draw FFP</th>
<th>Estimated New Federal Revenues</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>$616,977</td>
<td>$1,079,929*</td>
<td>$1,386,225</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>$3,496,202</td>
<td>$6,119,598</td>
<td>$7,855,278</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4,113,179</strong></td>
<td><strong>$7,199,527</strong></td>
<td><strong>$9,241,503</strong></td>
<td><strong>125%</strong></td>
</tr>
</tbody>
</table>

*IGT from Public Provider

While private providers are typically not prohibited from receiving Medicaid payment increases resulting from an IGT program, private corporations are not eligible to IGT funds. Therefore, in order to maximize reimbursement for both public and private providers, public providers would need to make a total contribution of $7.2 million to cover the private providers’ room for a state share of just under $1.1 million. As described above, the use of an independent provider association would allow supplemental payments to be balanced in order to make public providers whole for this initial outlay.
**Recommended Next Steps**

Based on our analysis of the potential fiscal benefit for EMS providers, PCG recommends that KEMSA further their initiative for additional reimbursement through the implementation of an IGT methodology. It is imperative to note that an IGT methodology would most likely require the establishment of an independent provider organization to operate as a fiscal intermediary, as outlined in the Louisiana Case Study. This would require further engagement and cooperation of stakeholders to establish contractual language for provider participation and to modify existing MCO agreements.

PCG submitted a draft feasibility study and recommendations report summarizing these findings to KEMSA on December 2, 2016 for review. On December 14, 2016, representatives from PCG and the KEMSA task force held a collaborative conference call to discuss the feasibility study and subsequent recommendations report. The purpose of this call was to discuss PCG’s findings and also address any stakeholder questions or concerns.

The next step in this initiative will be to actively engage the Kansas Department of Health & Environment (KDHE) to gain approval to design a detailed plan of execution. To ensure successful implementation, KDHE along with the EMS provider community must be appropriately engaged in the establishment of the program. PCG looks forward to continuing our involvement in this process and working alongside KDHE, KEMSA, and the provider community to advance this initiative.