Legislative Analysis

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SUPPLEMENTAL PAYMENT PLAN FOR MEDICAID AMBULANCE PROVIDERS

House Bill 5695 (proposed substitute H-2)
Sponsor: Rep. Mike McFall
Committee: Local Government and Municipal Finance
Complete to 11-13-24

SUMMARY:

House Bill 5695 would amend the Social Welfare Act to authorize a supplemental reimbursement program for ***eligible ground emergency medical transportation providers*** (i.e., ambulances) that provide services to Medicaid recipients. Participation in the reimbursement program would be voluntary.

> ***Eligible ground emergency medical transportation provider*** would mean a public provider that provides ground emergency medical transportation services to medical assistance recipients, is enrolled as a Medicaid provider for the period for which reimbursement is being claimed, and is owned or operated by an ***eligible governmental entity***.
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> ***Eligible governmental entity*** would mean an entity that is eligible under federal law to provide ground medical transportation services, including the state, a city, a county, a fire authority, a township, an ambulance authority, a federally recognized Indian tribe, or a local unit of government.

The Michigan Department of Health and Human Services (DHHS) would have to initiate the process to amend the state's Medicaid state plan to establish and administer the ambulance reimbursement program no later than 90 days after at least two eligible ground emergency medical transportation providers have submitted a complete and acceptable cost report.

DHHS could limit the program to the reimbursement of costs that are allowable under title XIX of the federal Social Security Act.[1] The department would have to submit claims for federal financial participation for federally allowable expenditures and submit necessary materials to the federal government to provide assurances that claims for federal financial participation will only include those allowable expenditures. (DHHS could use intergovernmental transfers or certified public expenditures to implement this provision.)

The supplemental reimbursement would have to be distributed exclusively to eligible providers under a payment methodology based on the ground emergency medical transportation services provided to Medicaid recipients. The amount of supplemental reimbursement to an eligible provider would be equal to the amount of federal financial participation received for the provider's cost for the services, up to 100% of the actual cost incurred (as determined under the state Medicaid program for ground emergency medical transportation services) when combined with the amount received from all other sources of Medicaid reimbursement.

[1] Title XIX provides for federal grant payments to states for Medicaid programs.

In order to calculate the amount of supplemental reimbursement due, an eligible provider would have to make any information that establishes that the expenditures qualify for federal financial participation readily available to DHHS.

DHHS would have to pay supplemental reimbursements to eligible ground emergency medical transportation providers for services provided on a fee-for-services basis and managed care program recipients in the state's Medicaid program.

Proposed MCL 400.109p

FISCAL IMPACT:

Aside from additional, nominal administrative costs for the Department of Health and Human Services to implement and maintain the supplemental payment program, House Bill 5695 would not incur any additional costs to the state and would increase federal funding to eligible local units of government. The bill would allow DHHS to aggregate ground emergency medical transportation costs incurred by participating local units of government, as well as any other public provider of these services operating in this state, and submit the expenditures to the Centers for Medicare and Medicaid Services (CMS) for the purposes of drawing down federal matching dollars. These additional funds could then be redistributed as a pass-through by the state to cover local units' gap between Medicaid reimbursements issued by the state (including specialty payments such as QAAP) and the actual costs of providing the services, resulting in a substantive, yet indeterminate net increase in revenues for those local units of government. Public providers who voluntarily participate in this program would be the only entities able to draw the additional funds due to the ability to verify costs through publicly funded accounting and reporting (i.e., less variance in costs due to the providers operating in an environment that limits what can be charged for providing services to approximately "at-cost"). Programs such as the Medicaid School Based Services, which is also based on federal pass-through funding for certified public spending, operate in a similar manner.

The amount of federal revenues available for services is dependent on several variables, the most important of which is the Federal Medical Assistance Percentage (FMAP), which for FY 2024-25 is 65.13%, meaning that for every dollar the state/locals spend on Medicaid services, the federal government will reimburse approximately $0.65. Similarly, the Health Michigan Plan (HMP)—Michigan's Medicaid expansion under the Affordable Care Act—has a statutorily set reimbursement rate at 90% that supersedes the annual FMAP adjustment and provides $0.90 for every state/local Medicaid dollar spent.

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