FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: HB 4030 - A**

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Legislative Fiscal Office

Only Impacts on Original or Engrossed Versions are Considered Official

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Measure Description:
Requires Oregon Health Authority to amend Medicaid state plan to implement programs to increase medical assistance reimbursement paid to public providers of emergency medical services.

Government Unit(s) Affected:
Oregon Health Authority (OHA), local government

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Analysis:
Historically, emergency medical services and transportation (EMS) providers have expressed concerns that Medicaid reimbursement has not covered the costs of providing services. This concern has been exacerbated by individuals who request transportation services inappropriately for non-emergencies. While federal law (the Emergency Medical Treatment, and Labor Act), prohibits EMS providers from refusing to provide requested transportation services, Medicaid health plans deny payment for services that do not meet the definition of medical emergency. House Bill 4030 effectively mandates that the Oregon Health Authority (OHA) develops and implements two programs to better reimburse providers of emergency medical services and transportation:

1. A Fee-For-Service program in which public EMS fee-for-service providers have the opportunity to participate in the program on a voluntary basis. Participating providers would receive a supplemental payment equal to the amount of federal match received based on the provider's cost for emergency medical services.
2. A Coordinated Care Organization (CCO) Program in which OHA will establish and maintain an intergovernmental transfer of funds program. Participating EMS providers who receive reimbursement from CCOs shall pay a fee to OHA not to exceed 20% of the costs of emergency medical services provided to CCO members. The purpose of the fee is to reimburse OHA for the costs of administering the program. That fee is then considered part of the EMS provider's cost and eligible for reimbursement.

The bill stipulates that General Fund moneys may not be used to implement these programs.

In addition, the bill directs OHA to convene a workgroup to develop recommendations to align these two programs with the goals of the Oregon Integrated and Coordinated Health Care Delivery System. Members must include representatives from OHA, fire departments, and CCOs. It outlines broad goals for the workgroup's recommendations, including identifying the amount of federal financial participation (FFP) needed to sustain EMS (not limited to Medicaid clients), exemption from criteria to participate for small, rural, or financially-strapped fire departments, and appropriate metrics.

The bill stipulates that if OHA does not receive approval from Centers for Medicare and Medicaid Services (CMS), OHA is directed to modify the Medicaid state plan to exclude the providers.

This fiscal attempts to estimate the preliminary costs for preparing to develop these programs. However, the full fiscal impact of completely developing and implementing HB 4030 is indeterminate because of the following undefined, potentially conflicting, and as such unquantifiable factors:

Consultant Costs:

- Participation in these two program is voluntary and the number of participating providers will impact the scope and complexity of the work to be done. Once this parameter is defined, OHA anticipates contracting with consulting services to identify appropriate provider costs, assist with provider-specific rate setting, analyze fee-for-service claims and perform reconciliation services. However, the cost of consulting services cannot be calculated until the scope of work can be defined.

Revenue Projections, Source of Funding and Share of Costs:

- The bill stipulates that General Fund monies cannot be used to implement these two programs. For the Fee-for-Service program, participating providers would receive a supplemental payment equal to the amount of federal match received based on the provider's cost for emergency medical services. Participating fee-for-service providers must enter into an agreement to reimburse OHA for the "costs of administering" the program related to fee-for-service claims. It is unclear whether "costs of administering" includes just administrative costs or both administrative and program costs to the state.
- For the CCO program, participating EMS providers who receive reimbursement from CCOs are required pay a fee to OHA not to exceed 20% of the costs of emergency medical services provided to CCO members. The purpose of the fee is to reimburse OHA for the costs of administering the program. That fee is then considered part of the EMS provider's cost and eligible for reimbursement. It is unclear if the 20% administrative fee is meant to cover only administrative costs relating to the program or the state share of program costs. In some cases, the revenue from the 20% fee might not offset the administrative and state share of program costs. Currently, the state share percentage for some eligibility groups can be as high as 35.6%. In addition, OHA will need to renegotiate contracts with CCOs, because requiring CCOs to pay their providers a specific supplemental payment is not feasible under current contracts.
- Revenue related to these programs to offset administrative costs, and potentially program costs, is indeterminate depending on the number of participating providers, and their specific costs of services.

Program Costs:

- The bill mandates that OHA consult with EMS providers and CCOs in the development, implementation and operation of these programs in order to establish program policies. Until these policies are establish, and the above share of costs issues are defined, program costs cannot be calculated.

Compression Costs:

- Although the bill only applies to public providers, passage of the bill could result in upward pressure on rates for private providers to receive similar reimbursement for similar services. The impact of this potential consequence cannot be predicted at this time.

The bill directs OHA to convene a workgroup to develop recommendations to align these two programs with the goals of the Oregon Integrated and Coordinated Health Care Delivery System. OHA anticipates that the workgroup will need to address the following risks in implementing these programs:

- Increasing costs without a connection to improved access and quality is inconsistent with Oregon's health system expectations. Oregon statute directs OHA to encourage the use of alternative payment methodologies that reimburse providers on the basis of health outcomes and quality measures instead of the volume of care. OHA is directed to use payment structures to create incentives to provide person-centered care, reward comprehensive care coordination, and to limit increases in costs. These two programs risk moving towards a cost-based methodology that is not aligned with state and federal health system objectives that encourage value-based incentives in payment.
- Increasing costs could jeopardize Oregon's ability to stay within the 3.4% cap on the state's total fund per member per month (PMPM) Medicaid inflation.

- Creating inequality with a two-tiered payment methodology that pays public providers more than private providers for the same service.

With the above caveats, if this bill passes, OHA anticipates the agency's first steps would be to convene the workgroup, seek CMS approval, and work to modify its information technology system. The system must be able to delineate participating providers and non-participating providers in order to augment the reimbursement to those providers on a fee-for-service basis. Reimbursement is based in part on revenue available associated with those providers in a leverage account. While there is existing functionality that may be leveraged to support this process, OHA estimates the fiscal impact of this work to be $283,928 Total Funds. The bill stipulates that General Fund moneys cannot be used for these two programs. It is assumed that the revenue for these programs will come from the fees on providers, although as noted above, it is not certain whether enough revenue will be available to cover costs. OHA will need to work with CMS and participating providers to negotiate a combination of Other Funds and federal match. At this time, the fund split cannot be determined.

This bill requires budgetary action for the allocation of funds.