Kansas Emergency Medical Services Association

"Unity Is Strength"

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Kansas House Committee on Vision 20/20 **February 2, 2015**

Background on Kansas Emergency Medical Services.....171 ground ambulance services, 10,500 certified technicians with 2,500 of those being paramedics. Ground ambulances provide 320,000 responses a year with about 225,000 of those being patient transports.

Basics of how ground ambulance services are funded.....The majority of ground ambulance services are subsidized by a local unit of government or a hospital yet the collection of user fees is critical for the financial stability of almost every agency. Collection of user fees is 100% of revenue for some private firms and all agencies that are subsidized require the collection of user fees to have adequate revenues. Payments from insurance companies, the federal Medicare program, state Medicaid program and "private pay" constitute user fees.

Kansas Medicaid rates for ambulance services fall far below the comparable Medicare rates and well below surrounding states (chart attached). This means cost shifting to those who can pay (Medicare, insurance and government subsidy payments disproportionally covering the cost of Medicaid patients). KDHE goal of Medicaid payments is to pay 60-65% of comparable Medicare rates. Our present Medicaid rates are far below that level and have not been adjusted since 2005. Many patients treated and transported by ground ambulance services that cannot pay for the services fall into the income level where they would qualify for KanCare if the additional federal funds were accepted by Kansas.

KEMSA conducted a survey of eleven ambulance services across Kansas to estimates the impact of KanCare expansion. Those eleven services do 53% of the transport volume in KS, we measured the number of private pay patients age 19-64, considered a 50% utilization rate and applying current KS Medicaid payment rates, we estimate that ground ambulances would conservatively gain an extra $2.5 million /year from additional KanCare payments if expansion were to occur.

Impact of hospital closures on EMS. Nationally the impact of Medicaid Expansion (or lack of it) has been dramatic with rural hospitals. From a combination of general media sources in 2013 approximately 13-14 rural hospitals closed in the nation, in 2014 approximately 12. Another source identified that out of the last 22 hospital closures in the nation 20 were in states that had not adopted the additional federal funds.

Examples; Alabama had 6 rural hospital closures in 2013 with 22 hospitals currently in financial trouble and Georgia had 4/ 65 rural hospitals close in 2013 with 15 more in trouble. Missouri had 2 rural hospital closures in 2014.

By definition rural indicates that the nearest additional hospital will be a significant distance away. So if Kansas experiences rural hospital closures there will be greater patient transport

times and the loss of local health resources to stabilize critical patients prior to transfer for more advanced services

Again, general media reports on rural hospital closures over the last few years are replete with comments regarding the negative patient impact related with ambulance transport times etc.

The situation also applies additional pressure on the current use of volunteers in many KS ambulance services. We are already witnessing the steady decline of the availability of volunteers forcing ambulance services to find funding for the payment of full time personnel. If transport times increase for the local ambulance service the availability of personnel to volunteer from their jobs and homes decreases.

Jason White

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Government Affairs Liaison, KEMSA

Procedure		Kansas	Oklahoma	Missouri	Nebraska	Colorado	Arkansas	Iowa		Kansas
Code	Type	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	AVG	Medicare
AO425	Mileage	$2.50	$5.71	$3.50	$5.35	$1.61	$3.20	$2.16		$7.16
AO426	S Non-Emerg	$40.00	$207.91	$167.20	$326.55	$98.37	$240.46	$113.29	$192.30	$248.37
AO427	ALS Emergen	$180.00	$374.19	$239.79	$326.55	$132.20	$240.46	$113.29	$237.75	$393.24
AO428	S Non-Emerg	$40.00	$173.26	$102.52	$130.62	$98.31	$183.86	$69.98	$126.43	$206.97
AO429	BLS Emergen	$150.00	$322.20	$147.52	$160.16	$90.59	$127.25	$69.98	$152.95	$331.15
AO433	ALS 2	$180.00	$476.46	NA	$326.55	$158.65	NA	NA	$320.55	$569.17
AO434	ecial Care Tra	$80.00	$563.09	NA	$326.55	$181.16	$75.00	NA	$286.45	$672.66
	Oxygen	NA	$12.87	NA	NA	$10.98	$17.13	$10.79		

Medicaid Expansion

By Jason White, EMS Consultant for MARCER (Kansas City area bi-state EMS region)

The term Obamacare conjures up all kinds of political debate. So does the term Medicaid Expansion around Kansas. Despite the political mud that gets thrown around, let's wander through some of the issues regarding Medicaid Expansion, Kansas, and EMS.

Medicaid was created to provide access to health care for the poor.

The current Medicaid program is a combined federal/state endeavor with the federal government providing about 60 cents to every 40 cents of state funding. The two groups work together to establish a Medicaid plan, which defines who will be covered and to what extent, meaning that the Medicaid program varies in each state.

While the ACA (Affordable Care Act, the real name for what is often called Obamacare) is a political hot potato in national politics and the brunt of many jokes, it is the law of the land and unlikely to be repealed just as other major social legislative topics were castigated for years upon their initial passage including Social Security, Medicare, and the original Medicaid law. The US Supreme Court has weighed in on the ACA and overruled only one provision; that the federal government could not mandate that every state expand their Medicaid program.

Since the June 2012 US Supreme Court ruling much of the political anger about the ACA has been directed at the feasibility of each state to voluntarily accept Medicaid Expansion.

The idea of Medicaid Expansion in the ACA had been to provide access to care for those people who lived between the new health insurance market place, the federal mandate that we all have health insurance, and below a certain level of income. This was to help get more people access to health care by putting some sort of insurance card in their pocket.

Nationally, Medicaid Expansion has already added millions of people to the Medicaid programs because of the 27 states that have adopted the expansion. In Kansas the number is conservatively estimated at around 100,000 additional Medicaid recipients if the state were to adopt Medicaid Expansion. These are Kansans who live below 138% of the federal poverty level (FPL). In Kansas that means a family of four with a combined income of $31,721 or less.

The states that have accepted Medicaid Expansion will have the first three years paid 100% by the federal government and after that a sliding scale occurs until a state is paying a 10% match instead of the old 40% match as mentioned before. Already one year has passed regarding that offer and for all practical purposes Kansas has already lost out on millions of dollars to support the program.

In the next 6-10 months, it appears likely that the states of Indiana, Pennsylvania, Tennessee, and Utah will accept the provisions of Medicaid Expansion. This is similar to the chronology of the acceptance of the initial Medicaid program passed by congress in 1965. It was not endorsed by all states until 1982 when the last state (Arizona, which has already adopted Medicaid Expansion under the ACA) started their Medicaid program.

The financial framework for the expansion of Medicaid is based on the political bargain that was struck in order to pass the ACA through congress. The hospitals agreed to a combination of Medicare cuts and the elimination of the Disproportionate Share funding (a complex program to funnel more federal funds to hospitals that treat poor people) in trade for funding the Medicaid Expansion program. This bargain was intended to assure that more people could pay directly for the health care services (via Medicaid) they were already getting from the hospitals.

This bargain set forth in the ACA means that the hospitals in Kansas have already given up millions of Medicare dollars and Disproportionate Share funding, but they are not getting any relief as we have not enacted Medicaid Expansion. What was a good

bargain in Congress became a really bad deal for the 24 states not accepting Medicaid Expansion because the US Supreme Court ruling made it a state option and not mandatory.

Kansas has a republican controlled state legislature and a republican governor all of which are seeking to avoid accepting the Medicaid Expansion due to philosophical hatred of the ACA, concern on how to fund the state match of 10%, and worries about the federal government going broke and leaving the states holding the bag for an expanded Medicaid program. There has been little real discussion on any plan such as those adopted in Arkansas and Iowa (the ideas most often touted as fitting states like Kansas).

Accepting Medicaid Expansion causes several things to occur, including: Kansas health care facilities would hire around 4,000 additional health care workers by 2020 (yes, accepting Medicaid Expansion is a huge infusion of new dollars into the Kansas economy and would mean the addition of several thousand well-paying jobs), hospitals would get a serious financial boost, and additional Kansans would have access to health care.

The November 2014 election is over, and we will now learn if the close race has changed anything in Topeka. Prior to the election, there were various republican legislators claiming that Medicaid Expansion had no chance with a Democratic governor getting elected but that the effort might move forward if the Republican was re-elected.

Politics makes strange bedfellows.

Let's discuss the serious consequences for EMS if Kansas does not expand Medicaid.

Over the last two years, Georgia has had four rural hospitals close. The closings are directly attributed to the financial difficulties related to serving the poor and sustaining the financial losses as described earlier as Georgia has also refused to expand Medicaid.

EMS agencies serving communities where local hospitals close will need to consider increased ambulance transport times and the lack of a close hospital to stabilize patients while a transfer can be arranged.

If Medicaid Expansion were to occur, many of our patients who are presently billed as "private pay" (typically meaning that they will become bad debt on the books) will now at least have Medicaid level payments, which is estimated to increase revenue for all ground ambulance services in Kansas by at least $2.3 million/year.

KanCare is in trouble. Let's throw into the discussion that the three private companies running KanCare are losing huge sums of money. For-profit companies don't like losing millions and millions of dollars. No great crystal ball is needed to know that the current KanCare structure will undergo serious changes in the next 6-12 months.

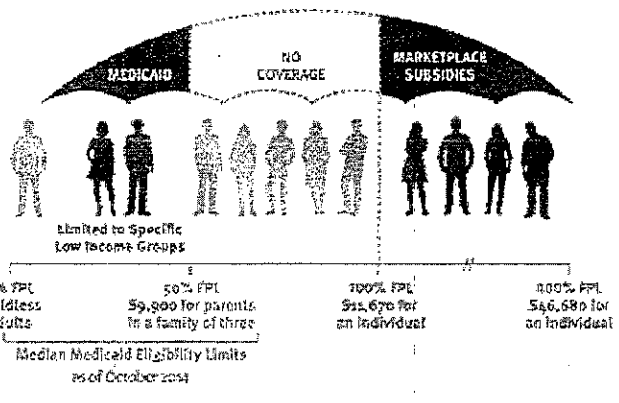
The Kansas Hospital Association is leading the discussion to develop a plan to Expand Medicaid in Kansas. They have a plan to use the "provider assessment" program (also known as the FRA) to create the state match thus not requiring any Kansas general revenue funds. If this concept moves forward in legislative debate, KEMSA is ready to request the legislature to establish an FRA for ground ambulance services. A similar program in Missouri is generating an extra $16 million/year for ground ambulance service Medicaid payments.

Moving forward, the KEMSA Board of Directors has voted unanimously to endorse Medicaid Expansion in Kansas (although to be politically correct, we now need to call it KanCare Expansion).

Complicated, controversial but important; keep the topic on your radar screen.

Figure 1

In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.



In states that do not expand Medicaid under the ACA, there will be large gaps in coverage available for adults.
Graphic Courtesy of The Henry J. Kaiser Family Foundation