Date of Hearing: April 25, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 55 (Rodriguez) – As Amended March 30, 2023

SUBJECT: Medi-Cal: workforce adjustment for ground ambulance transports.

SUMMARY: Establishes a "workforce adjustment" supplemental Medi-Cal payment for emergency and non-emergency ambulance services, to establish overall payment for ambulance services at 100% of the Medicare rate, for ambulance services provided by private medical transportation providers who raise wages for several classes of employees. Specifies the new payments are in addition to base Medi-Cal payments and "add-on" payments made through an existing supplemental payment program. Specifically, **this bill**:

1) Requires the Department of Health Care Services (DHCS), for dates of service on or after July 1, 2024, to establish a workforce adjustment for each ground ambulance transport performed by a non-public provider of medical transportation services that meets the workforce standard specified by this bill.

2) Establishes the workforce adjustment payment level for emergency ground ambulance transports as equal to the difference between the lowest maximum allowance established by the federal Medicare Program for the applicable base rate and mileage rate for the transportation service in the ZIP Code of the point of pickup, minus the fee-for-service (FFS) payment schedule amount for the 2015–16 state fiscal year. (The FFS payment schedule amount for the 2015–16 state fiscal year is comprised of the following:
   a) Medi-Cal base payments for the trip in 2015-16; plus,
   b) The add-on payment established through a Quality Assurance Fee (QAF) program pursuant to existing law in 2015-16.

3) Establishes the workforce adjustment payment level for nonemergency ground ambulance transports as equal to the lowest maximum allowance established by the federal Medicare Program for the applicable base rate and mileage rate for the transportation service in the ZIP Code of the point of pickup, or, if the point of pickup is without an apparent ZIP Code, the ZIP Code nearest to the point of pickup, reduced by the FFS payment schedule amount for the 2022–23 state fiscal year.

4) Applies the workforce standard to specified classes of employees, including dispatchers, certified emergency medical technicians (EMTs) and advanced EMTs, licensed paramedics, and registered nurses, who are performing duties in the scope of that certification or licensure and who are not managers or supervisors.

5) Establishes distinct payment parameters for new and existing providers of medical transportation services, beginning in the 2024-25 fiscal year, based on the providers' compliance with provisions summarized as follows:

   a) For existing providers:

   i) For the 2024–25 fiscal year, payment of a base hourly wage to each employee within a class of employees that is at least 110% of the average base hourly wage paid to that employee during the 2023–24 fiscal year; and,
   ii) For the 2025–26 fiscal year, and each subsequent fiscal year, payment of each employee at a higher rate year-over-year commensurate with a Medicare cost growth benchmark, and payment of each new employee at least the lowest average base hourly wage paid by the provider to an employee in the respective class in the respective county.

b) For new providers, for the 2024–25 fiscal year, and each subsequent fiscal year:
   i) Payment of each employee within a class of employees a base hourly wage that is at least the lowest base hourly wage paid by any provider of ground ambulance services to an employee in the respective class in the respective county; and,
   ii) Payment of an average base hourly wage to all employees in each class of employees that is at least the average base hourly wage paid by all providers of ground ambulance services to all employees in the respective class in the respective county.

6) Requires DHCS to direct each Medi-Cal managed care plan to implement a value-based purchasing model that provides for reimbursement to a network provider that meets the workforce standard requirement, as specified, and that furnishes emergency ambulance transport services to a Medi-Cal beneficiary enrolled in that plan, at a rate that is at least at a level reflecting:
   a) The workforce adjustment payment level established by the bill;
   b) The fee-for-service payment schedule amount for the 2015–16 state fiscal year; plus
   c) The add-on payment established by an existing QAF mechanism (further discussed under Existing Law, 5), below).

7) Establishes similar requirements as in 6) above, for nonemergency ambulance transport services, but excluding the add-on payment established by the QAF mechanism that only applies to emergency services.

8) Requires payments to noncontracted providers for emergency ambulance transport services to be at the same rates as described in 6) above, consistent with federal law.

9) Establishes the following requirements related to implementation and administration:

   a) Requires DHCS to add the workforce adjustment to payments to a provider that attests to meeting the established workforce standards;
   b) Requires each provider that has received the workforce adjustment to certify under penalty of perjury that it met the workforce standard during the state fiscal year with such supporting data as may be determined by the department;
   c) Allows DHCS to recoup overpayments and specifies interest is assessed on overpayments or payments to providers in a fiscal year in which the provider does not meet the workforce standard;
   d) Specifies implementation of the workforce adjustment to not affect the calculation of the add-on established by the existing QAF mechanism;
   e) Conditions implementation on federal approval and availability of federal financial participation (FFP); and,

f) Allows DHCS to adjust the workforce adjustment only to the minimum extent necessary to obtain federal approval and after exercising the current-law authority to adjust the QAF to the full extent permitted by law.

EXISTING LAW:

1) Establishes, under federal law, that a provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary was not enrolled in managed care. [Title 42, United States Code 1396u-2(b)(2)(D)]

2) Establishes the Medi-Cal program, administered by DHCS, under which health care services are provided to qualified low-income persons. [Welfare & Institutions Code (WIC) § 14000, *et seq*.]

3) Establishes a schedule of benefits under the Medi-Cal program, which includes emergency and non-emergency medical transportation. [WIC § 14132]

4) Establishes the Public Provider Intergovernmental Transfer Program, with the following major provisions: [WIC § 14105.945]

   a) Makes public ground ambulance providers eligible for increased reimbursement through the application of an add-on to the Medi-Cal FFS payment rate for emergency medical transports;

   b) Allows the non-federal share of payment for the add-on to be through voluntary intergovernmental transfers (IGTs) of funds provided by public entities;

   c) Requires DHCS to provide appropriate funding to each applicable Medi-Cal managed care plan to account for the fiscal impact of the add-on in the plans' capitation rates; and,

   d) Requires DHCS to assess a 10% fee on each transfer of public funds to the state to pay for health care coverage and to reimburse the department for its costs associated with administering the program.

5) Establishes the Medi-Cal Emergency Medical Transportation Reimbursement Act, with the following major provisions: [WIC § 14129-14129.7]

   a) Establishes a QAF on revenue from three specified emergency medical transport codes provided by an emergency medical transport provider, as specified, excluding public providers subject to 4), above. [WIC § 14129]

   b) Requires DHCS to deposit the collected QAF revenue into the continuously appropriated Medi-Cal Emergency Medical Transport Fund, for exclusive use in a specified order of priority to enhance FFP for ambulance services under the Medi-Cal program, to provide additional reimbursement and support quality improvement efforts of emergency medical

transport providers, to pay for state administrative costs, and to provide funding for health care coverage for Californians. [WIC § 14129.2]

6) Establishes the Skilled Nursing Facility Quality and Accountability Supplemental Payment (QASP) System, which creates mechanisms for the collection and payment of QAF revenue from skilled nursing facilities in the form of Medi-Cal supplemental payments, including, beginning in the 2024 calendar year, a workforce adjustment for a skilled nursing facility that meets workforce standards, as determined by DHCS in consultation with representatives from the long-term care industry, organized labor, and consumer advocates. Specifies the workforce standards may include, but need not be limited to, criteria such as maintaining a collective bargaining agreement or comparable, legally binding, written commitment with its direct and indirect care staff; payment of a prevailing wage for its direct and indirect care staff; payment of an average salary above minimum wage; participation in a statewide, multiemployer joint labor-management committee of skilled nursing facility employers and workers; or other factors, as determined by the department in consultation with stakeholders. Imposes limits on supplemental payments for those facilities who do not meet workforce standards. [WIC § 14126.033 (c)(17)-(20)]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, decades of below-cost Medi-Cal reimbursement, combined with Medi-Cal expansion, is crippling California's ability to recruit and retain qualified EMTs and paramedics. Unfortunately, the author asserts, this issue has been building long before the pandemic started, and it now threatens to undermine the stability of the state's emergency and non-emergency ambulance transport infrastructure. To address retention and recruitment issues, the author explains, ambulance providers need a Medi-Cal reimbursement increase that ensures a sustainable living wage for workers, now and into the future. The author further explains current reimbursement rates for Medi-Cal and Medicare patients do not cover the costs of an ambulance transport, indigent care costs providers millions in losses a year, and commercial health insurers often deny coverage for services or seek to pay rates below costs or below a provider's set rate. The author concludes this bill is intended to increase the Medi-Cal reimbursement rate for emergency medical transports to $350 per transport from the current rate of approximately $110 and ensure higher payment for workers to address workforce issues of recruitment and retention in the medical transportation sector.

2) **BACKGROUND.**

   a) **Medical Transportation Services under Medi-Cal**. Ground emergency medical transportation (GEMT) and non-emergency medical transportation (NEMT) are covered Medi-Cal benefits. Medi-Cal covers GEMT to the nearest hospital or acute care facility capable of meeting a recipient's needs. NEMT is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance.

   Ambulances bill Medi-Cal for a base rate for emergency medical transportation. The base rate for Basic Life Support – Emergency is $118.20, but the effective rate is $106.38,

which accounts for a 10% rate reduction imposed as a cost-saving measure pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. In addition to the base rate, Medi-Cal provides additional funding for additional costs and services, such as mileage, night calls, extra attendants, waiting times, and certain supplies and services.

b) Existing Supplemental Payment Programs. For services provided under Medicaid, the federal government matches state spending for eligible beneficiaries based on formulas specified in federal law. In California, although the General Fund pays for the largest share of state spending on Medi-Cal, there are many other sources of the "state spending," or non-federal share that is matched by federal funds, including special funds, local governmental funds, and provider fee revenue. DHCS is the single state agency accountable to ensure all funds are expended on allowable purposes consistent with federal Medicaid rules.

Supplemental payment programs allow states to draw down federal funds to enhance Medicaid rates for specific services, subject to federal approval. These supplemental payment programs are generally funded by non-General Fund (GF) sources of revenue. Since 2011, the state has implemented various supplemental payment programs for GEMT. Because different financing mechanisms are available for public and private providers under federal Medicaid requirements, these two provider groups benefit from supplemental reimbursement in different ways. For both public and private programs, the non-federal share of costs for the GEMT supplemental payments is revenue collected from the providers—fee revenue from the private providers, and contributions of local governmental funds from the public providers. These funds are used as the non-federal share to claim federal matching funds, which are paid out as supplemental reimbursement on top of the base rate and additional funding for mileage and other components, as described above.

i) Private Providers. SB 523 (Hernandez), Chapter 773, Statutes of 2017, created the GEMT QAF Program. To generate revenue for the program, SB 523 imposed a GEMT QAF, a type of provider fee, on GEMT providers. The revenues from the QAF are designated to be used, along with a federal match, to provide an add-on to the base reimbursement rates for GEMT services, to pay for DHCS staffing and administrative costs to implement the QAF program, and to pay for health care coverage. Public providers were later exempted from this program, as discussed below.

Under this program, private GEMT providers pay a fee on each transport they provide for Healthcare Common Procedure Coding System emergency transport codes, including A0429 (Basic Life Support, Emergency), A0427 (Advanced Life Support, Level 1, Emergency), A0433 (Advanced Life Support, Level 2), A0225 (Specialty Care Transport), and A0434 (Neonatal Emergency Transport).

Providers pay a fee of $33.42 for fiscal year 2020-21 on each transport, regardless of payer type. Providers then receive an add-on to the base rate each time these codes are billed to Medi-Cal; the add-on was $220.80 for fiscal year 2020-21.

ii) Public Providers. AB 678 (Pan), Chapter 397, Statutes of 2011, created the GEMT Certified Public Expenditure (CPE) Supplemental Reimbursement Program whereby public providers of GEMT could receive increased federal matching funds using a

CPE methodology, under which expenditures by participating local public agencies were certified as being spent on providing GEMT services. The GEMT CPE Supplemental Reimbursement Program only applied to trips covered under the Medi-Cal FFS delivery system. Public providers also participated in the GEMT QAF program described above.

However, this year, a new program has been implemented for public providers pursuant to AB 1705 (Bonta), Statutes of 2019, Chapter 544. The Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment 22-0015 on December 21, 2022, establishing the Public Provider-GEMT Intergovernmental Transfer (PP-GEMT IGT) Program as of January 1, 2023. The program is funded by voluntary contributions by eligible public providers and their affiliated governmental entities or other public entities. The PP-GEMT IGT Program add-on for calendar year 2023 is $946.92 per transport.

This reimbursement methodology is now the only supplemental payment program for public providers of GEMT services and applies to all public GEMT providers. For periods during which the new PP-GEMT IGT Program is in effect, public GEMT providers are excluded from all other GEMT supplemental payment programs, including the GEMT QAF Program and the GEMT CPE Supplemental Reimbursement Program.

c) **Limits on "Directed Payments" in Medi-Cal Managed Care.** Most individuals enrolled in Medi-Cal receive care not through the FFS Medi-Cal program administered directly by DHCS, but through a Medi-Cal managed care plan. By 2024, DHCS projects over 99% of enrollees will be enrolled in managed care. Emergency transportation services are covered benefits under DHCS's contract with managed care plans. In relation to this bill, this means managed care plans, not the state, will reimburse providers directly for the vast majority of emergency medical transportation services.

Any state effort to ensure enhanced reimbursement for a particular service that is covered by managed care plans must be federally approved and meet stringent federal requirements. This limits the state's ability to dictate specific rates that must be paid by managed care plans to providers. In general, per federal CMS regulations, states are not permitted to direct the expenditures of a Medicaid managed care plan, or to make payments to providers for services covered under the contract between the state and the plan. However, CMS has also specified allowable types of these "directed payments" to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement. These permissible state directed payments may include: value-based purchasing models, multi-payer or Medicaid-specific delivery system reform or performance improvement initiatives, or fee schedule requirements for provider reimbursement (e.g., minimum fee schedules, maximum fee schedules, and uniform increases). This bill specifies enhanced payment rates to be paid by managed care plans as a supplement to the base FFS rate through a "value-based purchasing program," which is one of the allowable exceptions to the prohibition on directed payments.

In addition, there are specific requirements for payments in managed care related to non-contracted emergency services. DHCS specifies that consistent with federal law, Medi-Cal managed care plans must reimburse eligible non-contracted providers of GEMT

services at the FFS rate, including any applicable FFS add-on amount for specified GEMT services. Plans may negotiate reimbursement rates with ambulance providers; however, plans are required to pay non-contracted GEMT providers the enhanced reimbursement rate. These rules do not apply to nonemergency medical transportation or to contracted providers.

d) Budget Request. On February 28, 2023, Assemblymember Rodriguez and nine other Legislators submitted a budget request for $200 million to fund the supplemental payments under this bill.

e) Mechanics of "Workforce Adjustment" Payments. This bill establishes a workforce adjustment supplemental Medi-Cal payment for emergency and non-emergency ambulance services. It establishes overall payment levels for ambulance services at 100% of the Medicare rate, for ambulance services provided by private medical transportation providers who raise wages for several classes of employees.

The amount of the workforce adjustment for a particular emergency ambulance service claim would be calculated by starting with what Medicare would pay for the service based on the ZIP code in which the trip originated, then subtracting the base rate and additional payments, like mileage, that Medi-Cal would normally pay, then subtracting the amount of the QAF payment described in b) i) above. The remainder would be the amount of the workforce adjustment payment for that particular claim. In simple terms, the workforce adjustment payment is intended to "fill the bucket" until the total payment for each claim is 100% of the Medicare rate. It applies a similar calculation for NEMT services, except it excludes the QAF payment from the calculation, given the QAF only applies to emergency services.

Only eligible providers would receive the payments. Eligibility for each provider would be established for each year, depending on whether the provider met the workforce standard as defined for that year. Different eligibility parameters are established for new and existing providers. The operation of these provisions are intended to establish eligibility for existing providers that give a 10% raise to each dispatcher, certified EMT, advanced EMT, licensed paramedic, and registered nurse, then provide a year-over-year increase in wages commensurate with an economic inflator in future years. New providers can become eligible by paying each employee a base hourly wage that is at least the lowest base hourly wage paid by any provider of ground ambulance services to an employee in the respective class in the respective county.

3) SUPPORT. Ambulance providers and two labor groups representing ambulance workers support this bill. Provider associations indicate due to extremely low Medi-Cal reimbursement rates, their members find it difficult to offer sufficient wages and benefits to attract qualified EMS workers, with many earning barely more than minimum wage. SEMSA, an ambulance provider, indicates, in 2023, California implemented an IGT program to increase reimbursements for emergency medical transports provided by eligible public GEMT providers, but private providers remain ineligible for this add-on, resulting in an unjust reimbursement gap. United Steel Workers, District 12 indicates workers and the industry are coming together as a unified front to request increased reimbursement rates, which is important to secure neighborhoods safety while providing necessary services. According to the International Association of EMTs and Paramedics, under existing law in

today's EMS workforce, private sector ambulance providers are woefully unprofitable in their operations and as a result, providers aren't able to pay EMS workers the wages they deserve, recruitment and retention plummets in this competitive ambulance market, and California residents end up suffering when they are in need of fast and comprehensive emergency care.

4) **RELATED LEGISLATION.** SB 525 (Durazo) establishes a $25 minimum wage for covered health care employment for employees of health care facilities, as specified. SB 525 is pending in the Senate Committee on Appropriations.

5) **PREVIOUS LEGISLATION.**

   a) AB 1705 implements the Public Provider-GEMT IGT Program and exempts an eligible provider from the GEMT QAF.

   b) AB 678 established the GEMT CPE Supplemental Reimbursement Program for public providers of GEMT.

   c) AB 2118 (Cooley) of 2018 was substantially similar to AB 1705. AB 2118 was held on the Senate Appropriations suspense file.

   d) AB 2436 (Mathis) would have required DHCS to establish payment rates for Medi-Cal ground ambulance services based on changes in the Consumer Price Index-Urban. AB 2436 was held on the Assembly Appropriations Committee suspense file.

6) **POLICY COMMENTS.**

   a) **Source of Nonfederal Share.** Prior supplemental payment programs have generally not resulted in an overall state GF impact. The Committee should consider whether imposing new ongoing GF costs for these payments is a priority in an uncertain budget time with projected deficits, and whether this should be considered through the budget process.

   b) **Reimbursement Level.** This bill proposes the total level of Medi-Cal payments for GEMT services for eligible providers at 100% of the Medicare level, which is out of step with most other Medi-Cal payments. For instance, according to Kaiser Family Foundation's 2019 Medicaid-to-Medicare Fee Index for physician services, California's physician rates were at about 73% of Medicare's rates. While supporters have cited anecdotal evidence about the difficulty financially sustaining private ambulance programs and private NEMT providers leaving various service areas, quantitative evidence of lack of access to ambulance services that normally supports a rate increase has not been provided.

   c) **Expansion of "Workforce Adjustment" Model for Medi-Cal Payments.** The state has not widely conditioned Medi-Cal rates or the payment of Medi-Cal supplemental payments on specific wage rates paid to health care employees. The author and sponsor cite precedent for the consideration of labor costs in payments made pursuant to the QASP System, established to collect and pay revenues associated with a QAF collected from long-term care facilities. Unique and complex payment structures like the QASP have been created in the context of allocating payments of revenue raised from fees on facilities. Additionally, about two-thirds of all individuals receiving skilled nursing

facility services rely on Medi-Cal as a payer, establishing a highly direct link between Medi-Cal payments and overall facility revenues, labor costs, and wages that does not exist in many other health care sectors.

However, even if addressing wages of particular groups of workers is of interest, it is not self-evident that conditioning Medi-Cal supplemental payments on the payment of particular wages is a model that warrants additional depth and expansion, versus other methods that more directly address wages in industries of interest or more broadly. Expanding the workforce adjustment model, as this bill does, would increase administrative complexity and cost for DHCS and for Medi-Cal managed care plans, and change the focus of Medi-Cal payment levels from whether rates appropriately maintain access to care in the health care marketplace, to issues related to workforce and employee wages. This raises additional questions the Committee should consider, including:

i) Is it an appropriate role of a public health care coverage program to directly incentivize providing wage increases to certain classes of employees, or are these issues better addressed through traditional labor and workforce strategies like minimum wages or ensuring fair opportunities to unionize and collectively bargain?

ii) If this is deemed an appropriate role for a health care coverage program, is it better to take a systematic approach and conduct an overall study of health care wages and workforce issues or an ad-hoc approach providing supplemental payments to one industry and group of employees?

d) Administrative Workload and Complexity. Apart from policy considerations regarding the expansion of the workforce adjustment model, the administrative complexity of this payment structure may result in significant administrative cost and burden to the state, including redirecting administrative effort from existing initiatives to develop the data collection and payment infrastructure and seek federal approval.

DHCS and its Medi-Cal managed care plan partners have taken on numerous and wide-ranging transformation initiatives in recent years as part of California Advancing and Innovating Medi-Cal (CalAIM), a five-year demonstration project that lasts through December 2026. A key component of CalAIM and recent program improvement initiatives is to streamline, standardize, and reduce administrative complexity in the Medi-Cal program. Medi-Cal has grown dramatically and has developed many administrative idiosyncrasies that take additional time, require administrative staff effort and information technology systems, and increase risk of error. Introducing a new, highly complex payment model that requires analysis of new and detailed data that is not currently collected, including employee-level wage data and ZIP code level comparisons to Medicare rates in order to determine appropriate payment levels for each claim, appears to be at odds with the goal of administrative streamlining that can improve and simplify program operations and reduce program risk.

7) AMENDMENTS. To address the concern listed in 6) b) above about setting a total reimbursement level benchmark at 100% of Medicare for only these specific benefits, amendments will insert an additional "check" on the amount of the workforce adjustment to ensure the state liability for payments, excluding any QAF-related payments not funded by the state, does not exceed the state share of an 80% of Medicare payment level benchmark.

The amendments ensure the state's normal payment rate plus the workforce adjustment does not exceed an 80% of Medicare payment level benchmark.

REGISTERED SUPPORT / OPPOSITION:

Support

9-1-1 Ambulance Provider's Alliance
AirCare Ambulance
AlphaOne Ambulance Medical Services
AmbuServe
American Ambulance
American Federation of State, County and Municipal Employees, AFSCME
AMWEST Ambulance
Bell's Healdsburg Ambulance Service
California Ambulance Association
Covalent Health
Global Medical Response
Hall Ambulance
International Association of EMTS and Paramedics
King American Ambulance Company
Lifeline Ambulance
Lifewest Ambulance
MaxCare Ambulance
Medic Ambulance
Medstar Ambulance
Pistoresi Ambulance Service
PMT Ambulance
Rescue Services International
Riggs Ambulance
Royal Ambulance INC
San Gabriel Valley Economic Partnership
SEMSA
Sierra Ambulance Service, INC
Sierra Emergency Medical Services Alliance
Symons Emergency Specialties, INC. DBA Symbiosis
The Code Green Campaign
United Steelworkers District 12
West Side Community Healthcare District
Westside Ambulance Association

Opposition

None on file.

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