STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Ground Emergency Medical Transportation

Provider Training and Resources

2023

GEMT Provider Training Table of Contents

Program Overview

Iowa Medicaid GEMT 2022

IOWA HHS

Overview

The Ground Emergency Medical Transportation (GEMT) Program is a voluntary program that allows publicly owned or operated emergency ground ambulance transportation providers to receive supplemental payments that cover the difference between a provider's actual costs per GEMT transport and the Medicaid base payment, mileage and other sources of reimbursement.

Transport Services receive cost-based, supplemental payments on a prospective basis for emergency ground ambulance transportation of Medicaid Fee-for-Service (FFS) and Medicaid managed care (MCO) members under Title XIX of the federal Social Security Act (SSA) and the Affordable Care Act (ACA) only.

- House File 2285 passed during the 2018 legislative session
- State Plan Amendment 19-002

Participation Requirements

Iowa Medicaid 2022

Participation Requirements

To be eligible for the GEMT program, GEMT enrollees must meet all the following requirements:

- Be enrolled as an Iowa Medicaid provider for the period being claimed on their annual cost report;
- Provide ground emergency medical transport services to Iowa Medicaid Members; and
- Owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, health care district or other unit of government in the state that has taxing authority, has direct access to tax revenues, or is a federally recognized Indian tribe.

Enrollment and Annual Submission Requirements

Iowa Medicaid 2022

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Enrollment and Annual Submission Requirements

- Be enrolled as an Iowa Medicaid provider for the period being claimed on their annual cost report.
- Notify the Iowa Medicaid Provider Cost Audit and Rate Setting (PCA) Unit
- Complete an Intergovernmental Transfer Agreement
  - SFY 2023 IGT
- Complete and submit the GEMT Program cost report
  - Cost report template
  - Schedule 4 Employee Hour Support Template
  - Schedule 9 Transport Support Template
  - Cost report instructions
  - IGT Funding Source Certification

Intergovernmental Transfer Agreement (IGT)

- IGTs are transfers of funds from another government entity (e.g. county, city, or another state agency) to the state Medicaid agency
- Provides the funding of the state share of payments
- Requires an executed IGT agreement
- Managed care required use of IGTs

Cost Reporting

- Cost reports are completed for costs incurred during the state fiscal year.
- State fiscal year is July 1 through June 30.
- Submit to: costaudit@dhs.state.ia.us
- Iowa Medicaid reviews the cost report for completeness and carries out the desk review within 90 business days of receipt.
  - If the cost report is incomplete, the provider must make the necessary correction and resubmit the cost report for review.

Prospective Payments

Iowa Medicaid 2022

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Prospective Payments

- Submitted cost report is used to set the GEMT prospective payment rate for the upcoming state fiscal year.
  - Example: SFY 2023 cost report will establish the July 1, 2024 prospective payment rate.
- Prospective Payment rate is calculated as follows:

1) Actual allowable direct and indirect costs

- Medicaid payments for mileage and base rate

Uncompensated care cost

2) Uncompensated care cost / Total number of transports =

Uncompensated average cost per transport

Establishing an Indirect Cost Rate

- GEMT services are required to establish an indirect cost rate before any indirect costs can be claimed on the cost report (Cost report schedule 9).

- 45 CFR 75.412 indicates that there is no universal rule for classifying certain costs as either direct or indirect under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is critical that each item of cost incurred for the same purpose be treated consistently in like circumstances as either a direct or indirect cost in order to avoid possible double charging of Federal awards.

- 45 C.F.R. § 75.405, specifies that "[a] cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received."

Establishing an Indirect Cost Rate

- Any of the following methodologies are acceptable for identifying indirect costs:
  - A cost allocation plan (CAP) with the entity's local government
  - An indirect rate negotiated with the entity's local government
  - Direct identification through use of a cost report
  - A 10% "de minimis rate"

Billable Services

Iowa Medicaid 2022

Billing and Claims

- Services do not adjust the method in which they submit claims
- The only difference for GEMT providers is the use of an additional line item entry for A0999
  - A0999 pays the provider their specific uncompensated average cost per transport for the current state fiscal year.
- GEMT Payment Program is conducted in such a way that is does not result in any additional expenditures from the state general fund:
  - Payments are not considered to be an individual increase to current fee-for-service rates.
  - Payments are based on the actual costs to perform EMS transports.

Ensuring Proper Billing

- GEMT base rate transportation codes must:
  - *"… use one of the appropriate* **emergency** *transportation procedure codes: A0225, A0427, A0429, A0433, A0434."*

- Per the GEMT Program, HCPCS A0999 is ONLY appropriate for **emergent** BLS/ALS base transport services:
  - **Non-emergent** transports are **EXCLUDED** from this payment program.

- GEMT Payment Program: *"There must be Iowa Medicaid payment for a covered GEMT transport (i.e., base rate and mileage) for the obligation to pay the GEMT supplemental payment…"*
    - GEMT not covered: **non-emergent** and/or unsupported emergent services.

Ensuring Proper Billing

1. Ambulance Transport Guidelines

Medicaid will pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility *only when transportation by any other means could endanger the member's health*. In order to receive payment, the provider must document the medical necessity of this transport on the run report. It is the responsibility of the ambulance supplier to furnish complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria.

https://dhs.iowa.gov/sites/default/files/Amb.pdf?030220212238

20.1.3 - Services Provided

(Rev. 1696; Issued: 03-06-09; Effective/Implementation Date: 04-06-09) AB-03-106

Payment is based on the level of service provided, not on the vehicle used. Occasionally, local jurisdictions require the dispatch of an ambulance that is above the level of service that ends up being provided to the Medicare beneficiary. In this, as in most instances, Medicare pays only for the level of service provided, and then only when the service provided is medically necessary.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

Ensuring Proper Billing

Ambulance Services 441 IAC.78.11
https://www.legis.iowa.gov/docs/iac/rule/04-06-2011.441.78.11.pdf

Covered Services:
*Transport to the nearest hospital with appropriate facilities or to one in the same locality,

*Transport from one hospital to another, to the patient's home or to a nursing facility.

*Transport to the nearest hospital for outpatient service for emergency treatment.

Dry Run versus Treat no Transport

Per CMS Guidelines:

- A dry run is a service call in which transport was sent out but no treatment or transport was provided due to:
  - A refusal of treatment by the member
  - Unable to locate the member

- A Treat no Transport is a service call in which billable treatment was provided to the member but transportation to a medical facility did not occur.

Approximate Rate Timing

- June 30th- End of the state fiscal year.
- November 30th- Cost reports are due to Iowa Medicaid.
- March 31st- Prospective payment rates calculated, provider notification and prospective payment rate sent to the Managed Care Organizations.
- July 1st- Prospective payment rates effective date.

Questions