

SUPPLEMENTAL PAYMENT FOR PUBLICLY OWNED OR OPERATED EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

This program provides supplemental payments for eligible Public Emergency Medical Transportation (PEMT) entities that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that the eligible PEMT entities receive for emergency medical transportation services to Medicaid eligible recipients. Eligible PEMT entities must provide to the Agency for Health Care Administration (AHCA) certification for the total expenditure of funds and certification of federal financial participation (FFP) eligibility for the amount claimed.

Providers must submit as-filed cost reports for the previous SFY by November 30 of the current SFY. Following the cost report submission, the corresponding lump-sum payments will be disbursed annually prior to the certified forward period of the current SFY (September 30). For example, cost reports with data covering SFY 2014-15 must be submitted by November 30, 2015. AHCA will then review the SFY 2014-15 submission and process a payment prior to September 30, 2016.

Payments will not be disbursed as supplemental increases to current reimbursement rates for specific services. Costs will be identified through the Centers for Medicare and Medicaid Services (CMS) approved cost report.

Costs covered will include the following applicable Medicaid emergency services: Ambulance Services: both Basic Life Support and Advanced Life Support, Advanced Life Support Level 2, and Specialty Care Transport (SCT). Services must be provided by fire rescue or ambulance services.

This supplemental payment program will be in effect beginning October 1, 2015.

A. Definitions

1. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet medical transportation mandates.
2. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using AHCA approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with OMB Circular A-87 and CMS non-institutional reimbursement policy.
3. "PEMT entity" is determined to be eligible if it is a county, city, healthcare district, or public university in Florida and provides emergency medical transportation services for Medicaid beneficiaries.

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4. "PEMT services" means both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced life support, advanced life support II, basic life support, and specialty care transport services provided to an individual by PEMT providers before or during the act of transportation.
 - a. "Advanced life support" means the assessment or treatment through the use of techniques described in the Emergency Medical Technician (EMT)-Paramedic: National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards, provided by an emergency medical technician-intermediate or EMT-Paramedic. These are special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.
 - b. "Advanced life support level 2" means transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including one of the following:
 - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids).
 - Provision of manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or intraosseous line.
 - c. "Basic life support" means the assessment or treatment through the use of techniques described in the EMT-Basic National Standard Curriculum or the National EMS Education Standards. It includes emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.
 - d. "Specialty care transport" means the inter-facility transportation of a critically injured or ill recipient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic that must be furnished by one or more health professionals in an appropriate specialty area.
5. "Shared direct costs" are direct costs that can be allocated to two or more departmental functions on the basis of shared benefits.

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B. Supplemental Payment Methodology

Supplemental payments provided by this program to an eligible PEMT entity will consist of FFP for Medicaid uncompensated emergency medical transportation costs based on the difference between the Medicaid reimbursement amount and the providers actual cost for providing emergency medical transportation services to eligible Medicaid recipients. The supplemental payment methodology is as follows:

1. As described in Section D, the expenditures certified by the eligible PEMT entity to AHCA will represent the payment eligible for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.
2. In no instance will the amount certified pursuant to Paragraph D.1, when combined with the amount received for emergency medical transportation services pursuant to any other provision of this State Plan or any Medicaid waiver granted by CMS, exceed 100 percent of the allowable costs for such emergency medical transportation services.
3. Pursuant to Paragraph D.1, the eligible PEMT entity will annually certify to AHCA the total costs for providing emergency medical transportation services for Medicaid beneficiaries offset by the received Medicaid payments for the previous state fiscal year. The supplemental Medicaid reimbursement received pursuant to this segment of the State Plan will be distributed in one annual lump-sum payment after submission of such annual certification.
4. For the subject year, the emergency medical transportation service costs that are certified pursuant to Paragraph D.1 will be computed in a manner consistent with Medicaid cost principles regarding allowable costs, and will only include costs that satisfy applicable Medicaid requirements.
5. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and OMB Circular A-87, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.
6. Medicaid base payments to the PEMT providers for providing PEMT services are derived from the Medical Transportation fee-schedule established for reimbursements payable by the Medicaid program by procedure code. The base payments for these eligible PEMT providers are fee-for-service (FFS) payments. The primary source of paid claims data and other Medicaid reimbursements is the Florida Medicaid Management Information System (FLMMIS). The number of paid

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Medicaid FFS PEMT transports is derived from and supported by the FLMMIS reports for services during the applicable service period.

- 7. For each eligible PEMT provider in this supplemental program, the total uncompensated care costs available for reimbursement will be no greater than the shortfall resulting from the allowable costs calculated using the Cost Determination Protocols (Section C.). Each eligible PEMT provider must provide PEMT services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such PEMT services provided to Medicaid beneficiaries. Eligible PEMT providers that do not have any uncompensated care costs will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

- 1. An eligible PEMT provider’s specific allowable cost per-medical transport rate will be calculated based on the provider’s audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.
 - a. Direct costs for providing medical transport services include only the unallocated payroll costs and fringe benefits for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.
 - b. Shared direct costs for emergency medical transport services, as defined by Paragraph A.5., must be allocated for salaries and benefits and capital outlay. The salaries and benefits will be allocated based on the percentage of total hours logged performing EMT activities versus other activities. The capital related costs will be allocated based on the percentage of total square footage.
 - c. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Paragraph A.1.) or derived from provider’s approved cost allocation plan. Eligible PEMT providers that do not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare Cost

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Principle (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and Part 2), and Medicaid non-institutional reimbursement policy.

- d. The PEMT provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Paragraphs A.1. and A.2.) of the specific provider by the total number of medical transports as reported in the transportation daily logs provided by the PEMT provider for the applicable service period.
- 2. Medicaid’s portion of the total allowable cost for providing PEMT services by each eligible PEMT provider is calculated by multiplying the total number of Medicaid FFS PEMT transports provided by the PEMT provider’s specific per-medical transport cost rate (Paragraph C.1.d.) for the applicable service period.

D. Responsibilities and Reporting Requirements of the Eligible PEMT Entity

An eligible PEMT entity must do all of the following:

- 1. Certify that the claimed expenditures for emergency medical transportation services made by the eligible PEMT entity are eligible for FFP.
- 2. Provide evidence supporting the certification as specified by AHCA.
- 3. Submit data as specified by AHCA to determine the appropriate amounts to claim as qualifying expenditures for FFP through the CMS approved cost report and cost identification methodology.
- 4. Keep, maintain, and have readily retrievable any records required by AHCA or CMS.

E. AHCA’s Responsibilities

- 1. AHCA will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.
- 2. AHCA will, on an annual basis, submit to the federal government any necessary materials, including but not limited to the CMS approved cost report, in order to provide assurances that FFP will include only those expenditures that are allowable under federal law.

F. Interim Supplemental Payment

- 1. AHCA will make annual interim Medicaid supplemental payments to eligible PEMT providers. The interim supplemental payments for each provider are based on the provider’s completed annual cost report in the format prescribed by AHCA and

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approved by CMS for the applicable cost reporting year. AHCA will make adjustments to the as-filed cost report based on the results of the most recently retrieved FLMMIS report.

2. Each eligible PEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section C.) and must submit the completed annual as-filed cost report to AHCA five months after the close of the SFY.
3. The interim supplemental payment is calculated by subtracting the total Medicaid base payments (Paragraph B.6.) and other payments, such as Medicaid co-payments, received by the providers for PEMT services to Medicaid beneficiaries from the Medicaid portion of the total PEMT allowable costs (Paragraph C.2.) reported in the as-filed cost report or the as-filed cost report adjusted by AHCA (Paragraph F.1.).

G. Final Reconciliation

1. Providers must submit auditable documentation to AHCA within two years following the end of the state fiscal year in which payments have been received. AHCA will perform a final reconciliation where it will settle the provider's annual cost report as audited, three years following the state fiscal year end. AHCA will compute the net Medicaid PEMT allowable cost using audited per-medical transport cost, and the number of Medicaid FFS PEMT transports data from the updated FLMMIS reports. Actual net Medicaid allowable cost will be compared to the total base and interim supplemental payments and settlement payments made, and any other source of reimbursement received by the provider for the period.
2. If at the end of the final reconciliation it is determined that the PEMT provider has been overpaid, the facility will return the overpayment to AHCA, and AHCA will return the overpayment to the federal government pursuant to 42 CFR 433.316. If at the end of the final reconciliation it is determined that the PEMT provider has been underpaid, the PEMT provider will receive a final supplemental payment in the amount of the underpayment.
3. All cost report information for which Medicaid payments are calculated and reconciled are subject to CMS review and must be furnished upon request.

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