STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

This program provides supplemental reimbursement for eligible Ground Emergency Medical Transportation (GEMT) providers that meet specified requirements and provide GEMT services to Medi-Cal beneficiaries.

Supplemental reimbursements provided by this program are available only for the uncompensated care costs incurred by eligible GEMT providers for providing GEMT services to Medi-Cal beneficiaries, which are the allowable costs that are in excess of the payments made to each eligible GEMT provider for GEMT services to Medi-Cal beneficiaries. Eligible GEMT providers must certify to the State the total expenditure incurred for providing the GEMT services that will be used to determine the supplemental payments.

The supplemental payments determined under this supplement to Attachment 4.19-B shall be made annually on a lump-sum basis after the conclusion of each state fiscal year. Payments shall not be paid as individual increases to current reimbursement rates as described in other parts of this state plan for GEMT services.

This supplemental payment applies only to Medi-Cal services rendered to Medi-Cal beneficiaries by eligible GEMT providers on or after January 30, 2010.

A. Definitions

1. "Department" means the California Department of Health Care Services.

2. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet medical transportation mandates.

3. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using an agency 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.

4. "Eligible GEMT provider" means a provider who is eligible to receive supplemental payments under this Supplement because it meets the following requirements continuously during the claiming period:

    a. Provides Ground Emergency Medical Transportation services to Medi-Cal beneficiaries.

    b. It is a provider that is enrolled as a Medi-Cal provider for the period being claimed.

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c. Is owned or operated by an eligible governmental entity, to include the state, a city, county, city and county, fire protection district organized pursuant to Part 2.7 (commencing with Section 13800) of Division 12 of the Health and Safety Code, special district organized pursuant to Chapter 1 (commencing with Section 58000) of Division 1 of Title 6 of the Government Code, community services district organized pursuant to Part 1 (commencing with Section 61000) of Division 3 of Title 6 of the Government Code, health care district organized pursuant to Chapter 1 (commencing with Section 32000) of Division 23 of the Health and Safety Code, or a federally recognized Indian tribe as these laws are in effect on January 30, 2010.

5. "Dry run" means GEMT services (basic, limited-advanced, and advanced life support services as defined in Paragraph A.7) provided by an eligible GEMT provider to an individual who is released on the scene without transportation by ambulance to a medical facility.

6. "GEMT Transport" means GEMT Services provided by eligible GEMT providers to individuals, including dry runs as defined in Paragraph A.5.

7. GEMT 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, limited-advanced, and basic life support services provided to an individual by GEMT providers before or during the act of transportation. Additionally, GEMT services include dry runs as defined in Paragraph A.5.

    a. "Advanced life support" means 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. "Limited advanced life" support means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services.

    c. "Basic life support" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

8. "Medical transport" means transportation to secure medical examinations and treatment for an individual. This umbrella term encompasses both GEMT transports and non-

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emergency transports that have met the requirements as listed under Item 24(a) of Limitations on Attachment 3.1-A and Item 23(a) of Limitations on Attachment 3.1-B.

9. "Service Period" means July 1 through June 30 of each California state fiscal year.

10. "Shift" means a standard period of time assigned for a complete cycle of work, as set by each eligible GEMT provider. The number of hours in a shift may vary by GEMT provider, but will be consistent to each GEMT provider.

B. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare & Medicaid Services (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 Medi-Cal program, except as expressly modified below.

2. Medi-Cal base payments to the GEMT providers for providing GEMT services are derived from the Medical Transportation-Ground fee-schedule established for reimbursements payable by the Medi-Cal program by procedure code. The base payments for these eligible GEMT providers are fee-for-service (FFS) payments. The primary source of paid claims data and other Medi-Cal reimbursements is the California Medicaid Management Information System (CA-MMIS). The number of paid Medi-Cal FFS GEMT transports is derived from and supported by the CA-MMIS reports for services during the applicable service period.

3. The total uncompensated care costs of each eligible GEMT provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols (Section C.) for each eligible GEMT provider providing GEMT services to Medi-Cal beneficiaries net of the amounts received and payable from the Medi-Cal program and all other sources of reimbursement for such services provided to Medi-Cal beneficiaries. If the eligible GEMT providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

4. The Medi-Cal supplemental reimbursement under this segment are the uncompensated care costs for GEMT services provided by eligible GEMT providers to Medi-Cal beneficiaries as determined by Interim Supplemental Payment (Section D.) and reconciled in Sections E. and F.

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C. Cost Determination Protocols

1. An eligible GEMT 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 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. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Item 2.a.) or derived from provider's approved cost allocation plan. Eligible GEMT 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 Principle (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and Part 2), and Medicaid non-institutional reimbursement policy.

   c. The GEMT provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Item 2.a and Item 2.b.) of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

2. Medi-Cal's portion of the total allowable cost for providing GEMT services by each eligible GEMT provider is calculated by multiplying the total number of Medi-Cal FFS GEMT transports provided by the GEMT provider's specific per-medical transport cost rate (Paragraph C.1.c) for the applicable service period.

D. Interim Supplemental Payment

1. The Department will make annual interim Medi-Cal supplemental payments to eligible GEMT providers. The interim supplemental payments for each provider is based on the

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provider's completed annual cost report in the format prescribed by the Department and approved by CMS for the applicable cost reporting year. The Department will make adjustments to the as-filed cost report based on the results of the most recently retrieved CA-MMIS report.

2. Each eligible GEMT 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 the Department five (5) months after the close of the State's Fiscal Year (SFY).

3. The interim supplemental payment is calculated by subtracting from the Medi-Cal's portion of the total GEMT allowable costs (Paragraph C.2) from the as-filed cost report or the as-filed cost report adjusted by the Department (Paragraph D.1.), the total Medi-Cal base payments (Paragraph B.2.) and other payments, such as Medi-Cal co-payments, received by the providers for providing GEMT services to Medi-Cal beneficiaries.

E. Interim Settlement

1. The GEMT Medi-Cal payments and the number of transport data reported in the as-filed cost report will be reconciled to the CA-MMIS reports generated for the cost reporting period within two years of receipt of the as-filed cost report. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved CA-MMIS report.

2. If it is determined that a GEMT provider received an overpayment, the total base and interim supplemental payments exceeded the Medi-Cal portion of the allowable costs based on the reconciliation process (Paragraph E.1.); then the GEMT provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is instead determined, then the GEMT provider will receive a supplemental payment in the amount of the underpayment.

F. Final Reconciliation

1. The Department will perform a final reconciliation where it will settle the provider's annual cost report as audited. The Department will compute the net Medi-Cal GEMT allowable cost using audited per-medical transport cost, and the number of Medi-Cal FFS GEMT transports data from the updated CA-MMIS reports. Actual net Medi-Cal 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.

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2. If, at the end of the final reconciliation, it is determined that the GEMT provider has been overpaid, the facility will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If, at the end of the final reconciliation, it is determined that the GEMT provider has been underpaid, the GEMT provider will receive a final supplemental payment in the amount of the underpayment.

3. All cost report information for which Medi-Cal payments are calculated and reconciled are subject to CMS review and must be furnished upon request.

G. Eligible GEMT Provider Reporting Requirements

GEMT eligible provider shall:

1. Report and certify total computable allowable costs annually on a Department and CMS approved cost report. Eligible providers will submit cost reports no later than five (5) months after the close of the SFY, unless a provider has made a written request for an extension and such request is granted by the Department.

2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination as specified by the Department.

3. Keep, maintain, and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS.

4. The GEMT provider will comply with the allowable cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87, and Medicaid non-institutional reimbursement policy.

H. Department's Responsibilities

1. The Department will submit to CMS claims based on total computable certified expenditures for GEMT services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.

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2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.

3. The Department will complete the audit and settlement process of the interim payments for the service period within three years of the postmark date of the cost report and conduct on-site audits as necessary.