SEMT QUESTIONS

Question: 7 AAC 145.442(c) allows a provider to submit a written request for an extension at least 30 days before the due date of the annual report. Would difficulty completing financial audits be acceptable grounds to grant an extension?

Response: The Department will add clarification to the proposed regulations to more closely align with the treatment of extensions for other cost reports submissions.

The Office of Rate Review will grant extensions for other Medicaid provider types if the Medicare fiscal intermediary grants extensions to providers for cost reports such as those for hospitals, long term care facilities, end stage renal dialysis facilities, and federally qualified health centers. While the supplemental emergency medical transportation (SEMT) cost report is not submitted to Medicare, the regulations will clarify that if the Centers for Medicare and Medicaid Services (CMS) grants extensions to providers submitting Medicare Cost Reports, such as the three month extension they granted for the COVID-19 pandemic, or the extension granted to Alaska providers for the November 2019 earthquake, that those extensions would also be granted to SEMT providers.

Additionally, the regulations will include clarification that the department will allow one 30 day extension for good cause shown to the department's satisfaction.

Question: **I am a calendar year provider. The approved Medicaid State Plan Amendment (SPA) for the SEMT program only allows claims on or after August 31, 2019 to be eligible for federal supplemental payment. How should a calendar year (CY) provider handle submitting their CY19 report since the program can allow supplemental payments for a portion of the fiscal year? Will the state require a full year's cost report and then determine the number of transports for the last four months of the year? Or will providers be required to identify each cost/expense and number of transports for those four months?**

Response: Providers will be required to submit their cost reports for a complete fiscal year because it is required that the cost report ties to the facility's audited financial statements. That full years' worth of costs and transports would be used to calculate the average cost per medical transportation service transport on Schedule 7.

The situation the commenter notes only applies to Calendar Year (CY)19, Federal Fiscal Year (FFY)19, and State Fiscal Year (SFY)20 reports because in all future years the emergency medical transports for the entire year are allowed when determining supplemental payments.

The paragraphs below explain the specifics for each of the different fiscal year end providers.

Calendar Year

In the case presented, a calendar year (CY) fiscal year end provider would submit their complete CY19 cost report for Schedules 1-8. The interim and final settlement schedules that determine the supplemental payments are populated by the department after the provider submits the completed Schedule 1-8 cost report and utilizes the average cost per medical transport in calculating the settlements.

The Department determines the interim supplemental payments by populating Schedule 9 of the cost report with Medicaid claims data from the Medicaid Management Information System (MMIS) shortly after the cost report has been submitted by the provider. The Medicaid State Plan allows only services on or after August 31, 2019 be allowed as part of the SEMT program. Therefore, for a CY19 fiscal year end provider, the Department would only utilize claims information from dates of service August 31, 2019 through December 31, 2019 on Schedule 9. Similarly, when the Department determines the final supplemental payments by populating Schedule 10 with Medicaid claims data from the MMIS after timely filing has concluded, the Department would only utilize claims information from dates of service August 31, 2019 through December 31, 2019.

Federal Fiscal Year

A similar situation will apply to FFY19 year end providers for August 31, 2019 through September 30, 2019 where they would submit their complete FFY19 cost report, but the Department would only utilize dates of service August 31, 2019 through September 30, 2019 for determining interim and final supplemental payments.

State Fiscal Year

Additionally, a similar situation would apply to SFY20 year end providers for August 31, 2019 through June 30, 2020 where they would submit their complete SFY20 cost report, but the Department would only utilize dates of service August 31, 2019 through June 30, 2020 for determining interim and final supplemental payments.

Question: Please describe the timeline for how interim and final supplemental payments are made and which year's costs are utilized in the calculation.

Response: Barring any changes to the proposed regulations as a result of public comment, the 1st year reports (FY19, CY19, and SFY20) are due 90 days after the effective date of the regulations and all subsequent reports are due 5 months after the provider's fiscal year end. The regulations notes that the most recently filed cost reports are used to determine interim payments.

In providing an example, the Department will utilize a calendar year fiscal year end provider who only provides ground medical transportation and submits a CY20 report.

As currently written in the proposed regulations, the CY20 report would be due May 31, 2021. That cost report establishes the provider's as filed CY20 average cost per medical transport for ground medical transportation. That as-filed CY20 average cost per medical transportation and the Medicaid Management Information System (MMIS) claims data populated by the Department in Schedule 9 would be utilized to calculate the equal quarterly interim supplemental payments that would be paid in the middle of each subsequent quarter, anticipated in August 2021, November 2021, February 2022, and May 2022.

That CY20 cost report would undergo a desk review audit by the Office of Rate Review. As noted in 7 AAC 145.444, this desk review may result in adjustments to the cost report that could change the average cost per medical transport for ground medical transportation. The 1) CY20 adjusted average cost per medical transportation for ground medical transportation, 2) MMIS emergency transport claims data pulled for dates of service CY20 after timely filing for the cost reporting period has concluded that is populated by the Department in Schedule 10, and 3) the quarterly interim payments already made will be used to calculate the final supplemental payment. The final supplemental payment or recoupment cannot be made until timely filing has concluded, which is 12 months after the date of service of the claim. Additionally, the approved Medicaid State Plan allows the Department up to three years after the receipt of the as-filed cost report to make the final supplemental payment. Therefore, in the CY20 example listed above, the earliest a CY20 final settlement could be made is after December 31, 2021 since that is 12 months after the last date of service of December 31, 2020 for timely filing purposes. The latest the final settlement for the CY20 report could be made is May 31, 2024, since that is three years after the as-filed date of May 31, 2021.

Question: Please explain the purpose of Schedule 7, Line 12 that reads: Est. Percentage of Medicaid MTS Transports that are Emergency Medical Transports. Why would this number not always be 100%?

Response: It is first important to note that a provider is reporting on their cost report all medical transports for all payers for both those transports considered emergency medical transports and those considered non-emergency medical transports. All medical transports are used to calculate the provider's average cost per medical transport.

Schedule 7 is a schedule that helps providers estimate the combined value of the four quarterly interim supplemental payments. It utilizes the provider's as-filed average cost per medical transportation service (MTS) transport determined in Schedule 7, Line 8 and the provider's reported Medicaid transports in Line 6a to calculate a provider's estimated cost of Medicaid fee-for-service medical transportation services. A provider will report all Medicaid transports on Schedule 7, Line 6a, however, only emergency medical transportation claims will be utilized to determine the supplemental payments on Schedules 9 (Interim) and Schedule 10 (Final). Since the cost report utilizes all medical transports to determine the average medical transport costs while supplemental payments can only be for emergency medical transports, in order to not overestimate the supplemental payment on Schedule 7, the Department added Line 12 using historical Medicaid information to inform that 50% of Medicaid ground ambulance transports, 90% of Medicaid air ambulance transports, and 50% of Medicaid water ambulance transports are considered emergency medical transports.

In Schedules 9 and 10 that the department populates, the Department will only include transports for codes determined to be emergency medical transports on the final adjudication of the claim as determined by the nurse reviewers utilizing the clinical criterion included in Ambulance Clinical Criteria instead of relying on the estimated percentages supplied in Schedule 7, Line 12.

Please note, emergency medical transports are based on the final adjudication of the claim.

Ground and Water transports

For example, for ground and water ambulance services, as noted in the fee schedule, below are the list of which codes are considered emergency or nonemergency codes.

Ground/Water Emergency Procedure Codes/Modifiers:

- A0225
- A0427
- A0427 TN
- A0429
- A0429 TN
- A0433
- A0433 TN

Ground/Water Non-Emergency Procedure Codes/Modifiers

- A0426
- A0426 TN
- A0428
- A0428 TN

Air transports

For air ambulance services, claims with "Y" for data element R Emrgcy Ind are considered emergency transports; claims with an "N" are considered non-emergency transports.

While the cost report must always include all cost for all transports since it must tie to audited financial statements, the Department originally considered structuring the cost report such that a provider separately reported costs and transports for emergency medical transports and non emergency medical transports. It was determined that this would be exceptionally difficult for providers since they would have to track expenses by procedure code and sort claims that they may bill under a certain procedure code that could be adjusted by the nurse reviewers using the clinical criterion included in Ambulance Clinical Criteria prior to final adjudication of the claim in the MMIS system. Therefore, the decision was all costs would be reported together to determine the average medical transport cost per trip, and the split between emergency and non-emergency transports to determine supplemental payments would occur by the Department using final adjudicated claims from the MMIS System on Schedule 9 and Schedule 10.

<u>Question:</u> Can the state describe how the administrative fee will be calculated? Will the administrative fee be split evenly among participants or weighted based on the number of transports? Shouldn't a provider with fewer transports pay a smaller administrative fee?

<u>Response:</u> The Department employees will be using positive timekeeping for any activities related to the SEMT program such as performing desk reviews, issuing supplemental payments, etc. The non-federal funds portion of the employees' salaries related to SEMT activities derived from the positive timekeeping for a twelve month time period will be aggregated together. The department will determine all the cost reports that are submitted during that twelve month period and divide the non-federal funds portion of the employees' salaries by the number of cost reports to determine the non-federal funds cost for each cost report. The provider's administrative fee will be determined by multiplying the non-federal funds cost for each cost report by the number of cost reports the provider submitted during the time period. Please note, in all years except the first year, barring any extensions, a provider would only be submitting a single cost report during the time period. However certain providers in the first year, depending on their fiscal year, may be submitting two cost reports.

The federal government is currently proposing legislation related to "retention of payments" in response to what it perceives as creative Medicaid financing across the country that hold providers harmless in various financing mechanisms. This proposed legislation states that it will determine compliance with its retention of payments provision by examining any associated transactions that are related to the provider's total computable Medicaid payment. Associated transactions may include the payment of an administrative fee. The proposed federal regulations state that an administrative fee that is a flat fee is not considered an associated transaction. This flat administrative fee is considered allowable. The proposed SEMT regulations were written to align more closely with the proposed federal regulations. Additionally, while providers may have varying numbers of transports, the department still must perform a desk review of the cost report. Based on historical experience from other costs reports, service volume does not greatly affect the work required for a desk review. A large or a small provider's desk review may require the same amount of staff resources.