Public Provider Ground Emergency Medical Transportation Intergovernmental Transfer Program FAQ

GEMT QAF Program

Q: By Qualify Assurance Fee (QAF) payment, does that mean collection of QAF fees?

A: Yes, this is the collection of the QAF fees.

Q: If a provider opts to not participate in Public Provider-Ground Emergency Medical Transportation Intergovernmental Transfer (PP-GEMT IGT) Program, will they be required to participate in the QAF Program?

A: No. Once the PP-GEMT IGT Program implements, public providers will no longer be eligible to participate in the GEMT QAF Program.

Q: How are the PP-GEMT IGT fee-for-service (FFS) collection amounts different from what we currently pay for GEMT QAF?

A: The PP-GEMT IGT collection amount is the non-federal share of expenditures for the PP-GEMT IGT Program based on the projected trips. Using data available at this time to analyze service A0429 Basic Life Support, the PP-GEMT IGT collection amount is anticipated to be approximately $321.95 per transport in comparison to the current GEMT QAF rate for SFY 2021-22 of $33.42 per transport. The estimated PP-GEMT IGT collection amount includes the 10 percent administration fee. Please note that the figures are estimates offered for illustrative purposes only and the PP-GEMT IGT collection amount is subject to change depending on provider participation. The higher the participation, then the lower the PP-GEMT IGT collection per transport will be for each funding entity.

Q: What are providers supposed to do if a Medi-Cal Managed Care Organization pays the QAF on transports with 2023 dates of service?

A: If you continue to receive historical Add-On Supplemental Payment amounts for 2023 service, contact your Managed Care Plan (MCP) and notify them or point them to that error and discrepancy and hopefully this will be sufficient to resolve. MCPs should be informed of the PP-GEMT IGT Program.

Eligibility

Q: Who is eligible for the PP-GEMT IGT Program?

A: Following implementation, a public provider is eligible for the PP-GEMT IGT Program if they continually meet all of the following requirements during the entirety of any Medi-Cal managed care rating period:

- Provides emergency medical transports to Medi-Cal beneficiaries,
- Is enrolled as a Medi-Cal provider for the period being claimed, and
- Is owned or operated by the state, a city, county, city and county, fire protection district, special district, community services district, health care district, or a federally recognized Indian tribe.

Additional details regarding eligibility are explained in Assembly Bill 1705 section 14105.945.

Q: Would you please elaborate further about reviewing non-contracted services contracts to be eligible for the PP-GEMT IGT Program.

A: As part of the managed care (MC) delivery system, MCPs must reimburse eligible **non-contracted** public providers of GEMT services at the FFS rate, including any applicable FFS add-on amount ("Rogers Rate") for specified GEMT services. Thus, only non-contracted providers are eligible to receive the PP-GEMT IGT add-on through the Rogers Rate. Qualifying emergency ambulance transports must be billed using specific Current Procedural Terminology (CPT) codes. MCPs may negotiate reimbursement rates with ambulance providers; however, as noted above, MCPs are required to pay non-contracted GEMT providers enhanced reimbursement for specific CPT codes.

Participation

Q: Is the PP-GEMT IGT Program and the associated reimbursement methodology voluntary?

A: The PP-GEMT IGT Program is mandatory for public providers, though enrolling as a funding entity is voluntary. The PP-GEMT IGT Program is a new program authorized by the Legislature, and is mandated as the only supplemental payment program for public providers of GEMT services. This reimbursement methodology applies to all public GEMT providers effective January 1, 2023, pending federal approval. For periods during which the new PP-GEMT IGT Program is in effect, public GEMT providers will be excluded from all other GEMT supplemental payment programs currently available, including the GEMT QAF Program and the GEMT Certified Public Expenditure (CPE) Supplemental Reimbursement Program.

Q: Why would a public provider want to participate as a funding entity and want this PP-GEMT IGT Program to succeed? What benefit does the Program have compared to the existing QAF and CPE Programs?

A: In enacting AB 1705, the Legislature sought to ensure that all public GEMT providers serving Medi-Cal beneficiaries receive sufficient reimbursement. Per transport, the total reimbursement under the new PP-GEMT IGT Program is expected to be higher than what was received historically under existing GEMT supplemental reimbursement programs, but the provider contribution through the IGTs is also expected to be higher than QAF payments when compared on a per transport basis. Moreover, the new Program will apply to both FFS and managed care providers. For reference, the GEMT CPE Supplemental Reimbursement Program only applies to trips covered under the Medi-Cal fee-for-service e (FFS) delivery system. The vast majority of GEMT trips currently fall within the managed care (MC) delivery system. The current proportion of managed care trips to fee-for-service e trips is expected to continue to increase as additional populations shift into managed care under CalAIM. However, public GEMT providers that contract with MCPs for a lower level of reimbursement will be paid at their negotiated rate.

The non-federal share of the PP-GEMT IGT Program is intended to be funded through voluntary contributions by eligible public providers and their affiliated governmental entities or other public entities, as permitted by federal law for federal fund matching. Contributions from funding entities (i.e. participation in the collection portion of the program as a funding entity) are voluntary; however, if DHCS determines that the projected amount of voluntary contributions is not sufficient to support implementation of the Program, the Program would not be continued in future rating periods.

If the Program ends, public GEMT providers would revert to reimbursement under existing programs, including the GEMT CPE Supplemental Payment Program and GEMT-QAF.

Q: How do I let DHCS know that I want to participate in this program?

A: Eligible providers are able to express interest in participating as a funding entity by emailing the PP-GEMT IGT Program at AB1705@DHCS.ca.gov. DHCS has extended the deadline for expressing interest in the CY 2023 year to October 1, 2022. When reaching out, interested providers will need to outline the following information:

- Legal name of participating funding entity
- All applicable email contacts (including titles)
- Any National Provider Identifiers (NPI) associated with your Funding Entity

DHCS will use this information to calculate your estimated contribution amount (i.e. the non-federal share of projected costs plus administrative fee).

Q: If we miss the participation deadline, will providers have the opportunity to opt in as a funding entity at a later time?

A: Yes. You can submit your required information after the deadline. However, DHCS strongly recommends meeting the extended deadline of October 1, 2022 in order to ensure the program will successfully fund the non-federal share of expenditures and remain functioning into CY 2024.

Q: Can you explain how the Letter of Intent works? Do public providers need to fill in the estimated collection dollars?

A: After providers submit the requested participation information to the Department, DHCS will use the information to calculate an estimated contribution amount (i.e. non-federal share of projected costs), which will be included on a Letter of Intent (LOI) and sent back to the funding entity for completion. The amount included in the LOI is not inclusive of the 10 percent administrative fee. Please note, the Department will not have an estimated non-federal share calculation until we receive a final list of participating providers. To see a sample LOI, please visit our webpage here.

Note: This amount is estimated to the best of the Department's ability and may change at the time of invoicing.

Q: Will public providers need to provide data such as cost reports or transports to DHCS to determine the amount included on the collection invoice? How is that amount calculated?

A: No. The collection amounts will be based on the projected number of FFS and managed care transports for each funding entity as a percentage of the projected transports across all participating funding entities. FFS trips will be projected based on the most recent available paid claims data. Managed care trips will be based on an actuarial analysis, which will include historical trips and information that may inform future trips. The proportional percentage for each funding entity will be applied to the total estimate non-federal share of projected expenditures, inclusive of expenditures for transports by providers electing not to voluntarily participate in the PP-GEMT IGT Program. A 10 percent administrative fee will also be assessed on each IGT fund transfer.

IGT Funding, Collection and Invoicing

Q: What does it mean that the PP-GEMT IGT Program will end when it "is no longer financially and programmatically supportive of the Medi-Cal program"?

A: The non-federal share of the PP-GEMT IGT Program is intended to be funded through voluntary contributions by eligible public providers and their affiliated governmental entities or other public entities, as permitted by federal law for federal fund matching. Contributions from funding entities (i.e. participation in the collection portion of the program as a funding entity) are voluntary; however, if DHCS determines that the projected amount of voluntary contributions is not sufficient to support implementation of the Program, the Program would end, and not be continued in future rating periods.

If the Program ends, public GEMT providers would revert to reimbursement under existing programs, including the GEMT CPE Supplemental Payment Program and GEMT QAF Program.

Q: Who is eligible to sign the IGT Certification?

A: An authorized representative on behalf of the funding entity may sign the IGT Certification.

Q: Will there be a reconciliation process for collection amounts? If so, how will it work?

A: For both managed care and FFS, reconciliations will be conducted for each rating period. In the event of under/over contributions, future collections will be evaluated for potential adjustments. Please note that reconciliations are retrospective and therefore the first reconciliation for CY 2023 collections will occur no earlier than CY 2024.

Add-on Calculation

Q: What is the add-on amount for eligible providers?

A: The PP-GEMT IGT Program proposed add-on for CY 2023 is $946.92 per transport, pending federal approval. The managed care delivery system includes this add-on amount in MCP capitation rates.

Q: How is the add-on calculation amount determined?

A: DHCS calculated an initial statewide add-on increase amount for calendar year 2023 pursuant to Welfare and Institutions Code section 14105.945(d), based on the difference e between:

(a) the weighted average reimbursement paid pursuant to the applicable base Medi-Cal FFS payment fee schedule for an emergency medical transport, and
(b) the weighted average cost directly associated with providing a Medi-Cal emergency medical transport under the Medi-Cal program by an eligible provider.

The average cost data was drawn from the most recently audited cost reports of eligible providers available at the time the add-on amount was developed, which are the 2017-18 audited reports. The proposed add-on amount was adjusted to account for inflation and trend. For subsequent calendar years, DHCS, in consultation with participating eligible providers, may adjust the statewide add-on increase amount to account for inflation, trend adjustments, or other material changes, in accordance with federal law and actuarial standards.

The managed care delivery system includes the add-on amount in managed care plans' capitation rates. Actuarially sound rates are based on projected number of applicable trips for a given rating period.

Reimbursement

Q: What is the Rogers rate?

A: The Rogers rate is the threshold for which MCPs must reimburse non-contracted eligible providers of GEMT services. The Rogers rate is equal to the FFS rate including any applicable FFS Add-On amounts.

Q: If we submit for the GEMT Cost Reporting program through DHCS and with this, we receive some reimbursements, will our reimbursements affect how much we would receive in PP-GEMT amount?

A: Public providers will no longer be able to participate in the GEMT CPE Supplemental Reimbursement Program once the PP-GEMT IGT Program implements. Therefore, reimbursements from the GEMT CPE Supplemental Reimbursement Program would not affect the new PP-GEMT Program, as they are separate and distinct and any payments received will be for different time periods.

Rate Range

Q: How is the Voluntary Rate Range Program (VRRP) related to the PP-GEMT IGT Program? Is this a separate program from the PP-GEMT IGT?

A: The PP-GEMT IGT Program may reduce undercompensated costs available to be reported on the VRRP declaration documents and therefore may impact available participation room at the provider level; however, this impact and other programmatic considerations are still being evaluated by DHCS. Regardless, VRRP will continue as a separate program from the PP-GEMT IGT Program. Please note that the VRRP is implemented on an annual basis **at the discretion of the State and is voluntary** whereas the PP-GEMT IGT Program is a mandatory program that is statutorily required. Additional information regarding VRRP timing is forthcoming.