Illinois EMS Supplemental Payment Program Information Session

September 30, 2019

PUBLIC CONSULTING GROUP

Introductions

Agenda

1. Introductions
2. EMS Cost Recovery Opportunity
3. How we Support our Clients
4. Process and Key Milestones
5. Next Steps

PCG Attendee

Joe Weber
Associate Manager

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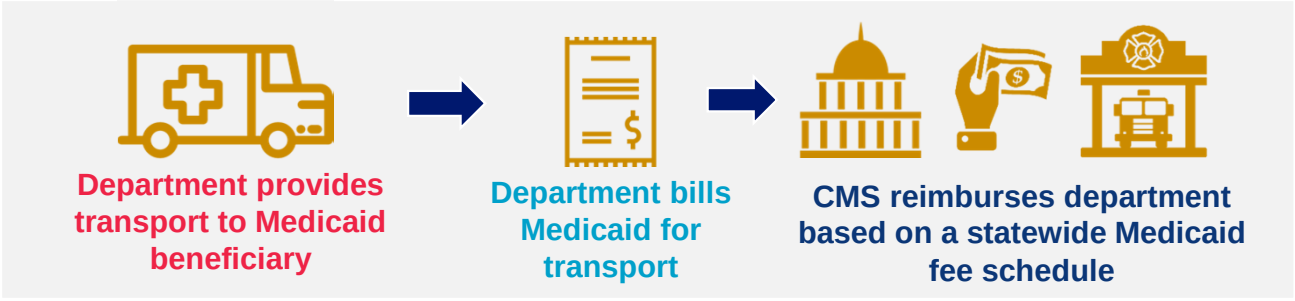
Since 2006, PCG has worked with the provider community to increase EMS reimbursement

PCG established the first EMS Supplemental Payment Program for the State of Texas and today works with over 350 EMS providers on an annual basis

	TX	MA	FL	WA	MO	CO	OR	OK
Year of System Launch	2009	2014	2016	2018	2018	2019	2019	2019
PCG Role	Provider Submission	Statewide Admin	Provider Submission	Provider Submission	Provider Submission	Statewide Admin	Provider Submission	Provider Submission
Number of Providers	~60	~70	~60	~70	~10	~50	~20	~20

EMS providers across the country are facing a difficult financial situation



CMS payment rates **do not recognize the actual costs** incurred by EMS providers for the provision of EMS services

CMS Medicaid Fee Schedule	
ALS1	$XX
ALS2	$XX
BLS1	$XX
BLS2	$XX

Typically the rate at which Medicaid transports are reimbursed is ***20% or less*** of the actual cost to the department

Budget

- General Funds
- EMS Special Funds
  - Tobacco taxes
  - State vehicle registration fees

This requires municipalities and counties to use ***alternative funding sources*** to cover the costs such as the allocation of taxes and fees

A supplemental payment program helps to “make up” the difference between the revenue received from the claiming process and the true cost

Overcoming “declining” Medicaid reimbursement:

CMS allows states to establish **supplemental payment methodologies**

Optimal route to revenue maximization is dependent on state/local rules & regulations, provider mix, and Medicaid payor mix

Bill Medicaid Fee-For-Service (FFS) Interim Payments throughout the Fiscal Year

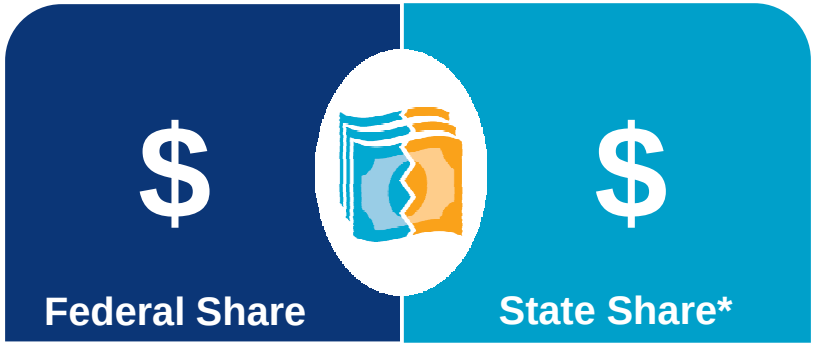
Receive **Medicaid FFS Interim Payments** throughout the Fiscal Year

Complete **Annual Cost Report** after the close of the Fiscal Year to report cost of EMS services

Receive supplemental reimbursement through **Cost Settlement** process

Supplemental Payment Programs allow states to "draw down" the federal share of costs for healthcare services

Since Medicaid is a joint Federal and State program each entity is responsible for its share of costs



*The State Share is financed by the provider as expenses already incurred by the EMS department

If it costs an EMS department **$100 to transport** a patient; and

The Federal Financial Participation (FFP) for the state is **50.14%:**

- The State/EMS department is responsible for **$49.86**

This portion can be financed by the provider as expenses already incurred by the EMS department through a CPE or IGT

The Federal Government is responsible for $50.14

Designing the GEMT for Optimal Funding

Clients	Design	Considerations	Where Implemented
Fee-for-Service (FFS) clients	Reimbursement is based on the actual costs of providing emergency medical services.	▪ An established methodology and quicker to implement. ▪ The population of FFS clients is declining. ▪ Can be pursued concurrently with Managed Care.	▪ California ▪ Florida ▪ Massachusetts ▪ California ▪ Missouri ▪ Oklahoma ▪ Oregon ▪ Texas ▪ Washington
Managed Care clients	One of two methodologies can be used to establish this program: a carve out of EMS services, or a change to MCO contracts.	▪ Will take more upfront work to determine the best methodology. ▪ Can be pursued concurrently with FFS.	▪ Illinois (in process) ▪ Florida ▪ Texas ▪ Washington
All Medicaid (FFS & MCO) clients	Rate is set to the state-wide average commercial rate.	▪ Leaves money on the table as rate often does not meet or exceed a provider's per trip cost.	▪ Georgia

The Illinois GEMT Program – What We Know Today

Illinois will be implementing a GEMT program, effective July 1, 2019

- The Illinois Department of Healthcare and Family Services (HFS) released a public notice on June 28, 2019 indicating a plan to change the reimbursement methodology for public ambulance providers, effective July 1, 2019.

- HFS has been working to develop a State Plan Amendment (SPA) that details the new payment methodology for submission to the Centers for Medicare and Medicaid Services (CMS).
  - HFS must submit the SPA by September 30, 2019 to retain the July 1, 2019 effective date.
  - The SPA would include a cost report template and instructions – the proposed template matches that recently distributed to providers.

- The SPA approval process includes a 90-day period for CMS review followed by a 90-day period for HFS revisions and a second 90-day review and approval period for CMS.

The Illinois GEMT Program – What We Know Today

Illinois will be implementing a GEMT program, effective July 1, 2019

- The program will be administered through the Managed Care Organizations (MCOs) for both Medicaid FFS and Medicaid Managed Care transports.
- Participation in GEMT is only available to public EMS providers.
- Providers will be required to complete an Intergovernmental Agreement (IGA) with HFS to participate in the program.
  - The IGA will include a commitment by the public providers to fund the state share of the program through an Intergovernmental Transfer (IGT).
  - HFS has indicated that they would fund the state share to support the first round of supplemental payments.
- HFS will leverage a portion (23%) of the increased federal funding to support rate increases for private ambulance providers, Medicar providers, and state administration costs.

The Illinois GEMT Program – What We Know Today

Illinois will be implementing a GEMT program, effective July 1, 2019

- Providers must complete annual cost reports in order to establish the available funding pools and the IGT funding expectation for the providers.
  - HFS has requested initial cost reports by 10/1/19 for participation in the program effective 7/1/19.
  - HFS has allowed for an extension until 11/1/19 for participation in the program during the 2019-20 fiscal year (date unknown).
  - Annual cost reports would be required for continued participation – date to be established in the approved SPA.

- Supplemental payments to the providers from the MCOs will be made on a monthly basis.
  - Providers will be asked to fund the IGT payments following receipt of their supplemental payment.

- Payments to providers will be made based on actual transport volume during the month.

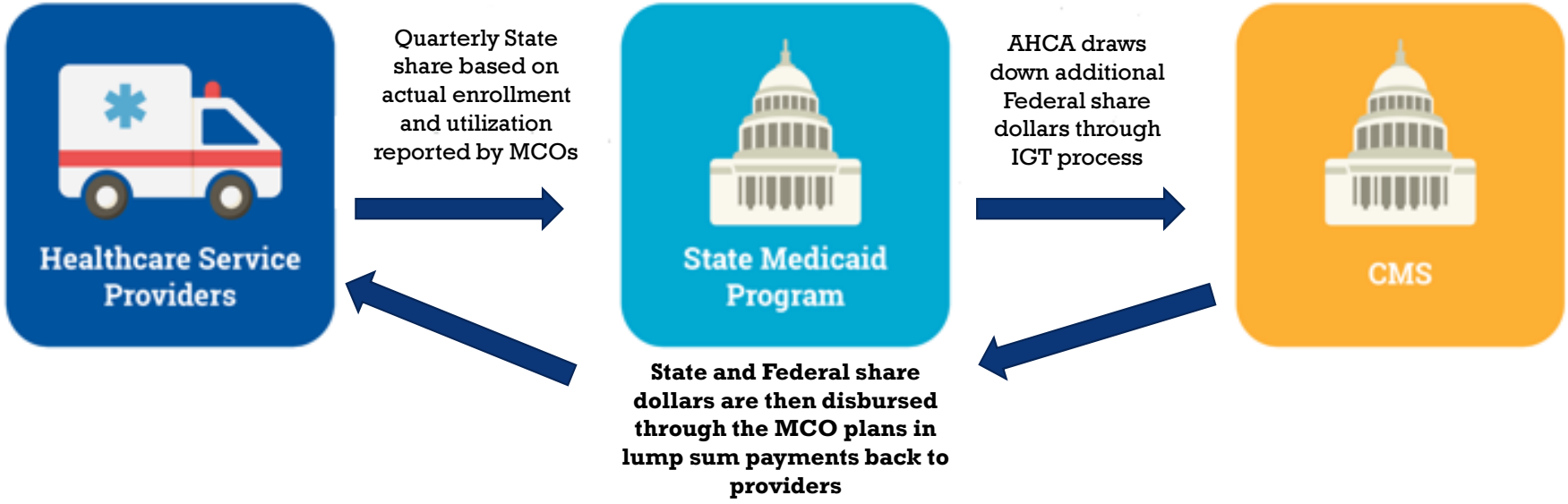
Medicaid Managed Care Supplemental Payment Program - State Share Funding Requirements

Overview of IGTs

Intergovernmental transfers (**IGTs**) are a transfer of funds from another government entity (e.g., county, city or another state agency) to the state **Medicaid** agency.

- This provides a guarantee of federal matching funds for state expenditures for health and long-term care services for the country's low-income population.

- IGTs are the backbone and necessary for the success of the Medicaid managed care supplemental payment strategy – If providers do not IGT, it may impact the viability of the program.



IGT Intergovernmental Agreement Form

HFS facilitates IGT participation through the Intergovernmental Agreement (IGA) form.

- The form will be an agreement between HFS and the provider to IGT for the State share of the supplemental payment program.
- It will be required to be submitted around with the initial cost report submissions either **10/01/2019 or 11/01/2019**.
- Typically little flexibility on the language of the form in terms of accommodating changes to the agreement.
- If not submitted by this time, providers will not be eligible to IGT the State share that is needed to draw down federal funding.

PCG Services to Support EMS Providers

PCG assists providers from the very beginning by designing and implementing a program

Design and develop the right approach for maximum revenue potential

- Conduct feasibility analysis including an in-depth review of billing and financial data to assemble revenue projections
- Assess revenue maximization options and provide program recommendations to stakeholders

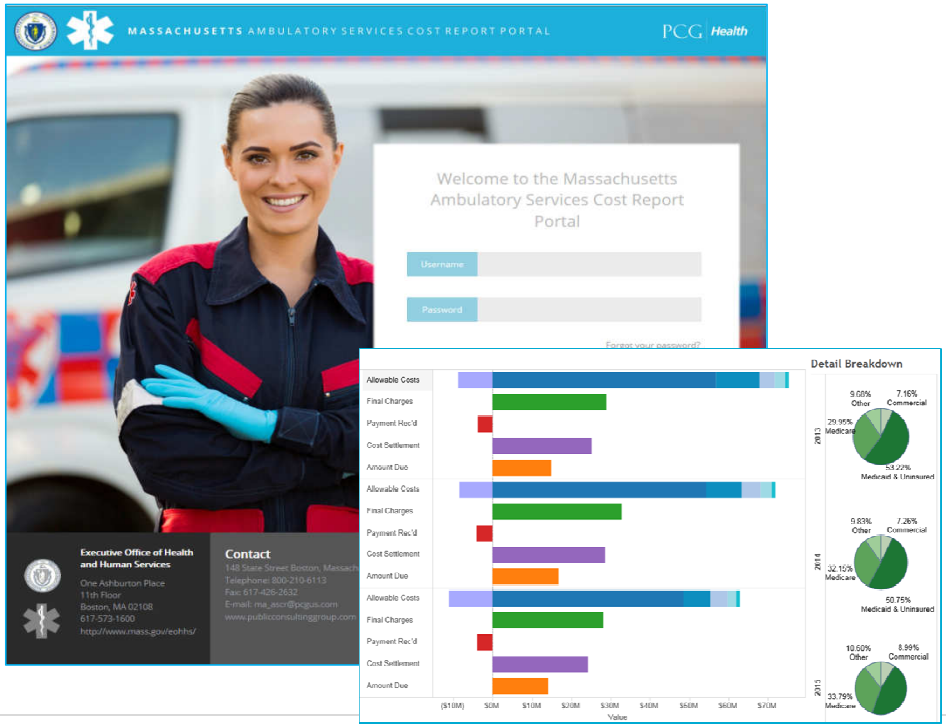
Develop legislation, Public Notice of Intent, and State Plan Amendment documentation to facilitate CMS approval

- Expediently prepare responses to CMS requests for additional information
- Complete requested analyses to document compliance with federal regulations
- Participate in negotiations and meetings with CMS
- Maintain an audit trail of all supporting documentation in the event CMS revisits the items in the future

Once a program is approved, PCG implements a web portal for annual Cost Reporting

PCG leverages a web-based cost reporting system to calculate charges, expenditures, revenues, and other statistical information used to determine CPE reimbursement and to establish increased payment modeling for the IGT

- Streamlines data entry and cost settlement calculations
- Exports submission-ready cost reports in accordance with federally-approved template
- Implements real-time validation checks for quality assurance and accuracy
- Enhanced reporting capabilities



Finally, PCG offers audit support to be a help at each step of the process

PCG's approach to providing cost report audit support focuses on identifying and mitigating risk:

- Conducting a detailed analysis of key cost report entries including Medicaid billing data, personnel and other operating expenditures, depreciation, indirect costs, and CAD data
- Evaluating the accuracy and integrity of the cost report and financial data. Verifying that only allowable costs and charges are included in the cost reports
- Maintaining supporting data that is well-organized and readily accessible
- Documenting processes and identifying strengths, weaknesses, and mitigating controls. Proactively offering recommendations for strengthening compliance
- Serving as designated liaisons with State/Federal auditors

PCG's Approach and Services

PCG has worked hand-in-hand with the IL Fire Chiefs Association to establish a program which best meets the needs of the needs of the state and the EMS provider community.

Following official program approval, we will work with IL providers to support ongoing operations of the program.

Step 1: Design Program Model

Step 2: Engage Stakeholders

Step 3: Develop SPA and Facilitate CMS Review and Approval

Step 4: Implement Program

Step 5: (Ongoing): Administer Program

Process and Key Milestones to Launch and Administer Supplemental Reimbursement Program

Step 1: Design Program Model

Feasibility
Conduct feasibility study to explore the opportunity and define expectations for the program

Assessment
Discuss and assess the Supplemental Payment Program options

Recommendation
Provide recommendations and gain consensus on moving forward

Process and Key Milestones to Launch and Administer Supplemental Reimbursement Program

Process and Key Milestones to Launch and Administer Supplemental Reimbursement Program

Step 3: Develop SPA and Facilitate CMS Review and Approval

Engage DHS	Draft Legislation	Engage CMS
Begin conversations based on agreed upon approach Follow-up with all requests for information or further analyses	1. Public Notice of Intent 2. State Plan Amendment 3. Cost Reporting Template	• Submit SPA for approval • Prepare responses to requests for additional information • Complete requested analyses to document compliance with federal regulations • Participate in negotiations and meetings • Maintain an audit trail of all supporting documentation

Process and Key Milestones to Launch and Administer Supplemental Reimbursement Program

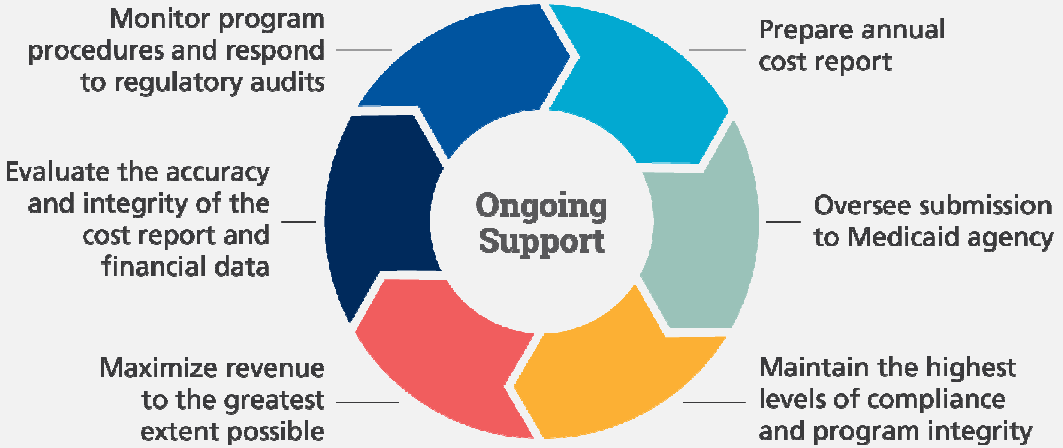
Step 4: Implement Program

- Guide stakeholders through program implementation process
- Develop training materials and provide training to the Department
- Develop necessary program materials to guide process
- Rollout EMS Cost Reporting System*

*Designed for data collection, annual cost reporting, pre-submission audits, and reporting

Process and Key Milestones to Launch and Administer Supplemental Reimbursement Program

Step 5: Administer Program



Questions and Answer Session

Questions?

Need Additional Help?

Need Additional Help?

PCG can provide technical assistance throughout the planning and approval process.

Our services include:

- Medicaid managed care payment projection and modeling.
- Training and education assistance in board/governing discussions.
- Cost report preparation and review.
- Audit support for submitted cost reports.
- Assistance and strategies to help with Medicaid MCO contracting.
- Ongoing Medicaid MCO payment analysis and assistance.

Contact Us

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