ILLINOIS FIRE CHIEFS ASSOCIATION

Dedicated to excellence in the Fire Service

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As many of our members are aware, the IFCA has been pursuing a program for supplemental Medicaid payments commonly known as GEMT (Ground Emergency Medical Transportation). The final details will not be available until the approval of the State Plan Amendment that was recently submitted to the Centers for Medicare and Medicaid Services for approval. We believe that plan will be approved before the end of 2019. This is a very important program that will generate millions of Federal dollars for Illinois Fire Departments and Districts.

Here are some of the details:

- To be eligible to receive funding your organization must meet the following criteria:
    - Submit to Medicaid for the cost of transportation to a recognized facility (hospital) under a National Provider Identifier (NPI) registered to a public provider (Municipality or District)
    - Be considered an "obligated provider" of emergency response and transportation to a hospital. This means that you are required by law or statute to respond, treat and transport
- Annually complete a detailed cost report that delineates your cost of service EMS per response on a Department of Health and Family Services (HFS) approved form
- Execute an Intergovernmental Agreement (IGA) with the State of Illinois HFS
- Maintain a completed cost report and IGA on file with HFS
- The distribution process
    - Based on cost reports filed, HFS will take the cost per trip and subtract out the weighted average fee schedule reimbursement to develop a uniform per trip supplemental payment. For Departments/Districts (FDs) in a region, HFS will calculate and average cost per trip
    - The weighted average fee schedule reimbursement will use the regional fee schedule for the four codes for emergency and non-emergency BLS and ALS
    - FDs will submit to Medicaid through your normal billing process
    - For Fee-for-Service (FFS) claims, this add-on amount will be added to the HFS fee schedule rate so that FDs are paid the full amount as claims are processed
    - MCO claims will be initially paid at their current fee schedule rates
        - On a quarterly basis, HFS will identify in MCO encounter claims (encounter claims are claims paid by MCOs to the FDs)
        - HFS will count all paid claims to participating FDs and multiply the supplemental add-on amount by the number of claims to calculate how much is owed to each FD
        - A supplemental capitation payment will be sent to each MCO with instructions on how much is owed to each FD
        - MCOs will forward these payments to FDs within a short time of receipt
    - Following receipt of these supplemental payments from the MCOs, FDs will receive an invoice from HFS for 50% of the amount they received froml the MCOs plus 50% of the supplemental amount paid in fee-for-service claims
    - The invoiced amount must be remitted back to the State in accordance with the previously submitted IGA

A calculation example follows. Please note these dollar amounts are used as an example and not indicative of actual experience. THIS IS JUST AN EXAMPLE

The average cost per trip for a given region is $2000.
The average standard Medicaid fee schedule will pay $500
For fee for service claims the FD will receive the full $2000
For MCO claims the FD will initially receive the weighted fee $500.
These claims will be reviewed quarterly and the FD will then receive an additional $1500
HFS will invoice the FD for $750.00 for each Medicaid claim (both FFS and MCO)
The net gain to the FD will be $750.00 for this trip

It must be noted that this is a voluntary program, there is no requirement to participate.

Below is important information on the current timeline.

- For FDs that submitted cost reports prior to October 1 and a signed IGA by November 1, HFS will adjust their fee-for-service rate for dates of service October 1 and after.
    - In this case, the first supplemental MCO Directed Payment cannot be sent until federal approval of the HFS plan for the Directed Payments. We expect this to happen late in the fourth quarter of calendar 2019.
- For FDs that submit a cost report and IGA in October (PRIOR TO NOVEMBER 1st), they will begin receiving supplemental payments effective January 2020 for both fee-for-service and MCO claims
    - Again, the first supplemental MCO Directed Payment cannot be sent until federal approval of our plan for the Directed Payments.
- Departments that do not have a cost report and IGA submitted in October will not be eligible to join the program until 2021. The Deadline for submitting cost reports and IGAs for 2021 participation will be October 1, 2021

As noted above, this program has not yet received Federal approval, the information above is the best available and represents what was submitted to CMS. Without Federal approval, the actual cost report form is not yet available. The IFCA also strongly recommends that interested Departments and Districts work very closely with their billing agency to complete the required cost report.

Historically, these programs have been subject to stringent audits by Medicaid and participating agencies should be prepared for this likelihood.

More information will be available as the program proceeds through the Federal approval process. Updates have been posted to the Illinois Fire Chiefs Association website under the Legislative section https://www.illinoisfirechiefs.org/legislation/GEMT/.

Additionally, HFS is hosting a conference call on **Monday October 7, 2019 at 9:00am** to address questions about the cost report. The call in information is:

Phone Number: **888-494-4032**
Passcode: **2949284410**

The main contact will be Jim Parker, with assistance from Randy Hulskotter from the Medicaid office.