MISSISSIPPI DIVISION OF
MEDICAID

Transforming Reimbursement for Emergency Ambulance Transportation (TREAT)

HB 657 (2022) authorizes the Division of Medicaid (DOM) to levy a health care provider assessment on ground emergency ambulance transportation providers and make access payments for all covered emergency ambulance services.

Frequently Asked Questions (FAQs)
SFY 2023 as of August 23, 2022

1. **Where may I find information on the program?**

   Information regarding the program may be found on the DOM website at: https://medicaid.ms.gov/transforming-reimbursement-for-emergency-ambulance-transportation-treat/

2. **How are participants in the TREAT program determined?**

   Participants include all Mississippi-licensed 911 ground ambulance transport providers.

3. **Is the program fully approved?**

   The ambulance assessment and payment program is authorized in state law through House Bill 657 of the 2022 Regular Session. DOM will seek stakeholder input throughout the design phase. Program design will require approval from the Centers for Medicare & Medicaid Services (CMS).

4. **When will the program begin?**

   DOM is working to have a program effective date of July 1, 2022 with the first year of the program running through June 30, 2023 and covering state fiscal year 2023.

5. **How is DOM ensuring stakeholder input?**

   Weekly calls are being held with representatives of the MS Ambulance Alliance (MAA), which is a group formed by interested ambulance providers. Training will be held the week of August 22, 2022 to discuss the program. DOM has a web page that includes

program information. DOM, through its contractor Myers and Stauffer LC, has established an e-mail account for questions and correspondence about the program. Please contact MSambulance@MSLC.com with your questions or requests for assistance.

6. **How will DOM collect data needed to model, design and calculate the assessment?**

   DOM, through its contractor Myers and Stauffer LC, and in coordination with the MS Ambulance Alliance will collect a financial survey from all Mississippi-licensed 911 ground ambulance providers. The survey data and Medicaid claims data will be modeled in compliance with CMS requirements to design a program for MS. The selected model will include calculations for the assessment and the payments.

7. **Does failure to complete a Financial Survey exempt a provider from the assessment or the payment program?**

   No. All impacted providers must remit the assessment, in accordance with HB 657 (2022). However, the program's design will depend on information being gathered in the survey. Estimates will be used for non-responsive providers. To ensure accurate program design, a survey should be submitted by each provider.

8. **How will the payments be calculated?**

   An average commercial rate (ACR) will be calculated for each applicable ambulance service corresponding to the Medicaid-covered procedure codes listed in Schedule 3 of the Financial Survey. To calculate the payment limit, the ACR for each procedure code will be multiplied by the volume of Medicaid paid ambulance service units for the period. To calculate the payment, the payment limit will be reduced by total Medicaid claim payments (Medicaid payments and any third party liability payments).

9. **Does the program apply to Medicaid Managed Care?**

   Yes. DOM is planning an upper payment limit program for fee-for-service (FFS) activity and a directed payments program through the managed care organizations.

10. **Does the program apply only to Mississippi Medicaid claims where Mississippi Medicaid is the primary payer?**

    The payment program applies to Mississippi Medicaid FFS and Medicaid managed care claims, including claims where Medicaid is not the primary payer, such as claims with a third party insurance payment. The program does not apply to Medicare crossover claims for Medicare/Medicaid dual eligible beneficiaries.

11. **Why must there be an assessment?**

    The purpose of the assessment is to collect funds from eligible providers to fund the non-federal share of program payments. The federal government funds a large share of the Medicaid payments. However, the State must provide matching funds. The MS

State Legislature has authorized the payments program with the matching funds to be provided by eligible participants.

12. **How will each provider's assessment amount be determined?**

    The pool of funds to be collected through the assessment will be determined in the data modeling phase of program development and will not exceed the limit set by federal regulations. The allocation methodology for determining the assessment to be paid by each provider will also be modeled. All of the proceeds of the assessment will be used as matching funds for program payments.

13. **Will the assessment be due prior to the Medicaid TREAT payment being paid?**

    Yes. The provider assessment will be due and collected prior to the Medicaid TREAT payment being made.

14. **How is the non-federal (State) share calculated?**

    Medicaid payments are financed by the federal government and the state. The state share can be obtained through a provider assessment. On an annual basis, the federal government determines the level of federal support for the Medicaid program, which is calculated through a percentage known as the Federal Medical Assistance Percentage (FMAP). The state share is equal to the total payment, minus the federal share. The federal fiscal year 2022 FMAP for the state of Mississippi is 84.51% (78.31% base FMAP + 6.2% public health emergency increase). If a Medicaid payment is $100, the federal share is $84.51 ($100 * .8451), and the state share is $15.49 ($100 - $84.51). The FMAP is recalculated each federal fiscal year.

15. **Will the State keep a portion of the provider assessment supplied by the providers?**

    No. The State does not keep the funds supplied by the ambulance provider. The provider assessment is structured to fund the program payments. The payments are determined, and the state share needed to fund the payments is calculated to determine the total assessment to be collected. The Medicaid agency draws federal dollars from the federal government and returns the total Medicaid payment to the ambulance providers.

16. **Will the State provide any funding toward the program or will the state share be paid fully by providers?**

    The State will not contribute funding for the state share of TREAT program payments. The state share of payments will be financed by ambulance companies through a provider assessment.

17. **How will the provider assessment be allocated across providers?**

The assessment will be allocated across all 911 ground ambulance providers based on a statistic, such as net patient revenue or total trips. The data for the allocations must be reported on Schedule 2 of the Financial Survey. As a result of the allocation, the provider assessment will be higher for providers with a higher statistic. Modeling will be performed to evaluate statistics for the overall best outcome state-wide.

18. What period is included in the Provider Financial Survey?

Data from January 1, 2021 through December 31, 2021 is being collected in the survey.

19. Is supporting documentation required to be submitted with the survey?

No. Supporting documentation for survey responses must be maintained in accordance with DOM maintenance of records requirements, or, for a period of not less than ten (10) years. Documentation may be requested by DOM or its contractors.

20. How are mileage and supply units captured on the survey?

Do *not* count and include mileage or supply units in the transport counts on the survey. Only billable transports originating in Mississippi during the survey period should be counted.

21. Should collections be included on Schedule 2 for contractual payments, such as for on-site ambulance and EMT services?

Only collections associated with a billable transport should be included. Do not include on Schedule 2 collections for contractual services that are not directly related to a patient transport.

22. Transport data is being collected by HCPCS code on Schedule 2. How should data be reported when the ambulance company records do not provide the needed detail?

For transports that cannot be identified by HCPCS code, the provider should identify the transport as either emergency or non-emergency. Emergency transport data should be reported in a selected transport line within the "Ground Emergency Ambulance Services" section.

23. How should collections data be reported on Schedule 2, when the ambulance company records do not provide the needed detail?

If ancillary services, including mileage, cannot be separated from the transport code, the provider should report the ancillary collections with the related transport code. If transport collections for the period cannot be separated by procedure code, enter the total of emergency transport collections on the survey. If the provider's records do not support data requested in Column 2, Column 3 Gross Charges must be completed.

24. **The Provider Financial Survey requests rates from the top three to five commercial payers. What if I have less than 5 commercial payers?**

    The top three to five payers should be identified based on payments received during the survey period. If the provider does not have a minimum of three payers during the survey period, the provider may extend the survey period to six months before the survey period and six months after the survey period. If the provider still does not have at least three payers for a listed procedure code, an explanation should be included in the box at the bottom of Schedule 3 of the Financial Survey.

25. **Should the commercial payment amount represent the allowed amount or the amount paid after the patient's responsibility?**

    The commercial payment amount reported on Schedule 3 should be the gross allowed amount before any reductions in payment (i.e., co-pays/co-insurance, third party payments, etc.).

26. **Should a provider treat a large self-funded plan as a commercial carrier?**

    Yes. Each is considered a separate commercial payer. Often a large commercial payer operates the self-funded plan and also operates as the primary insurer. In these cases the self-funded plan and the commercial insurer are considered to be separate payers.

27. **Which payers are not commercial payers and must be excluded from the survey responses?**

    Do not include rates from Medicare, Medicare Advantage plans, Medicare crossover payments, Medicaid, CHIP, Medicaid and CHIP managed care, Worker's Compensation, TRICARE, motor vehicle accidents or other settlements.

28. **Are Marketplace health insurers considered commercial payers for the survey?**

    No. Do not include rates from Marketplace insurers.

29. **What payer rates should be reported if the provider is in a network and contracted**?

    The fee schedule amounts would be entered into the appropriate payer rate line.

30. **Will the calculation of the average commercial rate (ACR) be provider-specific or state-wide?**

    The ACR will be computed on a provider-specific basis by procedure code. The state may use a state-wide median rate for providers with less than three payers.

31. **If a provider operates in several areas/counties, will their average commercial rate be based on each area, or their service as a whole?**

The average commercial rate will be calculated based on the top three to five commercial payers for the ambulance provider's services as a whole.

32. **Must the ambulance provider have claims for all of the program codes to be eligible for participation in the program?**

    No. Providers are not required to have Medicaid utilization for all codes to participate in the TREAT program.

33. **If I have multiple Medicaid billing numbers do I submit multiple forms?**

    A separate survey is required for each separate Medicaid and/or NPI number of 911 ground ambulance providers.

34. **When are Financial Surveys due to Myers and Stauffer LC?**

    Financial Surveys are due September 2, 2022.

35. **How will DOM seek CMS approval for the program?**

    State plan amendment #22-0023 will be submitted to request approval of the fee-for-service payments. A state directed payments "CMS Preprint" will be submitted to CMS to request approval for payments made through the managed care organizations.

36. **How will DOM address the CMS requirement for quality measures for the managed care program?**

    As part of the managed care Preprint approval process, DOM will propose selected quality measures and metrics in accordance with CMS requirements. It is anticipated that the following three measures will be proposed. First a measure of access to emergency ambulance services for all MS counties will be proposed, in recognition that the legislature authorized ambulance service access payments through the program. Secondly, a measure of stroke assessment completion is being evaluated for use, and lastly, the identification of available data for future metrics will be pursued as a measure. DOM will not link any payments to the quality measures during the first year of the program.

37. **Where should I submit questions about the program?**

    Questions about the program may be submitted to:

    The MS TREAT Help Desk: MSambulance@MSLC.com

    MS Ambulance Alliance: Lydia Jefcoat (601) 264-3581, ljefcoat@aaaambulance.net

    DOM: Michael Daschbach, Director Supplemental Payments (601) 359-6196, Michael.Daschbach@Medicaid.ms.gov

The FAQ will be updated during design, development, and implementation of the TREAT program. Any changes to the above responses will be provided in future FAQ versions.