MISSISSIPPI DIVISION OF MEDICAID

Transforming Reimbursement for Emergency Ambulance Transportation (TREAT)

HB 657 (2022) amended Section 43-13-117 of MS Code Annotated to authorize 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)
as of February 7, 2025

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. **Where may I submit questions about the program?**

   Questions and requests for assistance regarding the program may be e-mailed to MSambulance@mslc.com. Please Cc the MS TREAT mailbox, TREAT@Medicaid.ms.gov on all correspondence.

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

   Participants include Mississippi-licensed 911 and critical emergency ground ambulance transport providers.

4. **What was the effective date of program approval?**

   The ambulance assessment and payment program is authorized in state law §43-13-117 (A)(18)(b)(ii), as amended through House Bill 657 of the 2022 Regular Session. DOM actively worked with stakeholders throughout the design phase and gained approval from the Centers for Medicare & Medicaid Services (CMS) for fee-for-service payments effective July 1, 2022. Annual CMS approval is required for the managed care state directed payment program and has been granted for program years beginning July

1, 2022, July 1, 2023, and July 1, 2024. The annual state fiscal year provider assessment that began July 1, 2022, is used to fund the non-federal share of payments.

5. **How does DOM ensure stakeholder input?**

   DOM has a web page that includes program information, including training materials first issued in August, 2022 and updated throughout the years. 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. Please Cc the MS TREAT mailbox, TREAT@Medicaid.ms.gov on all correspondence. Weekly calls were held throughout most of state fiscal year 2023 with representatives of the MS Ambulance Alliance (MAA). This group formed by interested ambulance providers continues to contribute input and feedback on the program.

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 ground ambulance providers every two years.

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. 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 the state plan and 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 has developed an upper payment limit program for fee-for-service (FFS) activity and a state directed payments program to be paid 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 or CHIP.

11. Why must there be an assessment?

The purpose of the assessment is to collect fees from eligible providers to fund the non-federal (state) 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 authorized the assessment so that matching funds for program payments are supplied 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 TREAT program allocates the assessment across providers on a uniform basis. 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 quarterly, 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 (FFY) 2026 FMAP for the state of Mississippi is 76.90%. For the quarter that begins January 1, 2025, if a Medicaid payment is $100, the federal share is $76.90 [$100 * .7690], and the state share is $23.10 ($100 - $76.90). The FMAP is recalculated each federal fiscal year by CMS.

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 only the program payments. Once the payment pool is determined, 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 solely through a provider assessment.

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

The assessment will be allocated across all ground emergency ambulance providers using a uniform statistic, typically based on emergency transports or emergency net patient revenue. 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.

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

Data from July 1, 2024, through December 31, 2024, is being collected in the 2025 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 must be made available upon request 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. How will the first 25 miles of Medicaid transports be covered by the program?

DOM's coverage of the first twenty-five (25) miles of each transport at a rate of $0.01 per mile became effective February 1, 2023, with CMS approval of state plan amendment 23-0004. DOM will include mileage units billed on procedure code A0888 through January 14, 2024, to determine program payments associated with the first 25 miles of Medicaid transports.

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

No. 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 billable patient transport.

23. Transport data is being collected by HCPCS code on Schedule 2. How should transport units 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. The emergency transport units should be reported in a selected transport line within Lines 1 through 5.

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

Instructions for Schedule 2 include options for alternative reporting for collections. 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 in Column 2, Line 10. If the provider's records do not support data requested in Column 2, complete Column 3 to report Gross Charges and complete Line 12.

25. 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 after the survey period. If the provider still does not have at least three payers for a listed procedure code, commercial rate entries are not required, but an explanation should be included in the box at the bottom of Schedule 3 of the Financial Survey.

26. 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.).

27. 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.

28. 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, government employee

healthcare plans, Worker's Compensation, TRICARE, motor vehicle accidents or other settlements.

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

No. Do not include rates from Marketplace insurers.

30. 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.

31. 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 is assigning a state-wide average rate for each procedure code for providers with less than three payers.

32. 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.

33. 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.

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

No. A separate survey is required for each separate NPI number of 911 ground ambulance providers. In recent years, multiple Medicaid numbers have been assigned for each in-state location.

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

2025 Financial Surveys are due February 28, 2025.

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 selected quality measures and metrics in accordance with CMS requirements. Four measures are included for SFY 2025. First is a measure of access to emergency ambulance services for all MS counties, in recognition that legislation authorizes ambulance service access payments through the program. Secondly, access to ground emergency ambulance services for Medicaid managed care beneficiaries will be measured. The Trauma Pain Scale Assessment rate

for EMS transports will be measured for transports originating from a 911 request for patients with injury who were assessed for pain. Lastly, the program will monitor the state's participation in the CARES program. DOM has not linked payments to quality measures through SFY 2025; however, payments may be linked to quality measures in future years 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

Invoices: Curtis Collins, Director Accounts Receivable, Curtis.Collins@Medicaid.ms.gov

Please Cc the MS TREAT mailbox: TREAT@Medicaid.ms.gov on all correspondence.

Any changes to the above responses will be provided in future FAQ versions.