DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMCS Informational Bulletin

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SUBJECT: Applicable Federal Cost Principles for Ground Emergency Medical Transportation (GEMT)

Background

CMS is issuing this informational bulletin to remind states of existing federal requirements relevant to payment for GEMT services in Medicaid to assist them in developing state plan amendments (SPAs) and other proposals that are consistent with such federal requirements.

Comprehensive Cost Reconciliation Methods in the Medicaid State Plan

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires Medicaid state plans to provide for methods and procedures relating to the utilization of, and payment for, Medicaid-covered services as may be necessary to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care. Further, state payment rates or methodologies must be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

While states use a variety of payment methodologies for Medicaid transportation services, this bulletin specifically concerns state proposals to make Medicaid payments to GEMT providers up to the allowable and incurred cost of providing emergency medical transportation services to Medicaid beneficiaries. In order to be approved, as required by regulations at 42 C.F.R § 430.10 and § 447.201, a SPA must contain all information necessary for CMS to determine whether it can be approved to serve as a basis for federal financial participation (FFP) in the state's Medicaid program and requires that a state plan describe the policy and methods to be used to set payment rates for each type of service included in the State's Medicaid program. Accordingly, for an allowable cost identification methodology that includes an interim payment methodology with cost reconciliation, a payment SPA must comprehensively describe the cost identification and reconciliation methodology that will be used to determine payments to providers, where applicable. Such a GEMT payment SPA must describe: the interim rate that will be paid to providers during the cost reporting period; the allowable direct and indirect cost associated with furnishing Medicaid-covered GEMT services; the cost identification and allocation processes used to determine the portion of provider costs claimed for Medicaid payment; and the procedures and timing for cost report completion and submission, and cost reconciliation with the providers.

The state's cost identification procedures and associated state-developed cost report templates and instructions must be consistent with federal cost allocation regulations under 2 C.F.R. § 200 and 45

C.F.R. § 75.[1] CMS reviews the state's cost report template and instructions prior to approving proposed SPAs to ensure that they are consistent with the applicable federal cost regulations; however, it is incumbent upon states to ensure that reported costs and associated claims for FFP are accurate and represent only costs associated with the provision of Medicaid-covered services. Costs that are claimed improperly may be subject to financial reviews and/or audit findings and place states at financial risk of liability to repay the federal share of any identified overpayments.

Use of Certified Public Expenditures to Support GEMT Payment Proposals

Section 1903(w)(6)(A) of the Act allows state and local units of government to fund the non-federal share of Medicaid payments through a certified public expenditure (CPE) process. Medicaid payments that are funded through CPEs must be accompanied by an approved state plan cost identification methodology in which a unit of government certifies its incurred costs for furnishing Medicaid-covered services. As discussed above, states that rely on cost reconciliation methodologies to pay for Medicaid-covered services must do so using federal cost principles to identify and allocate eligible service costs to the Medicaid program.

Past GEMT SPAs have proposed funding additional Medicaid payments through a CPE process using a cost reconciliation methodology to pay units of local government for costs incurred in furnishing GEMT services. In reviewing these proposals, CMS has identified potential issues with the scope of the costs that states have proposed as potentially allocable to Medicaid-covered GEMT services and the methods of allocation states have proposed to apportion GEMT costs for purposes of claiming Medicaid FFP. Cost identification and allocation methodologies should not shift costs to the Medicaid program that are not related to a Medicaid-covered service, such as GEMT, or allocate costs to Medicaid without using an appropriate allocation statistic to identify the portion of GEMT costs eligible for Medicaid payment.

Costs such as fire and rescue personnel and equipment are generally not directly or indirectly related to Medicaid covered services. As such, cost identification methodologies that inappropriately allocate costs associated with fire and rescue personnel and equipment to the Medicaid program potentially would be unallowable under the federal cost allocation requirements. For example, if state or local law requires that both a fire truck and an ambulance be dispatched to emergency scenes to transport a potential patient, even though the ambulance will be the only vehicle that participates in the transport of the Medicaid beneficiaries to a facility for treatment, h only costs incurred in the provision of a Medicaid-covered service may be allocated to Medicaid. *See* 45 C.F.R. § 75.405, specifying that "[a] cost is allocable to a particular Federal award or other cost objective if the goods or services involved are chargeable or assignable to that Federal award or cost objective in accordance with relative benefits received." As relevant to GEMT, such costs are those associated with the personnel, vehicle, and equipment used to transport a beneficiary to a facility for treatment. Similarly, costs associated with other emergency response personnel, vehicles, and equipment that are not involved in the provision of a Medicaid-covered service, such as police and their vehicles and equipment, should not be included in GEMT cost identification and allocation methodologies for Medicaid payment and potentially would be unallowable. For example, costs associated with fire and rescue personnel who do not provide Medicaid covered services to Medicaid beneficiaries on the scene of an emergency but who are present during the emergency as required by state law or local code would potentially be unallowable. However, all

[1] Certain specific federal regulations related to cost identification and cost allocation processes are detailed in the appendix to this informational bulletin.

personnel who meet applicable Medicaid provider qualifications (such as Medicaid-participating, licensed or certified emergency medical technicians) and provide Medicaid -covered services at an emergency site to beneficiaries may be included in the GEMT cost allocations, provided the unit of government can properly identify the portion of costs properly allocable to the provider's furnishing of Medicaid-covered services (as opposed to conducting other duties or functions that do not constitute a Medicaid-covered service) and allocate that portion of costs to the Medicaid program.

CMS encourages states to look to the current federal cost allocation regulations to appropriately and accurately define and allocate costs to the relevant Medicaid cost objectives, which are costs incurred for the purpose of delivering allowable Medicaid services to Medicaid beneficiaries. For example, there have been proposals that attempted to define fire and rescue costs that appear unrelated to Medicaid GEMT as "shared direct costs" or "indirect costs." However, as described below, "shared direct cost" is not defined as a category of allowable costs for purposes of federal claiming under applicable federal regulations in 45 C.F.R. § 75 subpart E, and "indirect cost" is specifically defined in regulation in 45 C.F.R. § 75.2 as "benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted[.]" For Medicaid GEMT services, the cost objective is the transportation of a Medicaid beneficiary to a facility to receive emergently needed medical care; general fire and rescue activities would not be expected to benefit this objective. In the case of the costs associated with fire and rescue personnel who are not Medicaid-participating providers performing covered services and their vehicles and equipment, those costs are readily assignable to the fire and rescue cost objectives rather than to the Medicaid objective of furnishing GEMT services and are not directly or indirectly attributable to a Medicaid-covered service furnished to a beneficiary.

Further, the Medicaid assurance of transportation at 42 C.F.R. § 431.53 and the defined transportation benefit at 42 C.F.R. 440.170(a) define the transportation, specifically, of a beneficiary. This is also referred to as "loaded mileage" or the time during which a beneficiary is traveling in a transportation provider's vehicle.[2] There are no Medicaid benefits which specifically cover the transportation of a provider to a beneficiary. That is a cost to the provider. In addition, the definition of "reasonable cost" in 45 C.F.R. § 75.404 states that "a cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost." Likewise, Medicare, in the Principles of Reasonable Cost in 42 C.F.R. Part 413 defines Apportionment of Allowable Cost using the principles identified in 42 C.F.R. § 413.50 which says: "(a) Consistent with prevailing practice in which third-party organizations pay for health care on a cost basis, reimbursement under the Medicare program involves a determination of - (1) Each provider's allowable costs for producing services; and (2) The share of these costs which is to be borne by Medicare." Within the context of the provision of a Medicaid-covered transportation service requiring the presence of a Medicaid beneficiary, it would not be reasonable to recognize the cost of any and all methods of transportation a provider may employ to reach a beneficiary's location in order to provide a service.

To properly allocate GEMT costs to the Medicaid program, states must rely on data that appropriately apportion costs to the Medicaid GEMT cost objective, then allocate only those GEMT costs to the Medicaid program according to the program's share of the provider's total services, that is, in proportion to the benefit to the Medicaid program of the provider's activities. Federal regulations in 42 C.F.R. § 431.107(b) require that "[a] State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization

[2] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf

agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries; (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under § 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan[.]" CMS has advised states to use such relevant documentation in assigning costs to Medicaid for cost-based payment methodologies. For instance, localities that operate GEMT providers and wish to claim payment from insurers, including Medicaid payment, must gather claims data by payer status for all individuals who receive GEMT services from the locality-operated provider during the cost reporting period.

Conclusion

States are encouraged to request technical assistance from CMS on GEMT cost allocation to ensure that proposed or approved programs meet the policy requirements described within this bulletin. To the extent states have approved state plan language describing "shared direct costs," states should review those costs to ensure they are consistent with the applicable federal cost principles, are direct or indirect costs of furnishing Medicaid-covered services, and are properly allocated to Medicaid. Based on the similarities of recent proposals submitted to CMS by states, we are concerned that there are significant misunderstandings regarding the applicable federal cost allocation regulations and that these misunderstandings may result in impermissible cost-shifting to Medicaid and potential adverse financial findings for states. CMS is available to assist states in determining appropriate cost allocation methodologies to ensure claims for FFP are accurate and appropriate.

For technical assistance, please contact Andrew Badaracco, Acting Director of the Division of Reimbursement Policy at Andrew.Badaracco@cms.hhs.gov.

Appendix

Federal Citation	Transportation-Related Examples
Allocation (45 C.F.R. § 75.2) - the process of assigning a cost, or a group of costs, to one or more cost objective(s), in reasonable proportion to the benefit provided or other equitable relationship.	For GEMT, this means allocating (or assigning) transportation costs to the transportation cost objective, and other costs to other cost objectives. For example, a qualified EMT/paramedic's salary and benefits could be assigned to the transportation cost objective, while fire fighters who do not provide Medicaid-covered services would be assigned to the fire department's cost objective.
Direct Cost - 45 C.F.R. § 75.413(a) defines "direct costs" as those costs that can be identified specifically with a particular final cost objective, such as a Federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy. Costs incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect (facilities & administration) costs.	These are costs specifically related to the actual transportation of a beneficiary to medical care, or provision of another Medicaid-covered service. Examples of direct costs for transportation could include: • Salary of the ambulance personnel • Transport vehicle expenses (including depreciated capital expenses) • Transport vehicle fuel expenses Any costs that are directly related to the provision of the Medicaid-covered service would be a "direct cost" for cost reporting purposes. A cost may not be defined as "indirect" for one purpose and "direct" for another. Additionally, applicable federal regulations do not identify "shared direct costs;" costs are either direct or indirect to a cost objective for purposes of cost identification. See 45 C.F.R. § 75.2 (definition of Final cost objective).
Direct Cost Allocation - 45 C.F.R. § 75.405(d) elaborates on the direct cost allocation processes by specifying, "if a cost benefits two or more projects or activities in proportions that can be determined without undue effort or cost, the cost must be allocated to the projects based on the proportional benefit. If a cost benefits two or more projects or activities in proportions that cannot be determined because of the interrelationship of the work involved, then, notwithstanding paragraph (c) of this section, the costs may be allocated or transferred to benefitted projects on any reasonable documented basis. Where the purchase of equipment or other capital asset is specifically authorized under a Federal award, the costs are assignable to the Federal award regardless of the use that may be made of the equipment or other capital asset involved when no longer needed for the purpose for which it was originally required."	In instances where some direct costs might serve more than one cost objective (e.g., the salary of an ambulance driver whom the locality also employs as a fire truck driver), the state must propose a process by which these costs reasonably can be allocated to the two distinct cost objectives (i.e., Medicaid GEMT, and fire and rescue). To allocate these costs, states may use source documentation including time studies, trip logs, and/or worker logs. Once the cost is allocated to the Medicaid transportation cost objective, the remaining cost must be allocated to the other cost objective(s). A state or local law that requires a fire truck to accompany the ambulance on a call does not authorize the fire truck or fire fighters to be considered an allowable Medicaid service, and such costs not otherwise attributable to a Medicaid-covered service may not be allocated to Medicaid.

Federal Citation	Transportation-Related Examples
Indirect (facilities & administrative (F&A)) costs (45 C.F.R. § 75.2; *see also* § 75.414) means those costs incurred for a common or joint purpose benefitting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved. Indirect cost pools must be distributed to benefitted cost objectives on bases that will produce an equitable result in consideration of the benefits derived.	Some of the provider's overhead expenses related to the operations and management of the transportation activities. Examples of indirect costs could include: • Administrative support staff, • Rent, • Heating and cooling of an office space, • Non-service provider supervisory salaries. Costs that serves multiple cost objectives and cannot be readily assigned to a particular cost objective without undue effort can be considered an indirect cost.
Indirect Cost Rate Appendix VII to Part 75 - States and Local Government and Indian Tribe Indirect Cost Proposals[3]	States have options for determining the allocation of indirect costs, using the following procedures: • Develop an allocation of indirect costs to the total direct cost using a methodology approved by CMS. [4] • Use an approved federally-recognized indirect cost rate negotiated between the subrecipient and the Federal Government. • Use a rate negotiated between the pass-through entity (in this case, the state Medicaid agency) and the subrecipient of the federal grant award (in this case, the GEMT provider), in compliance with 42 C.F.R. § 75.352. • Use a de minimis indirect cost rate as provided in § 75.414(f). Once the states and/or provider elects the method of indirect cost finding, the selected indirect cost rate is multiplied by the total direct cost amount to determine the allowable indirect cost.

[3] Appendix VII to Part 75 - https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75/appendix-Appendix%20VII%20to%20Part%2075

[4] One such methodology is described in the "Certified Community Behavioral Health Clinic Cost Report Instructions" (OMB #0398-1148) published on December 14, 2015, Chapter 7. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ccbhc-cost-report-instruction.pdf