Memo

To: Centers for Medicare and Medicaid Services (CMS)

From: National Association of Emergency Medical Technicians (NAEMT)

Date: January 25, 2024

Re: GEMT Program Update

Summary of Concerns

The NAEMT, on behalf of its EMS membership, would like to address CMS concerns as it relates to CMS approval of Ground Emergency Medical Transportation (GEMT) supplemental payment programs for new states. It has come to our attention that CMS is currently withholding approval of recently submitted State Plan Amendments (SPAs) citing the potential inclusion of federally unallowable costs that are non-ambulance service delivery related.

As part of the conditions for approval of new state programs, CMS is limiting Medicaid allowable costs to direct time spent transporting the patient to the hospital emergency department, and depending on the state, sometimes excluding all indirect costs such as administrative and operational support for ambulance services.

We have noted that the approach CMS is taking in their review of new state programs may be inconsistent with the guidance stated in the informational bulletin published by CMS August 17, 2022, which addresses allowable costs under Medicaid supplemental payment programs for GEMT providers. The informational bulletin states:

> "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."

In the CMS Informational bulletin and in existing GEMT state programs, allowable costs have historically included all wages, benefits and administrative and general expenses that are directly

attributable to provision of Medicaid-covered services. The use of computer-aided dispatch (CAD) call duration has been cited within the SPAs of certain states as an accepted CMS methodology for allocating costs between ambulance versus Fire-only and non-ambulance service activities.

1. NAEMT is requesting CMS include the following joint services as allowable costs in any new state programs:

   CMS currently recognizes the role of ambulance responders in ***transporting*** the patient. The NAEMT would also urge CMS to include the ***direct costs of ambulance personnel providing treatment and stabilization of patients on the scene*** as Medicaid-eligible services as it meets federal cost principles cited in 1902(a)(30)(A) of the Social Security Act and requirements regarding economy and efficiency according to the Department of Health (DOH) for the following reasons:

   Fluctuations in demand and resource availability: Ambulance services require a continuous reassessment of staff resources given fluctuations in demand for services. Emergency care cannot be scheduled ahead of time, nor can ambulance services predict the location, duration and nature of incidents resulting in emergency responses. Consequently, providers need to be equipped with resource agility to cover as many incidents as possible as quickly as possible. This is particularly crucial when higher than average EMS call volume occurs. Utilizing dually certified staff to provide additional coverage for EMS response is the most cost effective way to reduce response times and save lives.

   Essentially, if CMS determines that only ambulance ***transport*** is eligible for reimbursement, then joint ambulance agencies will need to purchase additional ambulances and hire additional dedicated staff to ensure adequate coverage. This is inefficient and costly to implement.

   - **Frequency of EMS Calls**: Of all the different types of calls that the typical fire department receives, the overwhelming majority (70%-80%) represent incidents requiring emergency medical service or EMS. Due to the high frequency of EMS versus “fire-only” calls, cross-training staff and sharing vehicles is even more crucial to ensuring adequate staffing and providing efficient emergency medical care.

   - **Response times for Medical Emergencies**: During some medical emergencies, time is of the essence. In medical emergencies where the patient has suffered a stroke, heart attack or a severe traumatic accident, quick EMS response time may provide the best chance of ensuring a positive outcome and reducing long-term complications for these patients. In many cases, fire vehicles are the first on the scene because they are needed to extract patients from motor vehicles or burning buildings or because an ambulance is unavailable. It is during these and other serious emergencies where the firefighter/EMT’s ability to arrive early, assess and treat victims quickly is a huge asset for the community. Waiting for the closest ambulance in these scenarios would have a catastrophic impact on patient outcomes. Studies indicate that for patients with cardiac arrest, survival rates

dropped from 23.3% to 8.8% when EMS response time increased from 6 minutes or less to 10 to 15 minutes.[1]

- **Commit Time**: To alleviate CMS concerns that the cost of fire-only calls is being excluded, ambulance providers maintain detailed digital call logs which ensure that all ambulance activities are tracked to the second via their CAD systems. This allows providers to accurately pinpoint time spent on ambulance responses and ensures that all costs associated with responding to non-medical calls are appropriately excluded as Non-Medical Transportation Services (Non-MTS) or Unallowable Personnel expenditures.

    - **Commit time** focuses on "time on task" for each individual staff member providing ambulance services and is not contingent on the total vehicle time.

    - Commit time eliminates the need for CMS' proposed Random Moment Time Studies (RMTS) to carve out time for "treatment/stabilization on the scene time" and "transport" for the following reasons:

        - **A RMTS still requires use of a Medicaid Eligibility ratio against allowable costs:** An RMTS does not distinguish between Medicaid and non-Medicaid eligible patients. Emergency personnel do not know if the patient is Medicaid eligible or not, thus the currently proposed process of applying a Medicaid eligibility ratio to identified costs is still necessary. This is the same process followed in other school-based, child welfare, and eligibility worker RMTS programs where eligibility ratios are applied during the cost allocation process (and not identified by workers responding to the RMTS). Additionally, if an RMTS was used in place of billing data to allocate the Medicaid share of ambulance service cost, a separate allocation statistic would be needed to allocate "non-personnel cost" to Medicaid.

        - **RMTS poses an administrative burden on EMS personnel**: Asking ambulance personnel to log entries for RMTS can pull focus and time from other important activities such as patient care, training, and quality assurance. It would also be an extreme administrative burden to meet requirements that all staff are sampled during work time as shifts and EMS calls are unpredictable in frequency and duration. Again, nurses in a hospital are not required to submit an RMTS to justify the moments in the day that they are actually treating patients, as opposed to performing QA, charting and developing plans of care. Hospital time recording does not break down these activities into tasks for each nurse on a shift.

- **RMTS still relies on CAD data:** The reality is ambulance personnel are not going to delay services to log their random moments, especially during periods of high call volume. To accurately complete a moment, ambulance staff would reference CAD data to inform these entries. Workers only noting momentary activities in the RMTS, and still relying on CAD data, would likely yield a less accurate result than simply utilizing CAD data directly.

- **Potentially disallows 'readiness time'**: The use of RMTS also does not take into consideration that many ambulance departments rely on paid on call staff to respond quickly and efficiently exactly like hospitals do, and direct support should be factored into allowable staff time. With RMTS, the cost of always having personnel available, 24/7 to respond is not included in CMS' approach. However, hospitals are reimbursed by Medicaid to staff not only Emergency, Surgery, Med/Surg and Intensive Care nursing departments, but also Radiology, Pharmacy, Lab, and other ancillary departments in order to be appropriately prepared to immediately treat incoming Emergency and Trauma patients that are transported to the ED by EMS responders. Whether services are provided in a hospital or ambulance, paid on-call time is a central tenet of providing emergency care given that these are unscheduled and time-sensitive events.

2. **Allowable Costs for other Providers that support the ambulance response.** As mentioned previously, an ambulance is not the only provider that CMS reimburses for providing emergency care and treatment. With respect to hospitals, the Medicare 2552-96 hospital cost report includes the following allowable costs for hospital emergency departments in calculating a hospital's Medicare and Medicaid Interim per diem rate.[2] The NAEMT would appreciate CMS' consideration in recognizing similar direct and indirect costs as allowable for EMS and Fire Rescue departments:

   - **Worksheet A** – **Trial Balance of Expenses**. The Trial Balance for each hospital emergency department includes allowable salaries and benefits for all staff - not just nurses - but also directors, supervisors, technicians, and administrative staff. CMS does not require an RMTS of treatment vs non-treatment time for nurses and then an allocation of time spent on Medicare/Medicaid activities. Nurses are paid to staff the unit and "be ready to accept all patients". We would request ambulance responders be treated in a similar fashion, and that "readiness time" be included as a critical direct care allowable cost.

     Likewise, administrative costs of the ED nursing department such as training, scheduling, supplies and dues/memberships are also included in departmental costs. These combined expenses are deemed "direct costs" of care, and we would request that similar operational support services be deemed direct costs for ambulance service delivery.

- **Worksheet B Part 1** – **Allocation of Indirect Costs**. In addition, Medicare Provider Reimbursement allows hospitals to allocate costs from overhead departments such as Administration, Purchasing, Admitting, Operation of Plant, Laundry, Housekeeping, Dietary, Cafeteria, Nursing Administration, Central Supply and Medical Records. These allocated overhead departments do not provide "direct treatment or service" to patients; however, these overhead costs are essential to overall department operations, are deemed "allowable", and included in the hospital's interim rate paid by Medicare/Medicaid. CMS allows for these costs in other settings as well including Federally Qualified Health Centers and other community-based provider cost reports. Similar indirect administrative costs exist for ambulance services that are critical to operations such as Dispatch, Finance, IT, Training, Payroll and Accounting.

In conclusion, the provision of ambulance service requires more than an ambulance and two certified Paramedic/EMTs. The provision of ambulance transportation is dependent on several support systems, similar to the hospital ancillary support services described above.

Currently, ambulance agencies abide by the following guidelines below when allocating costs:

- **Unallowable Costs**: All costs related to Non-MTS calls, including personnel salaries and fringe benefits, are directly attributed to "Unallowable Expense", such as fire calls and non-transport calls. These costs are excluded.

- **Direct Costs**: Commit Time for ambulance staff members on response vehicles are attributed to Direct Service Personnel Costs.

- **Indirect Costs**: Salaries reported under Indirect Personnel Cost would include the pro-rated cost dedicated to the provision of ambulance services such as administrative and overhead staff supporting ambulance response and ambulance transportation service operations.

Below is a summary of NAEMT recommendations to address CMS concerns with the GEMT program

- **Use of CAD data.** CAD data provides the most extensive tracking of individual staff time for ambulances to incidents. CAD is automated, more reliable, and less administratively burdensome than an RMTS. EMS CAD can identify the various time elements CMS is requesting be tracked to ensure only federally allowable costs are included in the cost report:
    - Transport Time by ambulance staff for allocating ambulance costs.
    - Treatment Time by ambulance staff for allocating ambulance costs.
    - Total Time by ambulance staff.

- **Readiness Costs**. Like hospital emergency departments, ambulance responders must be available 24/7 to be “ready to respond” to medical calls. Hospital Medicare and Medicaid regulations consider nursing salaries and benefits that include readiness time as an allowable cost of direct care; NAEMT requests that CMS consider ambulance readiness time also as an allowable direct care cost.

- **Indirect Costs.** Hospitals and community-based providers allocate indirect costs for supporting departments using accumulated costs, patient days, square footage, and other approved allocation methods. Ambulance services should also be allowed to pro-rate indirect costs using accumulated costs just like hospitals do.

On behalf of all of our members, the NAEMT appreciates the consideration of these items as CMS works with state agencies to develop new GEMT Supplemental Payment Programs for the benefit of EMS providers.