**GEMT Facts**

**What are CPE’s?**

* “Certified Public Expenditures” is a mechanism that is used to draw down federal money for use by local or state government. Requires the use of an approved cost report that defines what is allowed to be included as a cost. Must comply with federal OMB Circular A-087. The agency that is submitting the cost report is “certifying” that it meets all federal and state regulations and that the agency has actually “expended” the funds for the services. Has been around since the 60’s. Is limited to public agencies only

**What are IGT’s**

* “Intergovernmental Transfers” is a mechanism that is used to draw down federal money for use by local or state government. Does not require the use of a cost report but does require an approved program. Has been around since the 60’s and is also limited to public providers.

**Non-federal share**

* The non-federal share is the money that is provided or paid by the local or state government. If the state is a 50/50 state the non-federal share of a $1 million dollar CPE would be $500k

**Uncompensated cost of Service**

* “UCS” is the difference between what the state medicaid pays for the service and the actual cost. The “UCS” is what the split is between the non-federal share and the federal share. If the benefit paid is $100 and the cost to provide the service was $300 the “UCS” is $200. The non-federal share is $100 and the federal share is $100

**Federal Match**

* The federal share of the “UCS”

**Federal Financial Participation**

* Mandate to provide funds to support the state medicaid program

**Fee For Service**

* “FFS” medicaid that is not assigned to a Managed Care program

**Managed Care**

* Medicaid that has been assigned to an HMO provider

**CMS**

* Centers for Medicaid/Medicare

**Who is allowed to participate in these programs?**

* Any governmental entity that is recognized as a “Unit of Government” can participate in these programs. The definition is located in 42 CFR 433.50. Basically if the agency has taxing authority or the ability to create ordinances they are considered a unit of government

**Why can’t the private ambulance industry participate in these programs?**

* Private ambulance providers voluntarily enter into a business model that fits their needs and are not supported by tax dollars. They do not possess taxing authority and are not identified as a “unit of government”

**Don’t these programs hurt the private providers?**

* None of the money that is paid out to public ambulance providers comes from or is “pulled” from the local ambulance system. All money comes from the federal Medicaid program. There will be no financial impact to the private providers. They will continue to be paid that same amount for the same services.

**Won’t the Fire departments just come in and take over the ambulance industry?**

* While it is true the public providers can receive more money for providing the same service it is also true that there is a significant financial consideration in developing a new program. Each agency and local governing board or counsel will have to weigh the pro’s and con’s of entering into a new service delivery model.

**Where does this money come from?**

* These programs are entitlement programs and are part of the federal Medicaid system. They operate as part of the Social Security act title XIX. They have been in use since 1965

**How long will this money last?**

* There are no current plans in place to repeal or withdraw from providing this benefit

**Is the money paid out from a single pot?**

* No, the money is part of the federal Medicaid program. The state must create a “placeholder” each year to notify CMS of the anticipated amount that will be required by the providers?

**What is a place holder?**

* Each year the state does a survey of the participating providers to determine the amount of money needed to fund the program. They typically will add 10-20% to that number in order to insure there will be enough money for that years participants. Money that is not used is returned back to CMS. Each year the participants and amount of funds can change

**How will the Affordable Care Act “ACA” affect this program?**

* Currently the ACA has only expanded the number of Medicaid beneficiaries that are in the program. However, the trend by most states is to move as many people from FFS to HMO plans. This will shift more and more of the program to the IGT mechanism

**How is the money spent when it reimbursed back to the providers?**

* CPE’s allowed to be returned to the General Fund because they represent money that has already be expended. IGT funds must be used to provide the service for which the IGT was generated. The total amount of revenue that is collected cannot exceed the cost of providing the service. If your agency provides ambulance services that cost $1 million dollars. You collect $100k in medicaid reimburses your CPE/IGT cannot exceed $900k

**Why are the fire departments allowed to do this?**

* It is not the fire departments that are allowed, these programs have been operating for 50 years. In the past it was never really conceived that a public ambulance provider could participate. The public ambulance providers are now just using the same programs that public hospitals and public health care clinics have been using.

**Aren’t the fire departments just taking advantage of the tax payer?**

* The cost of providing the service is far more expensive than what the state Medicaid program currently pays. As a result the local taxpayer is supplementing those who are not able to pay for the services being provided. The Social Security Act title XIX is mandated to provide supplemental reimbursement for those who incur a cost of providing the services to medicaid beneficiaries. By reducing the amount of “local” tax payer money needed to supplement the ambulance services with federal money the local government can use the local tax dollar to enhance the delivery of local services

**Who pays the state for this program and what are the states costs?**

* For CPE’s the state cannot incur a cost for running the program. The states cost are divided between the providers and CMS on a 50/50 basis. There is no cost to the tax payer for CPE programs. When it comes to IGT’s the state is allowed to charge a fee for their part of the services provided as long as it is either included in statute or part of the state plan. The amount of the fee is determined by each state. Some are minimal while others are fairly large. California is 20%, Indiana is 28.5% Utah has a sliding scale that amounts to a little more than 1.1%

**If this is such a great deal who else is do this?**

* To my knowledge every state including ours is participating in one or more of these programs with most dating back decades. The application of these types of programs for use in the ambulance services was really just an oversight as ambulance transport is a very small part and dollar amount in the nation’s healthcare system. Until California asked to be included it just wasn’t part of the thought process. CMS welcomed California’s public ambulance providers into the process.