FREQUENTLY ASKED QUESTIONS (FAQs)
SUPPLEMENTAL EMERGENCY MEDICAL TRANSPORTATION (SEMT)

Table of Contents

OVERVIEW

A1. What is the SEMT program?

The supplemental emergency medical transportation (SEMT) program is a *voluntary* program to make federal Medicaid supplemental payments on top of fee-for-service Medicaid payments for ground, air, and water emergency medical transportation services through a Certified Public Expenditure (CPE) program for publicly owned Medicaid emergency medical transportation providers.

A2. When is this program effective?

The State Plan Amendment (SPA), which is the state agreement with the Centers for Medicare and Medicaid Services regarding Medicaid, for the SEMT program was approved August 31, 2019. This means that any emergency medical transport on or after August 31, 2019, by qualified providers who opt into the program are eligible to be included in the SEMT program.

A3. What regulations govern this program?

Alaska SEMT regulations are 7 AAC 145.750-799. These regulations are effective October 9, 2021.

PROVIDER ELIGIBILITY

B1. Which providers are eligible for this program?

To be considered for inclusion in the SEMT program, a provider must meet the following criteria:

- Be enrolled as an Alaska Medicaid provider for emergency medical transport services for the period claimed on their annual cost report and
- Provide fee for services ground, air, or water emergency medical transportation services to Medicaid recipients, and
- Be publicly owned or operated
    - State
    - City, county, home rule municipality, borough, special purpose district, or other governmental unit in that state that has taxing authority or direct access to tax revenue
    - A federally recognized Indian tribe or tribal organization.

B2. Do I have to participate in this program if I am an eligible provider?

No, the SEMT program is a voluntary program.

B3. Are all providers eligible for SEMT automatically enrolled in the program?

No, eligible providers must actively opt into the program each year by submitting the required documents noted in 7 AAC 145.760(c) and listed in the annual report submission section (C) of this FAQ by the required due date.

B4. If I participate in the program for one year, do I have to do so the next year? Or, if I didn't opt into SEMT this year, am I barred from participating in SEMT in future years?

No, SEMT is a voluntary program, and the provider can elect each year to participate by submitting the annual report submission documents listed in 7 AAC 145.760(c) and in the annual report submission section (C) of this FAQ.

B5. Which transports qualify for this program?

Medicaid transports billed and paid by Medicaid that qualify for SEMT include transports for:

- Title XIX Medicaid recipients
- Title XXI Medicaid recipients
- Medicaid Expansion recipients
- Indian Health Services (IHS) recipients (including Tribal Refinancing)

Transports that are not included in the SEMT program include transports for:

- Transports for payors other than Medicaid
- Transports for Medicare recipients with dual eligibility for Medicaid
- Transports for Medicaid applicants
- Dry Runs

B6. What is Tribal Refinancing?

Historically, services provided by non-tribal providers have been jointly funded, approximately 50% federal funds and 50% state funds. Alternatively, services provided by Indian Health Service (IHS) providers to Medicaid recipients who are American Indian/Alaska Native (AI/AN) have been 100% federally funded. On February 26, 2016, the Centers for Medicare and Medicaid Services (CMS) issued State Health Official (SHO) letter #16-002 allowing 100% federal funding for services provided by a non-tribal provider with a signed care coordination agreement (referred to as a Transfer and Referral Agreement) in place to a Medicaid recipient who is AI/AN when referred by a tribal provider.

B7. How do I find out if my organization participates in care coordination agreements with Tribal entities?

To find out if your organization participates in tribal reclaiming or has a signed care coordination agreement (Transfer and Referral Agreement), please send an email to dhsstribalhealth@alaska.gov

B8. How do I enter into a care coordination agreement?

To enter into a care coordination agreement, a provider needs to complete the Care Coordination Agreement form (found at https://dhss.alaska.gov/dhcs/Pages/Tribal-Health/Tribal-Refinancing.aspx#agreements). The form is then sent to Alaska Native Tribal Health Corporation who oversees the initiative for all the participating tribal health organizations.

ANNUAL REPORT SUBMISSION

C1. What documents are required to be submitted?

Each year a provider opts into/participates in the program; the provider must submit the following documents:

- SEMT Provider Participation Agreement
- SEMT Cost Report
- Audited Financial Statements (AFS)
- Post Audit Working Trial Balance (PAWTB)
- Reconciliation of the PAWTB to the cost report
- Supporting documentation to substantiate the cost report includes but is not limited to:
    - Call logs
    - Floor Plans
    - Depreciation Schedules
    - Time studies

Please submit the cost report, post audit working trial balance, and reconciliation in pdf and excel formats.

C2. Is a new SEMT Provider Participation Agreement due for each annual report submission?

Yes, a separate SEMT Provider Participation Agreement (PPA) is due for each annual report submission. For example, if a provider is submitting their CY19 and CY20 reports submissions on or before April 7, 2022, a different PPA is due for each fiscal year.

C3. When are annual report submission documents due?

Per 7 AAC 145.760(b), annual report submission documents are required to be submitted 5 months after the close of the provider's fiscal year end. Generally, this would mean that after a provider's fiscal year, their annual report submission would be due:

FFY provider	February 28th
CY provider	May 31st
SFY provider	November 30th

Since the State Plan Amendment (SPA) was approved with an effective date of August 31, 2019, but regulations were not effective until October 9, 2021, there is a backlog of reports for fiscal years that have already passed. Per 7 AAC 145.760(h), report submissions for the prior time periods of FFY19-20, CY19-20, and SFY20-21 are due April 7, 2022, which is 180 days after the October 9, 2021, effective date of the regulations.

While FFY21 is not listed in 7 AAC 145.760(h) as a report submission that is due 180 days after the regulations are effective, the Department has issued an extension letter to April 7, 2022, for FFY21, and has placed the letter on the SEMT website. Without this extension, the FFY21 report submissions would have been due on February 28, 2022, which is before the FFY19-20 reports submissions. This extension letter aligns FFY21 reports submissions with the treatment of all other 'past fiscal years' submissions.

C4. What if the report submission documents due date is on a Saturday, Sunday, or holiday?

A report submission due on a Saturday, Sunday, or holiday is considered timely filed if it is received on or before 5 PM AKST the following business day.

C5. Are extensions available?

Per 7 AAC 145.760(b), an extension of not more than 30 days can be granted for good cause. A provider must submit the request for an extension before the due date of the report submission documents in question in writing to AKsemt@alaska.gov.

C6. What if I just submit a portion of my report submission documents on time?

A complete report submission includes all the items identified in Question #C1. After a provider has been notified of any deficiencies in the annual report submission, the provider will have 10 days to submit the necessary documentation.

C7. Can I submit my report submission documents before the due date?

Yes, providers can submit their annual report submission documents before the due date. Please ensure the report submission includes all required documentation.

C8. Where do I submit my reports?

Please submit all the annual report submission documents to AKsemt@alaska.gov.

C9. What is a reconciliation of the Post Audit Working Trial Balance (PAWTB) to the cost report?

A reconciliation is a blueprint of where each account on the PAWTB is reported on the cost report. For example, it would state that account XYZ is reported on Schedule 4, Line 1, Col 1. In the case where a single PAWTB account is reported on more than one line, the reconciliation would note how the cost is allocated between the lines and the provider would provide support for the allocation. For example, a provider may split a single wage PAWTB account to more than one line and state that the salary costs are allocated using call logs between fire suppression and EMS time. The provider would then submit the call logs that show that X% of calls were for fire suppression and Y% of calls were for EMS. Examples of reconciliations are provided in the training PowerPoint slides on the SEMT website located at Supplemental Emergency Medical Transport (SEMT) Program Website

C10. Do we have to use your reconciliation template?

No, a provider does not have to use the reconciliation template provided on the Alaska SEMT webpage; however, a reconciliation from the working trial balance to the SEMT cost report is required.

COST REPORT

D1. Do I only report costs/transports related to Medicaid on the cost report?

The SEMT cost report should include all the provider's costs and transports. Total allowable costs will be divided by total transports from all payors to calculate a provider's average cost per transport.

D2. What types of things are unallowable costs?

The list of potential unallowable costs can be extensive. Please review CMS Publication 15-1 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929), in particular Chapter 21, to determine if a potential cost is allowable.

At a high level, costs not related to patient care are not allowable. Examples of this include, but are not limited to:

- Fundraising costs
- Advertising costs that are promotional
- Donations / Gifts
- Entertainment
- Fines or Penalties
- Contracts where payment is on a percentage basis

Per 7 AAC 145.780(b), the administrative fee paid to the Department for the SEMT program is not an allowable cost.

D3. Where should I put cost X on the cost report?

Providers should review the SEMT cost report instructions and 2 C.F.R Part 200, 42 C.F.R Part 413 to determine cost placement or unallowable costs. The C.F.R. can be found online at Code of Federal Regulations. There exists a conflict of interest if ORR provides feedback on expense placement and then subsequently audits our own work. Additionally, the SEMT cost report is built in a manner so there are multiple ways a provider can report a cost depending on their own working trial balance (WTB) structure, allocations, and/or support documentation. For example, a provider may report a specific WTB account on Schedule 4 where the cost is allocated using square footage or call log hours or a provider may use a different allocation method to split costs and report the MTS costs on Schedule 2 and the non-MTS costs on Schedule 3.

D4. Is a contribution to an Internal Service Fund for the purchase of equipment in the future considered an eligible expenditure to include on the cost report?

No. 7 AAC 145.780(c) states "All financial and medical transport information must be based on an accrual method of accounting and the participating provider must comply with generally accepted accounting principles (GAAP). Revenue must be reported in the period earned, regardless of when payment was received. Expenses must be reported in the period in which incurred."

D5. Do I need to complete Schedules 9 and 10?

No. Schedules 9 and 10 are schedules to be populated by the Department using claims information from the Medicaid Management Information System (MMIS) and will be used to calculate interim and final settlements. A provider in signing the cost report is certifying the accuracy of Schedules 1-8, which are the provider populated schedules.

D6. Are there instructions or assistance in how to fill out the cost survey?

Instructions for filling out the cost survey are located on the SEMT website at Supplemental Emergency Medical Transport (SEMT) Program Website

D7. How will CARES Act Funding impact SEMT Supplemental Payments?

The following response is an update to the original response to include the information we received from CMS
The Department has reached out to the Center of Medicare and Medicaid Services (CMS) regarding the impact of CARES Act Funding on SEMT supplemental payments. CMS has indicated that CARES Act Funding will not be considered in determining SEMT supplemental payments. As noted in the HRSA Provider Relief Fund Terms and Conditions, providers are required to attest that "…those expenses or lost revenues were not reimbursed from other sources and other sources were not obligated to reimbursement them".

D8. What support do we need to provide related to city administrative costs (home office costs or intergovernmental charges) for which a portion of expenses are allocated to the EMS/Fire division?

A provider's costs from the SEMT cost report must tie to the AFS. For many SEMT providers, this tying may be to a detailed schedule on the AFS specific to their component of a governmental provider. However, a provider may also include central governmental administrative & general costs allocated to their component of a governmental provider. In this case, the variance between the AFS expenses for the EMS/Fire component and the SEMT cost report would be the central governmental administrative and general costs. To support this variance, the provider must include documentation support as to:

1. The amount of administrative & general expenses allocated to the EMS/Fire component
2. The total amount of administrative & general expenses for the central governmental component(s)
3. The allocation method(s) for each central governmental component (# of departments, direct billing, # of employees, etc.)

D9. Should we be reporting revenue based on a cash basis or on an accrual basis based on the dates of service on Schedule 6 of the SEMT cost report?

Some providers have their accounting done on a cash basis, while others have their accounting done on an accrual basis. The answer to the question posed depends on each provider's accounting structure. The important thing is that the total revenue on Schedule 6's Row 44, Column 6 ties to the revenue reported on the Audited Financial Statement.

D10. Must CARES Act funding for EMS services be offset against a provider's cost for determining supplemental payments under SEMT?

"In general, CARES Act Provider Relief Funds are not required to be offset for purposes of cost reimbursement with a few program exceptions where the relief is related to uninsured. Beginning on page 128 of the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies", CMS addresses treatment of the CARES Act and Provider Relief Funds under *H. Miscellaneous.*

More specifically, Q#8 on page 130 of the FAQ discusses treatment for purposes of cost reimbursement and explains that the funds are not required as an offset to cost. The FAQ #8 of *H. Miscellaneous* also provides a link to the CARES Act Provider Relief Fund FAQs on the HRSA.gov website. COVID-19 FAQs for State Medicaid and CHIP Agencies

D11. Are there any stipulations in the regulations for the use of the reimbursement? Must the reimbursement be used for EMS services, or can public providers utilize the reimbursement for non-EMS purposes?

The State Plan Amendment (SPA) and the Alaska Administrative Code (7 AAC 145.750) do not contain any stipulations for the use of reimbursement.

D12. Where should we report grant expenses on the SEMT cost report?

Grant expenses should be reported on Schedule 3. All expenses on Schedule 3 are not included in determining SEMT supplemental payments. For CARES Act Funding guidance, please see FAQ D7.

D13. Which column on Schedule 6 of the SEMT Cost Report should revenues such as property taxes be reported?

Please report property taxes and other such revenues on Column 5 (non-MTS) on the Schedule 6.

INTERIM PAYMENTS

E1. How are interim settlements calculated?

Interim payments will be based off a provider's as filed cost per transport. The calculation is:

CALCULATION		SOURCE
	Provider's as filed cost per transport	Provider's as-filed cost report
X	# of SEMT Eligible Transports	Medicaid claims from the MMIS
=	Provider's SEMT Eligible Allowable Costs	
-	Medicaid fee-for-service payment	Medicaid claims from the MMIS
-	Medicaid third party liability payment	Medicaid claims from the MMIS
=	CPE costs not covered via other sources of payments	
X	Title XIX Federal Medical Assistance Percentage (FMAP)	Federal Guidance
=	Interim federal supplemental payment	

For example:

Provider's cost per medical transport per cost report *as filed*:	$2,500
X # of SEMT Eligible Transports	4
Provider's SEMT Eligible Allowable Costs	$10,000

MINUS Medicaid fee-for service (FFS) payment:	$(2,000)
MINUS Medicaid third party liability (TPL) payment:	$(100)
CPE Costs not covered via other sources of payment	$7,900
Federal Medical Assistance Percentage (FMAP) Title XIX*	50%
Interim Supplemental Payment	$3,950

MMIS = Medicaid Management Information System – It is the claims system where Medicaid claims are paid and is accessed by Department staff during the interim settlement process.

E2. Will I owe back the interim settlement?

After interim payments are made, a desk review is performed to substantiate the provider's as filed cost per transport. This could result in an adjusted cost per transport if adjustments are made during the desk review process. A final settlement is made using the audited cost per transport and Medicaid claims data that is past timely filing.

This can result in a potential overpayment that a provider would be liable to pay back within 30 calendar days. A provider agrees to this as part of signing the SEMT Provider Participation Agreement. The interim payment calculations are set up to limit the chance of overpayment. For example, only the lowest Federal Medical Assistance Percentage (FMAP) is utilized in calculating the interim payment instead of the actual FMAP applicable to the transport. For example, if a transport is for a Medicaid Expansion recipient, the federal interim supplemental payment utilizes the Title XIX FMAP of 50% for calculating the federal interim payment, but the final supplemental payment would utilize the Medicaid Expansion FMAP of 90%.

E3. When are interim settlements paid out?

Per 7 AAC 145.700(b), the department will pay the interim payment not later than the end of the second quarter following the report submission.

If a provider submits their documents April 7, 2022, the second quarter following the report submission is October 1 – December 31, 2022. In this case, an interim payment would be paid on or before December 31, 2022. It is not the intention of the department to hold all providers' interim payments until the end, but instead to pay the interim payments out as each annual report submission is processed.

DESK REVIEW

F1. What happens once I submit my annual report submission documents? Do I have to do anything else?

Once the annual report submission documents are submitted and determined complete, the Office of Rate Review (ORR) will begin issuing interim payments, then conducting a desk review to substantiate a provider's cost per transport, and then issuing final settlements.

During the desk review, the ORR may have questions that a provider will need to answer or provide documentation for to be able to determine the provider's audited cost per transport.

F2. I just received from ORR my final SEMT cost report and list of any adjustments made . What happens now?

Upon completion of the desk review, ORR will forward a desk review report to the provider.
If a provider disagrees with the results of the desk review and any adjustment made, the provider has 40 days to submit in writing a request for a reconsideration to AKsemt@alaska.gov. See question F3 for more detail.

If a provider agrees with the results of the desk review and any adjustments made, the next step is the final settlement payment/overpayment take back. If the provider notifies the Department at AKsemt@alaska.gov of acceptance of the desk review, the Department will move to the next steps for final settlement payment/take

back. If the Department is not notified in writing of acceptance of the desk review, the Department will hold off on the next steps until the 40-day reconsideration window closes.

F3. I disagree with adjustments made to my cost report. What do I do?

Providers have a right to request a reconsideration of the final results of their desk review. A provider requesting a reconsideration of their desk review must submit the basis of their disagreement and any supporting documents in writing to AKsemt@alaska.gov within 40 days after the submission date of the adjusted desk review.

If a facility is aggrieved by the determination made during reconsideration, the provider may file a written notice of appeal with the commissioner's office at 3601 C Street, Suite 902, Anchorage, Alaska 99503 within 30 days after the date a written determination is made. The notice of the appeal must include:

- Statement of issues
- Identify basis for the provider's contention
- Specify the relief requested
- Provide a name, address, telephone number, and other contact information for the provider representative designated as the point of contact for the appeal.
- Include a certificate of mailing

FINAL PAYMENTS

G1. How are final settlements calculated?

Final payments will be based off a provider's audited/adjusted cost per transport. The calculation is:

CALCULATION		SOURCE
Provider's audited cost per transport		Provider's audited cost report
X	# of SEMT Eligible Transports	Medicaid claims from the MMIS
=	Provider's SEMT Eligible Allowable Costs	
-	Medicaid fee-for-service payment	Medicaid claims from the MMIS
-	Medicaid third party liability payment	Medicaid claims from the MMIS
=	CPE costs not covered via other sources of payments	
X	Applicable Federal Medical Assistance Percentage (FMAP)	Federal Guidance
=	Federal CPE costs not covered via other sources of payment	
-	Interim federal supplemental payment	Department records
=	Final federal supplemental payment or overpayment due back to the department	

For example, if a provider has 4 transports, where all four are Title XXI FMAPs (65%).

Provider's cost per medical transport per cost report *as filed*:	$2,400
X # of SEMT Eligible Transports	4
Provider's SEMT Eligible Allowable Costs	$9,600
MINUS Medicaid fee-for service (FFS) payment:	$(2,000)
MINUS Medicaid third party liability (TPL) payment:	$(100)
CPE Costs not covered via other sources of payment	$7,500
X Federal Medical Assistance Percentage (FMAP)	65%
Federal CPE costs not covered via other sources of payment	$4,875
MINUS Interim federal supplemental payment	$(3,950)
Final federal supplemental payment	$925

G2. What are FMAPs?

Federal medical assistance percentages (FMAPs) refer to the federal government's share of a state's Medicaid expenditures. A portion of Medicaid services are paid via state general funds and a portion are paid via federal funds which is calculated using the FMAP.
FMAPs vary state to state for their Medicaid program. Additionally, FMAPs vary within a state based on the recipient's eligibility type for Medicaid. For example, claims for recipients eligible for Medicaid under Title XIX of the Social Security Act get a different FMAP than claims for recipients eligible for Medicaid under Title XXI of the Social Security Act. FMAPs can change based on the federal fiscal year (FFY), with the exception of Medicaid Expansion, which changes on the calendar year.

For example, the FMAPs for FFY19-21 (baring Covid enhanced FMAP noted below) are:

	FFY19	**FFY20***	**FFY21***
Title XIX	50%	50%	50%
Title XXI	88%	76.5%	65%
Medicaid Expansion**	94% / 93%	93% / 90%	90%
Indian Health Services	100%	100%	100%

* The federal legislation for the Families First Coronavirus Response Act resulted in an Enhanced Medicaid FMAP add-on. This FMAP is temporary and is effective January 1, 2020. Currently the enhanced FMAP is through 12/31/21, though federal regulations could extend this amount. The enhanced Covid FMAPs are applicable only to Title XIX and Title XXI.

** Medicaid Expansion FMAP is on a calendar year basis.

Enhanced Medicaid FMAP for Covid January 1, 2020 – September 30, 2020:

Title XIX	56.2%
Title XXI	80.84%

Enhanced Medicaid FMAP for Covid October 1, 2021, through currently December 31, 2021

Title XIX	56.2%
Title XXI	69.34%

G3. Am I supposed to know which FMAP is applicable to each transport?

No, a provider is not responsible and would not know which FMAP applies to each transport. The Department will be pulling claims information from the Medicaid Management Information System (MMIS) to calculate the final supplemental payment on Schedule 10. The claims information in the MMIS indicate which FMAP applies to each claim.

G4. When are final settlements paid out?

The earliest a final settlement can occur is 1 year after the provider's fiscal year end because Alaska Medicaid claims have a one-year timeframe in which they can be submitted and be considered timely filed. Therefore, settlements cannot be finalized at least until timely filing has passed.

Per 7 AAC 145.780(g), the final settlements must occur within 3 years of the receipt of the as filed report.

Therefore, the first batch of past due reports for FFY19-21, CY19-20, and SFY20-21 that will be reported April 7, 2022, must have their final settlements occur on or before April 7, 2025. Timely filing will have passed by April 7,

2022, for FFY19-20, CY19-20, and SFY20. Desk reviews must be conducted to be able to calculate final settlements using audited cost reports. The Department asks for the providers patience as the Department works to finalize the first rounds of final payments considering the first batch of several years of reports coming in and in the learning curve for the department auditors on this program.

ADMINISTRATIVE FEE

H1. What is the admin fee or why is there an Admin Fee?

The SEMT program is authorized under AS. 47.07.085. The Alaska Legislature required that state general funds may not be used for this program. While the supplemental payments made to the providers are only federal funds, there are state Medicaid staff who are required to audit the cost reports and pay out federal funds interim/final supplemental payments. State Medicaid staff time are Medicaid administrative expenses that is paid via 50% federal funds and 50% state funds. The administrative fee paid by participating providers covers the state fund cost of state Medicaid staff performing SEMT activities.

H2. How is the admin fee calculated?

At a high level, the admin fee is a fee per SEMT transport calculated by dividing the state fund costs of administering the program divided by SEMT transports. This admin fee per SEMT transport is the same for every provider; however, the total administrative fee the provider will pay is based on that provider's SEMT transports. Therefore, a provider with twice as many SEMT transports as another provider will be paying an admin fee that is two times larger than the other providers.

The numerator of the calculation is the state fund cost of state Medicaid staff's time performing SEMT activities. This is determined via positive timekeeping. The time period for the state funds for the first admin fee is the effective date of the regulations, October 9, 2021, through the March 31 following the first report submissions. The time period for subsequent admin fees is April 1 through March 31.

The denominator of the calculation is the SEMT transports from the cost reports submitted during the same time period as the numerator.

The admin fee will be variable, especially in the first 2-3 years of the program as everyone gains familiarity with the program and the department catches up on the backlog of reports submissions for past time periods. Below we show an example of an admin fee calculation when the program has stabilized:

For example, for the admin fee due June 15, 2024, is calculated as:

$$\frac{\text{State Medicaid staff state funds costs from April 1, 2023 – March 31, 2024}}{\text{SEMT transports for cost reports submitted April 1, 2023 – March 31, 2024}}$$

The denominator would include transports for CY22 cost reports submitted May 31, 2023, for SFY23 cost reports submitted November 30, 2023, and for FFY23 cost reports submitted February 28, 2024.

H3. Will the admin fee be the same each year?

No, the admin fee will fluctuate year to year. It is anticipated that the admin fee will begin to stabilize in predictability after several years when the providers have historical knowledge in completing and submitting cost reports, when the Department has historical knowledge in auditing the cost reports, and when the providers participating in the program have stabilized.

It is anticipated that the desk reviews will be roughly the same amount of time for each provider. Providers with smaller numbers of transports are anticipated to take the same amount of time as large providers. Therefore, the state funds staff cost for each provider opting into the program is expected to be roughly the same in the numerator. However, the number of SEMT transports added to the denominator for a small provider is small. Therefore, the more providers with small numbers of SEMT transports that opt into the program, the larger the admin fee per transport.

H4. When is the admin fee due?

Admin fees are due on or before June 15 each year a provider participates in the program.

H5. When will you notify us of the amount we must pay in an admin fee?

The department will notify providers of the admin fee by May 15 each year.

H6. The first admin fee for providers may be due on June 15, 2022, or June 15, 2023, depending on whether or not providers submit their previous fiscal years report submissions on or before March 31, 2022 or afterwards. This disparity only exists in the beginning of the program and not subsequent admin fees. If any providers submit prior to March 31, 2022, resulting in the first admin fee representing 6 months of SEMT time, is there a way to true up the admin fee calculations for the first 18 months (October 9, 2021 – March 31, 2023) during the second admin fee?

Alaska regulations do not allow the Department to utilize a different admin fee rate calculation. A true up of the admin fee between years one and two cannot be performed.

While a provider may wish to submit their previous years' reports in April 2022 to prevent paying an admin fee in year one, providers should weigh the following considerations:

- The timing of interim payments is made on a first submitted, first calculated basis.
    - Providers who submit annual reports between January 1 through March 31, 2022, will have their interim payments made on or before September 30, 2022.
    - Providers who submit annual reports between April 1 through June 30, 2022, will have their interim payments made on or before December 30, 2022
- The timing of final payments is made on a first submitted, first calculated basis.
- While providers who do not submit annual reports on or before March 31, 2022, will not pay an admin fee in year one, their admin fee in year two will be a larger percentage of the total fee since all SEMT eligible transports for the cost reports submitted April 1, 2022 – March 31, 2023, will include transports for each FYE submitted during that time.

AMBULANCE CRITERIA

I1. Where can I find guidance on Alaska Medicaid covered ambulance services?

Coverage guidance is located in the Air and Ground Ambulance billing manual.

I2. What is the Alaska Medicaid criteria for ambulance service (ground, air, or water)?

Ambulance transportation is only covered if all other modes of transportation are contraindicated. For more information on ambulance criteria see the Ambulance Clinical Criteria guidance.

I3. Does Alaska Medicaid have additional criteria for a member to qualify for an air ambulance?

An air ambulance may be covered by Alaska Medicaid if there is medical necessity to transport the patient, all other modes of transportation are contraindicated to include ground ambulance, and a member's physical or mental condition is such that traveling on a commercial flight is not safe for the recipient or other passengers.

I4. Does Alaska Medicaid have additional criteria for a member to qualify for a water ambulance?

No, transport via water ambulance must meet the ambulance criteria outlined in the Ambulance Clinical Criteria guidance and must be the most appropriate mode of ambulance being utilized.

I5. Are water rescues covered by Alaska Medicaid?

Water rescues may be covered by Alaska Medicaid if there is a medical service occurring at the point of pick-up and during transport and the transport meets the criteria outlined in the Ambulance Clinical Criteria guidance.

I6. How is water ambulance billed through Alaska Medicaid?

An ambulance provider bills a water ambulance in the same manner as ground ambulance except a place of service code of 42 is utilized. Ground ambulance CPT codes can be found on the Transportation/Accommodations fee schedule.