RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 05, 2018
TIME: 11:18 AM

WSR 18-12-091

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is removing all references to managed care from appropriate sections within Chapter 182-546 WAC. Effective January 1, 2018, the agency began covering all emergency and nonemergency ambulance services provided to Apple Health clients through fee-for-service, including those transports for clients in an agency-contract managed care organization.

Before the agency could implement HB 2007 (Ground Emergency Medical Transportation-GEMT)) Sec. 10, Laws of 2015, 64th Legislature, 2015 Regular Session approval from the Centers for Medicare and Medicaid Services (CMS) was required. CMS approved the state plan amendment with the requirement that the agency begin paying for all ground ambulance services through fee-for-service by January 1, 2018. The agency filed emergency rules, effective January 1, 2018, under WSR 18-02-023 for this change. This rule making order completed the permanent rulemaking.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-546-0150, 182-546-0400
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-09-114 on April 18, 2018 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

	New	____	Amended	____	Repealed	____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	____	Amended	2	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	2	Repealed	____

Date Adopted: June 5, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 14-07-042, filed 3/12/14, effective 4/12/14)

WAC 182-546-0150 Client eligibility for ambulance transportation. (1) Except for ((~~persons~~)) people in the Family Planning Only and TAKE CHARGE programs, fee-for-service clients are eligible for ambulance transportation to covered services with the following limitations:

(a) ((~~Persons~~)) People in the following Washington apple health ((~~(WAH)~~)) programs are eligible for ambulance services within Washington state or bordering cities only, as designated in WAC 182-501-0175:

(i) Medical care services (MCS) as described in WAC 182-508-0005;

(ii) Alien emergency medical (AEM) services as described in chapter 182-507 WAC.

(b) ((~~Persons~~)) People in the ((~~WAH~~)) apple health categorically needy/qualified medicare beneficiary (CN/QMB) and ((~~WAH~~)) apple health medically needy/qualified medicare beneficiary (MN/QMB) programs are covered by medicare and medicaid, with the payment limitations described in WAC 182-546-0400(5).

(2) ((~~Persons~~)) People enrolled in an agency-contracted managed care organization (MCO) must coordinate:

(a) Ground ambulance services through ((~~their designated MCO, subject to the MCO coverage and limitations~~)) the agency under fee-for-service, subject to the coverage and limitations within this chapter; and

(b) Air ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this chapter.

(3) ((~~Persons~~)) People enrolled in the agency's primary care case management (PCCM) program are eligible for ambulance services that are emergency medical services or that are approved by the PCCM in accordance with the agency's requirements. The agency pays for covered services for these ((~~persons~~)) people according to the agency's published ((~~medicaid provider~~)) billing guides and provider ((~~notices~~)) alerts.

(4) ((~~Persons~~)) People under the Involuntary Treatment Act (ITA) are not eligible for ambulance transportation coverage outside the state of Washington. This exclusion from coverage applies to ((~~individuals~~)) people who are being detained involuntarily for mental health treatment and being transported to or from bordering cities. See also WAC 182-546-4000.

(5) See WAC 182-546-0800 and 182-546-2500 for additional limitations on out-of-state coverage and coverage for ((~~persons~~)) people with other insurance.

(6) The agency does not pay for ambulance services for jail inmates and ((~~persons~~)) people living in a correctional facility, including ((~~persons~~)) people in work-release status. See WAC 182-503-0505(5).

AMENDATORY SECTION (Amending WSR 13-16-006, filed 7/25/13, effective 8/25/13)

WAC 182-546-0400 General limitations on payment for ambulance services. (1) In accordance with WAC 182-502-0100(8), the agency pays providers the lesser of the provider's usual and customary charges or

the maximum allowable rate established by the agency. The agency's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

(2) The agency:

(a) ((~~Does not~~)) Pays providers under fee-for-service for ground ambulance services provided to a client who is enrolled in an agency-contracted managed care organization (MCO). ((~~Payment in such cases is the responsibility of the client's agency-contracted MCO;~~))

(b) Pays providers under fee-for-service for air ambulance services provided to a client who is enrolled in an agency-contracted MCO.

(3) The agency does not pay providers for mileage incurred traveling to the point of pickup or any other distances traveled when the client is not on board the ambulance. The agency pays for loaded mileage only as follows:

(a) The agency pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pickup to the point of destination.

(b) The agency pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pickup to the point of destination.

(4) The agency does not pay for ambulance services if:

(a) The client is not transported;

(b) The client is transported but not to an appropriate treatment facility; or

(c) The client dies before the ambulance trip begins (see the single exception for ground ambulance providers at WAC 182-546-0500(2)).

(5) For clients in the categorically needy/qualified medicare beneficiary (CN/QMB) and medically needy/qualified medicare beneficiary (MN/QMB) programs, the agency's payment is as follows:

(a) If medicare covers the service, the agency ((~~will~~)) pays the lesser of:

(i) The full coinsurance and deductible amounts due, based upon medicaid's allowed amount; or

(ii) The agency's maximum allowable for that service minus the amount paid by medicare.

(b) If medicare does not cover or denies ambulance services that the agency covers according to this chapter, the agency pays its maximum allowable fee; except the agency does not pay for clients on the qualified medicare beneficiaries (QMB) only program.