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DATE: March 29, 2019
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WSR 19-08-058

RULE-MAKING ORDER
PERMANENT RULE ONLY

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

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) May 1, 2019 **(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: This rulemaking is necessary to implement House Bill 2007 that directed the agency to design and implement a supplemental Medicaid reimbursement in addition to the rate of payment that an eligible provider would otherwise receive for Medicaid ground emergency medical transportation services for both fee-for-service and managed care-enrolled clients. An eligible provider is one who provides ground emergency medical transportation services to Medicaid beneficiaries, is enrolled as a Medicaid provider, and is owned or operated by the state, a city, county fire protection district, community services district, health care district, federally recognized Indian tribe, or any unit of government as defined in 42 C.F.R. Sec. 433.50.

Citation of rules affected by this order:

New: 182-546-0505, 182-546-0510, 182-546-0515, 182-546-0520, 182-546-0525, 182-546-0530, 182-546-0535, 182-546-0540, 182-546-0545

Repealed:

Amended:

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160, HB 2007, Chapter 147, Laws of 2015, 64th Legislature, 2015 Regular Session

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-05-093 on February 20, 2019 (date).

Describe any changes other than editing from proposed to adopted version: N/A

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Federal statute:	New	____	Amended	____	Repealed	____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	9	Amended	____	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	9	Amended	____	Repealed	____

Date Adopted: March 29, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT)

NEW SECTION

WAC 182-546-0505 GEMT definitions. See WAC 182-546-0001 for additional definitions.

"Allowable costs" means an expenditure that meets the test of the appropriate Executive Office of the President of the United States Office of Management and Budget (OMB) Circular.

"Cost allocation plan (CAP)" means a document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The document also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received.

"Direct costs" means all costs identified specifically with a particular final cost objective in order to meet emergent medical transportation requirements. This includes unallocated payroll costs for personnel work shifts, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to delivering covered medical transportation services.

"Federal financial participation (FFP)" means the portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) according to the state plan for medical assistance. Clients under Title 19 (Health Resources and Services Administration (HRSA)) are eligible for FFP.

"Indirect costs" means the costs for a common or joint purpose benefiting more than one cost objective and allocated to each objective using an agency-approved indirect rate or an allocation methodology.

"Prehospital care" means assessment, stabilization, and emergency medical care of an ill or injured client by an emergency medical technician, paramedic, or other person before the client reaches the hospital.

"Publicly owned or operated" means an entity that is owned or operated by a unit of government. The unit of government is a state, city, county, special purpose district, or other governmental unit in the state that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in the Indian Self-Determination and Education Assistance Act, Section 4.

"Qualifying expenditure" means an expenditure for covered services provided to an eligible beneficiary.

"Service period" means July 1st through June 30th of each Washington state fiscal year.

"Shift" means a standard period of time assigned for a complete cycle of work as set by each participating provider.

NEW SECTION

WAC 182-546-0510 GEMT program overview. (1) The ground emergency medical transportation (GEMT) program permits publicly owned or operated providers to receive cost-based payments for emergency ground ambulance transportation of medicaid fee-for-service clients.

(2) This program is for clients under Title XIX of the federal Social Security Act and the Affordable Care Act (ACA) only. Participating providers do not receive supplemental payments for transporting:

(a) Medicaid applicants; or

(b) Medicare/medicaid recipients with dual eligibility.

(3) The cost-based payment, when combined with the amount received from all other sources of reimbursement for medicaid, must not exceed one hundred percent of allowable costs.

(4) Fire departments/districts must use the approved CAP of their local government. If the local government does not have a CAP, they must use the Centers for Medicare and Medicaid Services (CMS)-approved cost report.

(5) The state general fund cannot be used for GEMT cost-based payments.

NEW SECTION

WAC 182-546-0515 GEMT provider participation and qualifications. (1) Participation in the program by a GEMT provider is voluntary.

(2) To qualify under this program and receive supplemental payments, a participating provider must:

(a) Provide ground emergency transportation services to medicaid fee-for-service clients as described in WAC 182-546-0510(2).

(b) Be publicly owned or operated as defined in WAC 182-546-0505.

(c) Be enrolled as a medicaid provider, with an active core provider agreement, for the service period specified in the claim.

(d) Renew GEMT participation annually by submitting a participation agreement and the Centers for Medicare and Medicaid Services (CMS)-approved cost report to the agency.

NEW SECTION

WAC 182-546-0520 GEMT supplemental payments. (1) The agency makes supplemental payments for the uncompensated and allowable costs incurred while providing GEMT services to medicaid fee-for-service clients, as defined by the United States Office of Management and Budget (OMB).

(a) The amount of supplemental payments, when combined with the amount received from all other sources of reimbursement from the medicaid program, will not exceed one hundred percent of allowable costs.

(b) If the participating provider does not have any uncompensated care costs, then the participating provider will not receive payment under this program.

(2) The total payment is equal to the participating provider's allowable costs of providing the services.

(a) The participating provider must certify the uncompensated expenses using the cost reporting process described under WAC 182-546-0525. This cost reporting process allows medicaid to obtain federal matching dollars to be distributed to participating providers.

(b) The participating provider must:

(i) Include the expenditure in its budget.

(ii) Certify that the claimed expenditures for the GEMT services are eligible for FFP and that the costs were allocated to the appropriate cost objective according to the cost allocation plan.

(iii) Provide evidence, specified by the agency, supporting the certification.

(iv) Submit data, specified by the agency, determining the appropriate amounts to claim as expenditures qualifying for FFP.

NEW SECTION

WAC 182-546-0525 GEMT claim submission and cost reporting. (1) Each participating provider is responsible for submitting claims to the agency for services provided to eligible clients. Participating providers must submit the claims according to the rules and billing instructions in effect at the time the service is provided.

(2) On an annual basis, participating providers must certify and allocate their direct and indirect costs as qualifying expenditures eligible for FFP.

(3) The claimed costs must be necessary to carry out GEMT.

(4) Participating providers must complete cost reporting according to the Centers for Medicare and Medicaid Services (CMS)-approved cost identification principles and standards such as the most current editions of the CMS *Provider Reimbursement Manual* and the United States Office of Management and Budget Circular (OMB) Circular A-87.

(5) Participating providers must completely and accurately document the CMS-approved cost report as required under OMB Circular A-87 Attachment A.

(6) Participating providers must allocate direct and indirect costs to the appropriate cost objectives as indicated in the cost report instructions.

(7) Reported personnel costs including wages, salaries, and fringe benefits must be exclusively attributable to ground emergency ambulance services provided. Services do not include fire suppression.

(8) Revenues received directly, such as foundation grants and money from private fund-raising, are not eligible for certification because such revenues are not expenditures of a government entity.

(9) The sum of a participating provider's allowable direct and indirect costs are divided by the number of ground emergency medical transports to determine a participating provider's average cost per qualifying transport.

(10) Participating providers must complete an annual cost report documenting the participating provider's total CMS-approved, medicaid-allowable, direct and indirect costs of delivering medicaid-covered services using a CMS-approved cost-allocation methodology. Participating providers must:

(a) Submit the cost report within five months after the close of the service period.

(b) Request an extension to the cost report deadline in writing to the agency, if needed. The agency will review requests for an extension on a case-by-case basis.

(c) Provide additional documentation justifying the information in the cost report, upon request by the agency.

(d) Assure the agency receives the cost report or additional documentation according to WAC 182-502-0020.

(i) Participating providers must comply with WAC 182-502-0020 to receive the supplemental payment under this program.

(ii) The agency pays the claims for the following service period according to the agency's current ambulance fee schedule.

(11) The costs associated with releasing a client on the scene without transportation by ambulance to a medical facility are eligible for FFP and are eligible expenditures.

(12) Other expenses associated with the prehospital care are eligible costs associated with GEMT.

(13) Expenditures are not eligible costs until the services are provided.

NEW SECTION

WAC 182-546-0530 GEMT interim supplemental payment. (1) The agency pays an interim supplemental payment for GEMT. These payments using the interim supplemental payment allows the agency to pay participating providers for GEMT. The payments will approximate the GEMT costs eligible for federal financial participation claimed through the certified public expenditure (CPE) process.

(2) The agency computes the interim supplemental payment for GEMT on an annual basis.

(3) To determine the interim supplemental payment for GEMT, the agency uses the most recently filed cost reports of all participating providers to determine an average cost per qualifying transport. Therefore, the cost per participating provider and the amount of interim supplemental payments will vary among the participating providers.

(4) The agency distributes the interim supplemental payments to participating providers on a weekly basis using claims data as documented in the agency's claim system.

NEW SECTION

WAC 182-546-0535 GEMT cost reconciliation and settlement process. (1) The agency reconciles each interim supplemental payment for GEMT to the provider's filed cost report for the service year in which interim supplemental payments are made.

(2) The agency compares the total medicaid-allowable costs to the interim supplemental payments paid to the participating providers as documented in the agency's claim system, resulting in cost reconciliation.

(3) The agency performs cost settlements based on the final Centers for Medicare and Medicaid Services (CMS)-approved cost report schedules for all participating providers.

(a) The agency:

(i) Recovers from the participating provider the federal payments that exceed the participating provider's cost per qualifying transport; or

(ii) Pays the participating provider if the cost per transport exceeds the interim supplemental payment amount.

(b) If a participating provider disputes the reimbursement rate before there is an overpayment, the provider may appeal under WAC 182-502-0220.

(c) If a participating provider disputes the agency's determination that the participating provider has been overpaid, the participating provider may request a hearing under WAC 182-502-0230.

(4) The agency reports to the CMS any difference between the payments of federal funds made to the participating providers and the federal share of the qualifying expenditures and returns excess funds to CMS.

(5) Each participating provider must agree to reimburse the agency for the costs associated with administering the GEMT program. The costs are collected during the final reconciliation and settlement process and cannot be included as an expense in the participating provider's cost report.

NEW SECTION

WAC 182-546-0540 GEMT records maintenance. In addition to the health care record requirements in WAC 182-502-0020, GEMT participating providers must also maintain records of accounting procedures and practices that reflect all direct and indirect costs, of any nature, spent performing GEMT services.

NEW SECTION

WAC 182-546-0545 GEMT auditing. (1) Participating providers must follow the terms and conditions outlined in the agency's core provider agreement.

(2) The agency may conduct audit or investigation activities, as described under chapters 74.09 RCW and 182-502A WAC, to determine compliance with the rules and regulations of the core provider agreement, as well as of the GEMT program.

(3) If an audit or investigation is initiated, the participating provider must retain all original records and supporting documentation until the audit or investigation is completed and all issues are resolved, even if the period of retention extends beyond the required six-year period required under WAC 182-502-0020.