Washington State Health Care Authority

Ground Emergency Medical Transportation (GEMT) Program FAQs

Cost Reports and GEMT Annual Provider Participation Agreements (PPA)

When are PPAs due?

Providers no longer need to provide an updated Provider Participating Agreement (PPA) on a yearly basis. As long as providers have submitted their cost report by the set deadline and have submitted a signed Provider Participation Agreement form that was updated April 2022, the provider will continue to be enrolled in the program. HCA only needs written notice if providers wish to withdraw from the program.

When are cost reports due?

The cost report is due within five months after the state fiscal year closes. The state fiscal year closes June 30th, therefore, the cost report is due by November 30th. The cost report submitted on November 30th will cover the retrospective state fiscal year that closed five months prior to the current fiscal year.

Who is supposed to sign the PPA?

HCA requires that an individual with signature authority be the one to sign the GEMT Annual Provider Participation Agreement (i.e. the chief, battalion, or head of finance department). However, the contact information on the PPA should be the person HCA would contact if they have questions regarding documentation submissions (i.e. head of the billing department or administrative services).

How should I report capital expenditures on the cost report?

The Centers for Medicare and Medicaid Services (CMS) has provided guidance that straight line depreciation is the preferred method of accounting for capital expenditures.

When does the fiscal year begin and end?

The fiscal year begins July 1st of each year and ends June 30th of the consecutive year.

What is a Provider Statistics and Reimbursement (PS&R) report?

The Provider Statistics and Reimbursement report is a data report issued by HCA to GEMT providers to aid in the completion of the cost report. The information contained on the PS&R includes the number of transports performed during the fiscal year, the amounts your organization billed to Medicaid for the transports, the amounts Medicaid paid to your organization for the transports and the revenue paid to your organization from third party insurance carriers.

How do I use the PS&R?

The number of fee for service transports provided on the PS&R (column A of the PS&R) will be input onto Schedule 9 of the cost report, in the yellow highlighted box, titled, “MTS Transports by Transport Type,” under the fee for service column. The amounts Medicaid paid to your organization for the fee for service transports (column B) will

be input on Schedule 8 of the cost report in area A, titled, "WA Medicaid Fee For Service (FFS) Revenue from Transports."

Will my cost report be audited?

GEMT cost reports are reviewed by the program manager. The expenditures reported on the most recently submitted cost report will be compared to expenditures reported on your cost report submitted the year prior. Expenditures are compared line by line to identify audit risks or noticeable changes in expenditures. In cases where noticeable changes in expenditures from year to year are identified, a written explanation to support the expenditure will be required.

Pursuant to chapter 182-546 WAC, HCA does have the authority to conduct audit activities. Upon HCA discretion, a third-party auditor may be contracted to conduct a formal audit of the program. Providers will be notified of any audit activities.

Are performance based contracts allowable?

Under current federal regulations any contract that is performance based is not considered allowable. If your organization has a contract with a third party billing company where they are reimbursed for services based on a percentage of collections this is considered a performance based contact and would not be permissible. However, if the billing company is reimbursed on a fixed price, either on a per call basis or an overall cost, then any fixed cost contracts may be considered allowable.

Managed Care Intergovernmental Transfer (IGT)

When will I be asked to perform the next intergovernmental transfer?

The Centers for Medicare and Medicaid Services (CMS) approved the issuance of GEMT supplemental payment for the managed care transports performed during calendar year 2017. The GEMT providers performed a one-time intergovernmental transfer during the summer of 2019 to receive GEMT payment for managed care transports. Currently, GEMT providers are not required to perform an IGT to receive GEMT payment. The IGT requirement is subject to change based upon federal guidelines.

GEMT Settlements

What is the GEMT Interim Settlement process?

Approximately six months after cost reports are submitted, the interim settlement process will take place. The GEMT payments your fire department received during the fiscal year using your temporary average cost per transport will be reconciled with GEMT payments your agency would have received had your actual average cost per transport been used. If your fire department received higher GEMT payments using the temporary average cost per transport than you would have received had the actual average cost per transport been used, your fire department will be invoiced the difference. If your fire department received lower GEMT payment using the temporary average cost per transport than you would have received had the actual average cost per transport been used, your fire department will receive a lump sum, GEMT payment to bring you up to cost.

When should I expect the GEMT Interim Settlement process to happen?

The GEMT interim settlement process will take place approximately six months after cost reports are submitted.

What is the Final Settlement and Reconciliation process?

Approximately two-years after any given state fiscal year has closed, the corresponding cost report will be final settled and reconciled. For example, state fiscal year 2023 closed June 30, 2023, therefore cost report 2023 would be final settled reconciled June 30, 2025 or after. A two year waiting period is allotted to ensure all of the eligible GEMT claims are captured. The total GEMT payment your fire department would receive after the two-year waiting period will be calculated as a final settlement amount. The GEMT payment received by your fire department during the interim settlement process will be deducted from the final settlement amount determines if your fire department was overcompensated or under compensated. Lastly, the administrative fee due from your fire department for the fiscal year that is being closed will be calculated.

What is the GEMT administrative fee?

An administrative fee is invoiced to each participating GEMT provider to recover the costs to the Healthcare Authority for the administration and implementation of the program. The administrative fee will be assessed during the final settlement and reconciliation process. The Healthcare Authority's total cost to administer the program will be divided by the total number of fee-for-service transports performed by each participating GEMT provider; this will calculate the administrative fee per transport. The administrative fee per transport will be multiplied by the total number of fee for service transports your fire department performed during the fiscal year to calculate your administrative fee due.

GEMT Claims

How do we submit claims for Medicaid clients enrolled in a managed care plan?

Effective January 1, 2018, providers of emergency and non-emergency ambulance services will be required to submit claims as fee-for-service transportation claims through the ProviderOne system.

How do we submit claims when the client has other primary insurance?

Ambulance claims submitted for those individuals with TPL insurance (a third party insurer as primary) are still eligible for the GEMT supplemental payments. Any payments received from the TPL payer will be accounted for during the settlement process as another source of payment. HCA will cover the additional reimbursement, if applicable.

Would an inter-facility transfer claim be eligible for GEMT supplemental payment?

In most cases inter-facility transfers (IFT) would not be eligible for supplemental payments under the GEMT program because they are generally considered non-emergent. If an IFT transport is deemed an emergency then the claim would be eligible and providers would need to ensure the transport details were thoroughly documented.

What are timely filing billing practices?

GEMT claims must be submitted through the ProviderOne system for assignment of a transaction control number (TCN) within 365 days from any of the following:

- The date of service was furnished to the eligible client
- The date a final fair hearing decision is entered that impacts a particular claim

- The date a court orders HCA to cover services
- The date HCA certifies a client eligible under delayed certification criteria

HCA may grant exceptions to the timely filing limit when extenuating circumstances occur on a case by case basis.

GEMT Supplemental Payments

Are the GEMT supplemental payments considered a federal award that must be disclosed?

No. Based on an HCA determination, providers receiving supplemental payments under the GEMT program are considered to be contractors and not sub-recipients. As a result, supplemental payments are not required to be disclosed on schedule 16 of annual reports filed with the State Auditor's office.

Are transports provided to Medicare/Medicaid clients eligible for GEMT supplemental payment?

If a client has Medicare as their primary insurance then the transport claim would not be eligible for the GEMT supplemental payment. If Medicare claims are submitted with the A0999 SE line item, GEMT payment toward the line would be denied. Medicare claims should be submitted without the A0999 SE line item since both Medicare and GEMT are federally governed and funded programs. If a client has TPL insurance (i.e. Regence, Kaiser and Blue Cross) providers are to add the A0999 SE line item to their claim submission to both the TPL insurer and Medicaid.