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State/Territory Name: Washington

State Plan Amendment (SPA) #: 16-0005

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

July 11, 2017

MaryAnne Lindeblad, Medicaid Director
Health Care Authority
PO Box 45502
Olympia, WA 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 16-0005.

Dear Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number WA 16-0005. This amendment added the Ground Emergency Medical Transportation (GEMT) program as mandated by house bill 2007. The GEMT program provides supplemental payment to qualifying publicly owned or operated ground emergency transportation providers.

This SPA was approved by CMS on July 5, 2017, with an effective date of June 2, 2016.

If there are additional questions please contact me, or your staff may contact James Moreth at James.Moreth@cms.hhs.gov or (360) 943-0469.

Sincerely,

A black rectangular redaction box covering the handwritten signature of David L. Meacham.

Digitally signed by David L. Meacham
-S
DN: c=US, o=U.S. Government,
ou=HHS, ou=CMS, ou=People,
0.9.2342.19200300.100.1.1=20000418
58, cn=David L. Meacham -S
Date: 2017.07.11 14:46:37 -07'00'

David L. Meacham
Associate Regional Administrator

cc:
Ann Myers, SPA Coordinator

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:
16-0005

2. STATE
Washington

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
~~Jan. 1, 2016~~ ~~July 1, 2016 (P&I)~~ June 2, 2016 (P&I)

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 2016 \$4,728,000 ~~\$1,182,000 (P&I)~~ \$1,577,000 (P&I)

b. FFY 2017 \$4,674,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B pages 20b, 20c, 20d (all new)
20e, 20f (new) (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

10. SUBJECT OF AMENDMENT

Establishing the Ground Emergency Medical Transportation (GEMT) Program

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☒ OTHER, AS SPECIFIED: Exempt

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

MARYANNE LINDEBLAD

14. TITLE:

MEDICAID DIRECTOR

15. DATE SUBMITTED:

2/2/16

16. RETURN TO:

Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 02/02/16

18. DATE APPROVED: 07/05/17

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
06/02/16

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

David L. Meacham

22. TITLE:

Associate Regional Administrator

23. REMARKS:

6-1-16 - state authorized P&I to Box 4 and 7
6-9-16 - state authorized P&I change to Box 8
6-15-16 - state authorized P&I change to Box 4 and 7

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS

The Ground Emergency Medical Transportation (GEMT) program is a voluntary program that makes supplemental payments to eligible GEMT providers who furnish qualifying emergency ground ambulance services to Medicaid clients. The supplemental payments are funded using the certified public expenditures (CPE) payment method.

Using the CMS-approved cost report, eligible GEMT providers must certify to the State the total expenditures incurred for providing the GEMT services that will be used to determine the supplemental payments. The Agency makes supplemental payments only for the uncompensated and allowable direct and indirect costs incurred while providing GEMT services to Medicaid clients. The supplemental payment covers the gap between the provider's total allowable costs for providing GEMT services as reported on the CMS-approved cost report and the amount of the base payment, mileage, and all other sources of reimbursement.

The Agency makes supplemental payments only up to the amount uncompensated by all other sources of reimbursement. Total reimbursements from Medicaid including the supplemental payment do not exceed one hundred percent of actual costs.

The Agency does not consider these payments to be an individual increase to current FFS reimbursement rates.

The GEMT program must be implemented without any additional expenditure from the state general fund. As a condition of participation under this program, an eligible provider must agree to reimburse the Agency for any costs associated with implementing the GEMT program.

This supplemental payment applies only to GEMT services rendered to Washington Medicaid beneficiaries by eligible GEMT providers on or after June 2, 2016.

A. Definitions

1. "Agency" means the Washington State Health Care Authority.
2. "Advanced life support (ALS)" means special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.
3. "Allowable costs" means an expenditure which meets the test of the appropriate Executive Office of the President of the United States' Office of Management and Budget Circular (OMB).
4. "Basic life support (BLS)" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.
5. "Cognizant agency" is the Federal agency with the largest dollar value of direct Federal awards with a governmental unit or component.

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SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

- 6.. "Cost Allocation Plan (CAP)" is 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, on the basis of relative benefits received. For GEMT purposes, the fire departments/districts must use their local government's approved CAP.
7. Direct costs" are those costs that are identified by 45 CFR 75.413 that:
 - 1) Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; or
 - 2) Can be directly assigned to such activities relatively easily with a high degree of accuracy.
8. "Direct federal award" means an award that is being paid directly from the federal government. GEMT is not a direct award as it is being paid through the Washington State Health Care Authority or the agency.
9. "Dry run" means GEMT services (basic, limited-advanced, and advanced life support services) provided by an eligible GEMT provider to an individual who is released on the scene without transportation by ambulance to a medical facility.
10. "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 in accordance with the State Plan for medical assistance. Clients under Title XIX are eligible for FFP.
11. "GEMT Services" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced, and basic life support services provided to an individual by GEMT providers before or during the act of transportation.
12. "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.
13. "Limited advanced life support" means special services to provide prehospital emergency medical care limited to techniques and procedures that exceed basic life support but are less than advanced life support services.
14. "Publicly owned or operated" means a unit of government which is a state, a city, a county, a 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 Section 4 of the Indian Self-Determination and Education Assistance Act.
15. "Service period" means July 1 through June 30 of each Washington State fiscal year.

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16. "Shift" means a standard period of time assigned for a complete cycle of work, as set by each eligible GEMT provider. The number of hours in a shift may vary by GEMT provider, but will be consistent to each GEMT provider.
- B. To qualify for supplemental payments, GEMT providers must meet all of the following:
1. Be enrolled as a Medicaid provider for the period being claimed on their annual cost report.
 2. Provide ground emergency medical transport services to Medicaid enrollees.
 3. Be organizations owned or operated by the state, 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.
- C. Supplemental Reimbursement Methodology – General Provisions
1. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and OMB Circular A-87, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.
 2. Medicaid base payments to the GEMT providers for providing GEMT services are derived from the ground ambulance fee-for-service (FFS) fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursements is the Washington Medicaid Management Information System (MMIS) also called ProviderOne. The number of paid Medicaid FFS GEMT transports is derived from and supported by the ProviderOne reports for services during the applicable service period.
 3. The total uncompensated care costs of each eligible GEMT provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible GEMT provider providing GEMT services to Washington Medicaid beneficiaries, net of the amounts received and payable from the Washington Medicaid program and all other sources of reimbursement for such services provided to Washington Medicaid beneficiaries. If the eligible GEMT providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

D. Cost Determination Protocols

1. An eligible GEMT provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.
2. Direct costs for providing medical transport services include only the unallocated payroll costs for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.

3. Indirect costs

A. Fire Departments/Districts which are direct recipients of federal awards

- i. Fire departments/districts that receive more than \$35 million in direct federal awards must either have a Cost Allocation Plan (CAP) or a cognizant agency approved indirect rate agreement in place with its federal cognizant agency to identify indirect cost. If the fire department/district does not have a CAP or an indirect rate agreement in place with its federal cognizant agency and it would like to claim indirect cost in association with a non-institutional service, it must obtain one or the other before it can claim any indirect cost.
- ii. Fire departments/ districts that receive less than \$35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of audit. In the absence of an indirect rate proposal, fire departments/districts may use methods originating from a CAP to identify its indirect cost. If the fire department does not have an indirect rate proposal on file or a CAP in place and it would like to claim indirect cost in association with a non-institutional service, it must secure one or the other before it can claim any indirect cost.

B. Fire Departments/Districts which receive \$0 federal award

- i. Fire departments/districts which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
 - A CAP with its local government
 - An indirect rate negotiated with its local government
 - Direct identification through use of a cost report

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SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY-OWNED OR OPERATED GROUND EMERGENCY MEDICAL TRANSPORTATION (GEMT) PROVIDERS (CONT)

- ii. If the fire department/districts never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.
4. Cost incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect cost. Essentially, any cost incurred by a fire department/district which includes both cost incurred applicable to firefighting as well Emergency Medical Transportation (EMT) services must be consistently direct or indirect in its entirety.
5. The GEMT provider-specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs of the specific provider by the total number of medical transports provided by the provider for the applicable service period.
6. "Dry run" as defined in Section A is a covered service. Costs applicable to EMT services that do not result in a transport should be included in the total allowable costs.

E. Interim Supplemental Payment

1. Each eligible GEMT provider must compute the annual cost in accordance with the Cost Determination Protocols (Section D) and must submit the completed annual as-filed cost report, to the Agency within five (5) months after the close of the State's Fiscal Year (SFY).
2. The Agency will make annual interim supplemental payments to eligible GEMT providers. The interim supplemental payments for each provider is based on the provider's completed annual cost report in the format prescribed by the Agency and approved by CMS for the applicable cost reporting year.
3. To determine the interim GEMT payment rate, the Agency must use the most recently filed cost reports of all qualifying providers. The Agency will then determine an average cost per transport which will vary between the qualifying providers.

F. Cost Settlement Process

1. The GEMT Washington Medicaid payments and the number of transport data reported in the as-filed cost report will be reconciled to the ProviderOne reports generated for the cost reporting period within two (2) years of receipt of the as-filed cost report. The Agency will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved ProviderOne report.
2. Each provider will receive payments in an amount equal to the greater of the interim payment or the total CMS-approved Medicaid-allowable costs for GEMT services.

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3. If, at the end of the final reconciliation, it is determined that the GEMT provider has been overpaid, the provider will return the overpayment to the Agency and the Agency will return the overpayment to the federal government pursuant to section 433.316 of Title 42 of the Code of Federal Regulations. If an underpayment is determined, then the GEMT provider will receive a supplemental payment in the amount of the underpayment

G. Eligible GEMT Provider Reporting Requirements

A GEMT-eligible provider must:

1. Report and certify total computable allowable costs annually on an Agency- and CMS-approved cost report. Eligible providers will submit cost reports no later than five (5) months after the close of the SFY, unless a provider has made a written request for an extension and such request is granted by the Agency.
2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination as specified by the Agency.
3. Keep, maintain, and have readily retrievable, such records as specified by the Agency to fully disclose reimbursement amounts to which the eligible governmental entity is entitled, and any other records required by CMS.
4. Comply with the allowable cost requirements provided in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87, and Medicaid non-institutional reimbursement policy.

E. Agency Responsibilities

1. The Agency will submit to CMS claims based on total computable certified expenditures for GEMT services provided, that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.
2. The Agency will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims will include only those expenditures that are allowable under federal law.
3. The Agency will complete the audit and reconciliation process of the interim payments for the service period within three years of the postmark date of the cost report and conduct on-site audits as necessary.