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State/Territory Name: WI

State Plan Amendment (SPA) #: 23-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

01/14/2025

William Hannah
Medicaid Director
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

Dear Director Hannah,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wisconsin State Plan Amendment (SPA) to Attachment 4.19-B TN: #23-0002, which was submitted to CMS on March 29, 2023. This plan amendment proposes implement a supplemental payment program for GEMT providers.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or via email at matthew.klein@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0002

2. STATE: WI

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/23

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. Sec. 433.50.

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 20,822,518
b. FFY 2024 $ 41,936,066

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19b
Page 16.h-15.d, e, f, g, and h

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19b - NEW

9. SUBJECT OF AMENDMENT

Ground Emergency Medical Transportation (GEMT) Reimbursement Program

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED: [redacted]

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Jamie Kuhn

13. TITLE
Medicaid Director

14. DATE SUBMITTED
03/29/23

15. RETURN TO
Bailey Dvorak
State Plan Amendment Coordinator
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR CMS USE ONLY

16. DATE RECEIVED
03/29/2023

17. DATE APPROVED
January 14, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
01/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

45-a. Ground Emergency Medical Transportation (GEMT) Reimbursement Program

(a) Reimbursement rates for Emergency Service providers are outlined in Attachment 4.19- B.

(b) SUPPLEMENTAL PAYMENT FOR GROUND EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

Effective January 1, 2023, Ground Emergency Medical Transportation (GEMT) providers that meet the specified requirements outlined in Section 3(c) below and provide ground emergency transportation services to Medicaid recipients as defined in Attachment 3.1A, will be eligible for a supplemental payment. This supplemental payment applies to Emergency Transportation Services rendered to Medicaid recipients by eligible GEMT providers on or after January 1, 2023. The GEMT Reimbursement Program is a voluntary program, and GEMT providers are not required to participate. The approval of the GEMT Reimbursement Program will render 25a. Reimbursement to Local Governments for Emergency Ambulance Services under Attachment 4.19-B concluded as of January 1, 2023.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to GEMT providers in accordance with Attachment 4.19-B, that eligible entities receive for GEMT services rendered to eligible Medicaid recipients. Total reimbursements under the GEMT program are capped (including supplemental payments) at one hundred percent of actual costs. The Wisconsin Department of Health Services (the Department) will recognize a supplemental payment equal to the total allowable Medicaid costs of eligible GEMT services for providing services as set forth below.

(c) To qualify for supplemental payments, providers must meet all of the following:

1. Provides Ground Emergency Medical Transportation services to Wisconsin Medicaid members.

2. Is a provider that is enrolled as a Wisconsin Medicaid provider for the period being claimed.

3. Is owned or operated by an eligible governmental entity, to include 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.

Providers meeting all these qualifications will be considered “Eligible Providers.”

(d) 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), applicable CMS reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.

2. The total Medicaid shortfall will be equal to the difference between the actual Medicaid allowable costs and the state plan reimbursement for Medicaid services. Each Eligible Provider's Medicaid shortfall available to be reimbursed under this supplemental reimbursement program will equal the difference between the allowable costs determined using the Cost Determination Protocols for each Eligible Provider providing GEMT to Wisconsin Medicaid recipients, net of the amounts received and payable from the Wisconsin Medicaid program and all other sources of reimbursement for such services provided to Wisconsin Medicaid recipients.

(e) Cost Determination Protocols

1. An Eligible Provider's specific allowable cost per-GEMT service rate will be calculated based on the provider's financial data reported on the state-approved cost report. The per-GEMT service cost rate will be the sum of actual allowable direct and indirect costs of providing GEMT services divided by the actual number of GEMT services provided for the applicable service period.
    a. The cost report will include Direct Cost consistent with 2 CFR 200.413 and 2 CFR 200.405 which may include costs such as ambulance depreciation, salaries and benefits of paramedics and Emergency Medical Technicians (EMTs) providing GEMT services and medical supplies utilized in the delivery of GEMT services. Direct cost centers which support GEMT in addition to one or more non-GEMT functions, must be allocated.
        i. Direct costs can be reported if discretely tracked to GEMT services and otherwise in alignment with the definition of Direct Cost in 200.413. Unlike indirect costs as defined in 45 C.F.R. § 75.2, all direct costs must be readily assignable to GEMT, without effort disproportionate to the results achieved.
        ii. The cost of personnel providing GEMT in addition to other programs and services can be allocated based on a percentage of total hours logged performing GEMT activities versus activities identified with other cost objectives.
    b. The costs and related basis used to determine the allocated indirect costs must

be in compliance with Medicaid cost principles specified within 2. C.F.R. Part 200. Indirect costs are determined in one of two ways:

i. GEMT providers with a federally approved indirect cost rate will be required to apply the cognizant agency specific approved indirect cost rate to their total direct costs (Paragraph e.1.a)

ii. GEMT providers that do not have a cognizant agency specific approved indirect cost rate can identify indirect costs by applying the prevailing de minimis rate for the applicable service period to their total direct costs (Paragraph e.1.a).

c. All costs associated with a direct service cost objective other than GEMT that are readily assignable to the cost objectives specifically benefitted will be unallowable.

d. The provider specific per-GEMT service cost rate is calculated by dividing the total net GEMT services allowable costs (Paragraph e.1.a and e.1.b) of the specified provider by the total number of GEMT services provided by the provider for the applicable service period.

(f) Cost Settlement Process

1. The payments and the number of GEMT services reported in the as-filed cost report will be reconciled with the Department's Medicaid Management Information System (MMIS) reports generated for the cost reporting period within twelve months of the cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

2. Each Eligible Provider will receive an annual lump sum payment in an amount equal to the total of the Medicaid shortfall as defined in the above Supplemental Reimbursement Methodology – General Provisions Section 3(d)(2).

1. The Department will perform a final reconciliation where it will settle the Eligible Provider's annual cost report as reviewed. The Department will compute the net GEMT allowable costs using DHS-reviewed per-GEMT cost, and the number of fee-for-service GEMT services reflected in the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, settlement payments made, and any other source of reimbursement received by the Eligible Provider for the period for applicable Medicaid services. If, at the end of the final reconciliation, it is determined that the Eligible Provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the Eligible Provider will receive a final supplemental payment in the amount of the underpayment.

(g) Eligible Provider Reporting Requirements

1. The reporting period will be based on a Calendar Year (CY) spanning January to December. Cost reports are due no later than six months after the last day of the Calendar Year. A request for an extension shall only be approved when a provider's operations are significantly and/or adversely affected due to extraordinary circumstances, of which the provider has no control, such as flood or fire. The written request must include a detailed explanation of the circumstances supporting the need for additional time and be postmarked within six months after the last day of the applicable State Fiscal Year. Filing extensions may be granted by the Department for good cause, but such extensions are made at the discretion of the Department.

2. Only cost reports from Eligible Providers as defined in Section 3(c) will be accepted.

3. Participating Eligible Providers who meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with 3(c) through 3(f) for services provided on or after January 1, 2023.

    a. Eligible Providers will be paid interim rates equal to the Medicaid reimbursement rates paid to other GEMT providers in accordance with Attachment 4.19-B. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

    b. Eligible Providers will submit a state approved cost report annually, on a form approved by the Department.

    c. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
        i. "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 transportation service 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.
        ii. "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.

d. Eligible Provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio. The Medicaid utilization statistic ratio is based on paid GEMT claims based on billing data associated with the dates of service covered by the submitted cost report.