Washington State GEMT Summary

Washington State’s EMS delivery system is recognized as among the finest in the world. The statewide system provides outstanding service to all of the State’s population regardless of a patient’s ability to pay. The emergency transportation system is a vital component and considered an integral part of the State’s safety net of healthcare services. Washington is an active participant within the Federal Medicaid system and provides those services through the statewide “Apple Health” program. The reimbursement rate for emergency care and transport of Apple Health beneficiaries is far below the actual cost of providing those services. The base reimbursement rate provided for Apple Health transports is $115.00 for BLS and $168.00 ALS transport. These rates are far below the actual cost of providing the transport for both public and private providers. In 2007 the Federal GAO estimated the nationwide cost fell between the average of $415 and $1215 per transport. With the increase in supplies, benefits, fuel and operations these costs are much higher today.

As an active participant in the Federal Medicaid program, Washington enjoys the benefits of that relationship and the additional cost sharing that goes along with it. Within the current State Plan, Washington’s public hospitals participate in a Certified Public Expenditure program “WAC 182-550-4650” that has been in effect since 1996. This program allows public hospitals and programs to seek additional Federal Medicaid dollars to offset the cost of providing services that are not fully covered under the current Apple Health rate schedule. Although this program will not cover the entire cost of providing ambulance services, it will reimburse up to 50% of the uncompensated cost.

This Bill will provide the enabling legislation needed to create a State Plan Amendment “SPA” which will allow Washington’s public ambulance providers to;

- Participate in the authorized CPE program that is currently providing assistance for Washington’s public hospitals.
- Create an ambulance provider cost report for approval by CMS for determining the reimbursement rate.
- Include a provision for development of an Intergovernmental Transfer program or IGT that will allow further reimbursement of Apple Health Managed Care/HMO providers.
- **Stipulate that all the associated costs with this program will be done with no impact to the State General Fund, the State or the Apple Health program.**
- Include a mechanism in the IGT portion of the bill that will create with the approval of CMS a State Administration Fee that will not exceed 20% of the amount submitted for the transfer of funds.
- Insure no additional cost to local government.
- Include the federally recognized 638 Indian tribes.

**Your support will provide:**

- **Over $100 million dollars in new money to public safety!**
- **More than $20 million in new revenue to the Washington General fund!**
- **At no cost to the state or taxpayer!**
GEMT Medicaid Calculations

The following calculations demonstrate the financial impact on several counties in the State of Washington from the GEMT legislation. The calculations do not include private ambulance in these counties. By using the population in these three counties we extrapolated the potential financial impact on the State. The three counties of Pierce, Skagit and Whatcom are typical of counties throughout the State.

These calculations utilized information from fire departments and public EMS agencies. Using the Kaiser Family Foundation and Washington State Medicaid websites we were able to gain the information necessary to establish the averages used to develop the GEMT financial impacts. The Kaiser Family Foundation website states 20% of patients in Washington State are Medicaid Patients. The Washington State Medicaid website states of those, 20% are fee for service and 80% are managed care. The calculations below include the Certified Public Expenditure (CPE), the Inter-Governmental Transfer (IGT) and the Pre Hospital Stabilization (PHS).

To Calculate the CPE for the counties we determine:
- The percentage of Fee For Service (FFS) patients
- The cost of the transport
- The number of transports
- The reimbursed monies from Medicaid
- The State percentage reimbursable

Next we:
- We multiply the number of CPE qualified transports by the cost of the transports
- Subtract the money paid from Medicaid
- Multiply this uncompensated portion by 50% allowable to determine the CPE supplemental amount

To Calculate IGT for the counties we determine:
- The number of Managed Care Patients (MCP)
- The agency charge for transports

Next we:
- Multiply the calculated charge per transport by the number of MCP transports

To Calculate the PHS for the counties we determine:
- The number of calls the engine responds with EMT’s and Paramedics with and without an ambulance crew.
- Cost of response
- Calculate the CPE same as above
- Calculate the IGT same as above
In order to estimate the potential financial impact on the entire state we used the 2013 population figures. Using these figures we established the potential financial impact for the counties and estimated the financial impact for all state EMS agencies. These counties make up nearly 17% of the population of Washington State.

<table>
<thead>
<tr>
<th>Population</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Washington State</td>
<td>7,000,000</td>
</tr>
<tr>
<td>Population of Pierce County</td>
<td>819,743</td>
</tr>
<tr>
<td>Population of Whatcom County</td>
<td>206,353</td>
</tr>
<tr>
<td>Population of Skagit County</td>
<td>118,837</td>
</tr>
</tbody>
</table>

**Revenue for CPE, IGT and PHS**

**Pierce County**
- Transports 2014: 37,560
- CPE Pierce County Portion: $313,127.00
- IGT Pierce County Portion: $8,726,000.00
- PHS Pierce County Portion: $5,209,538.00
- Total CPE, IGT and PHS Pierce County: $14,248,665.00

**Whatcom County**
- Transports: 11,257
- CPE Whatcom County Portion: $93,847.00
- IGT Whatcom County Portion: $2,248,157.00
- PHS Whatcom County Portion: $1,561,405.00
- Total CPE, IGT and PHS Whatcom County: $3,803,409.00
Skagit County
Transports 2012 7481

CPE Skagit County Portion $62,367.00

IGT Skagit County Portion $1,494,000.00

PHS Skagit County Portion $1,561,405.00

Total CPE, IGT and PHS Skagit County $3,117,772.00

Potential new revenue for the three counties $21,269,846.00

Extrapolated potential revenue utilizing population figures

Washington State EMS Agencies $130,983,920.00

Revenue to State $24,420,484.00
Pierce County estimate - Conservative

**EXAMPLE:**

<table>
<thead>
<tr>
<th>CPE portion (fee for svc)</th>
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</thead>
<tbody>
<tr>
<td>37,560</td>
</tr>
<tr>
<td>Total Transports</td>
</tr>
<tr>
<td>22%</td>
</tr>
<tr>
<td>Percentage of total transports that are Medicaid</td>
</tr>
<tr>
<td>8,263</td>
</tr>
<tr>
<td>20% Medicaid demographic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IGT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>88%</td>
</tr>
<tr>
<td>% of Medicaid are managed care (IGT)</td>
</tr>
<tr>
<td>7,272</td>
</tr>
<tr>
<td># managed care (IGT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
</tr>
<tr>
<td>% of fee for svc (CPE)</td>
</tr>
<tr>
<td>992</td>
</tr>
<tr>
<td># of fee for svc (CPE)</td>
</tr>
<tr>
<td>168.43</td>
</tr>
<tr>
<td>Current Rate - Medicaid 168.43 / transport</td>
</tr>
<tr>
<td>$ 167,012</td>
</tr>
<tr>
<td>Total Rev Collected for fee for svc Medicaid Transports</td>
</tr>
</tbody>
</table>

**Gross Reimbursement Eligible TOTAL:**

<table>
<thead>
<tr>
<th># of fee for svc (CPE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>992</td>
</tr>
<tr>
<td>CPE reimbursable rate - applies to fee for svc transports, use $1200</td>
</tr>
<tr>
<td>(the actual rate will be determined at the state level as a range, will include indirect costs)</td>
</tr>
<tr>
<td>800</td>
</tr>
<tr>
<td>CPE Gross amount eligible for reimbursement</td>
</tr>
<tr>
<td>793,267</td>
</tr>
</tbody>
</table>

**Uncompensated Portion Eligible for Reimbursement:**

<table>
<thead>
<tr>
<th>Less compensation already received</th>
</tr>
</thead>
<tbody>
<tr>
<td>(167,012)</td>
</tr>
<tr>
<td>Uncompensated portion</td>
</tr>
<tr>
<td>626,255</td>
</tr>
</tbody>
</table>

**Reimbursement:**

<table>
<thead>
<tr>
<th>% Reimbursable in WA/OR (of uncompensated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
</tr>
<tr>
<td>ADDITIONAL REVENUE DUE TO CPE - Uncompensated costs of fee for svc is refundable (in Wash)</td>
</tr>
<tr>
<td>313,127.35</td>
</tr>
</tbody>
</table>
EXAMPLE: IGT (managed care portion)

37,560  Total Transports
22%  Percentage of total transports that are Medicaid

8,263  20% Medicaid demographic

IGT:  88%  % of Medicaid are managed care (IGT)

7,272  # managed care (IGT)

Gross Reimbursement Eligible TOTAL:

7,272  80% of Medicaid are managed care
IGT Reimbursement rate (also a state range of rates) of
cost, this rate includes indirect costs as well

1,200

8,725,939  IGT Gross amount eligible for Reimbursement
AN ACT Relating to reimbursement to eligible providers for medicaid ground emergency medical transportation services; and adding new sections to chapter 41.05 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. A new section is added to chapter 41.05 RCW to read as follows:

(1) An eligible provider, as described in subsection (2) of this section, must, in addition to the rate of payment that the provider would otherwise receive for medicaid ground emergency medical transportation services, receive supplemental medicaid reimbursement to the extent provided by law.

(2) A provider is eligible for supplemental reimbursement only if the provider has all of the following characteristics continuously during a state fiscal year:

(a) Provides ground emergency medical transportation services to medicaid beneficiaries;

(b) Is a provider that is enrolled as a medicaid provider for the period being claimed;

(c) 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;

(3) An eligible provider's supplemental reimbursement pursuant to this section must be calculated and paid as follows:

(a) The supplemental reimbursement to an eligible provider, as described in subsection (2) of this section, must be equal to the amount of federal financial participation received as a result of the claims submitted pursuant to subsection (6)(b) of this section;

(b) In no instance may the amount certified pursuant to subsection (5)(a) of this section, when combined with the amount received from all other sources of reimbursement from the medicaid program, exceed one hundred percent of actual costs, as determined pursuant to the medicaid state plan, for ground emergency medical transportation services;

(c) The supplemental medicaid reimbursement provided by this section must be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to medicaid beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The authority shall obtain approval from the federal centers for medicare and medicaid services for the payment methodology to be utilized, and may not make any payment pursuant to this section prior to obtaining that approval.

(4)(a) It is the legislature's intent in enacting this section to provide the supplemental reimbursement described in this section without any expenditure from the general fund. An eligible provider, as a condition of receiving supplemental reimbursement pursuant to this section, shall enter into, and maintain, an agreement with the authority for the purposes of implementing this section and reimbursing the department for the costs of administering this section.

(b) The nonfederal share of the supplemental reimbursement submitted to the federal centers for medicare and medicaid services for purposes of claiming federal financial participation shall be paid only with funds from the governmental entities described in subsection (2)(c) of this section and certified to the state as provided in subsection (5) of this section.

(5) Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this
section on behalf of an eligible provider owned or operated by the
text, as described in subsection (2)(c) of this section, the
governmental entity shall do all of the following:

(a) Certify, in conformity with the requirements of 42 C.F.R.
Sec. 433.51, that the claimed expenditures for the ground emergency
medical transportation services are eligible for federal financial
participation;

(b) Provide evidence supporting the certification as specified by
the department;

(c) Submit data as specified by the department to determine the
appropriate amounts to claim as expenditures qualifying for federal
financial participation;

(d) Keep, maintain, and have readily retrievable, any records
specified by the department to fully disclose reimbursement amounts
to which the eligible provider is entitled, and any other records
required by the federal centers for medicare and medicaid services.

(6) The department shall promptly seek any necessary federal
approvals for the implementation of this section. The department may
limit the program to those costs that are allowable expenditures
under Title XIX of the federal social security act (42 U.S.C. Sec.
1396 et seq.). If federal approval is not obtained for implementation
of this section, this section may not be implemented.

(a) The department shall submit claims for federal financial
participation for the expenditures for the services described in
subsection (5) of this section that are allowable expenditures under
federal law.

(b) The department shall, on an annual basis, submit any
necessary materials to the federal government to provide assurances
that claims for federal financial participation will include only
those expenditures that are allowable under federal law.

(7) If either a final judicial determination is made by any court
of appellate jurisdiction or a final determination is made by the
administrator of the federal centers for medicare and medicaid
services that the supplemental reimbursement provided for in this
section must be made to any provider not described in this section,
the director shall execute a declaration stating that the
determination has been made and on that date this section becomes
inoperative.
NEW SECTION.  Sec. 2. A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority shall design and implement, in consultation with eligible providers as described in subsection (2) of this section, an intergovernmental transfer program relating to medicaid managed care, ground emergency medical transport services including those services provided by emergency medical technicians at the basic, advanced, and paramedic levels in the prestabilization and preparation for transport in order to increase capitation payments for the purpose of increasing reimbursement to eligible providers.

(2) A provider is eligible for increased reimbursement pursuant to this section only if the provider meets both of the following conditions in an applicable state fiscal year:

(a) Provides ground emergency medical transport services to medicaid managed care enrollees pursuant to a contract or other arrangement with a medicaid managed care plan.

(b) Is owned or operated by the state, a city, county, fire protection district, special district, community services district, health care district, federally recognized Indian tribe or unit of government as defined in 42 C.F.R. Sec. 433.50.

(3) To the extent intergovernmental transfers are voluntarily made by, and accepted from, an eligible provider described in subsection (2) of this section, or a governmental entity affiliated with an eligible provider, the department shall make increased capitation payments to applicable medicaid managed care plans for covered ground emergency medical transportation services.

(a) The increased capitation payments made pursuant to this section must be in amounts at least actuarially equivalent to the supplemental fee-for-service payments available for eligible providers to the extent permissible under federal law.

(b) Except as provided in subsection (6) of this section, all funds associated with intergovernmental transfers made and accepted pursuant to this section must be used to fund additional payments to eligible providers.

(c) Medicaid managed care plans shall pay one hundred percent of any amount of increased capitation payments made pursuant to this section to eligible providers for providing and making available ground emergency medical transportation and paramedical services pursuant to a contract or other arrangement with a medicaid managed care plan.
(4) The intergovernmental transfer program developed pursuant to this section must be implemented on the date federal approval was obtained, and only to the extent intergovernmental transfers from the eligible provider, or the governmental entity with which it is affiliated, are provided for this purpose. To the extent permitted by federal law, the department may implement the intergovernmental transfer program and increased capitation payments pursuant to this section on a retroactive basis as needed.

(5) Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for purposes of all applicable federal laws.

(6) This section must be implemented without any additional expenditure from the state general fund. As a condition of participation under this section, each eligible provider as described in subsection (2) of this section, or the governmental entity affiliated with an eligible provider, shall agree to reimburse the department for any costs associated with implementing this section. Intergovernmental transfers described in this section are subject to a twenty percent administration fee of the nonfederal share paid to the department and is allowed to count as a cost of providing the services.

(7) As a condition of participation under this section, medicaid managed care plans, eligible providers as described in subsection (2) of this section, and governmental entities affiliated with eligible providers shall agree to comply with any requests for information or similar data requirements imposed by the department for purposes of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

(8) This section must be implemented only if and to the extent federal financial participation is available and is not otherwise jeopardized, and any necessary federal approvals have been obtained.

(9) To the extent that the director determines that the payments made pursuant to this section do not comply with federal medicaid requirements, the director retains the discretion to return or not accept an intergovernmental transfer, and may adjust payments pursuant to this section as necessary to comply with federal medicaid requirements.
(10) To the extent federal approval is obtained, the increased capitation payments under this section may commence for dates of service on or after January 1, 2015.