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State/Territory Name: Oregon

State Plan Amendment (SPA) #: 17-0010

This file contains the following documents in the order listed:

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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

April 26, 2018

Patrick Allen, Director
Oregon Health Authority
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1079

RE: Oregon State Plan Amendment (SPA) Transmittal Number 17-0010

Dear Mr. Allen:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Oregon State Plan Amendment (SPA) Transmittal Number 17-0010. This SPA creates the Ground Emergency Medical Transportation (GEMT) program. This SPA is approved effective July 1, 2017, as requested by the state.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Bill Vehrs at bill.vehrs@cms.hhs.gov or (503) 399-5682.

Sincerely,

David L. Meacham
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **17-0010**

2. STATE: Oregon

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

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

4. PROPOSED EFFECTIVE DATE: 7/1/17

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:
42 CFR 431.53, 440.170

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 ~~$ 4,000,000~~ $16,000,000 (P&I)
b. FFY 2019 $ 16,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 31- 39 (new)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to establish the Ground Emergency Medical Transportation (GEMT) program.

11. 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: The Governor does not wish to review any plan materials.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME David Simnitt

14. TITLE: Interim State Medicaid Director, OHA

15. DATE SUBMITTED: 9/26/17

16. RETURN TO:
Oregon Health Authority
Medical Assistance Programs
500 Summer Street NE E-65
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/26/17

18. DATE APPROVED: **4/26/18**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/17

20. SIGNATU
Digitally signed by David L. Meacham -S

21. TYPED NAME: David L. Meacham

22. TITLE: Associate Re ional Administrator

23. REMARKS:

2/8/18-State authorized P&I change to #7

Supplemental reimbursement for qualifying ground emergency medical transportation service providers.

The Ground Emergency Medical Transportation (GEMT) program is a voluntary program that makes supplemental payments to Eligible GEMT Providers who furnish qualifying emergency ambulance services to Oregon Health Authority (OHA) Medicaid recipients.
OHA makes supplemental payments only for the uncompensated and allowable direct and indirect costs incurred while providing GEMT services to its Medicaid recipients. The supplemental payment covers the gap between the Eligible GEMT Provider's total allowable costs for providing GEMT services as reported on the Centers for Medicare and Medicaid Services (CMS) approved cost report and the amount of the base payment, mileage, and all other sources of reimbursement.

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

The supplemental payments will be made at least annually on a lump-sum basis after the conclusion of each state fiscal year. These payments are not an increase to current fee-for-service (FFS) reimbursement rates.

This supplemental payment applies only to GEMT services rendered to OHA FFS Medicaid recipients by Eligible GEMT Providers on or after July 1, 2017**.**

A. Definitions

1. "Agency" means the Oregon Health Authority (OHA).

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2. "Advanced life support" 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" means emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

5. "Contracts with a local government" means contracts with a city, county, or local service district, including, but not limited to a rural fire protection district, and all administrative subdivisions of such city, county, or local service district, pursuant to a county plan for ambulance and emergency medical services that has been approved by the Oregon Health Authority.

6. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet emergency medical transportation requirements. This includes unallocated payroll costs for the shifts of personnel, medical equipment and supplies, professional and contracted services, travel, training, and other costs directly related to the delivery of covered medical transport services.

7. "Dry run" means EMT 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.

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8. "Eligible GEMT Provider" means a GEMT provider that meets all of the eligibility requirements described in [Section B] below.

9. "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.

10. "GEMT Services" means the act of transporting an individual by ground 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 Eligible GEMT Providers before or during the act of transportation.

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

12. "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.

13. "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.

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14. "Service period" means July 1 through June 30 of each Oregon state fiscal year (SFY).

15. "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. GEMT Provider Eligibility Requirements

To be eligible for supplemental payments, GEMT providers must meet all of the following requirements:

1. Be enrolled as an Oregon Health Plan Medicaid provider for the period being claimed on their annual cost report;

2. Provide ground emergency medical transport services to Medicaid recipients; and

3. Be an organization that:
   a. Is publicly owned or operated; or
   b. Contracts with a local government, as defined in [Section A].

C. Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 C.F.R. Part 200, 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.

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2. Medicaid base payments to the Eligible GEMT Providers for providing GEMT services are derived from the ambulance 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 Oregon Medicaid Management Information System (MMIS). The number of paid Medicaid FFS GEMT transports is derived from and supported by the MMIS 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 Oregon Medicaid beneficiaries, net of the amounts received and payable from the Oregon Medicaid program and all other sources of reimbursement for such services provided to Oregon 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. Total reimbursement from Medicaid must not exceed one hundred percent of actual cost of providing services to Oregon Medicaid beneficiaries.

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.

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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 are determined in accordance to one of the following options.

   a. Eligible GEMT Providers 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 Eligible GEMT Provider 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.

   b. Eligible GEMT Providers 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, Eligible GEMT Providers may use methods originating from a CAP to identify its indirect cost. If the Eligible GEMT Provider 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.

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c. Eligible GEMT Providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:
   i. A CAP with its local government
   ii. An indirect rate negotiated with its local government
   iii. Direct identification through use of a cost report

d. If the Eligible GEMT Provider 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. 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.

5. "Dry run" as defined in [Section A] is a covered service and the costs associated with a dry run should be included in the total allowable costs and counted as an allowable medical transport.

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 OHA within five (5) months after the close of the State's Fiscal Year.

2. OHA will make annual interim supplemental payments to Eligible GEMT Providers. The interim supplemental payments for each Eligible GEMT Provider is based on the provider's completed annual cost report in the format prescribed by OHA and approved by CMS for the applicable cost reporting year.

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3. To determine the interim supplemental GEMT payment rate, OHA must use the most recently filed cost reports of all Eligible GEMT Providers to determine the average cost per transport, which will vary between the providers.

F. Cost Settlement Process

1. The payments and the number of transport data reported in the as-filed cost report will be reconciled to the OHA MMIS reports generated for the cost reporting period within **1** year of receipt of the as-filed cost report. OHA will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

2. Each Eligible GEMT 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.
3. OHA will perform a final reconciliation where it will settle the provider's annual cost report as audited within the following calendar quarter. OHA will compute the net GEMT allowable costs using audited per-medical transport cost, and the number of fee-for-service GEMT transports data from the updated MMIS reports. Actual net allowable costs will be compared to the total base and interim supplemental payment and settlement payments made, and any other source of reimbursement received by the provider for the period.

   If, at the end of the final reconciliation, it is determined that the Eligible GEMT Provider has been overpaid, the provider will return the overpayment to OHA and OHA 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 Eligible GEMT Provider will receive an interim supplemental payment in the amount of the underpayment.

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G. Eligible GEMT Provider Reporting Requirements

1. Submit CMS approved cost reports to OHA no later than five (5) months after the close of the SFY, unless the Eligible GEMT Provider has made a written request for an extension and such request is granted by OHA.

2. Provide supporting documentation to serve as evidence supporting information on the cost report and the cost determination.

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3. Keep, maintain, and have readily retrievable, such records to fully disclose reimbursement amounts to which the Eligible GEMT Provider 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, 2 CFR Part 200, and Medicaid non-institutional reimbursement policy.

H. Agency Responsibilities

1. OHA will submit to CMS claims based on total computable expenditures for services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policy.

2. OHA 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. OHA will complete the audit and final reconciliation process of the interim supplemental payments for the service period within 9 months of the postmark date of the cost report and conduct on-site audits as necessary.