

## WA State Health Care Authority- GEMT

### GROUND EMERGENCY MEDICAL TRANSPORTATION SERVICES COST REPORT GENERAL INSTRUCTIONS FOR COMPLETING COST REPORT FORMS

#### A) GENERAL

To participate in the reimbursement program authorized by State Plan Amendment (SPA 16-0005), each eligible publicly owned or operated emergency medical transportation provider must submit the Centers for Medicare and Medicaid (CMS) approved cost report to the Washington State Health Care Authority Financial Services Division by December 1 of each Washington state fiscal year (July 1-June 30).

Each provider shall maintain fiscal and statistical records for the service period covered by the cost report. All records must be accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained until the later of a) the cost report is finalized and settled or b) a period of three years following the submission of the CMS-approved cost report. If an audit is in progress, all records relevant to the audit must be retained until the audit is completed or the final resolution of all audit exceptions, deferrals, and/or disallowances.

#### B) DEFINITIONS - GEMT

##### General

45 CFR 75.412 indicates there is no universal rule for classifying certain costs as either direct or indirect under every accounting system. A cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective. Therefore, it is essential that each item of cost incurred for the same purpose be treated consistently in like circumstances either as a direct or an indirect cost in order to avoid possible double-charging of Federal awards.

**Direct Cost** - 45 CFR 75.413 indicates that direct costs are those costs that:

- 1) Can be identified specifically with a particular final cost objective, 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.

45 CFR 75.413 also indicate that 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 which includes both cost incurred applicable to firefighting as well EMT services must be consistently direct or indirect in its entirety. For example, if travel expenses are assigned to EMT services as a direct cost, the remaining portion must be assigned to firefighting, or any other cost objective, as a direct cost in order to avoid possible double charging.

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**Indirect Cost** - Indirect costs are those that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes. After direct costs have been determined and assigned directly to Federal awards and other activities as appropriate, indirect costs are the remaining costs to be allocated to benefitting cost objectives.

### *Direct Cost for GEMT Services*

#### **Professional and Contracted Services**

- 1) **MTS Salaries/fringes** – The allocation statistic of MTS Hours/Non-MTS would be accomplished via use of worker day logs or a RMTS.
- 2) **Non-MTS Salaries/fringes** – Based on 45 CFR 75.413(c), the salary/fringes applicable to clerical support staff should be included in the direct cost pool. The definition at 45 CFR 75.413(a) requires the allocation/assignment to be specifically based on clerical/support staff hours supporting EMTs/hours supporting other functions. This would be accomplished via use of worker day logs or a RMTS.

#### **1<sup>st</sup> Line Supervisors:**

- 1) **Fire Chiefs** - Based on the portion of 45CFR 75.413 which refers to cost being assigned with a high degree of accuracy, this would be accomplished via use of worker day logs or a RMTS.
- 2) **Administrative Chiefs** - Based on 45 CFR 75.413(c), the salary/fringes applicable to the Administrative Chief should be included in the direct cost pool. The definition at 45 CFR 75.413(a) requires the allocation/assignment to be based on the Administrative Chief's hours supporting EMTs/hours supporting other functions. This would be accomplished via use of worker day logs or a RMTS.

**Medical Equipment and Supplies** –Assignment should be based on direct identification.

**Materials and Supplies** – Assignment should be based on direct identification..

**Travel** - Assignment should be based on direct identification.

**Training** – Assignment should be based on direct identification.

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### Capital Outlays:

**Depreciation – Building and Improvements** – An allocation statistic based solely on square footage may not be appropriate as a square footage statistic would not account for situations where more or all improvements were made to the portion of the building/facility that pertains to firefighting.

**Depreciation – Equipment**– Allocation statistic based solely on square footage may not be appropriate as a square footage statistic would not account for situations where a higher percentage of the equipment cost is applicable to firefighting.

**Depreciation – Other**– CMS anticipates that depreciation for the Fire trucks is recorded separately from the depreciation for the ambulance vehicles.

**Leases and Rentals**– Allocation/assignment statistic based on square footage is appropriate.

**Property Taxes**– Allocation/assignment statistic based on square footage is appropriate.

**Property Insurance**– Allocation/assignment statistic based on square footage is appropriate.

**Interest – Property, Plant and Equipment** – Allocation/assignment statistic based on square footage may be appropriate, however, this may take further discussion with the State to understand the equipment component.

**Transport** means Ground Emergency Medical Transportation Services as defined in the Medicaid State Plan Amendment (SPA) 16-0005 that are provided by eligible GEMT providers to individuals.

**Medical Transportation Service (MTS)** means transportation to secure medical examinations and treatment for an individual.

**Emergency Medical Response** is a cost objective that includes expenditures for medical service performed at the point of injury or illness, typically outside a medical facility, to evaluate or treat a health condition. An emergency medical response is classed a “medical” by dispatch if the primary reason for the response is to provide medical services.

**Non-Medical Emergency Response** includes all emergency response activities whose purpose is not primarily medical. These responses are classified by dispatch in a variety of categories and reported for the purpose of cost reporting in a summary category of non-medical emergency response. Expenditures assigned to this cost objective are not allowable for determining the cost of emergency transportation.

**Non-Medical Emergency Ancillary Services** include activities such as fire prevention and permit issuance that are performed in the absence of an emergency to support preparedness, mitigate the need for

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emergency response, or lessen the severity of an emergency that might occur. For the purpose of Medicaid cost identification, expenditures associated with non-emergency ancillary services are not allowable for determining the cost of emergency medical transportation.

**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.

**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.

**GEMT Services** means both 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. Costs applicable to EMT services that do not result in a transport cannot be covered and reimbursed as Medicaid transportation services.

**Service Period** means July 1 through June 30 of each Washington State fiscal year.

**Eligible GEMT Provider** means a provider who is eligible to receive supplemental payments under this program because it meets the following requirements continuously during the claiming period:

- a) It provides GEMT services to Medicaid beneficiaries.
- b) It is a provider that is enrolled as a Medicaid provider for the period being claimed.
- c) It is 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.

**Unallowable Costs** are those expenditures, such as bad debts and contributions and donations, which 2 CFR, Part 200 does not permit to be charged for federal program. Additionally, for the purposes of Medicaid cost identification for emergency medical transportation, expenditures benefitting the non-medical emergency response and non-emergency ancillary services cost objectives are not allowable. Costs associated with “dry runs” are not allowable. For a complete listing of federal allowable and unallowable costs, please refer to: OMB Circular A-87 – <http://www.whitehouse.gov/omb/circulars>.

### C) REPORTING REQUIREMENTS

All costs reported must be in accordance with the following:

1. SPA 16-0005. Supplemental reimbursement under this program is available only for allowable costs incurred for providing GEMT services to eligible Medicaid beneficiaries that are in excess

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of the payments the eligible GEMT provider receives per transport from any source of reimbursement.

- a) The allowable costs must be determined in accordance with the methodology specified under SPA 16-0005.
  - b) A copy of the State Plan which includes GEMT services can be found online at <https://www.hca.wa.gov/about-hca/apple-health-medicaid/medicaid-title-xix-state-plan>
2. 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). 42 CFR and the governing statute in the Federal Social Security Act outlines the manner in which allowable costs are considered reasonable, necessary, and related to beneficiary health care.
  3. These cost principles are reiterated in the Centers for Medicare and Medicaid Services, Provider Reimbursement Manual 15-1 (CMS Pub. 15-1). This manual is online at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>. Upon entering the site, select Paper-Based Manuals and then Publication 15-1. The relevant cost reimbursement chapters will be displayed. Within each chapter, the section numbers may appear out of sequence. Select the file containing the reference “TOC” to display the table of contents of the relevant sections within the chapter.
  4. All items of data and costs reported are subject to review by the Agency pursuant to Washington Administrative Code (WAC) 182-546. The text of this section is online at <http://apps.leg.wa.gov/wac/default.aspx?cite=182-546>. Such audits will be conducted to determine the extent that reported costs complies with the cost principles outlined in CMS Pub. 15-1. Reported costs that do not comply with these provisions will be adjusted accordingly.
  5. Allowable costs are those that are generally considered eligible for federal reimbursement based on the cost principles established in OMB Circular A-87. Allowable costs are those that are in compliance with CMS non-institutional reimbursement policy.

### D) LAWS AND REGULATIONS AT A GLANCE

Federal and State Regulations – GEMT Cost Reporting Requirements:

- WAC 182-546
- 42 C.F.R, Part 413 – Principles of reasonable cost.
- Office of Management and Budget (OMB) Circular A-87 – General Principles for Determining Allowable Costs.

### E) ADDITIONAL CRITERIA FOR COST REPORTING

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- Only costs for services provided to Medicaid beneficiaries on or after June 2, 2016, are eligible for supplemental reimbursement.
- Services rendered to patients who have coverage under both Medicare and Medicaid programs ("dually eligible patients") are not eligible for reimbursement under this program.
- Administrative costs incurred for reimbursing the Agency’s administration costs must be excluded from this cost report.
- The only administrative costs incurred for billing and/or accounting services that are eligible for reimbursement are those in compliance with the federal and state regulations as defined under Office of Management and Budget (OMB) Circular A-87 – General Principles for Determining Allowable Costs.

**F) COST REPORT SECTIONS AT A GLANCE**

<b>General Information and Certification</b>	<b>Certifies the GEMT Claim Packet</b>
Schedule 1	Schedule of Total Expenses
Schedule 2	Medical Transportation Services (MTS) Expenses
Schedule 3	Non-Medical Transportation Service (Non-MTS) Expenses
Schedule 4	Allocation of Capital Related and Salaries & Benefits
Schedule 5	Allocation of Administrative and General
Schedule 6	Reclassifications
Schedule 7	Adjustments
Schedule 8	Revenues
Schedule 9	Final Settlement
Schedule 10	Notes

**GENERAL INFORMATION AND CERTIFICATION**

Complete items 1-27. The individual signing the certification statement must be an Officer or Administrator. The Cost Report must be legibly completed and signed. Cost reports received that are not clear, legible, or have been altered, or are incomplete, and/or not signed will be rejected and returned with

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instructions noting the deficiencies in need of correction. Cost reports that are not accepted by the required filing deadline due to improper completion will be rejected and the Agency may subject the providers to the sanction provisions noted under “Filing Deadline.”

### **SCHEDULE 1 – TOTAL EXPENSE**

This worksheet should reflect all costs incurred by the GEMT provider. No input is necessary on this Schedule. All numbers will flow from other Schedules.

### **SCHEDULE 2 – MEDICAL TRANSPORTATION SERVICES (MTS) EXPENSE**

Enter the total unallocated direct expenses incurred from providing 100% MTS during each shift. Do not enter expenses for multiple activities (i.e. “shared” services) as 100% MTS. These expenses must be allocated on Schedule 4. For example, for staff that responds to both MTS transports and NON-MTS transports activities (i.e. firefighters), salary and fringe benefit expenses for that staff must be reported in Schedule 4 as allocated costs.

Column 1: Enter all costs that are 100% associated with MTS. Any costs that are not 100% MTS or considered a “shared” cost will be input on other Schedules.

Column 2: No input necessary. Information will flow from Schedule 4.

Column 3: No input necessary. Information will flow from Schedule 6.

Column 4: No input necessary. Information will flow from Schedule 7.

Column 5: No input necessary. Information will auto-calculate.

### **SCHEDULE 3 - NON-MEDICAL TRANSPORTATION SERVICES (NON-MTS) EXPENSE**

Enter total expenses applicable to 100% Non-Medical Transportation services.

Column 1: Enter all costs that are 100% associated with NON-MTS.

Column 2: No input necessary. Information will flow from Schedule 4.

Column 3: No input necessary. Information will flow from Schedule 6.

Column 4: No input necessary. Information will flow from Schedule 7.

Column 5: No input necessary. Information will auto-calculate.

### **SCHEDULE 4 - ALLOCATION OF CAPITAL RELATED AND SALARIES & BENEFITS**

Enter total shared expenses that will be apportioned between MTS and NON-MTS services.

Column 1: Enter all Capital Related and Salaries and Benefit costs that are not directly assigned to MTS and NON-MTS services.

Column 2: No input necessary. Information will flow from Schedule 6.

Column 3: No input necessary. Information will flow from Schedule 7.

Columns 4 thru 6: No input necessary. Information will auto-calculate.

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At the bottom on Schedule 4, identify in the yellow highlighted boxes, the appropriate hours spent that pertain to MTS services and NON-MTS services.

### SCHEDULE 5 – ALLOCATION OF ADMINISTRATIVE AND GENERAL

Enter total shared expenses for Administrative and General.

Column 1: Enter all Administrative and General (A&G) costs that are not directly assigned to MTS and NON-MTS services.

Column 2: No input necessary. Information will flow from Schedule 6.

Column 3: No input necessary. Information will flow from Schedule 7.

Columns 4 thru 6: No input necessary. Information will auto-calculate.

### SCHEDULE 6 - RECLASSIFICATIONS

A reclassification of expense is an entry that transfers costs from one cost center and/or schedule to another. Reclassification will be necessary when an expense has been improperly classified.

An explanation must be included for each reclassification in the column labeled “Explanation of Entry.”

Column 1: Enter sequential lettering system to identify individual reclassifications; i.e. A. B. C...

Column 2: Enter Cost Center this is increasing.

Column 3: Enter Line Number of schedule this increase pertains to.

Column 4: Enter Schedule Number this increase pertains to.

Column 5: Enter the Amount of increase.

Column 6: Enter Cost Center this is decreasing.

Column 7: Enter Line Number of schedule this decrease pertains to.

Column 8: Enter Schedule Number this decrease pertains to.

Column 9: Enter the Amount of decrease.

The increased total **must equal** the decreased total at the bottom of this schedule.

### SCHEDULE 7 – ADJUSTMENTS

An adjustment is an entry to adjust expenses. For example, the cost of fundraising activities is not a reimbursable expense under the CMS Pub.15-1 and OMB Circular A-87. Therefore, remove any costs associated with fundraising, which are included in your general ledger expenses, through an adjustment in Schedule 7.

### SCHEDULE 8 – REVENUES / FUNDING SOURCES

#### AREA A



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Column 1: Enter Medicaid FFS Revenue type.

Columns 2 thru 5: Enter dollar amount for revenue received.

Column 6: No input necessary. Information will auto-calculate.

### AREA B

Column 1: Enter Other Medicaid FFS Revenue type.

Columns 2 thru 5: Enter dollar amount for revenue received.

Column 6: No input necessary. Information will auto-calculate.

### AREA C

Report revenues for MTS and NON-MTS by type

Column 1: Report all revenue (i.e. Medicaid payments, Tax Revenue, Grants, etc.) received and list the funding source.

Column 2: Enter revenue amount if it's MTS specific.

Column 3: Enter revenue amount if it's NON-MTS specific.

Column 4: No input necessary. Information will auto calculate.

### SCHEDULE 9 – FINAL SETTLEMENT

Row 1: No input necessary; Cost of MTS will populate from Schedule 2.

Row 2: Indicate if the Indirect Cost Factor was based on MTS. Use the drop down box.

Row 3: If the answer for Row 2 above was NO, enter the base costs for calculating the Indirect Cost.

Row 4: Enter the Indirect Cost Factor. In most cases, when an Indirect Cost Factor is being applied, there should be no A&G cost allocated.

Row 5: No input necessary; A&G Allocation will populate from Schedule 5 (A).

Row 6: No input necessary; A&G totals to be included will populate.

Row 7: No input necessary; Grand Total of MTS Expense will populate.

Row 8: Enter the total number of MTS for the reporting period, by quarter where applicable.

Row 9: No input necessary; an average cost per medical transport will be determined by dividing Grand Total of MTS Expense to the Total Number of medical transports.

Row 10: No input necessary; FFS Transports will populate for the corresponding quarter from Schedule 9, Line 8.

Row 11: No input necessary; Total costs of Medicaid ground emergency medical transports will populate.

Row 12: No input necessary; Medicaid FFS revenue will populate for the corresponding quarters from Schedule 8, Lines 1-6. Note: The amount will be a negative value.

Row 13: No input necessary; Net cost of services for the corresponding quarter will populate.

Row 14: No input necessary; Federal Financial Participation reduction will populate for the corresponding quarter.

Row 15: No input necessary; Net amount due to the provider will populate based on the FMAP rate.

### SCHEDULE 10- NOTES

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Identify any contracting arrangements for expenditures reported on Schedules 1-5, the statistical basis for allocation on Schedules 4 and 5, and reasons for any schedules left blank.

### **FILING DEADLINE**

Cost reports are due no later than 150 days after the last day of the State Fiscal Year. A request for an extension shall only be approved when a GEMT provider's operations are significantly and/or adversely affected due to extraordinary circumstances, 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 the 150 days after the last day of the applicable State Fiscal Year. Filing extensions may be granted by the Agency for good cause, but such extensions are made at the discretion of the Agency.

An approved Provider Participation Agreement must be on file with the Agency in order to file Annual Cost Reports electronically. If you do not have an approved Provider Participation Agreement on file with the Agency, please contact us at 360-725-1763 or visit our website at <http://www.hca.wa.gov/XXX/XXX/XXX>.

A signed Adobe PDF™ version of the contract, the Excel™ version of the cost report, and any supporting documentation should be submitted electronically to [GEMT@hca.wa.gov](mailto:GEMT@hca.wa.gov).

After the Cost Report has been reviewed and accepted, the provider must maintain a copy of the signed and electronic version of the cost report and all supporting documentation. Pursuant to the timeframes outlined in SPA 16-0005, the Agency will contact providers individually to schedule audits.