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**SENATE BILL 5840**

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**State of Washington 64th Legislature 2015 Regular Session**

**By** Senators Dammeier, Rolfes, Braun, and Keiser

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.**  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 entity, 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.**  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.

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