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**Medicaid Cost-Based Reimbursement for the Provision of Emergency Medical Ground Transportation Services**

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This Section applies to reimbursement for Emergency Medical Transportation Services described in Section 24, Transportation Services, in Attachment 3.1 A, Page 9 and Section 24, Transportation Services, in Attachment 3.1 B, Page 8, and Transportation Services in Attachment 3.1D, Page 1.

This Section also governs reimbursement for Emergency Medical Service providers described in Attachment 3.1-A, Page 3, Supplement 1 to Attachment 3.1A, Page 9, Attachment 3.1-B, Page 3, and Supplement 1 to Attachment 3.1B, Page 8.

Effective April 1, 2019, eligible governmental emergency medical ground transportation providers will be eligible to receive Medicaid payments in accordance with the cost-based reimbursement methodology set forth in this Section for the provision of emergency medical ground transportation services to Medicaid recipients.

**I. GENERAL PROVISIONS**

- A. The purpose of this Section is to establish principles of reimbursement for eligible providers of emergency medical ground transportation services participating in the District of Columbia Medicaid program.
- B. Medicaid reimbursement to eligible providers of emergency medical ground transportation services provided beginning April 1, 2019 shall be consistent with the requirements of the cost-based reimbursement methodology set forth in this Section.
- C. In order to receive Medicaid reimbursement, a eligible provider shall enter into a provider agreement with the Department of Health Care Finance (DHCF) for the provision of emergency medical ground transportation services and comply with the screening and enrollment requirements set forth in Chapter 94 (Medicaid Provider and Supplier Screening, Enrollment, and Termination) of Title 29 of the District of Columbia Municipal Regulations (DCMR).
- D. Emergency medical ground transportation services shall be provided in accordance with the licensure, certification, and service delivery requirements set forth in Chapter 5 (Emergency Medical Services) of Title 29 of the DCMR.

**II. COST-BASED REIMBURSEMENT OF DISTRICT EMERGENCY MEDICAL GROUND TRANSPORTATION SERVICES**

- A. DHCF will reimburse eligible providers enrolled to provide Medicaid emergency medical ground transportation services in the District of Columbia in accordance with the cost-based reimbursement methodology set forth in this Chapter.
- B. Total Medicaid reimbursement to eligible providers shall equal the sum of:
  - i. Medicaid fee-for-service reimbursement as described in § III.A; and
  - ii. Reimbursement for total allowable costs in excess of Medicaid fee-for-service reimbursement and reimbursement from other sources for emergency medical ground transportation services to Medicaid-eligible beneficiaries, or reconciled costs as defined in § VI.

- C. DHCF will only provide cost-based reimbursement for allowable costs that are in excess of Medicaid fee-for-service reimbursement described in § III.A.
- D. Total Medicaid reimbursement shall not exceed one hundred percent (100%) of actual allowable costs. DHCF shall determine allowable costs in accordance with the reconciliation standards outlined in § VI and the cost reporting and auditing processes outlined in § VII.
- E. An eligible provider shall certify costs attributable to services provided to Medicaid beneficiaries through submission of the annual cost report in accordance with the requirements set forth in § VII.
- F. For each cost reporting period that an eligible provider's reconciled costs are greater than the sum of fee-for-service payments received from DHCF and reimbursement from other sources for emergency medical ground transportation services, DHCF shall make a payment to the eligible provider, following auditing of submitted cost reports and final determination of reconciled costs, equal to the amount of the difference, less the local Medicaid funding amount.
- G. For each cost reporting period that an eligible provider's reconciled costs are less than fee-for-service payments received from DHCF and reimbursement from other sources for emergency medical ground transportation services to Medicaid-eligible beneficiaries for the cost reporting period, the eligible provider shall make a payment to DHCF, following auditing of submitted cost reports and final determination of reconciled, equal to the amount of the difference.

### III. INTERIM RATE METHODOLOGY

- A. DHCF will provide fee-for-service reimbursement of emergency medical ground transportation services provided to District Medicaid-enrolled beneficiaries to eligible providers in accordance with the reimbursement rates set forth in the District of Columbia Medicaid Fee Schedule. The effective date of the fee schedule is identified on page 13a of Attachment 4.19B, Part 1 of the District of Columbia Medicaid State Plan. The Medicaid Fee Schedule is located on the DHCF website at <https://www.dc-medicaid.com/dcwebportal/home>. Medicaid fee-for-service reimbursement for emergency medical ground transportation services includes reimbursement for the services outlined below:
  - i. Advanced Life Support 1;
  - ii. Advanced Life Support 2;
  - iii. Basic Life Support; and
  - iv. Ground Mileage.
- B. All claims paid using interim rates for services provided during the reporting period, shall be subject to the reconciliation process set forth in § VI.
- C. Reconciliation of payments, pursuant to the process set forth in § VI, may result in the identification and remittance of an additional payment owed to the eligible provider or identification and recoupment of any overpayment due to DHCF.
- D. Following the close of each reporting year, DHCF may utilize audited financial data in the cost report to update interim rates for covered emergency medical ground transportation services, as identified in § III.A, for eligible governmental providers.

- E. All future updates to the reimbursement rates for emergency medical ground transportation services for eligible governmental providers shall comply with the public notice requirements set forth in District Rulemaking.

#### **IV. ELIGIBLE EMERGENCY MEDICAL GROUND TRANSPORTATION SERVICE PROVIDERS**

- A. To be eligible for cost-based reimbursement, emergency medical ground transportation service providers shall be a part of, owned by, or operated by the District of Columbia government.
- B. Emergency medical ground transportation service providers that are not part of, owned by, or operated by the District of Columbia government are not eligible to receive cost-based reimbursement described in this Chapter.
- C. Eligible emergency medical ground transportation services providers shall be enrolled with the District of Columbia Medicaid Program for the period claimed on the annual cost report.

#### **V. ALLOWABLE COSTS**

- A. Allowable costs shall include expenses incurred by the eligible provider in provision of emergency medical ground transportation services as identified in the cost reporting template and audited by DHCF in accordance with the requirements set forth in § VII.
- B. Allowable costs shall include items of expense incurred by the eligible provider within the following categories:
- i. Capital related (i.e. expenditures associated with depreciation of buildings and equipment, leases and rentals, property insurance, and other capital related costs);
  - ii. Employee salary and fringe benefits;
  - iii. Administrative (i.e. expenditures associated with general supplies, housekeeping, postage, and other administrative costs); and
  - iv. Operational (i.e. expenditures associated with medical supplies, minor medical equipment, communications, and other operational costs).
- C. An eligible provider may request reimbursement of allowable costs, up to the reconciled costs, as determined in accordance with § VI. Total Medicaid reimbursement to eligible providers shall not exceed one hundred percent (100%) of actual allowable costs
- D. DHCF and eligible providers shall calculate and allocate allowable costs in accordance with the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, and 2 CFR Part 225 (Cost Principles for State, Local, and Indian Tribal Governments), which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the District of Columbia Medicaid program.

#### **VI. CALCULATION OF RECONCILED COSTS**

- A. Reconciled costs shall be equal to an eligible provider's audited allowable costs less the sum of Medicaid fee-for-service payments and other sources of reimbursement.

- B. DHCF shall apportion an eligible provider's allowable costs per medical transport to calculate a cost per medical transport rate, as defined in VI.C, below. The cost per medical transport rate will be based on the allowable costs included in the submitted cost report.
- C. The cost per medical transport rate shall equal the sum of actual allowable direct and indirect costs of providing emergency medical ground transportation services and dry runs (or treat and refer services) to Medicaid-enrolled beneficiaries, divided by the number of actual medical transports in the applicable service period. Nonmedical consults that do not result in transportation to a medical facility are excluded from the numerator.
- D. Direct costs for the provision of emergency medical ground transportation services shall only include: the unallocated payroll costs for personnel who dedicate one hundred percent (100%) 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.
- E. Indirect costs shall be determined in accordance with one of the options, as authorized by DHCF prior to the start of the reporting period:
- i. Eligible providers that receive more than thirty-five million dollars (\$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 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;
  - ii. Eligible providers that receive less than thirty-five million dollars (\$35 million) of direct federal awards are required to develop and maintain an indirect proposal for purposes of audit. In the absence of an indirect rate proposal, the eligible provider may use methods originating from a CAP to identify its indirect cost. If the eligible 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 obtain one or the other before it can claim any indirect cost;
  - iii. Eligible providers that receive no direct federal funding may use any of the following previously established methodologies to identify indirect cost:
    - a. A CAP with DHCF or the District government;
    - b. An indirect rate negotiated with DHCF or the District government; or
    - c. Direct identification through use of a cost report; or
  - iv. If the eligible provider never established any of the above methodologies, it may do so, or it may elect to use the ten percent (10%) de minimis rate to identify its indirect cost.
- F. Total allowable costs, determined in accordance with the requirements of § V, shall equal the cost per medical transport, identified in §§ VI.B and VI.C, times the total number of Medicaid fee-for-service transports.
- G. The primary source of paid claims data, managed care encounter data, and other Medicaid reimbursement data is the Medicaid Management Information System (MMIS). The number of

paid Medicaid fee-for-service transports, as identified in is § VI.F, is derived from and supported by the MMIS reports for services during the applicable reporting period.

- H. Payment of reconciled costs, by DHCF or the eligible provider, shall be made in accordance with the requirements set forth in §§ II.F or II.G.
- I. Payment of reconciled costs by DHCF, shall be made in accordance with timely reimbursement and claiming requirements set forth at 42 CFR § 447 and 45 CFR § 95, Subpart A.

## **VII. COST REPORTING, AUDITS, AND RECORD MAINTENANCE**

- A. Eligible providers shall submit an annual cost report to DHCF within one hundred eighty days (180) days of the close of the provider's cost reporting period, which shall be concurrent with the District of Columbia government's fiscal year.
- B. Cost reports shall be submitted on the DHCF approved form and shall be completed according to the cost report instruction manual. If forms and instructions are modified, DHCF will provide advance notice in writing to each eligible provider and on the DHCF website.
- C. If an eligible provider does not submit the cost report within the timeframe indicated in §VII.A and has not received an extension of the deadline from DHCF based upon a showing of good cause for the delay, DHCF may issue a delinquency notice to the eligible provider.
- D. Only one (1) extension of time shall be granted to a provider for a cost reporting year and no extension of time shall exceed sixty (60) days.
- E. Eligible providers shall submit one (1) original hard-copy and (1) one electronic copy (in excel format) of the cost report. The eligible provider shall submit an original hard copy to DHCF that is signed by an authorized representative.
- F. The requirements for cost reports shall be detailed in the DHCF Emergency Ground Medical Transportation Services cost report instruction manual. Each cost report shall meet the following requirements:
  - i. Be properly completed in accordance with program instructions and forms and accompanied by supporting documentation; and
  - ii. Include copies of financial statements or other official documents submitted to a governmental agency justifying revenues and expenses;
- G. Eligible providers must ensure that computations included in the cost report shall be accurate and consistent with other related computations and the treatment of costs shall be consistent with the requirements set forth in this Section.
- H. In the absence of specific instructions or definitions contained in these rules or cost reporting forms and instructions, DHCF's decision of whether a cost is allowable shall be determined in accordance with the Medicare Principles of Reimbursement and the guidelines set forth in the Centers for Medicare and Medicaid Services Medicare Provider Reimbursement Manual as identified in § V.D.
- I. All cost reports shall cover, at most, a twelve (12) month cost reporting period, which shall be the same as the District's fiscal year, unless DHCF has approved an exception.

- J. A cost report that is not complete shall be considered an incomplete filing and the eligible provider shall be notified of the deficiency and requested to submit a corrected and complete version.
- K. Each eligible provider shall maintain adequate financial records and statistical data for proper determination of allowable costs and in support of the costs reflected on each line of the cost report. The financial records shall include the provider's accounting and related records including the general ledger and books of original entry, all transactions documents, statistical data, lease and rental agreements and any original documents which pertain to the determination of costs.
- L. Eligible providers shall maintain the records pertaining to each cost report as described in § VII.K for a period of not less than ten (10) years after filing of the cost report. If the records relate to a cost reporting period under audit or appeal, records shall be retained until the audit or appeal is completed.
- M. All records and other information may be subject to periodic verification and review. Each cost report may be subject to a desk review.
- N. Eligible providers shall:
- i. Use the accrual method of accounting; and
  - ii. Prepare the cost report in accordance with generally accepted accounting principles, the requirements of § V.D, and DHCF program instructions.

#### **VIII. ACCESS TO RECORDS**

- A. Eligible providers shall allow appropriate DHCF personnel, representatives of the United States Department of Health and Human Services and other authorized agents or officials of the District of Columbia government and federal government full access to all records during announced and unannounced audits and reviews.

#### **IX. APPEALS**

- A. At the conclusion of each audit, an eligible provider shall receive an audited cost report including a description of each audit adjustment and the reason for each adjustment.
- B. Within thirty (30) days of the date of receipt of the audited cost report, an eligible provider that disagrees with the audited cost report may request an administrative review by sending a written request for administrative review to DHCF.
- C. Any written request for an administrative review shall include an identification of the specific audit adjustment to be reviewed, the reason for the request for review of each audit adjustment and documentation supporting the request.
- D. DHCF shall mail a formal response to the eligible provider no later than forty-five (45) days from the date of receipt of the written request for administrative review.
- E. Decisions made by DHCF and communicated in the formal response described in § IX.D may be appealed to the District of Columbia Office of Administrative Hearings within thirty (30) days of the date of issuance of the formal response.

**X. DEFINITIONS**

When used in this Section, the following terms shall have the meanings ascribed:

**Accrual Method of Accounting** - A method of accounting where revenue is recorded in the period earned, regardless of when collected and expenses are recorded in the period incurred, regardless of when paid.

**Advanced Life Support** - Special services designed to provide definitive prehospital emergency medical care, such as, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

**Basic Life Support** - Emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

**Cognizant Agency** – Shall have the same meaning as set forth in Title 2 of the Code of Federal Regulations Part 200 Section 19.

**Direct Costs** - Costs incurred for the sole objective of meeting emergency medical transportation requirements or delivering covered medical transport services, such as: 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.

**Dry Run (or Treat and Refer)** - Services (basic and advanced life support services) provided by the eligible provider to an individual who is released on the scene without transportation by ambulance to a medical facility.

**Indirect Costs** - Costs incurred for a common or joint purpose benefitting more than one District entity which are allocated using an agency-approved indirect rate or an allocation methodology.

**Reporting Period** - The span of time from which financial information is gathered to be recorded in cost reports; typically, October 1 through September 30 of each District of Columbia fiscal year.