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TEMPORARY ADMINISTRATIVE ORDER
INCLUDING STATEMENT OF NEED & JUSTIFICATION

DMAP 48-2021
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

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& LEGISLATIVE COUNSEL

FILING CAPTION: Provider Requirements And Payment Processing For Ground Emergency Medical Transportation (GEMT) Supplemental Payments

EFFECTIVE DATE: 12/10/2021 THROUGH 06/07/2022

AGENCY APPROVED DATE: 12/07/2021

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NEED FOR THE RULE(S):

This is a rule for a new program that makes supplemental payments for qualifying applicable services offered through a CCO Program created under HB 4030 (2016) that passed state legislation, along with authority of the 42 CFR Section 438.6 (c) Preprint forms approved by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS).

JUSTIFICATION OF TEMPORARY FILING:

The Authority finds that failure to act promptly will result in serious prejudice to the public interest, the Authority, and recipients of Medicaid benefits. These rules need to be adopted promptly so that the Authority may describe requirements and operations for payment and reporting within the new Ground Emergency Medical Transportation CCO Supplemental Payment Program in accordance with §438.6(c) Preprint forms approved by CMS.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

ADOPT: 410-136-3371

RULE SUMMARY: Creating new rule to reflect program policy operations for requirements and process for the GEMT CCO Supplemental Payment Program. OAR 410-136-3371 is the OAR citation where Medicaid payment rules will be implemented.

CHANGES TO RULE:

410-136-3371
Provider Requirements and Payment Processing for the CCO Ground Emergency Medical Transportation (GEMT) Supplemental Payments
(1) Definitions:¶
(a) "Ground Emergency Medical Transportation Provider" or "GEMT Provider" means a GEMT provider that meets all the eligibility requirements as defined in the 42 CFR 438.6(c) Preprint.¶

(b) "Ground Emergency Medical Transportation Services" or "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 described in the 42 CFR 438.6(c) Preprint.¶
(c) "Participating Provider" has the meaning defined in OAR 410-141-3500.¶
(d) "Qualified Directed Payment" means a supplemental payment made by the Authority to CCOs for GEMT providers' qualifying services when rendered by provider classes as defined in 42 CFR 438.6(c) Preprint forms approved by CMS.¶
(e) "Supplemental Payment" means a payment amount set by the Authority, issued as a pass-through payment, for each approved procedure code to supplement allowable costs for GEMT services.¶
(f) "438.6(c) Preprint" means a 42 CFR 438.6(c) Preprint approved by U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) for Qualified Directed Payments to GEMT Providers for GEMT Services rendered during the applicable CCO contract rating period.¶
(2) GEMT Provider Eligibility Requirements:¶
(a) To be eligible for supplemental payments, GEMT providers shall meet the following requirements:¶
(A) Be licensed by the State of Oregon to provide emergency medical transportation services for the approved service period receiving supplemental payment;¶
(B) Be enrolled as an Oregon Health Plan (OHP) Medicaid provider for the approved service period receiving supplemental payment;¶
(C) Provide GEMT services to Medicaid recipients for the approved service period.¶
(b) Be a Governmental Unit provider in accordance with 2 CFR 200.¶
(A) Be a participating provider having a contractual relationship with a Coordinated Care Organizations (CCO) on the date of GEMT services; and¶
(B) Have an agreement in place with the Oregon Health Authority (Authority) to allow for transfer of funds between participating GEMT provider and the Authority to supplement the allowable costs of providing qualifying emergency medical services to CCO members.¶
(3) Supplemental qualified directed payment process:¶
(a) A GEMT provider may participate in the GEMT supplemental payment program described in this rule if the GEMT provider is aa Participating Provider in accordance with OAR 410-141-3500 on the date of service during the approved service period;¶
(b) The GEMT CCO Supplemental Payment Program is for supplemental payments made by the Authority to CCOs for GEMT providers' qualifying services when rendered by GEMT providers for the approved service period;¶
(c) In accordance with 42 CFR 438.6(c)(2)(i)(A), the supplemental payments are based on paid CCO member encounters in the Medicaid Management Information System for approved qualifying GEMT services procedure codes;¶
(d) The Authority shall pay any federal financial participation received from CMS, for qualifying GEMT services, to the CCO;¶
(e) The CCO shall increase, by the same amount, the amount of reimbursement paid to the appropriate GEMT provider;¶
(f) The non-federal share portion of the supplemental qualified directed payment is contributed by GEMT providers only;¶
(g) The GEMT provider shall agree to pay a fee to reimburse the Authority for the costs of administering the program. The fee may not exceed 20 percent of the supplemental payment provided;¶
(h) The Authority may adjust the amount of supplemental payments based on actual utilization and available GEMT funds for the period receiving supplemental payment.¶
(4) Reporting and Billing Processes:¶
(a) The Authority shall combine the weekly encounters into a report to assist CCOs in distributing the program's supplemental funds as a pass-through to the appropriate GEMT provider in the manner agreed to by CCO and GEMT provider.¶
(A) In 2021 the report shall be distributed at least once to each CCO and each GEMT provider;¶
(B) In 2022 and each subsequent program year the report shall be distributed monthly to each CCO and each GEMT provider.¶
(b) After receipt of the report, CCOs shall submit payment for the amount indicated on the report to an account established by the appropriate GEMT provider;¶
(A) Adjustments shall be processed weekly through the Medicaid payment system and included in the subsequent monthly report;¶
(B) If an error is identified in the monthly report, the CCO shall make the payment based on the original amount provided in the report. The Authority shall identify separately the correction in the following month's report and adjust the total payment amount to account for the error.¶

(c) Payment by the CCO as a Managed Care Entity (MCE) to participating providers for qualifying GEMT services shall be in accordance with OAR 410-141-3565 Managed Care Entity Billing;¶
(d) Consistent with OAR 410-141-3610, GEMT supplemental payments are considered premium equivalents and subject to the MCE assessment under OAR 410-141-3601.¶
(5) Quality Measurement:¶
(a) In accordance with 42 CFR 438.6(c)(2)(i)(C), this payment arrangement must advance at least one of the goals and objectives in Oregon's Medicaid quality strategy required per 42 CFR 438.340 and the Authority will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in this section;¶
(b) GEMT providers shall submit the quality measurement data specified in the 438.6(c) Preprint.¶
(6) Authority Responsibilities:¶
(a) The Authority shall apply for program authorization through a 438.6(c) Preprint for each calendar year;¶
(b) The Authority shall make a supplemental payment only if the GEMT provider meets criteria established by the Authority for the GEMT CCO Supplemental payment program in accordance with applicable federal requirements;¶
(c) The Authority shall make a supplemental payment for qualified paid CCO encounters submitted through the Medicaid Management Information System (MMIS) provided to members enrolled in a CCO, with an approved procedure code that meets criteria for payment established by the Authority, up to one encounter, per CCO member, per day;¶
(d) Upon receipt of an acceptable funds transfer from GEMT provider consistent with Section 3 of this rule, the Authority shall verify data received and draw the federal funds in an amount consistent with the applicable Oregon Federal Medical Assistance Percentage (FMAP).
Statutory/Other Authority: ORS 413.042, 414.025
Statutes/Other Implemented: ORS 413.234, 413.235