RULES OF

Department of Social Services

Division 70—MO HealthNet Division

Chapter 6—Emergency Ambulance Program

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TITLE 13 — DEPARTMENT OF SOCIAL SERVICES
Division 70 — MO HealthNet Division
Chapter 6 — Emergency Ambulance Program

13 CSR 70-6.010 Emergency Ambulance Program

PURPOSE: This rule establishes the regulatory basis for the administration of the emergency ambulance program. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available under the MO HealthNet program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of provider participation, criteria and methodology for provider reimbursement, participant eligibility, and amount, duration and scope of services covered are included in the ambulance program manual, which is incorporated by reference in this rule and available at the website.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The MO HealthNet ambulance program shall be administered by the Department of Social Services, MO HealthNet Division. The ambulance program services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the MO HealthNet Division and shall be included in the ambulance program provider manual, which is incorporated by reference and made part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/mhd, May 15, 2019. This rule does not incorporate any subsequent amendments or additions.

(2) Eligible Providers. To be eligible for participation in MO HealthNet, the following requirements shall be met:

(A) Ground Ambulance.

1. The provider must be licensed by the Missouri Department of Health and Senior Services if located in Missouri or licensed by the state regulating authority if located outside the state of Missouri.

2. The provider must be certified to participate in the Title XVIII Medicare program and have a signed and accepted Participation Agreement in effect with the Missouri Department of Social Services, MO HealthNet Division; and

(B) Air Ambulance. Air ambulance is defined as any privately or publicly owned conventional air service, rotary wing or fixed-wing specially designed, constructed or modified, maintained or equipped with the intent to be used for the transportation of patients as defined in Federal Aviation Regulations, Part 135.

1. The air ambulance provider must have a current valid air ambulance license, be licensed by the state regulating authority if located outside of Missouri, have submitted a copy of the current Federal Aviation Regulations, Part 135, (FAA) Air Carrier Certificate issued by the United States Department of Transportation.

2. The air ambulance provider must have a signed and accepted Participation Agreement for the air ambulance program in effect with the Missouri Department of Social Services, MO HealthNet Division.

(3) Participant Eligibility. The ambulance provider must ascertain the patient's MO HealthNet status before billing for services. The participant's MO HealthNet/Managed Care eligibility is determined by the Family Support Division. The participant must be eligible for MO HealthNet on the date that a service is provided in order for a provider to receive MO HealthNet reimbursement. It is the provider's responsibility to determine the coverage benefits for a participant based on their type of assistance as outlined in the ambulance program manual. The participant's eligibility shall be verified in accordance with methodology outlined in the ambulance program manual.

(4) Prior Authorization. Emergency ambulance services do not require prior authorization. All non-emergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants and for which MO HealthNet is to be billed, must be prior authorized before the out-of-state services are provided. A prior authorization is not required for out-of-state emergency services.

(5) Services Covered and Service Limitations. The MO HealthNet ambulance manual shall provide the detailed listing of procedure codes and pricing information covered by the MO HealthNet ambulance program.

(A) Covered ambulance services are —

1. Transportation is made to the nearest appropriate hospital when the criteria for emergency services is met (see (5)(B) below);

2. On-site treatment provided by an emergency medical technician or by a paramedic that meets the following criteria:

A. The treatment is a result of an emergent or immediate response made by a licensed ambulance service;

B. The emergency medical technician (EMT) or paramedic provides an assessment to determine the MO HealthNet participant's medical condition;

C. Medically necessary treatment is provided to the participant on-site; and

D. The participant is not transported by the responding service provider to an emergency department; and

3. On-site referral for further treatment that meets the following criteria:

A. The referral is a result of an emergent or immediate response made by a licensed ambulance services;

B. The EMT or paramedic provides an assessment to determine the MO HealthNet participant's medical condition;

C. The referral is provided to the participant; and

D. The participant is not transported by the responding service provider to an emergency department.

(B) Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Nearest appropriate hospital is the hospital that is equipped and staffed to provide the needed

care for the illness or injury involved. MO HealthNet does not allow transportation to a more distant hospital solely to avail a patient of the services of a specific physician or family or personal preference when considering the nearest appropriate facility.

(C) Exceptions to Emergency Services.

1. MO HealthNet covers medically necessary ambulance services for participants under twenty-one (21) years of age through the Healthy Children and Youth (EPSDT/HCY) program. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) expanded medically necessary services for children under the age of twenty-one (21) through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, also known as the Healthy Children and Youth (HCY) program. This allows for non-emergency transportation of children by ambulance for health care when other modes of travel are not medically appropriate and may endanger the child's health. When other modes of transportation are available that would allow for safe transport of the child, these options must be utilized.

2. Transportation to and from one hospital to another and return for specialized testing and/or treatment is covered.

3. MO HealthNet covers transportation from the point of pickup to two (2) different hospitals made on the same day by the same ambulance provider when it is medically necessary.

4. Ground ambulance transfers of patients from one hospital to another hospital to receive medically necessary inpatient services not available at the first facility shall be covered by MO HealthNet. Hospital transfers shall be covered when the patient has been stabilized at the first hospital, but needs a higher level of care available only at the second hospital.

(D) MO HealthNet covers emergency rotary wing air ambulance only when:

1. Transportation by ground ambulance is contraindicated; or

2. The patient's medical condition is such that immediate and rapid ambulance transportation is essential and cannot be provided by ground ambulance; or

3. Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities; or

4. The patient's medical condition is such that the time needed to transport by land, or the instability of transportation by land poses a threat to the patient's survival or seriously endangers the patient's health; or

5. The point of pickup is inaccessible by land vehicle; and

6. All other MO HealthNet requirements for coverage are met.

(E) MO HealthNet covers fixed-wing air ambulance when:

1. The weather situation at the time of transport prohibits the use of a rotary wing ambulance; or

2. Transportation by ground ambulance or rotary wing ambulance is contraindicated; or

3. The patient's medical condition is such that immediate and rapid ambulance transportation is essential and cannot be provided by ground ambulance or rotary wing ambulance; or

4. Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities; or

5. The patient's medical condition is such that the time needed to transport by land or rotary wing, or the instability of transportation by land or rotary wing ambulance poses a threat to the patient's survival or seriously endangers the patient's health; or

6. The point of pickup is inaccessible by land vehicle; and

7. All other MO HealthNet requirements for coverage are met.

(6) Services Not Covered.

(A) Ground Ambulance. The following services are not covered under the ground ambulance program:

1. Ambulance transportation to a physician's office, a dentist's office, a nursing home, or a patient's home except for participants under twenty-one (21) (except ME codes 76-79) through the EPSDT/HCY program;

2. Ambulance services to a hospital for the first stage of labor;

3. Non-emergency ambulance trips are not covered with the exceptions of those services listed above;

4. If a participant is pronounced dead before the ambulance is called, no MO HealthNet payment is made; or

5. Ancillary services and supplies are not covered when the patient is not transported.

(B) Air Ambulance. The following services are not covered under the air ambulance program:

1. Air ambulance trip for the patient's personal preference;

2. Patient not transported to the nearest hospital with appropriate facilities;

3. Ambulance trips ordered by the Veteran's Administration Hospital;

4. Transport of medical team (or other medical professionals) to meet a patient;

5. Ground mileage;

6. Transport to a facility that is not an acute care hospital, such as a nursing facility or physician's office or dentist's office or independent clinic or independent laboratory or to a patient's home;

7. Transport if a participant is pronounced dead before the air ambulance is called; or

8. Ancillary services and supplies when the patient is not transported.

(C) When individuals are transported by ambulance to an emergency room and are subsequently treated and released without admission to the hospital, the return trip is not covered under the emergency ambulance program.

(7) General Regulations. General regulations of the MO HealthNet program apply to the ambulance program.

(8) Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division. Providers must bill their usual and customary charge for ambulance services. Reimbursement will not exceed the lesser of the maximum allowed or the provider's billed charges. Ambulance program services are only payable to the enrolled, eligible, participating provider. The MO HealthNet program cannot reimburse for services performed by non-enrolled providers.

(9) Other Source Payment. The MO HealthNet payment for ambulance services cannot duplicate or replace benefits available to the participant from any other source, public or private. A settlement received from private insurance or litigation as the result of an accident must be used toward payment of the ambulance bill. MO HealthNet shall be the last source of payment on any claim. Any payment received from a private insurance carrier or other acceptable source shall be listed on the claim form. If the settlement received is equal to or exceeds the fee that could be allowed by MO HealthNet, no payment shall be made by MO HealthNet.

(10) Documentation Requirements for Emergency Ambulance Program. All services must be adequately documented in the medical record. Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Documentation includes the Missouri Ambulance Reporting Form (trip ticket). In addition to the above documentation requirements, each licensee of an air ambulance must maintain accurate records that contain information concerning the air transportation of each patient. The patient record shall be maintained and shall accurately document the patient care rendered by the medical flight crew and the disposition of the patient at the receiving facility. The documentation of the emergency air ambulance flight record (trip ticket) must contain a description of the patient's medical condition with sufficient detail to demonstrate the need for emergency air ambulance.

(11) Records Retention. The enrolled MO HealthNet ambulance provider shall keep any records necessary to fully document compliance with this regulation and the services the provider furnishes to participants. These records must be retained for seven (7) years from the date of service. Fiscal and medical records must coincide with and fully document services billed to the MO HealthNet agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the MO HealthNet program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2019. Original rule filed Feb. 10, 2006, effective Sept. 30, 2006. Amended: Filed Aug. 1, 2006, effective Feb. 28, 2007. Amended: Filed Aug. 23, 2007, effective March 30, 2008. Amended: Filed July 31, 2008, effective Feb. 28, 2009. Amended: Filed May 15, 2019, effective Dec. 30, 2019.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-6.020 Ground Emergency Medical Transportation Uncompensated Cost Reimbursement Program

PURPOSE: This rule implements the Ground Emergency Medical Transportation (GEMT) Uncompensated Cost Reimbursement Program established pursuant to section 208.1030, RSMo, which is a voluntary program that makes reconciled cost reimbursement to eligible GEMT providers that furnish qualifying emergency ambulance services to MO HealthNet participants on or after July 1, 2017.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Scope and Definitions.

(A) Under the Ground Emergency Medical Transportation (GEMT) Uncompensated Cost Reimbursement Program (hereinafter the "program"), the MO HealthNet Division (MHD) makes reconciled cost reimbursement to eligible GEMT providers up to the uncompensated Medicaid costs associated with GEMT services. This reconciled cost reimbursement applies only to GEMT services rendered to MHD participants by eligible GEMT providers on or after July 1, 2017. Total reimbursements from MHD, including the reconciled cost reimbursement, will not exceed one hundred percent (100%) of the eligible GEMT provider's actual costs of providing GEMT services to MHD participants. The supplemental MHD reimbursement shall be distributed to eligible GEMT providers based on GEMT services provided to MHD participants on a per-transport basis. The reconciled cost reimbursement is not an individual increase to current fee-for-service reimbursement rates.

(B) Definitions.

1. Cost objective means a function or category of service for which costs are incurred.

2. Direct cost means those costs that —

A. Meet the direct costs definition in accordance with 2 CFR 200.413.

(I) Can be identified specifically with a particular final cost objective, such as a federal award, or other internally or externally funded activity.

(II) Can be directly assigned to such activities relatively easily with a high degree of accuracy; and

B. The direct costs allocated based on a statistical allocation for emergency medical response (EMR) and non-emergency medical response (non-EMR) costs do not meet the definition of direct costs, but are included under direct allocated cost. Estimates are not allowed.

3. Direct allocated costs means costs that cannot be directly assigned to EMR services or non-EMR services relatively easily with a high degree of accuracy. Examples of direct allocated costs include personnel who perform EMR and non-EMR services and overhead departments who perform EMR and non-EMR services.

4. Dry run means a run that does not result in a transport or delivery of on-site Medicaid covered services. Covered services are defined by Medicaid per 13 CSR 70-6.010.

5. Eligible GEMT provider means a provider who is eligible to receive reconciled cost reimbursement under this program because it meets the following requirements continuously during the claiming period:

A. Provides GEMT services to MHD participants;

B. Is enrolled as an MHD provider for the period being claimed; and

C. Is owned, operated, or contracted by the state or a political subdivision of the state.

6. Emergency medical response (EMR) means a cost objective that includes all expenditures for GEMT services.

7. 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 & Medicaid Services in accordance with the state plan for medical assistance.

8. 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 eligible GEMT providers before or during the act of transportation. As of January 1, 2020, GEMT services also include advanced, limited advanced, and basic life support services provided

to an individual who is released on the scene without transportation by ambulance to a medical facility. Advanced, limited-advanced, or basic life support services provided to an individual who is released on the scene without transportation by ambulance to a medical facility prior to January 1, 2020, shall not be considered GEMT services. A dry run shall not be considered a transport for purposes of GEMT services. GEMT services exclude all air services.

9. Indirect cost means those costs that are incurred by a supporting organization or related party which are not directly accounted for as costs for EMR services, non-EMR services, or direct allocated costs. Examples of indirect costs include overhead costs (i.e., accounting, human resources, etc.) incurred by a city, county, or other local government agency or special district that benefit the eligible GEMT provider, but the eligible GEMT provider has not been charged for those costs. The identification of direct allocated costs does not preclude an eligible GEMT provider from also incurring indirect costs, and it is appropriate in certain cases for the uncompensated Medicaid costs to include both direct allocated costs and indirect costs.

10. MHD participant means a patient enrolled in fee-for-service Missouri Medicaid.

11. Non-emergency medical response (non-EMR) means a cost objective that includes expenditures for non-medical emergency services, such as fire suppression not including medical services, and non-emergency ancillary services, such as fire prevention and fire permit issuance that are performed in the absence of an emergency in order to support preparedness, mitigate the need for emergency response, or lessen the severity of an emergency that might occur. Expenditures assigned to this cost objective are not allowable for determining the cost of emergency transportation.

12. Reconciled cost reimbursement means a payment to eligible GEMT providers up to the uncompensated Medicaid costs associated with GEMT services for MHD participants.

13. 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 among providers but will be consistent for each individual provider.

14. Service period means July 1 through June 30 of each Missouri state fiscal year.

15. Transport means GEMT services that are provided by eligible GEMT providers to individuals, regardless of whether the service was billed or paid. Medicaid transports includes GEMT services for Medicaid managed care, Medicaid crossover, and Medicaid fee for service patients. Other payer program transports shall be GEMT services provided to patients with payer sources other than Medicaid. Transportation services that do not involve the act of transporting an individual to the nearest medical facility capable of meeting the emergency medical needs of a patient shall not be included as transports.

16. Uncompensated Medicaid costs means the cost of GEMT services for MHD participants that exceeds the reimbursement received from, but not limited to, Medicaid, patients, and enhanced supplemental payments received from the ambulance service reimbursement allowance under 13 CSR 70-3.200. Cost excludes Medicaid managed care and dual-eligible Medicaid transports.

17. Dual-eligible Medicaid transport means any transport where Medicaid is not the primary payor due to other coverage including Medicare or other private insurance. These costs will not be reimbursed in the GEMT supplemental program.

(2) Participation and Enrollment Requirements.

(A) Participation in the GEMT program is voluntary.

(B) Ambulance providers that are not owned, operated, or contracted by the state or a political subdivision of the state are not eligible to participate in the program.

(C) As a condition of participation under this program, eligible GEMT providers shall transfer an administrative fee to MHD in an amount not to exceed five percent (5%) of the nonfederal share of the uncompensated Medicaid costs associated with GEMT services as identified in the eligible GEMT provider's as-filed cost report. Such fee shall be transferred separately from the intergovernmental transfer of funds to MHD.

(D) To participate in the GEMT program, an eligible provider shall complete and execute the following forms and return them to MHD or its vendor. An eligible GEMT provider must complete and submit to MHD the following forms, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, September 22, 2021, and may be downloaded from https://dss.mo.gov/mhd/providers/gemt.htm, obtained by emailing a written request to Ask.GEMT@dss.mo.gov, or acquired in person at 615 Howerton Court, Jefferson City, MO 65109. This rule does not include any subsequent amendments or additions:

1. GEMT Program Provider Agreement for the MO HealthNet Division Ground Emergency Medical Transportation (GEMT) Uncompensated Cost Reimbursement Program;

2. Electronic Funds Transfer Authorization Agreement;

3. Intergovernmental Transfer of Public Funds Agreement; and

4. Administration Fee Agreement.

(3) Interim Payments and Cost Settlement Process.

(A) If the eligible GEMT provider's as-filed cost report reflects that the eligible GEMT provider has uncompensated Medicaid costs associated with GEMT services, the eligible GEMT provider is eligible to receive an interim payment from MHD. The eligible GEMT provider will make an intergovernmental transfer of funds to MHD in an amount equivalent to the nonfederal share of the uncompensated Medicaid costs amount shown on the as-filed cost report. MHD will then make an interim payment to the eligible GEMT provider in the amount of the total uncompensated Medicaid costs.

(B) If the eligible GEMT provider's as-filed cost report does not reflect any uncompensated Medicaid costs associated with GEMT services, then the provider is not entitled to receive an interim payment from MHD under this supplemental payment program and will not be responsible for any costs associated with implementing the GEMT program.

(C) MHD will audit and reconcile the as-filed cost reports within one (1) year of receipt of the as-filed cost reports, unless MHD determines that additional time is needed, not to exceed three (3) years from receipt of the as-filed cost reports. To audit and reconcile the as-filed cost reports, MHD will use paid claims data for the service period generated from the Medicaid Managed Information Systems (MMIS) and eligible GEMT provider records. MHD will make adjustments to the as-filed cost report based on the audit and reconciliation and send the provider its preliminary findings after receiving all relevant data from providers. The provider will be given fourteen (14) days to respond to MHD's preliminary findings, unless an extension is granted by MHD. MHD's final audit and reconciliation decision will be issued. Cost report will be deemed final once MHD issues a final determination letter and final adjusted cost report. If at the end of the final audit and reconciliation it is determined that the interim payment

made to the eligible GEMT provider exceeded the provider's uncompensated Medicaid costs associated with GEMT services, the provider shall return the excess amount associated with the federal share to MHD and MHD will return the amount to the federal government pursuant to 42 CFR 433.316. If at the end of the final reconciliation it is determined that the interim payment made to the eligible GEMT provider was lower than the provider's uncompensated Medicaid costs associated with GEMT services, the eligible GEMT provider shall make an additional intergovernmental transfer to MHD in an amount equivalent to the nonfederal share of the underpayment, and MHD will then make an additional payment to the eligible GEMT provider of the full underpayment amount. MHD shall recoup funds paid out under section 208.1030, RSMo, and this regulation upon a disallowance of federal financial participation (FFP) for those funds. The recoupment will follow the process outlined in 13 CSR 70-3.030(6).

(D) Each provider's uncompensated Medicaid cost associated with GEMT services is the sum of the number of transports for MHD participants provided during the applicable service period shown as paid in MMIS data, excluding Medicaid managed care and dual-eligible Medicaid transports, and contained in eligible GEMT provider records, multiplied by the provider's per-transport cost rate, less all amounts received and payable from MHD (excluding Medicaid managed care payments) and patients for such transports as shown in the MMIS and eligible GEMT provider records, and all other sources of reimbursement for such transports. Other sources of reimbursement include, but are not limited to, co-payments received from participants, and enhanced supplemental payments received from the ambulance service reimbursement allowance under 13 CSR 70-3.200.

(E) Each provider's per-transport cost rate is determined on the CMS-approved cost reports by adding the provider's allowable direct, direct allocated, and indirect costs of providing GEMT services divided by the total number of transports provided for the applicable service period.

(4) Cost Report Requirements.

(A) To receive reconciled cost reimbursement under the GEMT program, each eligible GEMT provider must submit an annual cost report to MHD. Providers shall provide any supporting documentation to substantiate information provided on the cost report as requested by MHD or its contractor. The cost report form and the cost report instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, September 22, 2021, and available at https://dss.mo.gov/mhd/providers/gemt.htm, or by emailing a written request to Ask.GEMT@dss.mo.gov. This rule does not incorporate any subsequent amendments or additions.

(B) The cost report must be completed in compliance with the requirements set forth in this regulation and the cost report instructions incorporated herein. The eligible GEMT provider shall submit the cost report to MHD by November 30 for the prior state fiscal year ending June 30, unless the provider has submitted a written request to MHD for an extension and such request is granted by MHD. Any written request for an extension must include a detailed explanation of the circumstances supporting the need for additional time. Extensions may be granted by MHD for good cause.

(C) Each provider shall maintain fiscal and statistical records for the services 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 —

1. The division certifies that the cost report is finalized and settled; or

2. A period of six (6) years following the submission of the 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.

(D) All costs reported must be in accordance with the following:

1. Allowable and unallowable costs.

A. Reconciled cost reimbursement is available only for allowable costs incurred for GEMT services rendered to MHD participants based on the provider's financial data reported on the cost report.

B. Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare & Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), 2 CFR Part 200, and 42 CFR Part 413, except as expressly modified herein.

(I) Part 200 of Title 2, Code of Federal Regulations, is incorporated by reference and made a part of this rule as published by the Office of the Federal Register, 800 North Capitol Street NW, Suite 700, Washington, D.C. 20408, and available at https://dss.mo.gov/proposed-rules, January 1, 2021. This rule does not incorporate any subsequent amendments or additions.

(II) Part 413 of Title 42, Code of Federal Regulations, is incorporated by reference and made a part of this rule as published by the Office of the Federal Register, 800 North Capitol Street NW, Suite 700, Washington, D.C. 20408, and available at https://dss.mo.gov/proposed-rules, October 1, 2020. This rule does not incorporate any subsequent amendments or additions.

(III) The Provider Reimbursement Manual — Part 1 (CMS Pub. 15-1) is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929, September 22, 2021. A copy is available at the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. This rule does not incorporate any subsequent amendments or additions.

C. Costs which are considered unallowable include expenditures, such as bad debts, contributions and donations, entertainment including alcoholic beverages, fundraising costs, lobbying, legal judgments, and fines or penalties, which 2 CFR Part 200 does not permit to be charged to federal programs. If unallowable costs are not easily identifiable from allowable costs, the associated revenues received for providing the unallowable services will be offset against allowable cost. Additionally, for the purposes of Medicaid cost identification for the GEMT program, expenditures attributed to the nonemergency medical response cost objective are not costs incurred for GEMT services.

D. Amounts required to be paid pursuant to the ambulance service reimbursement allowance (AFRA) under 13 CSR 70-3.200, excluding administrative fees and pooling fees, are allowable for GEMT services. Pooling payments received from participation in the ambulance service reimbursement allowance program shall reduce the ambulance service reimbursement allowance amount reported as allowable by the provider.

E. Administrative costs incurred for reimbursing MHD for costs associated with implementing the GEMT program must be excluded from the cost report.

F. Eligible GEMT providers routinely use contract billing service providers to assist with the administrative functions of billing and collecting on patient accounts. Payments to contract billing service providers are an allowable administrative cost. Fee arrangements based on hourly rates, fixed amounts, percentage of collection, or other methods are all considered allowable for computing uncompensated Medicaid costs; however, all payments to contract billing service providers must not exceed fair market value; and

2. Direct and indirect costs.

A. All direct costs must be reasonable and necessary and must be supported by documentation from which the costs incurred by the provider can be readily discerned and verified with reasonable certainty. Such documentation shall be subject to review by MHD.

B. Eligible GEMT providers that do not provide fire services would not have direct allocated costs and the cost report would reflect only EMR direct costs. Eligible GEMT providers that do not provide fire services but provide training (of non-employees) or nonemergency medical transportation services (e.g., non-emergency transportation between medical facilities or patient homes) shall include the costs of such services in their EMR direct costs, but shall offset those costs by any reimbursement received for such services up to the amount of costs for such services.

C. There is no universal rule for classifying certain costs as either direct cost or direct allocated cost under every accounting system. A cost may be direct cost with respect to some specific service or cost objective, but direct allocated cost 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 as a direct cost or a direct allocated cost in order to avoid possible double-charging of federal awards. For example, any cost incurred by an eligible GEMT provider which includes both costs incurred applicable to non-EMR services as well as GEMT services must in their entirety be consistently classified as direct or direct allocated costs.

D. Direct costs for providing GEMT services include only the unallocated payroll costs for the shifts in which personnel dedicate one hundred percent (100%) of their time to providing GEMT services, medical equipment and supplies, and other costs directly related to the delivery of GEMT 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 federal Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the GEMT services. Directly assigned costs must be supported by auditable records, such as general ledger detail and should be assigned as part of the normal ongoing accounting process.

E. Direct allocated costs for EMR and non-EMR services shall be allocated based on a reasonable method in accordance with the guidelines in 2 CFR Part 200. The allocation statistic should identify and exclude costs associated with any personnel who is not considered a licensed or certified emergency medical technician and/or did not perform Medicaid covered services at an emergency site. If the allocation statistic is not supported by a time study or other adequate documentation to demonstrate dispatched personnel were performing Medicaid covered services at the emergency site, then at a minimum, the cost associated with personnel not on the treating or transporting ambulance should be identified and removed. This would include the removal of all fire apparatus personnel dispatched to an emergency scene. The cost report shall allow the provider to use any reasonable method allowed in the Centers for Medicare & Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), 2 CFR Part 200, and 42 CFR Part 413, an example of reasonable methods include, among others —

(I) Square footage allocations for capital cost;

(II) Depreciation cost for capital cost; or

(III) Time studies for salaries and benefits.

F. When providing allocation information, statistics from the direct allocated costs should not be included in the calculations for allocation between EMR and non-EMR services.

G. Pursuant to 2 CFR Part 200, indirect costs are determined in accordance to one (1) of the following options:

(I) Eligible GEMT providers that receive more than thirty-five million dollars ($35,000,000) 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 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 (1) or the other before it can claim any indirect cost;

(II) Eligible GEMT providers that receive less than thirty-five million dollars ($35,000,000) 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, providers may use methods originating from a CAP to identify its indirect cost. If the 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 (1) or the other before it can claim any indirect cost;

(III) Eligible GEMT providers that receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:

(a) A CAP with its local government;

(b) An indirect rate negotiated with its local government; or

(c) Direct identification through use of a cost report; and

(IV) If the GEMT 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.

AUTHORITY sections 208.201, 208.1030, and 660.017, RSMo 2016. Original rule filed Sept. 22, 2021, effective April 30, 2022. Amended: Filed Dec. 23, 2025, effective June 30, 2026.*

**Original authority: 208.201, RSMo 1987, amended 2007; 208.1030, RSMo 2016; and 660.017, RSMo 1993, amended 1995.*