ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule SPA #2021-0008 Public Ambulance Supplemental Payment

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers

1. Effective July 1, 2021, governmental ambulance service providers that meet the specified requirements outlined in section A below and provide emergency ground medical transportation services to Medicaid clients will be eligible for a supplemental payment. This supplemental payment applies to emergency medical services (EMS) furnished to Medicaid clients by eligible governmental ambulance service providers on or after July 1, 2021.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to ambulance service providers in accordance with Attachment 4.19-B, Page 8 that eligible entities receive for emergency medical transportation services to eligible Medicaid fee-for-service clients. The Department of Human Services (DHS) will cap the total reimbursements from Medicaid (including supplemental payment) at one hundred percent. DHS will recognize, on a voluntary basis, a supplemental payment equal to the total allowable Medicaid costs of approved governmental ambulance service providers for providing services as set forth below.

2. To qualify for supplemental payments, providers must meet all the following:

(A) Be enrolled as a Medicaid provider for the period being claimed on their annual cost report;

(B) Provide ground emergency medical transportation services to Medicaid enrollees; and

(C) Be organizations 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.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

3. Supplemental Reimbursement Methodology—General Provisions

(A) Computation of allowable costs and their allocation methodology must be determined in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 1501), CMS non-institutional reimbursement policies, 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), and 2 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.

(B) The total uncompensated care costs of each eligible provider available to be reimbursed under this supplemental reimbursement program will equal the shortfall resulting from the allowable costs determined using the Cost Determination Protocols for each eligible provider furnishing emergency medical transportation services to Arkansas Medicaid clients, net of the amounts received and payable from the Arkansas Medicaid program and all other sources of reimbursement for such services provided to Arkansas Medicaid clients. If the eligible providers do not have any uncompensated care costs, then the provider will not receive a supplemental payment under this supplemental reimbursement program.

4. Cost Determination Protocols

(A) An eligible provider's specific allowable cost per-emergency medical transportation rate will be calculated based on the provider's financial data reported on the state-approved cost report. The per-emergency medical transportation cost rate will be the sum of actual allowable direct and indirect costs of providing emergency medical transportation services divided by the actual number of emergency medical transports provided for the applicable service period.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

4. Cost Determination Protocols (continued)

(B) Direct costs for providing emergency medical transportation services (MTS) include only the unallocated payroll costs for the shifts in which personnel dedicate one-hundred percent (100%) of their time to providing emergency medical transportation 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). These costs must comply with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the emergency medical transportation services.

(C) The total percentage of time spent on medical calls throughout the cost reporting period will be calculated using Computer Aided Dispatch (CAD) and trip statistics and will be used as an allocation methodology for those costs "shared" between MTS vs. Non-MTS divisions. Providers will allocate shared Capital Related and Salaries & Benefits (CRSB) costs based on CAD/Trip Statistics.

(D) Indirect costs are determined in accordance to one of the following options.

(1) Eligible 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 department approved indirect rate agreement in place with its federal cognizant department to identify indirect cost. If the Eligible provider does not have a CAP or an indirect rate agreement in place with its federal cognizant department and it would like to claim indirect cost in association with a non-institutional services, it must obtain one or the other before it can claim any indirect cost.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

4. Cost Determination Protocols (continued)

(E) Eligible providers that receive less than thirty-five million dollars ($35,000,000) in 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, eligible providers 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 secure one or the other before it can claim any indirect cost.

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

(1) A CAP with its local government;

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

(3) Direct identification through use of a cost report.

(G) If the eligible provider never established any of the methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost.

5. Cost Settlement Process

(A) The payments and the number of transport data reported in the as-filed cost report will be reconciled to the Arkansas Medicaid Management Information System (MMIS) reports generated for the cost reporting period with four (4) months of the as-filed cost report deadline. DHS will adjust the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

5. Cost Settlement Process (continued)

(B) Each eligible provider will receive an annual lump sum payment in an amount equal to the total of the uncompensated care costs as defined in the above Supplemental Reimbursement Methodology—General Provisions Section 3.B.

(C) DHS will perform a final reconciliation to settle the provider's annual cost report as reviewed, audited, or both, after three hundred sixty-five days (365). DHS will compute the net EMS allowable costs using reviewed, audited, or both, per medical transportation cost, and the number of fee-for-service EMS transports data from the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, spenddown, settlement payments made, and any other source of reimbursement received by the provider for the period. If, at the end of the final reconciliation, it is determined that the eligible provider has been overpaid, the provider will return the overpayment to DHS and DHS will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the eligible provider will receive a final supplemental payment in the amount of the underpayment.

(D) Providers will not submit a cost report if they withdraw from the Medicaid program or change ownership and become a non-governmental ambulance provider. All payments made to the provider will be considered final.

(E) Providers may submit partial year cost reports if they are newly enrolled providers or if they change ownership and become a governmental provider.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

6. Eligible Provider Reporting Requirements

(A) The Cost report will be completed on a state fiscal year basis and will be due to DHS no later than ninety (90) calendar days following the last day of the state fiscal year.

(B) "Governmental ambulance services provider" means an ambulance service provider that belongs to a unit of government which is a state, a city, a county, a special purpose district or authority, or other governmental unit in the State that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined by Section 4 of the Indian Self-Determination and Education Assistance Act.

(C) Participating government ambulance service providers that meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (a) through (d) for services provided on or after July 1, 2021.

(D) The governmental ambulance services provider will be paid interim rates equal to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with Attachment 4.19-B, Page 8. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

(E) The governmental ambulance services provider will submit a state approved cost report annually, on a form approved by DHS. The cost report will be completed on a state fiscal year basis and will be due to DHS no later than ninety (90) calendar days following the last day of the state fiscal year.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4.1) Supplemental Payment for Government Ambulance Service Providers (continued)

6. Eligible Provider Reporting Requirements (continued)

(F) "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, 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), and 2 CFR , part 200 as implemented by HHS at 45 CFR, part 75.

(1) "Direct costs" are those costs that are identified by 45 CFR 75.413 that:

i. Can be identified specifically with a particular final cost objective (to meet emergency medical transportation requirements), such as a federal award, or other internally or externally funded activity; or

ii. Can be directly assigned to such activities relatively easily with a high degree of accuracy.

(2) "Indirect costs" means the costs that cannot be readily assigned to a particular cost objective and are those that have been incurred for common or joint purposes.

i. The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid transports associated with paid claims for the dates of service covered by the submitted cost report.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** jason.callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE SPA 2021-0008 Public Ambulance Supplemental Payment

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	$0	Total	$0

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	0	General Revenue	0
Federal Funds	$7,866,650	Federal Funds	$7,877,374
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	$3,132,196	Other (Identify)	$3,121,473
Total	$10,998,846	Total	$10,998,846

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year $ $3,132,196

Next Fiscal Year $ $3,121,473

100% of the State Share will be paid by quarterly Intergovernmental Transfers (IGT) from the public ambulance providers.

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year $ 0

Next Fiscal Year $ 0

100% of the State Share will be paid by quarterly Intergovernmental Transfers (IGT) from the public ambulance providers.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose; **The rule establishes the Public Ambulance Supplemental Payment.**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; **The rule seeks to improve the quality and timeliness of medical transports in Arkansas.**

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

The rule seeks to improve the quality and timeliness of medical transports in Arkansas.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **No comments received to date.**

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **No Alternatives are proposed at this time**

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and **Not applicable**

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. **The Agency monitors State and Federal rules and policies for opportunities to reduce and control cost**.

Statement of Necessity and Rule Summary

State Plan Amendment (2021-0008) to Establish Public Ambulance Supplemental Payments

Statement of Necessity

The purpose of this State Plan Amendment is to establish a payment methodology for participation in the Ambulance Supplemental Payment Program (ASPP) by governmentally owned or operated emergency medical transportation providers. The supplemental payments will be for allowable costs that exceed Medicaid reimbursement rates and will not replace any currently authorized Medicaid Transportation payments.

Rule Summary

The Department of Human Services, Division of Medical Services is applying to the Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment to assist Public Emergency Medical Transportation Providers in receiving reimbursement for allowable costs that exceed Medicaid reimbursement rates. The payments will be calculated on an annual basis and paid on a quarterly basis. The methodology to be used to calculate these payments is identified on the submitted State Plan Amendment (SPA) proposal for attachment 4.19-B pages 8aa-3, 8aa-4, 8aa-5, 8aa-6, 8aa-7, 8aa-8, and 8aa-9.

The state share of the supplemental payments will be paid by the eligible Public EMS providers through an Intergovernmental Transfer (IGT) Agreement.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective October 1, 2021:

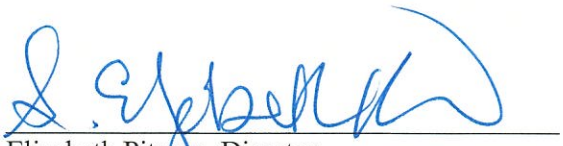
The Director of the Division of Medical Services (DMS) amends the Arkansas Medicaid State Plan to establish a payment methodology for governmentally owned or operated emergency medical transportation providers in the Ambulance Supplemental Payment Program. The amendment assists Public Emergency Medical Transportation providers in receiving reimbursement for allowable costs that exceed Medicaid reimbursement rates. The payments will be calculated on an annual basis and paid on a quarterly basis. The state share of the supplemental payments will be paid by the eligible Public Emergency Medical Services providers through an Intergovernmental Transfer Agreement. The proposed amendment is estimated to result in an increase in annual aggregate expenditures of $11 million for state fiscal year (SFY) 2023 consisting of $8 million in federal funds and $3 million in non-federal funds. These figures represent full participation by all eligible providers in the state.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than August 13, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on July 28, 2021 at 10:30a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/81576845602. The webinar ID is 815 7684 5602. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528



Elizabeth Pitman, Director
Division of Medical Services