

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised:

July 1, 2019

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

a. Transportation (Continued)

(2) Air Ambulance (continued)

Pediatric Hospitals

1. Helicopter Ambulance: Effective for dates of service occurring August 15, 2001 and after, helicopter ambulance services provided by in-state pediatric hospitals will be reimbursed based on reasonable costs with interim payments and year-end cost settlement. Interim payments are made at the lesser of the amount billed or the Title XIX (Medicaid) charge allowed. Arkansas Medicaid will use the lesser of the reasonable costs or customary charges as determined from the hospital's submitted cost report to establish cost settlements. The cost settlements will be calculated using the methods and standards used by the Medicare Program. Methods and standards refer to the allocation of costs on the cost report and do not include any current or future Medicare reimbursement limits for this particular service.

**(3) Emergency Medical Transportation Access Payment**

1. **Effective for dates of service on or after July 1, 2019, qualifying medical transportation providers within the State of Arkansas; except for volunteer ambulance services, ambulance services owned by the state or county and political subdivisions, non-emergency ambulance services, air ambulance services, specialty hospital based ambulance services, and ambulance services subject to the state's assessment on the revenue of hospitals; shall be eligible to receive emergency medical transportation access payments. All emergency medical transportation providers that meet this definition will be referred to as Qualified Emergency Medical Transportation (QEMT) providers for purpose of this section.**

2. **Payment Methodology**

(A) **The emergency medical transportation access payment to each QEMT shall be calculated on an annual basis and paid out quarterly. The access payment will be eighty percent (80%) of the difference between Medicaid payments otherwise made to QEMTs for the provision of emergency medical transportation services and the average amount that would have been paid at the equivalent community rate (hereinafter, average commercial rate or ACR).**

(1) **The Division shall align the paid Medicaid claims for each QEMT with the Medicare fees (Medicare Fee Schedule – Urban) for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code and calculate the Medicare payment for those claims.**

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a. Transportation (Continued)

(3) Emergency Medical Transportation Access Payment (continued)

(2) The Division shall calculate a separate Medicare equivalent of the ACR for each QEMT that qualifies for the access payment by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

(C) The specific payment methodology to be used in establishing the emergency medical transportation access payment for QEMTs is as follows:

(1) The Division shall send emergency medical transportation access payment data collection forms to QEMTs.

(2) For each QEMT who submits the required data, the Division shall identify the emergency medical transportation services for which the provider is eligible to be reimbursed.

(3) For each QEMT who submits the required data, the Division shall calculate the reimbursement paid to the QEMT for the provision of emergency medical ambulance transportation services excluding air ambulance services.

(4) For each QEMT, the Division shall calculate the QEMT's average commercial rate for all services identified under Subparagraph (2) of this Section.

(5) For each QEMT, the Division shall subtract an amount equal to the reimbursement calculation for each of emergency medical transportation service from the amount calculated for each of the emergency medical transportation services. [B (4)-B (3)]

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a. Transportation (Continued)

(3) Emergency Medical Transportation Access Payment (continued)

(6) For each QEMT, the Division shall calculate the sum of each of the amounts calculated for emergency medical transportation services in Subparagraph (B (5)).

(7) The Division shall provide a demonstration that access payments for the state fiscal year are within the applicable fee-for-service upper payment limits as defined in 42 CFR 447.272, when the upper payment limit demonstrations are due for the fiscal year. If the demonstration shows that payments for any category have exceeded the UPL, the state will take corrective action as determined by CMS.

(C) The Division shall reimburse QEMTs the access payment of eighty percent (80%) of their UPL gap.

(D) These access payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for emergency medical transportation services.

(4) Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) Transportation

Effective for claims with dates of service on or after July 1, 2018, EIDT and ADDT transportation providers will be reimbursed on a per mile basis at the lesser of the billed charges or the maximum Title XIX (Medicaid) charge allowed. Transportation will be covered from the point of pick-up to the EIDT and ADDT facility and from the EIDT and ADDT facility to the point of delivery. If more than one eligible Medicaid recipient is transported at the same time to the same location, Medicaid may be billed only for one recipient. If more than one Medicaid recipient is transported at the same time to different locations, the provider may bill only for the recipient traveling the farthest distance. The route must be planned to ensure that beneficiaries spend the least **amount** of time being transported. The maximum per mile is based on reasonable cost.

The EIDT and ADDT transportation providers will submit annual statements of mileage, revenues and expenses, i.e. salaries, repairs, supplies, rent, indirect overhead costs, etc. The State Agency will review the cost and mileage information at least biennially and adjust the reimbursement rate if necessary. Therefore, an inflation factor will not be automatically applied.

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a. Transportation (Continued)

(5) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after December 1, 2001, the following reimbursement applies to public transportation services:

Taxi and Wheelchair Van - Reimbursement is based on the lesser of billed charges or the Title XIX maximum allowable. The billed charges must reflect the same charges made to all other passengers for the same service as determined by the local municipality which issues the permit to operate or by the Interstate Commerce Commission. The Title XIX maximum was established utilizing the 1991 Taxicab Fact Book issued by the International Taxicab and Livery Association. The calculations are as follows:

Taxi - The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 25% = \$1.13 per mile (unit).

Wheelchair Van - Must transport **six (6)** or more passengers comfortably.

The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 65% = \$1.50 per mile (unit). An additional 40% was added to the reimbursement per mile due to the added cost of wheelchair van adaptation for wheelchair accessibility and for additional provider compensation for physically assisting the disabled.

The State Agency will negotiate with the affected provider group representative should recipient access become an issue.

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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)
- (5) Non-Emergency (Continued)
- (b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, Non-Public Transportation Services reimbursement is based on the lesser charges or the Title XIX maximum allowable. The Title XIX maximum is based on the Internal Revenue Service (IRS) reimbursement for private mileage in a business setting, plus an additional allowance for the cost of the driver. The standard mileage private reimbursement is compliant to the 1997 Standard Federal Tax Report, paragraph #8540.011. The calculation of the additional allowance for the cost of the driver is based on the minimum wage per hour, plus 28% of salaries (minimum wage) for fringe benefits, plus a fixed allowance of \$2.11 for the **provider's** overhead and billings, divided by 30 (average number of miles per trip). The average number of miles was determined by utilizing data from SFY 1996 and dividing the number of miles per trip by the number of trips made.

The State Agency will negotiate with the affected provider group representatives should recipients access become an issue.

- (6) Volunteer Transportation: Amount of payment is agreed on by County Human Services Office and the Carrier. Medicaid reimburses the County Human Services Office for the agreed amount.

The rate of reimbursement equals the amount of travel reimbursement per mile for a state employee. Medicaid reimbursement will not be made for services provided free of charge.

- (7) Domiciliary Care: Fixed price set by Assistant Director, Division of Medical Services, based on reasonable cost. The provider submits a statement of expenses, i.e. salaries, repairs, supplies, rent, etc. for their past fiscal year. These costs are reviewed by the **State's** auditors for reasonableness. These costs are reviewed annually and adjusted if necessary, therefore, an inflation factor is not applied.

The cost of meals and lodging are provided only when necessary in connection with transportation of a recipient to and from medical care.

## SECTION II - TRANSPORTATION CONTENTS

### *TOC Required*

#### **241.200      Emergency Medical Transportation Access Payment      11-1-20**

Qualifying medical transportation providers within the State of Arkansas, except for volunteer ambulance services, ambulance services owned by the state, county, or political subdivision, nonemergency ambulance services, air ambulance services, specialty hospital-based ambulance services, and ambulance services subject to the state's assessment on the revenue of hospitals shall be eligible to receive emergency medical transportation access payments. All emergency medical transportation providers that meet this definition will be referred to as Qualified Emergency Medical Transportation (QEMT) providers.

The emergency medical transportation access payment to each QEMT shall be calculated on an annual basis and paid out quarterly. The access payment shall be comprehensive and will be eighty percent (80%) of the difference between Medicaid payments otherwise made to QEMTs for the provision of emergency medical transportation services and the average amount that would have been paid at the equivalent community rate (hereinafter, average commercial rate or ACR). Emergency Medical Transportation Access Payments shall be made on a quarterly basis.

[View the Administrative Procedures for the Emergency Medical Transportation Assessment Fee and Access Payment.](#)

[View or print form DMS-0600, Initial Medical Transportation Access Payment Revenue Survey.](#)

[View or print form DMS-0601, Emergency Medicaid Transportation Access Payment Application.](#)

#### **260.000      EARLY INTERVENTION DAY TREATMENT (EIDT) AND ADULT DEVELOPMENTAL DAY TREATMENT (ADDT) TRANSPORTATION**

## **ADMINISTRATIVE PROCEDURES FOR THE EMERGENCY MEDICAL TRANSPORTATION ASSESSMENT FEE AND ACCESS PAYMENT**

### **DEFINITIONS**

- (1) "Accounts Receivable" means the Accounts Receivable Unit of the Office of Finance of the Department of Human Services;
- (2) "Air ambulance services" means services authorized and licensed by the Department of Health to provide care and air transportation of patients;
- (3) "Ambulance services" means services authorized and licensed by the department to provide care and transportation of patients upon the streets and highways of Arkansas;
- (4) "Division" means the Division of Medical Services of the Department of Human Services;
- (5) "Medical transportation" means emergency medical services provided through ambulance services and air ambulance services. The term does not include nonemergency ambulance services;
- (6) "Medical transportation provider" means a licensed provider of medical transportation;
- (7) "Net operating revenue" means the gross revenues earned for providing medical transportation in Arkansas, excluding amounts refunded to or recouped, offset, or otherwise deducted by a patient or payer for medical transportation;
- (8)
  - (A) "Nonemergency ambulance services" means the transport in a motor vehicle to or from medical facilities, including without limitation medical transportation providers, nursing homes, physicians' offices, and other healthcare facilities, of persons who are ill or injured and who are transported in a reclining position.
  - (B) "Nonemergency ambulance services" does not include transportation provided by licensed medical transportation providers that own and operate the ambulance for their own admitted patients;
- (9) "Specialty medical transportation provider-based ambulance services" means ambulance services provided by an acute care general medical transportation provider that limits healthcare services primarily to children and qualifies as exempt from the Medicare prospective payment system regulation;
- (10) "State plan amendment" means a change or update to the state Medicaid plan;
- (11) "Upper payment limit" means the lesser of the customary charges of the medical transportation provider for medical transportation or the prevailing charges in the locality of the medical transportation provider for comparable services under comparable circumstances, calculated according to methodology in an approved state plan amendment for the Arkansas Medicaid Program; and
- (12)
  - (A) "Upper payment limit gap" means the difference between the upper payment limit of the medical transportation provider and the Medicaid payments not financed using medical transportation assessment made to all medical transportation providers.

(B) "Upper payment limit gap" is calculated separately for ambulance services and air ambulance services.

## **INITIAL YEAR DETERMINATION**

Upon approval of the State Plan Amendment (SPA) by the Centers for Medicare & Medicaid Services (CMS), the model submitted to CMS as part of the SPA will be used to determine the Fee Assessments and access payments made under this program for the last quarter of State Fiscal Year 2020 and State Fiscal Year 2021. For State Fiscal Years after 2021, the methodology outlined in the following procedures will be used.

## **PROVIDER REVENUES & ASSESSMENT RATE**

An assessment is imposed on each medical transportation provider, except those exempted under Ark Code Ann. § 20-77-2806, for each state fiscal year in an amount calculated as a percentage of the aggregate net operating revenues of the medical transportation providers.

The assessment rate shall be determined annually based upon the percentage of net operating revenue needed to generate 80% of the upper payment limit gap plus the annual fee to be paid to the Arkansas Medicaid Program under § 20-77-2805, but in no case at a rate that would cause the assessment proceeds to exceed the indirect guarantee threshold set forth in 42 C.F.R. § 433.68(f)(3)(i).

For state fiscal year 2022 and following years, the medical transportation provider's net patient revenue from the most recently ended calendar year will be used.

The assessment rate described in this section shall be determined after consultation with the Arkansas Ambulance Association or its successor association.

## **FEE ASSESSMENT**

Annually, no later than January 31, the Division will send to all licensed medical transportation providers the net operating revenue assessment return. Medical transportation providers shall complete the returns for the previous year and deliver them to the Division or its contractor no later than March 31 of that year. Providers that fail to return the net operating revenue assessment form will have their assessment calculated based on the state per capita average assessment for that year. The Division will send a notice of assessment to each medical transportation provider informing the medical transportation provider of the assessment rate and the estimated assessment amount owed by the medical transportation provider for the applicable fiscal year.

With the exception of the initial notice of assessment, annual notices of assessment will be sent at least forty-five (45) calendar days before the due date for the first quarterly assessment payment of each fiscal year. The first notice of assessment will be sent within forty-five (45) calendar days after the Division has received notification from the Centers for Medicare and Medicaid Services that the payments required under Ark. Code Ann. § 20-77-2809 and, if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved. The medical transportation provider will have thirty (30) calendar days from the date of its receipt of a notice of assessment to review and verify the assessment rate and the estimated assessment amount.

If a medical transportation provider operates, conducts, or maintains more than one (1) medical transportation provider in the state, the medical transportation provider will pay the assessment for each medical transportation provider separately. However, if the medical transportation

provider operates more than one (1) medical transportation provider under one (1) Medicaid provider number, the medical transportation provider may pay the assessment for all such medical transportation providers in the aggregate.

For a medical transportation provider subject to the assessment imposed under Ark. Code Ann. § 20-77-2803 that ceases to conduct medical transportation provider operations or maintain its state license or did not conduct medical transportation provider operations throughout a state fiscal year, the assessment for the state fiscal year in which the cessation occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-2803 by a fraction, the numerator of which is the number of days during the year that the medical transportation provider operated and the denominator of which is three hundred sixty-five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%).

Immediately upon ceasing to operate, the medical transportation provider will pay the adjusted assessment for that state fiscal year to the extent not previously paid.

The medical transportation provider also shall receive payments under Ark. Code Ann. § 20-77-2809 for the state fiscal year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.

A medical transportation provider subject to an assessment under the Ark. Code Ann. § 20-77-2801 et seq. that has not been previously licensed as a medical transportation provider in Arkansas and that commences medical transportation provider operations during a state fiscal year will pay the required assessment computed under Ark. Code Ann. § 20-77-2803 and will be eligible for medical transportation provider access payments under Ark Code Ann. § 20-77-2809. The assessment will be calculated based on the effective date of licensure. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-2803 by a fraction, the numerator of which is the number of days during the year that the medical transportation provider is subject to the assessment and the denominator of which is three hundred sixty-five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%). The medical transportation provider also shall receive payments under Ark. Code Ann. § 20-77-2809 for the state fiscal year in which the medical transportation provider is licensed, which will be adjusted by the same fraction as its annual assessment. Access payments and assessment fees will not be reimbursed or collected until enrollment of the new provider has been approved by the Medicaid Provider Enrollment Section.

For new medical transportation providers, the Division will calculate revenue to be assessed based on the population of the county for which the medical transportation provider is licensed. The per capita amount will be assigned and calculated based on the average net operating revenue per capita for all other medical transportation providers in the State that are currently being assessed. Average revenue per capita will be used in this way through the end of the second fiscal year.

A medical transportation provider that is exempted from payment of the assessment under Ark. Code Ann. §20-77-2806 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it becomes subject to the assessment will pay the required assessment computed under Ark. Code Ann. § 20-77-2803 and will be eligible for medical transportation provider access payments under Ark. Code Ann. § 20-77-2809. The assessment will be calculated based on the effective date of status change as determined by the Medicaid Provider Enrollment Section. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-2803 by a fraction, the numerator of which is the number of days during the year

that the medical transportation provider is subject to the assessment and the denominator of which is three hundred sixty-five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%). The medical transportation provider also shall receive payments under Ark. Code Ann. § 20-77-2809 for the state fiscal year in which the medical transportation provider status change occurs as determined by the Medicaid Provider Enrollment Section, which will be adjusted by the same fraction as its annual assessment. Access payments and assessment fees will not be reimbursed or collected until enrollment due to the status change has been approved by the Medicaid Provider Enrollment Section.

A medical transportation provider that is subject to payment of the assessment computed under Ark. Code Ann. § 20-77-2803 at the beginning of a state fiscal year but during the state fiscal year experiences a change in status so that it is no longer subject to payment under Ark. Code Ann. § 20-77-2806 shall be relieved of its obligation to pay the medical transportation provider assessment and shall become ineligible for medical transportation provider access payments under Ark. Code Ann. §20-77-2809. The assessment for the state fiscal year in which the change occurs will be adjusted by multiplying the annual assessment computed under Ark. Code Ann. § 20-77-2803 by a fraction, the numerator of which is the number of days during the year that the medical transportation provider was subject to the assessment and the denominator of which is three hundred sixty-five (365). The fraction will be expressed as a percentage rounded to two places (Example – 65.23%). Immediately upon changing status, the medical transportation provider will pay the adjusted assessment for that state fiscal year to the extent not previously paid. The medical transportation provider also shall receive payments under Ark. Code Ann. § 20-77-2809 for the state fiscal year in which the status change occurs. The amount payable will be adjusted by the same fraction as its annual assessment.

## **FEE BILLING AND COLLECTION**

The annual assessment imposed under Ark Code Ann. § 20-77-2803 is due and payable quarterly. However, an installment payment of an assessment imposed by Ark. Code Ann. § 20-77-2803 will not be due and payable until:

- (A) The Division issues the written notice required by Ark. Code Ann. § 20-77-2808(a) stating that the payment methodologies to medical transportation providers required under Ark. Code Ann. § 20-77-2809 have been approved by the Centers for Medicare and Medicaid Services and the waiver under 42 C.F.R. § 433.68 for the assessment imposed by Ark. Code Ann. § 20-77-2803, if necessary, has been granted by the Centers for Medicare and Medicaid Services;
- (B) The Division receives all needed information, or the thirty-day verification period required by § 20-77-2808(b) has expired, whichever is later; and
- (C) The Division has made all quarterly installments of medical transportation provider access payments that were otherwise due under Ark. Code Ann. § 20-77-2809 consistent with the effective date of the approved state plan amendment and waiver.

After the initial installment has been paid under this section, each subsequent quarterly installment payment of an assessment imposed by Ark. Code Ann. § 20-77-2803 will be due and payable within ten (10) business days after the medical transportation provider has received its medical transportation provider access payments due under Ark. Code Ann. § 20-77-2809 for the applicable quarter by Accounts Receivable.

Failure of any medical transportation provider to provide required reports or pay fees on a timely basis may result in the withholding of Medicaid reimbursement, letters of caution, sanctions, or penalty assessment. Penalty assessments are detailed in the Sanctions Section identified below. The penalty assessment and outstanding medical transportation provider assessment fee shall accrue interest at the maximum rate permitted by law from the date the assessment fee is due until payment of the assessment fee and the penalty assessment.

Accounts Receivable will initiate the collection process on the 1st of the month following the due date for payments not received or postmarked by close of business on the 10th day following the notice of assessment due. An outstanding accounts report will be forwarded to the Division for determination of further action.

## **ADMINISTRATION OF FEES**

Fees assessed and collected, and sanctions and interest imposed and collected, will be deposited in a designated account known as the Medical Transportation Assessment Account within the Arkansas Medicaid Program Trust Fund as established under Ark. Code Ann. §20-77-2805.

## **SANCTIONS**

The Division will sanction medical transportation providers that fail to comply with Ark Code Ann. §20-77-2801 et seq., these rules, or both. If a medical transportation provider fails to timely pay the full amount of a quarterly assessment, the Division shall add to the assessment:

(A) A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date; and

(B) An additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts remaining on the last day of each quarter after the due date until the assessed amount and the penalties are paid in full.

Payments will be credited first to unpaid quarterly amounts, rather than to penalty or interest amounts, beginning with the most delinquent installment.

Any fee or penalty assessment imposed under these rules, as authorized by the Ark. Code Ann. § 20-77-2801 et seq., shall accrue interest at the maximum rate permitted by law from the date the fee or penalty assessment is imposed until the medical transportation provider pays the fee or penalty assessment.

For the purposes of these rules, "postmarked" will mean dated for delivery to the Division and submitted to the appropriate carrier by whatever means designated by the Division, including electronic or other means.

## **Recoupment Provisions**

The Division may withhold from a medical transportation provider's vendor payment any

amount owed the Medicaid program as a result of an imposed penalty assessment for non-compliance as detailed above, or any assessment fee not paid by the due date. For purposes of this paragraph, a penalty assessment is considered imposed once the Division notifies the medical transportation provider of the penalty assessment and the medical transportation provider has an opportunity to appeal the penalty assessment.

### **Emergency medical transportation access payments.**

To preserve and improve access to medical transportation services, for medical transportation services rendered on or after July 1, 2019, the Division shall make emergency medical transportation access payments as set forth in this section. These access payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for medical transportation services.

Eligibility: Medical transportation providers eligible to receive emergency medical transportation access payments are those medical transportation providers:

- (A) Subject to the assessment imposed under Ark. Code Ann. § 20-77-2803; and
- (B) That apply to receive the emergency medical transportation access payments as provided herein.

Application:

- (A) Not less than one-hundred eighty (180) days prior to the beginning of each state fiscal year, the Division will send to all qualified licensed medical transportation providers an application for emergency medical transportation access payments. The application will:
  - a. Allow the medical transportation provider to submit all information needed to calculate that medical transportation provider's average commercial rate;
  - b. Provide that the application must be received by the Division on a date certain which will be no less than one hundred twenty (120) days prior to the beginning of the state fiscal year;
  - c. Explain that, unless exempt from payment by law, the medical transportation provider will be required to pay the medical transportation provider assessment even if it fails to apply for the emergency medical transportation access payments; if it fails to supply the Revenue Survey the assessment will be calculated based on the state average assessment for that year; and
  - d. Explain that the medical transportation provider will not be eligible to receive emergency medical transportation access payments in the next fiscal year if the application is not timely filed but will still be assessed based on the average assessment.

- (B) A medical transportation provider that has previously received emergency medical transportation access payments is required to make an application for such payments and provide the Revenue Survey every year.

#### Calculation of Average Commercial Rate:

- (A) The emergency medical transportation access payment shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described herein. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.
- (B) The Division shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ambulance provider and calculate the Medicare payment for those claims.
- (C) The Division shall calculate an overall Medicare to commercial conversion factor for each qualifying medical transportation provider that submits an emergency medical transportation access payment application by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.
- (D) The commercial to Medicare ratio for each provider will be re-determined every year.

#### Payment Methodology:

- (A) The emergency medical transportation access payment to each eligible medical transportation provider shall not exceed the sum of the difference between the Medicaid payments otherwise made to these providers for the provision of emergency medical transportation services and the average amount that would have been paid at the equivalent community rate, expressed as the average commercial rate.
- (B) The emergency medical transportation access payment shall be determined in a manner to bring payments for these services up to the community rate level.
- (C) The specific payment methodology to be used in establishing the emergency medical transportation access payment due to each eligible medical transportation provider is as follows:
  - a. The Division will identify the emergency medical transportation services in the payment period for which the eligible medical transportation provider is eligible to be reimbursed.
  - b. The Division will calculate the reimbursement paid to the medical transportation provider for the provision of emergency medical transportation services in the payment period.
  - c. The Division will calculate the medical transportation provider's average commercial rate for the provider's services.
  - d. The Division shall calculate the medical transportation provider's upper payment limit gap by subtracting actual Medicaid services in the payment

period from the amount that would have been paid using the medical transportation provider's average commercial rate.

- e. The Division shall reimburse all eligible providers the same proportion of their upper payment limit gap, up to the lesser of:
  - i. the total computable generated from the available balance in the Medical Transportation Assessment Account; or
  - ii. 80 percent (80%) of the eligible medical transportation provider's upper payment limit gap.

(D) Emergency medical transportation access payments shall be made quarterly.

**FINANCIAL IMPACT STATEMENT**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

**DEPARTMENT**     Department of Human Services

**DIVISION**        Division of Medical Services

**PERSON COMPLETING THIS STATEMENT**   Lynn Burton

**TELEPHONE** (501) 682-1857    **FAX** (501) 682-8155    **EMAIL:** Lynn.burton@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#2019-0009, Transportation 1-19, Administrative Procedures for the Emergency Medical Transportation Assessment Fee and Access Payments

- 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**

General Revenue \_\_\_\_\_  
Federal Funds \_\_\_\_\_  
Cash Funds \_\_\_\_\_  
Special Revenue \_\_\_\_\_  
Other (Identify) \_\_\_\_\_

**Next Fiscal Year**

General Revenue \_\_\_\_\_  
Federal Funds \_\_\_\_\_  
Cash Funds \_\_\_\_\_  
Special Revenue \_\_\_\_\_  
Other (Identify) \_\_\_\_\_

Total \_\_\_\_\_

Total \_\_\_\_\_

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

**Current Fiscal Year**

**Next Fiscal Year**

General Revenue	_____
Federal Funds	<u>\$2,030,942</u>
Cash Funds	_____
Special Revenue	_____
Other	<u>\$821,905</u>
(Assessment Fee)	_____
Total	<u>\$2,852,847</u>

General Revenue	_____
Federal Funds	<u>\$8,167,132</u>
Cash Funds	_____
Special Revenue	_____
Other	<u>\$3,244,258</u>
(Assessment Fee)	_____
Total	<u>\$11,411,390</u>

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**

**Next Fiscal Year**

\$ 821,905

\$ 3,244,258

**The State Share will be funded by an assessment fee imposed on each medical transportation provider except those exempted under Arkansas Code Ann. § 20-77-2806.**

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**

**Next Fiscal Year**

\$ 821,905

\$ 3,244,258

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 Emergency Medical Transportation Access Payment.**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

**Act 969 of the 2017 regular session required the agency to implement this rule. 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;

**Act 969 of the 2017 regular session required the agency to implement this rule. 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.**