Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: August 31, 2022

The proposed policy is an Emergency Rule. The proposed policy was presented at the November 2, 2021 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on September 8, 2022 and the OHCA Board of Directors on September 21, 2022.

Reference: APA WF # 22-05

SUMMARY: Ambulance Service Provider Access Payment Program - The proposed revisions add rules to establish the Ambulance Service Provider Access Payment Program.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 CFR 433.50, 433.55, 433.56, 433.57, 433.68, 433.72; 63 O.S. 3241.1 – 3242.6; and Oklahoma House Bill (HB) 2950

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 22-05

A. Brief description of the purpose of the rule:

The proposed policy establishes rules to comply with Oklahoma HB 2950, which mandates that Oklahoma obtain federal and state authority to establish and enforce an Ambulance Service Provider Access Payment Program to assure access to quality emergency and non-emergency transports for state Medicaid members. The program will assess a fee to privately owned ambulance service providers licensed in Oklahoma to be used to supplement appropriations to support ambulance service provider reimbursement. The proposed rules will establish the program's provider fee calculation, provider exemptions, provider notification requirements, payment schedules, penalties, and appeals requirements.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Non-governmental privately owned ambulance service providers and state Medicaid members will be affected by the proposed rule. This rule change should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

Non-governmental privately owned ambulance service providers and state Medicaid members will benefit from this rule change.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The estimated total cost for SFY 2023 is $5,802,463 ($4,392,464 in federal share and $1,409,999 in state share). The estimated total cost for SFY 2024 is $5,802,463 ($3,908,539 in federal share and $1,893,924 in state share). Both SFY 2023 and SFY 2024 will include a $200,000 administrative cost collection from a provider tax.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

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The agency has taken measures to determine that there are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety or environment.

J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The agency does not anticipate any detrimental effect on the public health, safety or environment if the proposed rule is not implemented.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared date: July 6, 2022

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 33. TRANSPORTATION BY AMBULANCE

317:30-5-345. Ambulance Service Provider Access Payment Program (ASPAPP)

(a) **Purpose.** The Ambulance Service Provider Access Payment Program (ASPAPP) is an ambulance service provider (ASP) assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3242.1 through 3242.6 of Title 63 of the Oklahoma Statutes (O.S.).

(b) **Definitions.** The following words and terms, when used in this Section shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Air ambulance"** means ambulance services provided by fixed or rotor wing ambulance services.

(2) **"Alliance"** means the Oklahoma Ambulance Alliance or its successor association.

(3) **"Ambulance"** means a motor vehicle that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

(4) **"Ambulance service"** or **"ambulance service provider (ASP)"** means any private firm or governmental agency licensed by the Oklahoma State Department of Health (OSDH) to provide levels of medical care based on certification rules or standards promulgated by the Oklahoma state Commissioner of Health.

(5) **"Emergency"** or **"emergent"** means a serious situation or occurrence that happens unexpectedly and demands immediate action, such as a medical condition manifesting itself

by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

(6) **"Emergency transport"** means the movement of an acutely ill or injured patient from the scene to a health care facility or the movement of an acutely ill or injured patient from one health care facility to another health care facility.

(7) **"Medicaid"** means the medical assistance program established in Title XIX of the Social Security Act and administered in Oklahoma by the Oklahoma Health Care Authority (OHCA).

(8) **"Net operating revenue"** means the gross revenues earned for providing emergency transports in Oklahoma excluding revenues earned for providing air ambulance services, non-emergency transports, and amounts refunded to or recouped, offset, or otherwise deducted by a patient or payer for ground medical transportation.

(9) **"Non-emergency transport"** means the movement of any patient in an ambulance other than an emergency transport as defined in Part 33, 317:30-5-335.1.

(10) **"Upper payment limit"** means the lesser of the customary charges of the ASP or the prevailing charges in the locality of the ASP for comparable services under comparable circumstances, calculated according to methodology in an approved state plan amendment for the state Medicaid program.

(11) **"Upper payment limit gap"** means the difference between the upper payment limit of the ASP and the Medicaid payments not financed using the ASP assessments made to all ASPs, provided that the upper payment limit gap shall not include air ambulance services.

(c) **ASPAPP exemptions.**

(1) Pursuant to 63 O.S. §§ 3242.1 through 3242.6 the OHCA is mandated to assess ASPs licensed in Oklahoma pursuant to rules and standards promulgated by the Oklahoma state Commissioner of Health, unless exempted under (c) (2) of this Section, an ASP access payment program fee.

(2) The following ASPs are exempt from the ASPAPP fee:

(A) Owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service.

(B) Eligible for Supplemental Hospital Offset Payment Program (SHOPP) Medicaid reimbursement;

(C) Provides air ambulance services only; or

(D) Provides non-emergency transports only.

(d) **The ASPAPP assessment.**

(1) The ASPAPP assessment is imposed on each ambulance service provider, except those exempted under (c)(2) of this Section, for each calendar year in an amount calculated as a percentage of each ambulance service provider's net operating revenue.

(2) The assessment rate shall be determined annually based upon the percentage of net operating revenue needed to generate an amount up to the non-federal portion of the upper payment limit gap, plus the annual fee paid to OHCA for administrative expenses incurred in performing the activities, not to exceed $200,000 each year, plus the state share of ASP access payments for ASPs that participate in the assessment. At no time will the assessment rate exceed the maximum rate allowed by federal law or regulation.

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(3) OHCA will review and determine the amount of annual assessment in December of each year in consultation with the Oklahoma Ambulance Alliance.

(4) The annual assessment is due and payable quarterly. However, a payment of the assessment will not be due and payable until:

(A) OHCA issues written notice stating that the payment methodologies to the ASPs under 63 O.S. §§ 3242.1 through 3242.6 have been approved by the Centers for Medicare and Medicaid Services (CMS) and the waiver under 42. C.F.R. § 433.68 for the assessment, if necessary, has been granted by CMS.

(B) OHCA has made all quarterly installments of the ASP access payments that were otherwise due, consistent with the effective date of the approved state plan.

(5) The method of collection of net operating revenue is as follows:

(A) Annually, no later than January 31, OHCA will send all licensed ASPs the net operating revenue form. ASPs shall complete the forms and deliver them to OHCA or its contractor no later than March 31 of that year. ASPs that fail to return the net operating revenue form will have their assessment calculated based on the state per capita average assessment for that year. OHCA will send a notice of assessment to each ASP informing the provider of the assessment rate and the estimated annual amount owed by the ASP for the applicable calendar year.

(B) The first notice of assessment will be sent within forty-five (45) days of receipt by OHCA of notice from the Centers for Medicare and Medicaid Services that the payments under 63 O.S. §§ 3242.1 through 3242.6, and if necessary, the waiver granted under 42 C.F.R. § 433.68 have been approved.

(C) Annual notices of assessment will be sent at least forty-five (45) days before the due date for the first quarterly assessment payment of each calendar year. The ASP shall have thirty (30) days from the date of its receipt of a notice of assessment to review and verify the assessment rate and the estimated assessment amount.

(D) If an ASP operates, conducts, or maintains more than one (1) ASP in the state, the ASP will pay the assessment for each ASP separately. However, if the ASP operates more than one (1) ASP under one (1) Medicaid provider number, the ASP provider may pay the assessment for all such ASPs in the aggregate.

(6) The method of collection of the assessment fee is as follows:

(A) After the initial installment has been paid, each subsequent quarterly payment of an assessment will be due and payable by the 15th day on the first month of the applicable quarter (i.e., January 15th, April 15th, etc.)

(B) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of five percent (5%) of the amount and interest of one and one-quarter percent (1.25%) per month.

(e) **Penalties and adjustments**

(1) If an ASP fails to timely pay the full amount of a quarterly assessment, OHCA will add to the assessment:

(A) A penalty 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 on any unpaid quarterly and unpaid penalty amounts on the last day of each quarter after the due date until the assessed amount and the penalty imposed under subpart (A) of this paragraph are paid in full.

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(2) The quarterly assessment including applicable penalties and interest must be paid regardless of any appeals action requested by the facility. If an ASP fails to pay the OHCA the assessment within the timeframes noted on the invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the ASP's payment.
(3) Any change in payment amount resulting from an appeals decision will be adjusted in future payments.
(4) If Medicaid reimbursement rates are adjusted, ASP rates may not be adjusted less favorably than the average percentage-rate reduction or increase applicable to the majority of other provider groups.

(f) **Closure, merger, and new Ambulance Service Providers (ASPs).**

(1) If an ASP ceases to operate as an ASP for any reason or ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the ASP is subject to the assessment and the denominator of which is three hundred sixty-five (365). Within thirty (30) days of ceasing to operate as an ASP, or otherwise ceasing to be subject to the assessment, the ASP will pay the assessment for the year as so adjusted, to the extent not previously paid.
(2) The ASP also shall receive payments under 63 O.S. §§ 3242.1 through 3242.6, for the calendar year in which the cessation occurs, which will be adjusted by the same fraction as its annual assessment.
(3) For new ASPs, the OHCA will calculate revenue to be assessed based on the population of the county for which the ASP is licensed. The per capita amount will be assigned and calculated based on the average net operating revenue per capita for all other ASPs in the state that are currently being assessed. Average revenue per capita will be used in this way through the end of the second calendar year.
(4) Any assessment paid by a provider on revenue subject to another health care related tax as defined in 42 CFR § 433.68 shall be a credit against any assessment due under these rules.

(g) **Disbursement of payment to ASPs.**

(1) To preserve and improve access to ambulance services, for ambulance services rendered on or after the approval of the ASPAPP by CMS, OHCA shall make ASP payments as set forth in this section. These payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for ambulance services.
(2) OHCA shall pay all quarterly ASP access payments within ten (10) calendar days of the due date for the quarterly assessment payments established in subsection (d) of this section.
(3) OHCA shall calculate the ASP access payment amount as the balance of the ASPAPP Fund plus any federal matching funds earned on the balance up to but not to exceed the upper payment limit gap for all ASPs.
(4) All ASPs shall be eligible for ASP access payments each year as set forth in this subsection except ambulance services excluded or exempted in subsection (c)(2) of this section.
(5) Access payments shall be made on a quarterly basis.
(6) ASPs eligible to receive ASP access payments are those providers:
(A) Subject to this assessment; and
(B) That apply to receive the ASP access payment as provided in Section 317:30-5-345.

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(7) An application by the ASP shall be submitted to OHCA to be eligible to receive payments.

(A) Not less than one-hundred eighty (180) days prior to the beginning of each state fiscal year, OHCA will send all qualified licensed ASPs an application for ASP access payments.

(B) The application will:

(i) Allow the ASP to submit all information needed to calculate that ASP's average commercial rate;

(ii) Provide that the application must be received by OHCA on a date which will be no less than one- hundred twenty (120) days prior to the beginning of the calendar year;

(iii) Explain that unless exempt from payment by law, the ASP will be required to pay the ASP assessment even if the provider fails to apply for the ASP access payments;

(iv) Explain that if the ASP fails to supply the Net Operating Revenue Survey, the assessment will be calculated based on the state per capita average assessment for that year; and

(v) Explain that the ASP will not be eligible to receive ASP access payments in the next calendar year if the application is not timely filed but will still be assessed based on the average assessment.

(C) An ASP that has previously received ASP access payments is required to make an application for such payments and provide the revenue survey no less than every three (3) years.

(8) The Average Commercial Rate will be calculated as follows:

(A) The ASP access payment shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Section 317:30-5-345. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.

(B) OHCA 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 ASP and calculate the Medicare payment for those claims.

(C) OHCA shall calculate an overall Medicare to commercial conversion factor for each qualifying ASP that submits an ASP 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 redetermined every three (3) years.