METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

Payment is made for the least expensive means of transportation commensurate with the patient's needs. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulance transportation services. The agency's fee schedule rate was set as of October 1, 2018 and is effective for services provided on or after that date. All rates and any annual/periodic adjustments are published on the agency's website at www.okhca.org/feeschedules.

A. Transportation by Ambulance

1. **Ground Ambulance Transports** – Payment will be made for each level of service based on the geographically adjusted Medicare Ambulance Fee Schedule (AFS). A uniform rate is paid to governmental and non-governmental providers.

a. **Supplemental Reimbursement for Ground Ambulance Transportation Providers -** Effective October 1, 2018, qualified governmental ground ambulance transportation providers will be eligible to receive supplemental Medicaid payments to provide reimbursement for uncompensated costs incurred by providing ambulance transportation services to Medicaid beneficiaries. Eligible providers will certify their uncompensated cost for providing ambulance transportation services for Medicaid recipients through an annual submission of the Centers for Medicare and Medicaid Services (CMS)-approved cost report.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that eligible entities receive for ground ambulance transportation services to Medicaid recipients. Total reimbursements from Medicaid including the supplemental payment must not exceed one hundred percent of actual costs.

The Oklahoma Health Care Authority will recognize, on a voluntary basis, the allowable certified public expenditures of approved governmental ambulance service providers for providing services as set forth below.

The allowable certified public expenditures of a participating provider who meets the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (i.) through (iv.) for services provided on or after October 1, 2018:

i. The governmental ambulance services provider will submit a CMS approved cost report annually, on a form approved by the Oklahoma Health Care Authority. The cost report will be completed on a state fiscal year basis and will be due to the Oklahoma Health Care Authority no later than 90 days following the last day of the state fiscal year
ii. Cost reconciliation and cost settlement processes will be completed within 12 months of the end of the cost reporting period.
iii. The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio to Medicaid charges associated with paid claims for the dates of service covered by the submitted cost report.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

A. Transportation by Ambulance *(continued)*

1. Ground Ambulance Transports *(continued)*

a. Supplemental Reimbursement for Ground Ambulance Transportation Providers *(continued)*

iv. The Oklahoma Health Care Authority will make annual interim supplemental payments to eligible providers. The interim supplement payments for each provider will be based on the provider's completed annual cost report in the form prescribed by the Oklahoma Health Care Authority and approved by CMS for the applicable cost reporting year. Each eligible provider must compute their annual cost in accordance with Cost Determination Protocols (see section d). Interim payments will be equal to 75 percent of the total Uncompensated Medicaid Fee for Service Ambulance Cost as indicated on the as-filed cost report.

v. A reconciliation will be computed by the Oklahoma Health Care Authority based on the difference between the interim payments and total allowable Medicaid costs from the approved cost report. Any excess payments determined in the reconciliation processes are recouped and the federal share is returned to CMS on the quarterly expenditure report in which the recoupment is made.

b. Ground Ambulance Provider Eligibility Requirements - To be eligible for supplemental payments, providers must meet all of the following requirements:

i. Be enrolled as an Oklahoma Medicaid provider for the period being claimed on their annual cost report;

ii. Provide ground ambulance transportation services to Medicaid recipients; and

iii. Be an organization that:

I. Is publicly owned or operated, defined as a unit of government which is a State, a city, a county, a special purpose district or authority, or other government unit in the State that has taxing authority, has direct access to tax revenues, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act; or

II. Contracts with a local government, defined as an interlocal agreement with a city, county, or local service district, including but not limited to, a rural fire protection district, and all administrative subdivisions of such city, county, or local service district, pursuant to a plan for emergency medical services.

c. Supplemental Reimbursement Methodology – General Provisions

i. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), and 2 CFR Part 225 (Cost Principles for State, Local, and Indian Tribal Governments), which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program.

ii. Medicaid base payments to the providers for providing ground ambulance transportation services are derived from the ground ambulance fee-for-service (FFS) fee schedule established for reimbursements payable by the Medicaid program by procedure code. The primary source of paid claims data is derived from reimbursements in the Oklahoma Medicaid Management Information System (MMIS). The number of paid Medicaid FFS transports is derived from and supported by the MMIS reports for services during the applicable service period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

A. Transportation by Ambulance *(continued)*

1. Ground Ambulance Transports *(continued)*

c. Supplemental Reimbursement Methodology – General Provisions *(continued)*

iii. 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 for each eligible provider providing ground ambulance transportation services to Oklahoma Medicaid beneficiaries, net the payments received and payable from the Oklahoma Medicaid program and all other sources of reimbursement for such services provided to Oklahoma Medicaid beneficiaries. If the eligible provider does not have any uncompensated care costs, then the provider will not receive a supplemental payment under the supplemental payment program.

d. Cost Determination Protocols

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

ii. Direct costs for providing ground ambulance transportation services include only the unallocated payroll costs for the shifts in which personnel dedicate one hundred percent of their time to providing ground ambulance 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 be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the ground ambulance transportation services.

iii. Indirect costs are determined in accordance to one of the following options.

I. Eligible providers that receive more than $35 million 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 eligible 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 or the other before it can claim any indirect cost.

II. Eligible providers that receive less than $35 million of direct federal awards are required to develop and maintain an indirect rate proposal for purposes of an 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.

III. Eligible providers which receive no direct federal funding can use any of the following previously established methodologies to identify indirect cost:

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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Transportation

A. Transportation by Ambulance *(continued)*
1. Ground Ambulance Transports *(continued)*
d. Cost Determination Protocols *(continued)*

IV. If the eligible provider never established any of the above methodologies, it may do so, or it may elect to use the 10% de minimis rate to identify its indirect cost. The provider-specific cost per medical transport rate is calculated by dividing the total net medical transport allowable costs of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

V. "Dry run," defined as an emergency medical service provided by an eligible provider to an individual who is released on the scene without transportation by ambulance to a medical facility. is a covered service and the costs associated with a dry run should be included in the total allowable costs and counted as an allowable medical transport.

~~A~~ 2. **Air Ambulance Transports** – Reimbursement for air ambulance service is made based on the Medicare AFS. Payment will not exceed 100% of the Medicare allowable rates.

a. Rotary Wing (RW) - Payment to providers affiliated with Level I Trauma Centers is based on a blend of the urban and rural rates for both the base payment and the mileage rate. The blended ratio is .41/.59 for the POP. The rate for base and mileage for all other RW providers is based on the urban rate, regardless of the POP. A uniform rate is paid to governmental and non-governmental providers.

b. Fixed wing (FW) – Payment is calculated using the urban base rate and mileage, regardless of the POP. Effective with claims for dates of service on or after July 1, 2008, reimbursement is made based on the 2008 Medicare AFS. A uniform rate is paid to governmental and non-governmental providers.