

TITLE 1                   ADMINISTRATION  
PART 15                   TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
CHAPTER 355            REIMBURSEMENT RATES  
SUBCHAPTER J           PURCHASED HEALTH SERVICES  
DIVISION 31            AMBULANCE SERVICES

§355.8600. Reimbursement Methodology for Ambulance Services.

(a) Authority. Payments are made to private and governmental providers of ground and air ambulance services as specified in the ambulance program rules in Chapter 354, Subchapter A, Division 9 of this title (relating to Ambulance Services). The reimbursement determination authority is specified in §355.101 of this chapter (relating to Introduction).

(b) Definitions. The following words and terms, when used in this section, have the following meanings unless the context clearly indicates otherwise.

(1) Allowable costs--Expenses that are reasonable and necessary for the normal conduct of operations relating to the provision of ground and air ambulance services.

(2) Average Commercial Rate--The average amount payable by commercial payers for the same service.

(3) Centers for Medicare and Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid, or its successor.

(4) Governmental ambulance provider--An ambulance provider that uses paid government employees to provide ambulance services. The ambulance services must be directly funded by a unit of government that has taxing authority or has direct access to tax revenues, such as a local government, hospital authority, hospital district, city, county, or state. A private ambulance provider under contract with a governmental entity to provide ambulance services is not considered a governmental ambulance provider for the purposes of this section.

(5) Medicaid shortfall--The unreimbursed cost to an ambulance provider of providing Medicaid ambulance services to Medicaid clients.

(6) Private ambulance provider--An ambulance provider that uses paid employees associated and financed through a private entity to provide ambulance services and may be under contract with a local, state, or federal government.

(7) Uncompensated care costs--The sum of the Medicaid shortfall and the uninsured costs.

(8) Uninsured costs--The unreimbursed cost to an ambulance provider of providing ambulance services that meet the definition of "medical assistance" in Social Security Act §1905(a) to uninsured patients as defined by CMS.

(9) Unit of service--A unit of service based on one or more allowable ambulance services provided to a client by all modes of approved transportation.

(c) Reimbursement methodologies.

(1) Fee-for-service ambulance fee. Fee-for-service reimbursement is based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC). HHSC establishes fees by reviewing the Medicare fee schedule and analyzing any other available ambulance-related data. Fee-for-service rates apply to both private and governmental ambulance providers.

(2) Supplemental payment and enhanced supplemental payment for governmental ambulance providers. ~~As of October 1, 2019, For services provided through September 30, 2019,~~ a governmental ambulance provider may be eligible to receive a supplemental payment in addition to the fee-for-service payment described in paragraph (1) of this subsection. For services provided beginning October 1, 2019, eligibility for governmental ambulance providers to receive a supplemental payment, and the methodology for calculating the payment amount, are described in §355.8210 of this subchapter (relating to Waiver Payments to Governmental Ambulance Providers for Uncompensated Charity Care).

(A) Eligibility for supplemental payments. A governmental ambulance provider must submit a written request for determination of eligibility for supplemental payment in a manner designated by HHSC. If eligible, a governmental ambulance provider may begin to claim uncompensated care costs related to services provided on or after the first day of the month after the request for determination of eligibility is approved. HHSC only considers requests for determination of eligibility from governmental ambulance providers as defined in subsection (b) of this section. HHSC will respond to all written requests for consideration, indicating the requestor's eligibility to receive supplemental payments. An acceptable request must include:

(i) an overview of the governmental agency;

(ii) a complete organizational chart of the governmental agency;

(iii) a complete organizational chart of the ambulance department within the governmental agency providing ambulance services;

(iv) an identification of the specific geographic service area covered by the ambulance department, by ZIP code;

(v) copies of all job descriptions for staff types or job categories of staff who work for the ambulance department and an estimated percentage of time spent working for the ambulance department and other departments of the governmental agency;

(vi) a primary contact person for the governmental agency who can respond to questions about the ambulance department; and

(vii) a signed letter documenting the governmental ambulance provider's voluntary contribution of non-federal funds.

(B) Eligibility for enhanced supplemental payments. A governmental ambulance provider must submit an application for enhanced supplemental payments to HHSC using a form designated by HHSC that includes the cost and payment data for paid Medicaid and commercial claims for all procedure codes specified in the application. If HHSC approves the application, a governmental ambulance provider may begin to claim enhanced supplemental payments based on the average commercial rate related only to ground ambulance services reimbursed by Texas Medicaid on a fee-for-service basis provided on or after the first day of the month after the application is approved. HHSC will respond to all applications, indicating approval or disapproval of the applicant's eligibility to receive enhanced supplemental payments. An acceptable application must include:

(i) proof of enrollment as a Medicaid provider in the State of Texas at the beginning of the current demonstration year as defined in §355.8210 of this subchapter;

(ii) a primary contact person for the government agency who can respond to questions about the ambulance department;

(iii) a statement from the provider expressing its intent to participate in the program; and

(iv) a cost report that includes the cost and payment data for paid Medicaid and commercial claims for all procedure codes specified by HHSC.

(C) Cost reports. Governmental ambulance providers that are eligible for supplemental or enhanced supplemental payments must submit an annual cost report for ground and air ambulance services delivered to Medicaid and, effective March 1, 2012, uninsured clients on a cost report form specified by HHSC. Providers certify through the cost report process their total actual federal and non-federal costs and expenditures for the cost reporting period. Cost reports must be completed for a full year based on the federal fiscal year. HHSC may require newly eligible providers to submit a partial-year cost report for their first year of eligibility. The beginning date for the partial-year cost report is the provider's first day of eligibility for supplemental or enhanced supplemental payments as determined by HHSC. The ending date of the partial-year cost report is the last day of the federal fiscal year that encompasses the cost report beginning date.

(i) Due date. The cost report is due on or before March 31 of the year following the cost reporting period ending date, [September 30](#), and must be certified in a manner specified by HHSC. If March 31 falls on a federal or state holiday or weekend, the due date is the first business day after March 31. A provider may request in writing, by regular mail or special mail delivery, an extension of up to 30 days after the due date to submit a cost report. HHSC will respond to all written requests for extensions, indicating whether the extension is granted. HHSC must receive a request for extension before the cost report due date. A request for extension received after the due date is considered denied. A provider whose cost report is not received by the due date or the extended due date is ineligible for supplemental or enhanced supplemental payments for the federal fiscal year.

(ii) Purpose. A cost report documents the provider's actual allowable Medicaid and uncompensated care costs for delivering ambulance services in accordance with the applicable state and federal regulations. Because the cost report is used to determine supplemental and enhanced supplemental payments, a provider must submit a complete and acceptable cost report to be eligible for a supplemental or enhanced supplemental payment.

(iii) Allocating allowable costs. A provider's total allowable reported costs for ambulance services are allocated to Medicaid and uninsured patients based on the ratio of charges for Medicaid and uninsured patients to the charges for all patients. Only allocable expenditures related to Medicaid, Medicaid managed care, and uncompensated care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program (1115 Waiver) will be included for supplemental payment.

(D) Calculation of [Enhanced Supplemental Payments](#).

(i) For services provided from October 1, 2011, through February 29, 2012, a governmental ambulance provider may be eligible to receive a supplemental payment equal to its Medicaid shortfall for the cost reporting period multiplied by the federal Medical assistance percentage (FMAP) in effect during the cost reporting period.

(ii) For services provided on or after March 1, 2012, and subject to approval by CMS, a governmental ambulance provider may be eligible to receive a supplemental payment equal to its uncompensated care costs for the cost reporting period multiplied by the FMAP in effect during the cost reporting period.

(iii) Supplemental payments based on uncompensated care costs are limited by the maximum aggregate amount of the estimated uncompensated care costs for all eligible governmental ambulance providers as determined by §355.8201 of this chapter (relating to Waiver Payments to Hospitals for Uncompensated Care).

(iv) If the actual aggregate uncompensated care costs for all eligible governmental ambulance providers is greater than the maximum aggregate amount of the estimated uncompensated care costs for all eligible governmental ambulance providers as described in clause (iii) of this subparagraph, then HHSC will reduce the supplemental payments for all participating governmental ambulance providers proportionately.

(v) The supplemental payment is contingent upon the governmental ambulance provider's certificate of public expenditures submitted with each cost report.

(vi) If the federal government disallows federal financial participation related to the receipt or use of supplemental payments under this section, HHSC will recoup an amount equal to the federal share of supplemental payments overpaid or disallowed.

(E) Enhanced supplemental payment.

(i) For ground services reimbursed on a fee-for-service basis provided on or after October 1, 2019, a governmental ambulance provider may be eligible to receive an enhanced supplemental payment equal to the difference between the average commercial rate and the sum of its reimbursed costs for the cost reporting period.

(I) HHSC will determine the paid Medicaid claims fees and enhanced supplemental payment amounts for all procedure codes specified in the application for each eligible publicly owned fee-for-service ground emergency ambulance service provider.

(II) HHSC will calculate an overall average commercial rate for the ambulance service providers based on the cost and payment data provided from each eligible ambulance provider.

(III) HHSC will apply the overall average commercial rate to an ambulance provider's total Medicaid utilization to determine the ambulance provider's total commercial reimbursement.

(IV) HHSC will subtract the ambulance provider's total Medicaid reimbursement from the ambulance provider's total commercial reimbursement calculated for each of the eligible services.

(V) HHSC will calculate each ambulance provider's maximum payment limit by summing each of the differences calculated in subclause (IV) of this clause for each of the provider's eligible services.

(VI) HHSC will re-determine the average commercial rate at least ~~every 3 years~~ annually.

(VII) The enhanced supplemental payment is contingent upon the governmental ambulance provider's data submitted with each cost report. HHSC will determine payment amounts on a quarterly basis, with a reimbursement of up to 100 percent for each ambulance provider's average commercial rate.

(ii) If CMS disallows federal financial participation related to a provider's receipt or use of enhanced supplemental payments under this section, HHSC will recoup from the provider an amount equal to the disallowance. If HHSC identifies an overpayment to a provider related to the receipt or use of enhanced supplemental payments under this section, HHSC will recoup from the provider an amount equal to the overpayment.

(d) General information. In addition to the requirements of this section, cost reporting guidelines are governed by: §355.101 of this chapter; §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs); §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs); §355.104 of this chapter (relating to Revenues); §355.105 of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures); §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports); §355.107 of this chapter (relating to Notification of Exclusions and Adjustments); §355.108 of this chapter (relating to Determination of Inflation Indices); §355.109 of this chapter (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs); and §355.110 of this chapter (relating to Informal Reviews and Formal Appeals). If conflicts arise between this section and other sections governing cost reporting, the provisions of this section prevail.