Ambulance Providers Average Commercial Rate (ACR) Application

The Texas Health and Human Services Commission (HHSC) announces the Ambulance Providers Average Commercial Rate (ACR) Application for the eligibility periods of Fiscal Year 2019 (10/1/2018 - 9/30/2019) and Fiscal Year 2020 (10/1/2019 - 9/30/2020). Providers that wish to participate in both years, will need to submit a separate application for each year.

Please reference rule TAC 355.8600 for background information.

Items to note for Section 2 - Ground Ambulance Enhanced Supplemental Payment Reporting Questions:

1) Payments reported are net of contractuals and any bad debts. Report only actual payments received.
2) Reporting period for payments should be based on date of service regardless of when payment was received.
3) MEDICAID - Enter the total payments received and service units for each of the corresponding HCPCS codes for Medicaid Fee-for-service (FFS).
4) MEDICAID - Medicaid FFS should be reported when Medicaid is the primary payer only. Dual eligibles are to be excluded.
5) COMMERCIAL - Enter the total payments received and service units for each of the corresponding HCPCS codes for the ALL COMMERCIAL PAYERS by volume.
6) COMMERCIAL - Payments should include allowable amounts (include coinsurance/deductible and other patient responsibility amounts in total actual payment).
7) Commercial payors exclude:

- Medicare
- Medicare Advantage/HMO
- TRICARE
- Workers' compensation
- Auto insurance plans
- Health care insurance purchased through the Marketplace
- Other government or facility payers

Application

The application is comprised of the following sections: (1) Texas Average Commercial Rate Survey Certification; (2) Ground Ambulance Enhanced Supplemental Payment Reporting Questions; (3) Legal Certification. The application must be submitted by 5:00 PM on May 5, 2021. No extensions beyond the May 5, 2021, due date will be awarded, any application submitted after the due date will not be accepted.

The contact information provided within this application will be used for further communications. Once the application period is complete, the applications will be processed and follow-up communication will be sent. For questions regarding the content of the application, please email the question(s) to PFDAcuteCare@hhs.texas.gov (mailto:PFDAcuteCare@hhs.texas.gov) with "Ambulance Application" in the subject line.

HHSC understands that you may believe that certain information you are providing falls within the exception to the Texas Public Information Act at Texas Government Code Section 552.110, Exception: Confidentiality of Trade Secrets; Confidentiality of Certain Commercial or Financial Information. If you believe the information you are providing contains trade secrets or commercial or financial information covered by Section 552.110, please check the box at the end of the survey.

* Required

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Section 1 - Texas Average Commercial Rate Survey Certification

In this section, please complete the provider demographic information as applicable.

1. Provider Name *

2. Doing Business As (DBA)

3. 9-Digit Texas Provider Identifier (TPI) *

The value must be a number

4. 10-Digit National Provider Identifier (NPI) *

The value must be a number

5. Provider Business Phone *

The value must be a number

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6. Billing Address *

7. City *

8. Zip Code *

The value must be a number

9. Name of Business Manager/Financial Director *

10. Title of Business Manager/Financial Director *

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11. Primary Report Contact Person *

12. Primary Report Contact Phone Number *

The value must be a number

13. Primary Report Contact Email Address *

14. Primary Report Contact Mailing Address- Street or P. O. Box *

15. Primary Report Contact City *

16. Primary Report Contact State *

17. Primary Report Contact Zip Code *

The value must be a number

18. Secondary Report Contact Person *

19. Secondary Report Contact Phone number *

The value must be a number

20. Secondary Report Contact Email Address *

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21. Please select the Fiscal year you are providing the information for *

- ◯ Fiscal Year 2019 (10/1/2018 - 9/30/2019)
- ◯ Fiscal Year 2020 (10/1/2019 - 9/30/2020)

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Section 2 - Ground Ambulance Enhanced Supplemental Payment Reporting Questions

Please provide the Medicaid Service Units, Medicaid Payments, Commercial Service Units and the Commercial Payments for each HCPCS code for the Fiscal year that was chosen above in question 21.

22. Medicaid Service Units for A0020 *

The value must be a number

23. Medicaid Payments for A0020 *

The value must be a number

24. Commercial Service Units for A0020 *

The value must be a number

25. Commercial Payments for A0020 *

The value must be a number

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26. Medicaid Service Units for A0382 *

The value must be a number

27. Medicaid Payments for A0382 *

The value must be a number

28. Commercial Service Units for A0382 *

The value must be a number

29. Commercial Payments for A0382 *

The value must be a number

30. Medicaid Service Units for A0398 *

The value must be a number

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31. Medicaid Payments for A0398 *

The value must be a number

32. Commercial Service Units for A0398 *

The value must be a number

33. Commercial Payments for A0398 *

The value must be a number

34. Medicaid Service Units for A0420 *

The value must be a number

35. Medicaid Payments for A0420 *

The value must be a number

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36. Commercial Service Units for A0420 *

The value must be a number

37. Commercial Payments for A0420 *

The value must be a number

38. Medicaid Service Units for A0422 *

The value must be a number

39. Medicaid Payments for A0422 *

The value must be a number

40. Commercial Service Units for A0422 *

The value must be a number

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41. Commercial Payments for A0422 *

The value must be a number

42. Medicaid Service Units for A0424 *

The value must be a number

43. Medicaid Payments for A0424 *

The value must be a number

44. Commercial Service Units for A0424 *

The value must be a number

45. Commercial Payments for A0424 *

The value must be a number

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46. Medicaid Service Units for A0425 *

The value must be a number

47. Medicaid Payments for A0425 *

The value must be a number

48. Commercial Service Units for A0425 *

The value must be a number

49. Commercial Payments for A0425 *

The value must be a number

50. Medicaid Service Units for A0427 *

The value must be a number

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51. Medicaid Payments for A0427 *

The value must be a number

52. Commercial Service Units for A0427 *

The value must be a number

53. Commercial Payments for A0427 *

The value must be a number

54. Medicaid Service Units for A0429 *

The value must be a number

55. Medicaid Payments for A0429 *

The value must be a number

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56. Commercial Service Units for A0429 *

The value must be a number

57. Commercial Payments for A0429 *

The value must be a number

58. Medicaid Service Units for A0433 *

The value must be a number

59. Medicaid Payments for A0433 *

The value must be a number

60. Commercial Service Units for A0433 *

The value must be a number

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61. Commercial Payments for A0433 *

The value must be a number

62. Medicaid Service Units for A0434 *

The value must be a number

63. Medicaid Payments for A0434 *

The value must be a number

64. Commercial Service Units for A0434 *

The value must be a number

65. Commercial Payments for A0434 *

The value must be a number

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Section 3 - Legal Certification

For this section, please acknowledge and certify each statement as applicable.

66. By checking this box, I certify that the information provided in this application is true and accurate to the best of my ability, and supported by the financial and other records of the ambulance service providers. Detailed support exists for all amounts reported in the application. These records will be retained for a period of not less than five years following the due date of the survey, and will be made available for inspection when requested. The provider acknowledges that the information is to be used for claiming Federal funds and understand this misinterpretation of information constitutes a violation of the Federal and State law. *

    ◯ Certify

67. By checking this box, I certify that I understand that information I provide may be published at the provider level in interim or final reports to CMS or provided to the public as required by the Texas Public Information Act. This information may include the ACR gap or the ACR Upper Payment Limit (UPL). *

    ◯ Certify

68. By checking this box, I certify that no part of any payment made under a supplemental payment program will be used to pay a contingent fee and that the agreement with the ambulance provider does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the ambulance provider's receipt of funds. *

    ◯ Certify

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69. Please check the box below if you believe the information you are providing is confidential.

☐ Confidential

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