

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER:  <b>09-003</b>	2. STATE:  <b>TEXAS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE:  <b>February 1, 2009</b>	
5. TYPE OF PLAN MATERIAL (Circle One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.170(a) 42 CFR §431.53 Section 1905(a)(28) of the Social Security Act		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT  a. FFY 2009                      \$ 420,996 b. FFY 2010                      \$ 669,374 c. FFY 2011                      \$ 721,320	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 AND 9.</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 AND 9.</b>	
10. SUBJECT OF AMENDMENT:  The proposed amendment updates the reimbursement methodology for ambulance services by allowing cost-based reimbursement to Austin-Travis County Emergency Medical Services, a municipal third-service ambulance service provider. The provider will be subject to annual cost reporting requirements, cost reconciliation, and cost settlement. The requested effective date for the proposed amendment is February 1, 2009.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Sent to Governor's Office this date. Comments, if any, will be <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      forwarded upon receipt.			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:  <b>Billy Millwee</b> Interim State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: <b>Billy Millwee</b>			
14. TITLE: <b>Interim State Medicaid Director</b>			
15. DATE SUBMITTED: <b>March 30, 2009</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 30 March, 2009		18. DATE APPROVED: 2-March, 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 February, 2009		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

STATE	<u>Texas</u>	A
DATE REC'D.	<u>3-30-09</u>	
DATE APP'VD	<u>3-2-11</u>	
DATE EFF	<u>2-1-09</u>	
HCFA 179	<u>09-03</u>	

State of Texas  
Attachment 4.19-B  
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**2. Ambulance Services.**

- (a) With the exception of the provider covered by paragraph (b), ground and air ambulance services are reimbursed based on the lesser of the provider's billed charges or fees established by the Texas Health and Human Services Commission (HHSC). Fees established by HHSC are based on a review of the Medicare fee schedule and/or an analysis of other data available to HHSC such as relevant fee schedules.
- (b) (1) Effective for services provided on and after February 1, 2009, Austin-Travis County Emergency Medical Services, a municipal third-service ambulance service provider, is paid the reimbursement rate posted on the current fee schedule equal to the Medicaid rates paid to other ambulance providers in accordance with paragraph (a) above. The reimbursement rates are provisional in nature and a supplemental payment, equal to the difference between the fee for service (FFS) rate and the provider reconciled cost, will be paid pending the submission of a Center for Medicare and Medicaid Services (CMS) approved annual cost report and the completion of a cost reconciliation and a cost settlement for that period.
- (2) The provider will submit cost reports completed on the provider's fiscal year. Cost reconciliation and cost settlement processes will be completed within twenty-four months from the end of the cost reporting period.
- (3) The provider's reported costs are allocated to the Medicaid program based on the percentage of Medicaid units of service to total units of service.
- (4) If the provider's interim payments exceed the Medicaid-allowable costs of the provider, the Texas Health and Human Services Commission (HHSC) will recoup the overpayment using one of these two methods:
- (A) Offset all future claims payments from the provider until the amount of federal and state shares of the overpayment is recovered; or
- (B) The provider will return an amount equal to the overpayment.
- (5) HHSC shall issue a notice of settlement to the provider that denotes the amount due to or from the provider.

TN No. 09-03

Approval Date 3-2-11

Effective Date 2-1-09

Supersedes TN No. 07-40

SUPERSEDES: TN- 07-40