

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202



Division of Medicaid & Children's Health, Region VI

March 4, 2011

Our Reference: SPA TX 09-18

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 09-18, dated June 22, 2009. This amendment updates the Ambulance Services fee schedule.

Additionally, please note that when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's Tribal consultation process for that SPA. Pursuant to the new section 1902(a)(73) of the Act added by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the State Plan Amendment. Such consultation must include all federally-recognized tribes, Indian Health Service and Urban Indian Organizations within the State.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 2009. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely, 

Bill Brooks
Associate Regional Administrator

Enclosures

cc: Emily Zalkovsky, Policy Development Support

STATE	<u>Texas</u>	A
DATE REC'D	<u>6-18-09</u>	
DATE APP'VD	<u>3-9-11</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-18</u>	

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 on and after February 1, 2009, Austin-Travis County Emergency Medical Services, a municipal third-service ambulance service provider, is paid interim rates equal to the Medicaid rates paid to other ambulance providers in accordance with paragraph (a) above. The interim rates are provisional in nature, pending the submission of an 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 federal and state shares of 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.

If the actual, Medicaid-allowable costs of the provider exceed the interim payments, HHSC will pay the federal share of the difference to the provider after the provider pays the state share of the difference through intergovernmental transfer (IGT). HHSC will submit claims to CMS for reimbursement of the federal share of the payment in the federal fiscal quarter following payment to the provider.

HHSC shall issue a notice of settlement to the provider that denotes the amount due to or from the provider.

- (C) All fee schedules are available through the agency's website as set out on Attachment 4.19-B, page 1.
- (D) The agency's fee schedule was revised with new fees for ambulance services effective for services on or after September 1, 2009. The fee schedule is to be posted on October 8, 2009.

TN No. 09-18

Approval Date 3-9-11

Effective Date 9-1-09

Supersedes TN No. 07-40

SUPERSEDES: TN 07-40

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 09-018	2. STATE: TEXAS
		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: September 1, 2009	
5. TYPE OF PLAN MATERIAL (<i>Circle One</i>): <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 (<i>Separate Transmittal for each amendment</i>)			
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 \$ 491,958 b. FFY 2010 \$7,005,920 c. FFY 2011 \$6,713,825	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 AND 9.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): SEE ATTACHMENT TO BLOCKS 8 AND 9.	
10. SUBJECT OF AMENDMENT: The proposed amendment updates the Ambulance Services fee schedule.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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 forwarded upon receipt. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Chris Traylor		Chris Traylor State Medicaid Director Post Office Box 13247 Austin, Texas 78711	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: June 18, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 18 June, 2009		18. DATE APPROVED: 4 March., 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2009		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: Pen and Ink change made per State's E-mail dated 21 March, 2011 correcting the approved page and correcting the language page to Attachment 4.19-B page 1b.			

Rupley, Cheryl A. (CMS/SC)

From: Fox, Ashley (HHSC) [Ashley.Fox@hhsc.state.tx.us]
Sent: Monday, March 21, 2011 12:27 PM
To: Rupley, Cheryl A. (CMS/SC)
Cc: Zalkovsky, Emily (HHSC); Sager, Beatrice (HHSC); Metayer, Shirin (HHSC)
Subject: Updated TN 09-018 (ambulance)
Attachments: Doc #5 09-018 Att 4 1-B p 1b.pdf; 20110321 09-018 Attach Blocks 8&9.doc

Good afternoon!

Please see the attached state plan page and Attachment to Blocks 8 & 9 for the Form 179 for TN 09-018 (ambulance). Please update the approval packet SPA with the correct state plan page and Attachment to Blocks 8 & 9 for the CMS Form 179.

Please note that this amendment includes the originally submitted Attachment 4.19-B, page 1b. It looks a lot like the new page, Attachment 4.19-B, page 1b.1, but it is not the same. Until SPA 10-031 is approved, there will be some redundant information in the state plan. Also, because TN 09-018 is superseded by TN 07-040, we are submitting the updated Attachment to Blocks 8 & 9 for the CMS Form 179.

Please let me know if you have further questions.

Ashley Fox
State Plan Coordinator
Medicaid & CHIP Division - Policy Development
Health and Human Services Commission
(512) 491-1165
ashley.fox@hhsc.state.tx.us

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TN No. _____ Approval Date _____ Effective Date _____

Supersedes TN No. _____

Attachment to Blocks 8 and 9 of CMS Form 179

Transmittal Number 09-018, Amendment 864

**Number of the
Plan Section or Attachment**

Attachment 4.19-B
Page 1b

**Number of the Superseded
Plan Section or Attachment**

Attachment 4.19-B
Page 1b (TN 07-040)