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 2, 2011

Our Reference: SPA TX 09-03

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 09-03, dated March 31, 2009. This amendment implements payment up to cost for ambulance services delivered to Austin-Travis County Emergency Medical Services, a governmental ambulance service provider.

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 February 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,

/s/

Bill Brooks
Associate Regional Administrator

Enclosures
cc: Emily Zalkovsky, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTER FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **09-003**

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: **February 1, 2009**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ 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:
SEE ATTACHMENT TO BLOCKS 8 AND 9.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 AND 9.

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)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Billy Millwee

14. TITLE:
Interim State Medicaid Director

15. DATE SUBMITTED:
March 30, 2009

16. RETURN TO:
Billy Millwee
Interim State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

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:

FORM CMS – 179 (07-92)

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.