



Texas Health and Human Services Commission (HHSC)

Ambulance Services Supplemental Payment Program (ASSPP) for Governmental Entities



Cost Report Training for FFY 2015



Webinar Support Instructions

Please download the presentation for today's session from the HHSC website

<http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/>.

There are two options that you may use to listen to the presentation:

- Dial in using your telephone: you must use the telephone number, access code, and audio pin found on the right side of your screen
- Listen through your computer: you must have speakers to listen and a microphone enabled computer to ask questions throughout the training



Webinar Support Instructions

- If you experience trouble please contact Webinar Support at:

1-800-263-6317

- Training duration is approximately 4 hours and short breaks will be provided.
- Please send questions to the Time and Financial Information email box at the following email address:

tafi@hhsc.state.tx.us

- A list of frequently asked question (FAQs) will be posted on the HHSC Rate Analysis website.

<http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/2015-amb-cr.shtml>



Webinar Support Instructions

 You have the ability to ask questions throughout the presentation by raising your hand.

- Your hand is raised if the arrow is pointing down
- Your hand is lowered if the arrow is pointing up



The hand/arrow image tells you the action you would like to take.

 You must be present and attentive throughout the entire training presentation to obtain credit.

- System tracks attentive levels
- Must have registered for the training



Website Overview

You can access the Health and Human Services Rate Analysis Department's Acute Care webpage by clicking on the link below. If you have problems accessing the link, copy the address to your web browser and it will take you directly to the webpage where you can get easy access to information on Ambulance Services.

<http://www.hhsc.state.tx.us/rad/>



HHSC Rate Analysis/Acute Care

The screenshot shows the Texas Health and Human Services Commission website. At the top left is the logo with the text "Texas Health and Human Services Commission". Below the logo is a navigation bar with "Google™ Custom Search" and "Search" buttons, followed by menu items: "Find Services", "News & Information", "Rules & Statutes", and "Business Information".

On the left side, there is a vertical menu with the following items: "About HHSC", "How to Get Help", "Questions about Your Benefits", "Providers and Vendors", "Research and Statistics", "Business Opportunities", "Meetings and Events", "Office of Inspector General » Report Waste, Abuse and Fraud", "HHSC Projects", "Community Resources", "Transformation Waiver", "Contact Us", "Advisory Committees", and "Job Opportunities". At the bottom of this menu is a "Sign Up for Email Updates" button.

The main content area is titled "HHSC Programs" and lists several services: "Rate Analysis", "Acute Care Services", "Hospital and Clinic Services", "Long-Term Services and Supports", "Managed Care Services", "Medicaid Administrative Claiming", and "Time Study". A blue dashed box highlights the text "Acute Care" in the main content area, with a green arrow pointing from this box to the "Acute Care Services" link in the list below.



Acute Care Services

Rate Analysis >> Acute Care Services

Acute Care Services

Overview

The Health and Human Services Commission (HHSC) Rate Analysis for Acute Care Services develops reimbursement methodology rules for determining payment rates/fees for Medicaid Acute Care Services. HHSC Rate Analysis develops payment rates/fees in accordance with published rules and policy guidelines for the following Services:

Services

- Advanced Practice Nurse (APN) see:
 - Certified Nurse Midwife (CNM)
 - Certified Registered Nurse Anesthetist (CRNA)
 - Nurse Practitioner and Clinical Nurse Specialist (NP) and (CNS)**

- Ambulance Services** ←
- Birthing Center Services
- Blind Children's Vocational Discovery & Development Program
- Certified Respiratory Care Practitioner Services (CRCP)
- Chemical Dependency Treatment Facility (CDTF)
- Children and Pregnant Women - Case Management (CPW)
- Chiropractic Services
- Dental Services
- Early Childhood Intervention - Case Management (ECI)**
- Early Childhood Intervention - Specialized Rehabilitative Services**
- Family Planning Services
- Genetic Services

Ambulance Services



Ambulance Cost Reporting Information

Medicaid Program Rate Analysis - Windows Internet Explorer provided by Health and Human Services

http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/2013-amb-cr.shtml

Rate Analysis >> Acute Care Services >> Ambulance Services >> 2013 Cost Report

Ambulance Services 2013 Cost Report Information

Overview

The due date for the 2013 cost report is March 31, 2014.

Training will be offered to all Governmental providers on how to complete this report and an overview of the excel file. Please see the training information section below.

Requirements

The Ambulance Services Supplemental Payment Cost Report (cost report) must be prepared and completed a governmental entity on an annual basis for fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. A provider who meets the definition of eligible governmental provider and who has been approved to submit a cost report for supplemental payment will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred Medicaid and Uncompensated (uninsured) costs/expenditures, including the federal share and the non-federal share applicable to the cost report period. The completed cost report will be sent to address below.

2013 Cost Report Documents

1. View the [Program Specific Methodology Rules](#)
2. View the [Cost Report Specific Instructions \(.pdf\)](#)
3. View the [Frequently Asked Questions \(.pdf\)](#)
4. Download the [Cost Report \(.xls\)](#)

Sign Up for Email Updates

OFFICE NOTICES
Closures due to weather or other emergencies

\$50 a year covers all your kids.
See if you qualify

Trusted sites 95%

Cost Report Instructions
Excel Template

<http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/2013-amb-cr.shtml>



Ambulance Services Contacts

Windows Internet Explorer provided by Health and Human Services

http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/

File Edit View Favorites Tools Help

Convert Select

Favorites GetFitTexas - Welcome Find a Physician - Texas Me... Welcome to myuhc Free Hotmail Oklahoma DHS Job Announc... Ross & Matthews, P.C Suggested

Texas Medicaid Program Rate Analysis

How to Get Help
Questions about Your Benefits
Providers and Vendors
Research and Statistics
Business Opportunities
Meetings and Events
Office of Inspector General ->
Report Waste, Abuse and Fraud
HHSC Projects
Community Resources
Transformation Weaver
Contact Us
Sunset Review
Advisory Committees
Job Opportunities

Sign Up for Email Updates

OFFICE NOTICES
Click here for weather or other emergencies

\$50 a year covers all your kids.
See if you qualify
CHIP Children's Medicaid

VOTE TEXAS.GOV
MAKE YOUR MARK ON TEXAS

Texas Veterans Portal
Think your state long-term care expenses covered?
Click here for more information
Own Your Future

Don't be in the dark about child care.
Find regulated child care in your area

Rate Analysis >> Acute Care Services >> Ambulance Services

Ambulance Services

General Information

Ambulance Services are nonemergency and emergency patient transports that are reimbursed by Texas Medicaid. These services include out-of-hospital acute medical care, transport to definitive care, and other medical transport to patients with illnesses and injuries which prevent the patients from transporting themselves. To enroll in the Texas Medicaid Program, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services. More information about these services may be found in the Ambulance Services Handbook portion of the Texas Medicaid Provider Procedure Manual located on the Texas Medicaid and Healthcare Partnership (TMHP) website.

Reporting Information

- 2012 Cost Report Information (DOS 03/01/12 thru 09/30/12)
- 2012 Cost Report Information (DOS 10/01/11 thru 02/29/12)
- 2011 Cost Report Information
- 2010 Cost Report Information

Contacts

Note: Rate Analysis staff can assist you with questions concerning only payment rates for the specified services. They are not able to answer other types of questions, such as the status of payment for services rendered or questions involving eligibility for care services.

If you have questions regarding Ambulance Services fee for service payment rates, please call the Rate Analyst on the **Contacts List**.

If you have questions regarding Ambulance Supplemental payments program, please call the Rate Analyst on the **Contacts List**.

If you have questions regarding Ambulance Services program/policy issues, please call the TMHP Contact Center on the **Contacts List**.

Methodology / Rules

The Ambulance Services program rules are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 354, SubChapter A, Division 9, Rule 1111, 1113, and 1115.

Reimbursement rules applicable to Ambulance Services are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 5, Rule 8081 and Division 31, Rule 8600.

The fee schedules and any periodic adjustment(s) to the fee schedules are published in banner messages contained in provider Remittance and Status (R&S) reports, Medicaid Bulletin articles, web postings, provider manual, fee schedules or other provider notification.

Contacts



Ambulance Services Supplemental Payment Program Criteria

Ambulance Supplemental Payment Program

General Information

Governmental ambulance providers may receive a supplemental payment if the governmental ambulance provider's allowable costs exceed the fee-for-service revenues received during the same period. An approved ambulance provider that meets the required enrollment criteria may receive supplemental payments up to reconciled costs with the submission of an annual cost report. Cost reports will be based on a cost to billed charge ratio methodology.

Eligibility for Ambulance Supplemental payment program

A governmental ambulance provider must submit a written request for a supplemental payment by regular mail or special mail delivery to the HHSC Rate Analysis Department. The request, if acceptable, will be effective the first day of the month after the request is approved.

View the [Application Request Criteria](#)

Notices

View a list of important notices regarding the [Ambulance Supplemental Payment Program \(ASPP\)](#)

Payment Rate Information

Payment rate information is published by procedure code in the applicable [Texas Medicaid Fee Schedule](#) located on the Texas Medicaid & Healthcare Partnership (TMHP) website (see Fee Schedules).

Contact Rate Analysis

[Send email to Rate Analysis](#)

Updated: July 20, 2012

- Eligibility Criteria
- Notices
- Payment Rate Information
- How to Contact Rate Analysis



Rate Analysis Program Contacts & Communication

Contacts:

Dan Huggins

Director, Acute Care Services

Dario Avila

Team Lead, Cost Reporting

Sandra Brabandt

Rate Analyst, Cost Reporting

<http://www.hhsc.state.tx.us/rad/acute-care/contacts.shtml>

Communication:

Predominantly sent/received via EMAIL

Send Cost Report Questions/Cost Report Submission to the following email box: tafi@hhsc.state.tx.us

Website:

Acute Care Website

<http://www.hhsc.state.tx.us/rad/acute-care/>





HHSC - Ambulance Services

Ambulance Services are nonemergency and emergency patient transports that are reimbursed by Texas Medicaid. These services include out-of-hospital acute medical care, transport to definitive care, and other medical transports to patients with illnesses and injuries which prevent the patients from transporting themselves.

Ground



Fixed Wing/Rotary



Water





Ambulance Supplemental Payment Program Overview

To be eligible to **receive and retain** federal reimbursement for the Texas Medicaid Ambulance program, a provider must:



Be enrolled and approved as a provider with the Texas Medicaid & Healthcare Partnership (TMHP);



Ensure that services are provided by approved/qualified providers as indicated in the Texas Medicaid Provider Procedures Manual (TMPPM);



Submit a request and receive approval from HHSC to be eligible to participate in the Ambulance Services Supplemental Payment Program;



Bill for allowable Medicaid services delivered in the Ambulance program;



Abide by HHSC rules and regulations;



Complete training for every odd-year cost report in order to complete cost reports for that year and the next year;



Submit an annual Ambulance Cost Report; and



Comply with all state and federal audits.



Ambulance Rules

The Ambulance Service program rules are located at Title 1 of the Texas Administrative Code (TAC) , Part 15, Chapter 354, SubChapter A, Division 9, Rule 1111, 1113, and 1115.

Reimbursement rules applicable to Ambulance Services are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 5, Rule 8081 and Division 31, Rule 8600.

Cost Determination Rules applicable to the Ambulance Program are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, Subchapter A, Rules 101-111.



Reimbursement Methodology Rule Amendments

 Effective March 1, 2012, approved governmental providers are eligible to report and receive reimbursement for uncompensated costs. These reimbursements are made available due to the approval of the Healthcare Transformation and Quality Improvement 1115 Waiver Program (1115 Transformation Waiver).



Billing for Ambulance Emergency Medical Transport Services

- Providers are required to submit claims for services delivered to a Medicaid client through the TMHP claim system.
- The TMHP claim system provides for prompt eligibility verification, identifies duplicate claim filings, creates a complete audit trail from service to claim, and documents payment data necessary for the Surveillance and Utilization Review Subsystem (SURS).
- Failure to bill for services in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM) will impact your entity's Medicaid funding.



Billing for Ambulance Services – TMHP Reference Information

- Refer to: Section 3: TMHP Electronic Data Interchange (EDI) (Vol. 1, General Information) for information on electronic claims submissions.
- Refer to Section 6: Claims Filing 6.1.3. (Vol. 1, General Information) for general information about claims filing. Claims must be received by TMHP within 95 days from each date of service (DOS). Appeals must be received by TMHP within 120 days of the disposition date on the R&S Report on which the claim appears. A 95-day or 120-day appeal filing deadline that falls on a weekend or a holiday is extended to the next business day following the weekend or holiday.
- Payment denial codes are applied to a Texas Provider Identifier (TPI) that has had no claim activity for a period of 24 months or more. The TPI will be considered inactive and will not be able to be used to submit claims. To have the payment denial code removed from a provider identifier, providers must submit a completed application for the state health-care program in which they wish to enroll, and the application must be approved.



Remittance and Status (R&S) Report

- TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP.
- The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions.
- If no claim activity or outstanding account receivables exist during the cycle week, the provider will not receive an R&S Report.
- Providers are responsible for reconciling their records to the R&S to determine payments and denials received.
- The R&S reflects claim payments processed during the period stated on the report regardless of the dates of service.



Billing for Ambulance Services

IMPORTANT

- Government Entities utilizing billing agencies must:
 - Reconcile payments to Billed Services
 - Ensure data is accurate and complete



Eligibility for Supplemental Payments

A governmental ambulance provider must submit a written request for a supplemental payment to the HHSC Rate Analysis Department. The request, if acceptable, **will be effective the first day of the month after the request is approved.** HHSC considers only requests from governmental ambulance providers as defined 42 CFR § 433.50 (a)(1)(i) . HHSC will respond to all written requests for consideration, indicating the requestor's eligibility to receive supplemental payments.



Request Criteria

An acceptable request must include the following at a minimum:

- (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 for other departments of the governmental agency;
- (vi) a primary contact person for the governmental agency who can respond to questions about the ambulance department;
- (vii) a signed letter documenting the governmental provider's voluntary contribution of non-federal funds.



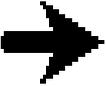
Ambulance Rates



- Ambulance rates for acute care programs are developed by Health and Human Services Commission (HHSC) Acute Care Rate Analysis Division.
- Rate Analysis staff work closely with other HHSC staff to coordinate program administration, service definitions, billing guidelines and rates.



Ambulance Fee-For-Service Rates



**Analysis of
Data by
Rate Analysts**



**Public
Rate
Hearing**



**HHSC Executive
Management
Approves Rates**



Purpose of the Cost Report

The purpose of the Ambulance Supplemental Payment Cost Report is to provide approved governmental ambulance providers with the opportunity to receive supplemental payments if the governmental ambulance provider's allowable costs exceed the fee-for-service revenues received during an applicable service period.

Effective March 1, 2013, approved government providers may be reimbursed for cost related to Uncompensated Care in accordance with the 1115 Transformation Waiver.



1115 Healthcare Transformation Waiver

Supplemental payment funding, managed care savings, and negotiated funding will go into two statewide pools now worth \$29 billion (all funds) over five years. Funding from the pools will be distributed to hospitals and other providers to support the following objectives: (1) an uncompensated care (UC) pool to reimburse for uncompensated care costs as reported in the annual waiver application/UC cost report; and (2) a Delivery System Reform Incentive Payment (DSRIP) pool to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.



Cost Report Training Requirements

In accordance with **Title 1 TAC Part 15, Chapter 355, Subchapter A, §355.102(d)**, it is the responsibility of the provider to ensure that each cost report preparer has completed the required state-sponsored cost report training. Effective October 1, 2011 Preparers must complete cost report training for each program for which a cost report is submitted. Also, per Title 1 TAC §355.102(d), **Preparers must complete cost report training every other year for the odd-year cost report in order to receive a certificate to complete both that odd-year cost report and the following even-year cost report.** If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, to receive training credit to complete the even-year cost report, he/she must complete an even-year cost report training. **NO EXEMPTIONS** from the cost report training requirements will be granted.



Cost Report - Due Dates

Ambulance Services Supplemental Payment Program (ASSPP)

FFY /DY	Report Service Period (1115 Waiver)	Report Due Date
FFY 2015/DY4	10/01/2014 – 09/30/2015	03/31/2016
FFY 2016/DY5	10/01/2015 – 09/30/2016	03/31/2017

All important information, notices, due dates, etc can be found on the following website:
<http://www.hhsc.state.tx.us/rad/acute-care/index.shtml>



How to Complete a Cost Report

-  Read the current year's Cost Report Specific Instructions
-  Gather all required documentation
-  Review General Ledger for unallowable costs and classification errors
-  Develop work papers that clearly reconcile between the provider's fiscal year end trial balance and the amounts reported on the Cost Report
-  Complete all required allocations
-  Check work for errors
-  Maintain all documents/worksheets, etc. in one centralized location with a copy of the cost report





Cost Report - Eligible Costs

Cost reports eligible under Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will include **only** allocable expenditures related to Medicaid Fee-for-Service, Medicaid Managed Care and Uncompensated Care as defined and approved in the 1115 Waiver Program.

For information regarding the definition to Uncompensated Cost, please refer to the Cost Report Instruction Guide listed on the HHSC Website under the reporting heading.

<http://www.hhsc.state.tx.us/rad/acute-care/amb-svcs/>



Purpose of Cost Allocation

The purpose of a cost allocation plan is to summarize, in writing, the methods and procedures that the organization will use to allocate costs to various programs, grants, contracts and agreements.

General guidance on cost allocation for federal grant funded programs is provided from the Office of Management and Budget (OMB) for state, local and Indian tribal governments, 2 CFR 225 applies.



Cost Accounting Standards (CAS)

2 CFR 225 applies to Governmental entities and municipalities; however, Cost Accounting Standards (CAS) can provide useful information to a governmental entity. CAS standards are designed “to achieve uniformity and consistency in cost accounting practices.”



Cost Allocation Methodology

Costs are allocated using statistics that have been approved by the Centers for Medicaid/Medicare Services to facilitate the identification of costs associated with Medicaid, Medicaid Managed Care and Uncompensated Care costs. These costs may be included as part of the allocation methods utilized in the Ambulance Cost Report. Keep in mind that appropriate documentation must be kept for all costs included in the Cost report.

Applies 3/1/2012 – 9/30/2016



Direct Medicaid and Uncompensated Care Cost to Charge Ratio – Report Total Allowable Costs of Medicaid and Uncompensated Care for the Period of Service / Total Billed Charges for the Period of Service Charges



Cost Allocation – Central Office

Administrative costs are indirect costs produced by administrative functions. Administrative costs can be directly charged or shared. If these costs are shared, they are considered central office costs and must be allocated.

Administrative functions include:

- General Administrative Oversight
- Central Management
- Personnel Functions
- Accounts Payable
- Accounts Receivable
- General Ledger Accounting Functions
- Risk Management Functions
- Financial Statement Functions
- Payroll Functions
- Benefit Management Functions
- Purchasing Functions
- Any other Administrative-Type Function



Cost Allocation – Direct Cost

Direct costs are those that can be identified specifically with a particular final cost objective.

Direct costs chargeable to Federal awards are:

-  Compensation of employees for the time devoted and identified specifically to the performance of those awards.
-  Cost of materials acquired, consumed, or expended specifically for the purpose of those awards.
-  Equipment and other approved capital expenditures.
-  Travel expenses incurred specifically to carry out the award.



Direct cost of a minor amount may be treated as an indirect cost for reasons of practicality where such accounting treatment for that item of cost is consistently applied to all cost objectives.



Cost Allocation- Indirect Cost

Indirect costs are incurred costs identified that have two or more cost objectives, but are not specifically identified with any final cost objective. These shared costs may include:

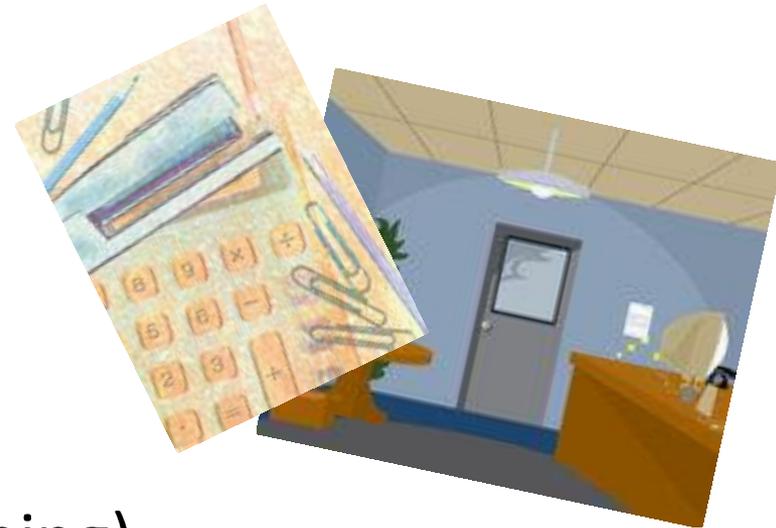
-  Building/facility rent or lease
-  Utilities costs
-  Telecommunications costs
-  Administrative staff salaries/wages
-  Advertising expenses
-  Travel expenses



Cost Allocation – Central Office

Costs related to administrative functions include:

- salaries/wages
- payroll taxes
- employee benefits
- supplies
- office space
- operations costs (travel/training)

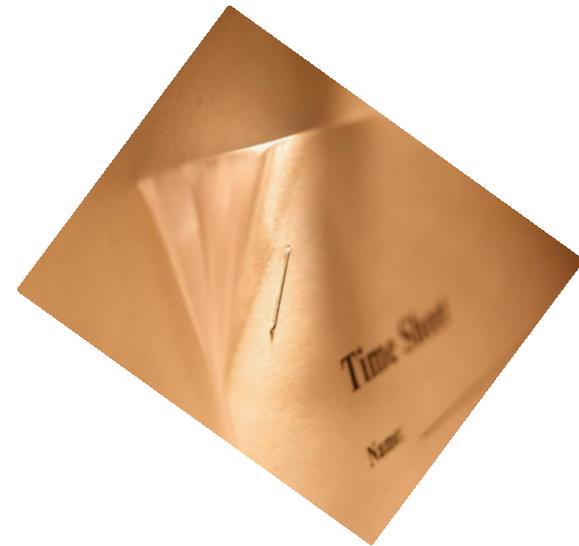




Allocation of Time – Time Sheets

Any staff whose duties include:

- multiple direct service types;
 - both direct and indirect service component types; and/or
 - both direct hands-on support and first-level supervision of direct care workers.
-
- ✓ Continuous record of time on a daily basis throughout the entire reporting period.
 - ✓ Maintained to directly charge ALL hours worked in each job function and activity for the entity





Allocation of Time – Time Sheets

Time sheets must include the following:

- Employee Name
- Date
- Start and Stop Time
- Total Hours Worked
- Time worked providing direct services in the program (in increments of 30 minutes or less)
- Time worked performing other functions
- Paid time off
- Appropriate Signatures and Dates



Time Sheet Example

HHSC Central Office Admin Support Daily Time Sheet

EMPLOYEE NAME

Marium DeMarco

DATE:

10/31/11

TIME(hh:mm)		Duties	Cost Centers by Department (Enter time in minutes)						
BEGINNING	ENDING		HR-1000	Legal-2000	Finance-3000	EMS-2000	Fire 5000	PD-6000	*Shared Admin costs
8:00 AM	9:30 AM	Payroll	90						
9:30 AM	10:30 AM	Accounting			60				
10:30 AM	11:15 AM	Meeting EMS				45			
11:15 AM	12:30	Meeting FIRE Dept					45		
12:30 PM	1:00 PM	Travel Back to Office				30	30		
1:00 PM	2:00 PM	Lunch							60
1:30 PM	2:30 PM	Voucher Processing			60				
2:30	3:30	AMB Waiver Issues							
3:30	4:30 PM	Annual Leave / Vacation							60
Total Minutes per Cost Center			90	0	120	75	75	0	120

* Shared Admin Costs - Paid Lunches; Annual Leave; Sick Leave, Jury Duty; etc.

Legend		Daily Summary		Allocation of Shared Time		
Department	Cost Center	Cost Center	Total Minutes	Alloc/%	Alloc Time	Total Time
Central Office	HHSC-1000	HHSC-1000	90.00	25%	30	120
Legal	HHSC-2000	HHSC-2000	0.00	0%	0	0
Finance	HHSC-3000	HHSC-3000	120.00	33%	40	160
EMS	HHSC-4000	HHSC-4000	75.00	21%	25	100
Fire	HHSC-5000	HHSC-5000	75.00	21%	25	100
PD	HHSC-6000	HHSC-6000	0.00	0	0	0
Shared Admin Time	HHSC-7000	HHSC-7001	120.00	360.00	120.00	480
Total Minutes			480.00			

Jane Smith, CPA, MBA

9/30/2011

Signature:

Date:

Jerry Pritchard, City Manager

11/1/2011

Supervisor Signature/ Title:

Date:



Allowable vs. Unallowable Costs

Cost are allowable if they are reasonable and necessary.

Reasonable Cost - The provider seeks to minimize costs through arm's-length transactions. The amount expended does not exceed what a prudent, cost-conscious buyer pays for a given item or service.

Necessary Cost - Those costs that are appropriate for developing and maintaining the required standard of operation for providing client care.



Allowable Cost – Salary/Wages & Benefits

Allowable employee benefits are reported as either:

- Salaries and wages- Benefits reported as salaries and wages and directly charged to the individual employee to include paid vacation days, paid holidays, paid sick leave, other paid leave, and bonuses;
- Employee benefits - Employer contributions to deferred compensation plans, retirement funds or pension plans, certain employer-paid health/medical/dental and disability insurance premiums and paid claims, employer-paid life insurance premiums, employer-paid child day care for children of employees;
- Costs applicable to specific cost areas.



Allowable Cost - Other Benefit Expenses

Benefits that are reported as costs applicable to specific cost areas include:

- Employer-paid training/educational costs
- Employee relations costs
- Uniforms
- Mileage reimbursement



Allowable Costs - Benefits Continued

Providers must maintain documentation which clearly identifies each type of compensation. Examples of required documentation are:

- Insurance policies
- Provider benefit policies
- Records showing paid leave accrued and taken
- Documentation to support hours (regular & overtime) worked and wages paid
- Mileage logs
- Travel Allowances



Allowable Costs – Accounting/Audit/Legal Fees

ACCOUNTING, AUDITING, AND LEGAL FEES

Documentation for accounting, auditing and legal fees that are billed on an hourly basis and the allowable portion of legal retainers should include:

-  The amount of time spent on the activity
-  A written description of the activity performed
-  The person performing the activity
-  The hourly billing amount of the person performing the activity



Allowable Employer - Expenses

INTEREST EXPENSE

Loan Documentation

-  Signed copy of loan
-  Explanation of purpose of loan
-  Documentation of use of proceeds
-  Evidence of systematic principal and interest payments
-  Substantiation of costs of securing loan





Allowable Costs – Training

The following training expenses are ALLOWABLE on the cost report as long as the training has a direct relationship to the job:

-  CPR
-  On-The-Job Training
-  Instructors Costs
-  Materials
-  Registration Fees





Allowable Costs – Travel Costs

Please refer to the table below for FFY2016 Per Diem Rates.

<p>In-State or Out-of-State Meals and Lodging</p>	<p>•Refer to the GSA’s federal Domestic Maximum Per Diem Rates, effective Oct. 1, 2015.</p> <p>If the city is not listed, but the county is listed, use the rate of the county.</p> <p>For areas not listed (city or county), the rates are: Lodging In-State: up to \$85</p> <ul style="list-style-type: none"> •Lodging Out-of-State: up to \$83 (Sept. 1–30, 2015) •Lodging Out-of-State: up to \$89 (Oct. 1 – Aug. 31, 2016) •Meals In-State/Out-of-State: up to \$46 (Sept. 1–30, 2015) •Meals In-State/Out-of-State: up to \$51 (Oct. 1 – Aug. 31, 2016)
<p>In-State or Out-of-State Non-Overnight Meals</p>	<p>Not to exceed \$36</p>
<p>Automobile Mileage</p>	<p>57.5 cents per mile (Sept. 1 – Dec. 31, 2015)</p>
<p>Aircraft Mileage</p>	<p>\$1.29 per mile (Sept. 1 – Dec. 31, 2015)</p>



Allowable Costs – Travel Costs

The maximum for lodging per diem and meals per diem costs is 150% of the General Services Administration (GSA)'s federal travel rates for maximum lodging and meal reimbursement rates. The GSA's travel rates may be found at <http://www.gsa.gov> . Click on "Per Diem Rates".

For locations not specifically listed on the GSA website, the maximum allowable lodging and meals per diem rates for cost-reporting purposes are \$127.50 for lodging (plus applicable city/local/state taxes and energy surcharges) and \$54.00 for meals.



Allowable Costs – Mileage Rates

Applicable Period (s)		Rates (in cents per mile)	Source(s)	
2015	Jan. 1 – Dec. 31, 2013	57.5	IR-2014-114	https://fmx.cpa.state.tx.us/fm/travel/travelrates.php ; or http://www.irs.gov/Tax-Professionals/Standard-Mileage-Rates
2014	Jan. 1 – Aug. 31, 2014	56	IR-2013-95	
2013	Jan. 1 – Dec. 31, 2013	56.5	IR-2012-85	
2012	Jan. 1 – Dec. 31, 2012	55.5	IR-2012-85	
2011	July 1 – Dec. 31, 2011	55.5	IR-2011-69	



Allowable vs. Unallowable Costs

Memberships, Subscriptions, Lobbying, Contributions, & Donations

Costs for membership in professional associations directly and primarily concerned with the provision of services.

Allowable

-  Professional association dues
-  Dues or fees to maintain professional accreditation

Unallowable

-  Lobbying or campaign contributions
-  Civic organizations
-  Non-professional organizations



Depreciation

The purpose of depreciation is to apply the expense portion of an asset that relates to the revenue generated by the asset. As referenced in 2 CFR 225, depreciation and use allowances are means of allocating the cost of fixed assets to periods benefiting from asset use.

Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of an asset's cost over its useful life.

Amortization is the periodic reduction of the value of an intangible asset, such as a trademark or patent, or debt over its useful life.



Depreciation

The computation of depreciation or use allowances to ensure its classification and estimated useful life, is accurate if based on the following:

- Allowable cost specific to the ambulance program
- Historical cost
- Date of purchase
- Depreciable basis
- Use of values consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association

The following must be accessible in a field audit for each depreciable asset

- Estimated useful life
- Accumulated depreciation
- Calculation of gains and losses upon disposal



Depreciate or Expense?

Determining whether to expense or depreciate a purchased item:

- Cost < \$5,000 or 1 Year Useful Life - Expense any single item costing less than \$5,000 or having a useful life of one year or less.
- Cost \geq \$5,000 and 1 Year Useful Life - An asset valued at \$5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized, using the straight line method.
- Cost < \$5,000 and Useful Life is greater than a year – The provider has an option to either expense or depreciate the purchased item, but the reporting must be consistent each reporting period.



AMBULANCE BUILDING



A building's life must be reported as a minimum of 30 years, with a minimum salvage value of 10%. The depreciation computation or use allowances will exclude:

- The cost of land
- Any portion of the cost of building donated by the Federal Government.

A building's shell may be segregated from the major component of the building (e.g., plumbing system, heating, and air conditioning system, etc.) and each major component depreciated over its estimated useful life,

or

The entire building (i.e., the shell and all components) may be treated as a single asset and depreciated over a single useful life.

However, if a building is shared between an Ambulance and Fire Engine, an allocation method must be used.



OTHER AMBULANCE ASSETS

Use minimum schedules consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association.

Examples – Building equipment; buildings and grounds improvements and repairs; durable medical equipment, furniture, and appliances; and power equipment and tools used for buildings and grounds maintenance.



Un-Allowed Depreciable Assets

Examples:

- Engines
- Ladder Trucks
- Tactical Vests
- Brush Truck
- Hazard Materials Vehicle
- Pike Poles





Depreciation vs. Actual Expenses

TRANSPORTATION – LOGS

Not required if:

- Used by EMS staff providing emergency medical services and the services requires Ground, Air or Water Transport



Depreciation vs. Actual Expenses

GROUND TRANSPORTATION – MILEAGE LOG

Minimum elements:

- Date
- Driver
- Trip Mileage (beginning, ending and total)
- Purpose of trip
- Allocation Centers (departments, business entities)



Depreciation vs. Actual Expense

REPAIRS and MAINTENANCE



Ordinary repairs



recurring



usually involve expenditures for parts and labor to keep the asset in operating condition



Examples - painting, copy machine repair, oil changes



EXPENSE AS INCURRED



Depreciation

REPAIRS and MAINTENANCE



Extraordinary repairs



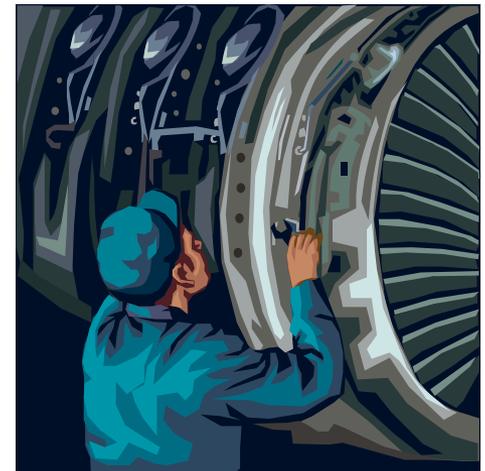
expenditures not normally recurring



usually increase the value of an asset



Examples - vehicle overhauls, replacing a roof and strengthening the foundation of a building





Depreciation

Required for each depreciable asset so that its classification and estimated useful life can be checked for accuracy

- Historical cost
- Date of purchase
- Depreciable basis

Must be accessible in a field audit for each depreciable asset

- Estimated useful life
- Accumulated depreciation
- Calculation of gains and losses upon disposal



Depreciation

UNALLOWABLE DEPRECIATION/AMORTIZATION

- Depreciation and amortization for unallowable assets
- Amounts in excess of those using the straight-line method
- Planning/evaluation expenses for depreciable assets not purchased and used in contracted services



Corrections/Adjustment Request

Corrections/Adjustments may be made up to **60** days after the original due date of the cost report. To make a correction to a cost report:



Send a written request for approval of correction submission to HHSC Rate Analysis.



Correction requests must be on agency letterhead and signed by the Chief Financial Officer, Executive Director or Judge (person with authority over the program).



Correction requests must be notarized.



Corrections/Adjustment Requests



Requests should include:

- Public Agency Name
- Agency NPI and TPI
- Year/Service Period of the cost report in need of correction
- Brief description of issue/correction
- Length of time needed to complete the revisions



Please be advised that the governmental entity will also need to re-submit new signed and notarized certification forms for the respective cost report year.



Official signature and notary dates must be no earlier than the electronic cost report re-submission date.



Report Certification(s)

Cost Report Certification

- Is required and formally acknowledges that the cost report is true, correct and complete, and was prepared in accordance to all rules and regulations.
- Must be completed & signed by an individual legally responsible for the conduct of the provider such as the authorized agent.
- The responsible party's signature must be notarized.



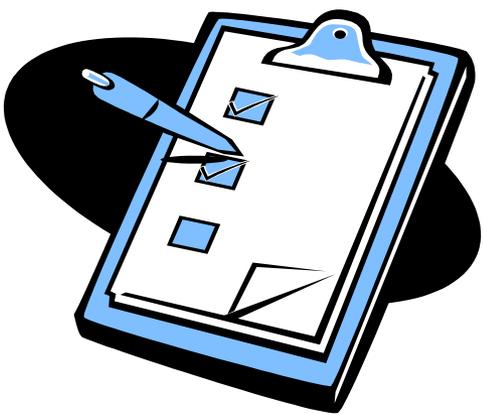
Report Certification(s)

Claimed Expenditures

- Certifies that expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the cost report year.
- Government Provider Name, Total Computable amount, and reporting period dates are auto-populated.
- Must be completed & signed by an individual legally responsible for the conduct of the provider such as the authorized agent.
- The responsible party's signature must be notarized.
- The responsible party should read the certification statements carefully before signing the form before a notary.



Cost Report Submission Process



Submitted Cost Reports are logged and tracked by HHSC



HHSC Conducts a Desk Review/Field Audit



Desk Reviews & Field Audits

- Providers are responsible to respond to the HHSC Rate Analyst within 15 days from the date HHSC requests clarification and/or additional information .
- Records must be accessible to HHSC Audit staff within 10 working days of notification. When records are not in Texas, the provider must pay the costs for HHSC staff to travel and review records out of state.



Common Desk Review Findings

- Documentation does not support services rendered.
- Documentation does not include billable time.
- Documentation does not include start and stop times, total minutes, activity performed or related objective (Time Sheets).
- Amount of time billed does not match amount of time documented.
- Documentation does not support costs reported on cost report



Desk Reviews & Field Audits

HHSC e-mails notices stating that the exclusions and adjustments reports for providers are available. These reports identify:



Items that have been adjusted



The amount of each adjustment



The reason for each adjustment



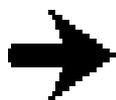
Informal Reviews

An image showing office supplies: a yellow folder with a "Company Report" sticky note, a red pencil, a white calculator displaying "5.731", and several colorful paper clips.

Informal

An image depicting a gavel and a large dollar sign, symbolizing the legal and financial aspects of an appeal process.

Appeal Process





Informal Review Requests

- Due within 30 days of notification
- Must include items in dispute, recommended resolution, supporting documentation
- Must be signed by individual legally responsible for the conduct of the contracted provider or their legal representative



Appeal Process

If a governmental entity does not agree with the decision made by the HHSC Rate Analysis Division, the entity has an option to appeal through the HHSC appeal process. Formal appeals are conducted in accordance with the provisions of Chapter 357, Subchapter I of this title (relating to Hearings under the Administrative Procedure Act). Requests for a formal appeal from the interested party must be received within 15 calendar days after the interested party receives the written decision. Requests must be sent directly to:

HHSC Appeals Division
Mail Code W-613
P.O. Box 149030
Austin, Texas 78714-9030



Medicaid Records Retention Policy

State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. **HIPAA requirements preempt State laws if they require shorter periods.** Your State may require a longer retention period. The HIPAA requirements are available at 45 CFR 164.316(b)(2)

http://ecfr.gpoaccess.gov/cgi/t/text/textdx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained **in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report.** This requirement is available at 42 CFR 482.24[b][1]

http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html



Unacceptable Cost Reports

-  Not completed in accordance with rules, instructions, and policy clarifications
-  Not completed for the correct reporting period
-  Not completed using a modified accrual method or cash basis of accounting
-  Preparer did not submit the required documentation (certification pages, allocation summaries, contractual agreements)
-  Provider does not have supporting work-papers
-  Provider fails to provide requested information/documentation in a timely fashion
-  Provider used unacceptable allocation method



Ambulance Supplemental Payment Cost Report Definitions:

Cognizant agency - agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Circular A-87.

Cost Allocation Plans - are the means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge ratio -- A provider's reported costs are allocated to the Medicaid program based on a cost-to-billed-charge ratio. Cost-to-billed charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio to the billed charges of the total Medicaid paid claims for the service period that represents the denominator of the ratio. This ratio is applied to calculate total billed charges associated with Medicaid paid claims or total computable amount for the cost report.

Federal Medical Assistance Participation (FMAP) Rate -- is the share of state Medicaid benefit costs paid for by the federal government.

Medicaid Fee-For-Service (FFS) Paid Claims -- Medicaid payments made by the Health and Human Services Commission through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care --provides for the delivery of Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services.



Ambulance Services Supplemental Payment Cost Report Definitions

Un-insured -- an individual who has no health insurance or other source of third-party coverage for medical/health services.

Uninsured cost -- the cost to provide ambulance services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Medicare -- A federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

Other third-party coverage -

Commercial Pay Insurance -- health insurance that covers medical expenses and disability income for the insured.

Self-Pay -- self pay patient pays in full at the time of visit for our services and we are not required to file claim or submit any documentation on his/her behalf to a third party.

Total Computable Amount – is the total Medicaid allowable amount payable for ambulance services prior to any reductions for interim payments.

Uncompensated Care (UC)—health care provided for which a charge was recorded but no payment was received; UC consists of two components, charity care in which the patient is unable to pay and bad debt in which a payment was expected but not received. Uncompensated care excludes other unfunded costs of care such as underpayment from Medicaid and Medicare.



Authority for Participation in the Ambulance Supplemental Payment Program

Governmentally owned ambulance providers are eligible to participate in the supplemental payment program if they are directly funded by a local government, hospital authority, hospital district, city, county or state as specified in 42 CFR § 433.50 (i) which describes a unit of government.

A unit of Government is defined as a state, city, county, special purpose district or other governmental unit in the State that: has taxing authority, has direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended (25 U.S.C. 450b).

The cost report will include 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.



Authority for Participation in the Ambulance Supplemental Payment Program Continued

For Cost Reports that include periods of services from March 1, 2013 forward, the cost report will include **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.



ASSPP Cost Report Template: Exhibit A – Cover Page

Exhibit A is the cost report cover page. This form includes a provider’s National and State provider identification number that is used by HHSC as a means to obtain fee-for-service cost data included in the cost report. Each governmental provider must enter their entity’s legal name, name of person responsible for submitting the cost report, the cost preparer’s name and physical location, mailing address, phone number and Fax number of all contacts listed. The information will be used by HHSC to contact the provider as necessary through the cost reconciliation and cost settlement process.

TEXAS AMBULANCE SERVICES COST REPORT		DRAFT
Complete Shaded Areas Only		Page 1 of 6
COST REPORT FOR:		
Reporting Period:		
9-Digit TPI:		
10-Digit NPI:		
PROVIDER INFORMATION		
Provider Name:		
Street Address:		
Mailing Address:		
Phone Number:		
FAX Number:		
Email:		
BUSINESS MANAGER / FINANCIAL DIRECTOR		
Name:		
Title:		
Business Name:	0	
Mailing Address:	0	
Phone Number:		
FAX Number:	0	
Email:		
REPORT PREPARER IDENTIFICATION		
Name:		
Title:		
Business Name:	0	
Mailing Address:	0	
Phone Number:		
FAX Number:	0	
Email:		
LOCATION OF ACCOUNTING RECORDS THAT SUPPORT THIS REPORT		
Physical Address:		



ASSPP Cost Report Template: Exhibit 1 – General & Statistical

Exhibit 1 is the General and Statistical Information page of the cost report. This exhibit includes general provider information and statistical information used in the cost report.

Cost Allocation Information Section : The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts and agreements. Additional information supporting an agencies methodology will be found on Exhibit 7.

TEXAS AMBULANCE SERVICES COST REPORT		Page 2 of 6	
COST REPORT for 2012		Period of Service:	
Complete Shaded Areas Only			
GENERAL AND STATISTICAL INFORMATION			
GENERAL PROVIDER INFORMATION			
1.00	a-Digit TPI:	b	
1.01	b-Digit NPI:	b	
1.02	Physical Address of Accounting Records:		
1.03	Reporting Period - Beginning		
1.04	Reporting Period - Ending		
1.05	Is Reporting Period less than a full year?		
Cost Allocation Information			
1.06	Does your agency have an approved Cost Allocation Plan (CAP)?		
1.07	If yes, please provide the name of the Cognizant Agency who approved the CAP		
1.08	Does your agency have an approved Indirect Cost Rate?		
1.09	Will you be utilizing an Indirect Cost Rate?		
1.10	If yes, what is your agency indirect cost rate		
Statistical Information			
1.11	Medicaid Fee for Service (FFS) Paid Claims Amount	\$	
1.12	Total Billed Charges Associated With Medicaid FFS Paid Claims	\$	
1.13	Medicaid Managed Care Organization (MCO) - Paid Claims Amount	\$	
1.14	Total MCO Billed Charges Amount Associated with Paid Claims	\$	
1.15	Uncompensated Care Billed Amount	\$	
1.16	Uncompensated Care Reimbursement (Enter as a Negative)	\$	
1.17	Total Allowable Costs for Reporting Period (Exhibit 2 - Direct Medical 2.)	\$	0.00
1.18	Total Billed Charges for Reporting Period (All Sources)	\$	
Additional Cost Data (Informational Purposes Only)			
a.	Medicare Costs	\$	-
b.	Other Third Party Coverage (Self-Pay, Commercial Pay) Costs	\$	-
c.	Uninsured (Charity Costs) Costs	\$	-
To be completed by HHSF Staff only Reviewed by: _____ Approved by: _____ Settlement Date: _____			



ASSPP Cost Report Template: Exhibit 2 – Direct Medical

Exhibit 2 identifies and summarizes from other exhibits all ambulance services costs within the cost report. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6; however, there are unique items of cost that are identified in this exhibit.

TEXAS AMBULANCE SERVICES COST REPORT			
COST REPORT for 2012 03/01/11 to 09/30/12			
Complete Shaded Areas Only			
9-Digit TPI:	0	10-Digit NPI:	0
AMBULANCE SERVICES			
			Amount
PAYROLL EXPENSES			
2.00	9-1-1 Call Technicians - Hours		
2.01	9-1-1 Call Technicians - Salaries & Wages	(From Worksheet B)	\$
2.02	Paramedics - Hours		
2.03	Paramedics - Salaries & Wages	(From Worksheet B)	\$
2.04	Training Coordinators - Hours		
2.05	Training Coordinators - Salaries & Wages	(From Worksheet B)	\$
2.06	Quality Assurance Techs - Hours		
2.07	Quality Assurance Techs - Salaries & Wages	(From Worksheet B)	\$
2.08	Safety Officer - Hours		
2.09	Safety Officer - Salaries & Wages	(From Worksheet B)	\$
2.10	Billing/Account Reps - Hours		
2.11	Billing/Account Reps - Salaries & Wages	(From Worksheet B)	\$
2.12	CPR Technicians - Hours		
2.13	CPR Technicians - Salaries & Wages	(From Worksheet B)	\$
2.14	Medical Director - Hours		
2.15	Medical Director - Salaries & Wages	(From Worksheet B)	\$
2.16	Director - Hours		
2.17	Director - Salaries & Wages	(From Worksheet B)	\$
2.18	Public Information Officer - Hours		
2.19	Public Information Officer - Salaries & Wages	(From Worksheet B)	\$
2.20	Contracted EMT/Paramedics - Hours		
2.21	Contracted EMT/Paramedics Compensation	(From Worksheet B)	\$
2.22	Employee Benefits (Describe in Explanation Box)	(From Worksheet B)	\$
2.23	Employer Retirement Contribution	(From Worksheet B)	\$
2.24	Employer FICA Payroll Taxes	(From Worksheet B)	\$
2.25	Employer Medicare Payroll Taxes	(From Worksheet B)	\$
2.26	State Unemployment Payroll Taxes	(From Worksheet B)	\$
2.27	Federal Unemployment Payroll Taxes	(From Worksheet B)	\$
2.28	Unemployment Compensation (Reimbursing Employer)	(From Worksheet B)	\$
2.29	Total Staff Costs (sum items 2.00 thru 2.30)		\$
OTHER COSTS			
2.30	Supplies & Materials: (Describe in Explanation Box)		\$
2.30.a.	Supplies & Materials Non-Medical		\$
2.30.b.	Supplies & Materials Medical		\$
2.31	Equipment: (Describe in Explanation Box)		\$
2.31.a.	Equipment Non Medical		\$
2.31.b.	Equipment Medical		\$
2.32	Support Services (IT, Dispatch, Call Handling, etc.) (Describe in Explanation Box)		\$
2.33	Other (Schedule A and Other) (Describe in Explanation Box)		\$
2.34	Total Direct Medical / Other Costs (sum items 2.30 through 2.33)		\$
2.35	TOTAL Staff and Direct Medical Other Costs (sum items 2.29 and 2.34)		\$
REDUCTIONS:			
2.36	Other Federal Funds and Grants (Non-Medical) (From Worksheet B)		\$
2.37	Other (Describe in Explanation Box)		\$
2.38	TOTAL Reductions (sum items 2.36 and 2.37)		\$
COST SETTLEMENT CALCULATION:			
2.39	Period of Service for Applicable Cost Report Period	From: XX/XX/XX to: xx/xx/xx	
2.40	Total Allowable Costs for Period of Service (Total Costs Less Other Non-Medical Federal Funds Reductions (Item 2.35 less Item 2.38))		\$
2.40	Divided by Total Billed Charges for Period of Service (provided by Govt. Agency)		\$
2.41	Equals Cost to Charge Ratio (CCR) (Ratio is based on lesser of cost or billed charges)		#DIV/0!
2.42	Total Billed Charges Associated with Medicaid Paid Claims		\$
2.43	Multiplied by Total Billed Charges Equals Total Computable (Medicaid-Allowable Costs for Ambulance Services)		\$
2.44	Total Medicaid Allowable Billed Charges (equals the lesser of 2.42 or 2.43 if 2.41 > 100%)		\$
2.45	Less Medicaid Paid Claims Amount for Period of Service		\$
2.46	Equals Settlement Amount		\$
2.47	Multiplied by FMAP for appropriate fiscal year		\$
2.48	Equals Amount due to Provider		\$



ASSPP Cost Report Template: Exhibit 3 – Report Certification

Exhibit 3 is the Certification of costs included in the cost report. This form attests to, and certifies the accuracy of the financial information contained within the cost report.

TEXAS AMBULANCE SERVICES COST REPORT COST REPORT for 2012 Complete Shaded Areas Only		
9-Digit TPI: _____ 0 _____		10-Digit NPI: _____ 0 _____
Cost Report Certification		
AS SIGNER OF THIS COST REPORT, I HEREBY CERTIFY THAT:		
<ul style="list-style-type: none"> The cost report will include only allowable 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. I have read the note below, the cover letter and all the instructions applicable to this cost report. I have reviewed this entire cost report after its preparation. To the best of my knowledge and belief, this cost report is true, correct and complete, and was prepared in accordance with and all the instructions applicable to this cost report. This cost report was prepared from the books and records of the Ambulance Services provider. The expenditures on this cost report have not been claimed on any other cost report. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law. 		
NOTE: This COST REPORT CERTIFICATION must be signed by an individual legally responsible for the authorized agent and/or ambulance services provider representative, such as the Chief Financial Officer, Business Officer, Director, or other official. Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under federal and/or state law.		
SIGNER IDENTIFICATION		
Printed/Typed Name of Signer _____		Title of Signer _____
Name of Provider: _____		
Address of Signer (street or P.O. Box, city, state, 9-digit zip): _____		
Phone Number (including area code) _____	FAX Number (including area code) _____	Email: _____
SIGNATURE OF SIGNER _____		DATE _____
SIGNER AUTHORITY: _____ CFO _____ Other Officer (describe) _____ (check one) _____ Business Officer _____ _____ Director _____		
Subscribed and sworn before me, _____, a notary public on _____ day / month / year		
NOTARY SEAL	NOTARY SIGNATURE _____	NOTARY PUBLIC, STATE OF _____ COMMISSION EXPIRES _____
Cost Report Certification		



ASSPP Cost Report Template: Exhibit 4 – Certification of funds

Exhibit 4 is **the Certification of Public Expenditure** that allows the state to use the computable Medicaid expenditures as the non-federal match of expenditures to draw the federal portion of Medicaid funding as identified in the settlement. This form attests to, and certifies the accuracy of the provided financial information and that the report was prepared in accordance with State and Federal audit and cost principle standards and that the costs have not been claimed on any other cost report for federal reimbursement purposes. This Exhibit also identifies the amount of local provider expenditure that is allowable for use as the state match.

TEXAS AMBULANCE SERVICES COST REPORT COST REPORT for 2012	
Complete Shaded Areas Only	
9-Digit TFC: 0	10-Digit NPI: 0
Governmental Provider Name and Address: _____	
Certification Of Funds	
This statement is of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the cost report federal fiscal year.	
Expenditures submitted to the Texas HHS for FFY 12 Ambulance direct Medicaid services: _____	Total Computable #DIV/0!
INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND STATE LAW.	
CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER	
HEREBY CERTIFY that for the reporting period: From: _____ To: _____	
<ol style="list-style-type: none"> I have examined this statement, the accompanying supporting exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the Provider in accordance with applicable instructions. The expenditures included in this statement are based on the actual cost of recorded expenditures. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs). The expenditures on this cost report have not been claimed on any other cost report. 	
<p>I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal and State civil or criminal law.</p>	
<ol style="list-style-type: none"> Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the Texas Health and Human Services Commission effective for the above indicated reporting period. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to assure that all information reported is true and accurate. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law. 	
SIGNATURE	DATE
Printed/Typed Name of Signer: _____ Title of Signer: _____	
Address of Signer (street or P.O. Box, city, state, 9-digit zip): _____	
Phone Number (including area code)	FAX Number (including area code)
Email: _____	
SIGNER AUTHORITY: _____ CFO _____ Business Officer _____ Director _____	
(check one) _____ Other Agent/Representative (describe) _____	
Subscribed and sworn before me, _____, a notary public on _____ day / month / year	
NOTARY SEAL: _____ Notary Signature _____ Notary Public, State Of _____ Commission Expires _____	



ASSPP Cost Report Template: Exhibit 6 – Schedule B

Exhibit 6 – Schedule B includes the salary and benefits, and appropriate reductions related to contracted and employed staff of the provider applicable to Medicaid, Medicaid Managed Care and Uncompensated Care. For this Exhibit, all employed and contracted staff related to the provision of Ambulance EMS services should be identified here.

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS					FEE FUNDING REDUCTION				
Employee #	Last Name	First Name	Job Title / Description	Employee or Contractor	Gross Salary	Contracted Program	Employee Benefits	Employer Retirement (401K/403B)	Employee - FICA Payroll	Employee - Medicare Payroll	Division Fully or Partially Funded by Fee Funds or Grants (Y/N)	% Fee Amount of Total Payroll	Other Amount to be Reported	Total Reduction
EMERGENCY MEDICAL TECHNICIANS														
11 Other 9-1-1 Call Technicians														
TOTAL														
PARAMEDICS														
11 Other Paramedics														
TOTAL														
TRAINING COORDINATORS														
11 Other Training Coordinators														
TOTAL														
QUALITY ASSURANCE														
11 Other Quality Assurance Techs														
TOTAL														
QUALITY OFFICER														
11 Other Quality Officer														
TOTAL														
BILINGUAL / ACCOUNT REPS														
11 Other Bilingual / Account Reps														
TOTAL														
EMS TECHNICIANS														
11 Other EMS Technicians														
TOTAL														
MEDICAL DIRECTOR														
11 Other Medical Director														
TOTAL														
CHIEF OF POLICE														
11 Other Chief of Police														
TOTAL														
PUBLIC INFORMATION OFFICER														
11 Other Public Information Officer														
TOTAL														
CONTRACTED														
11 Other Contracted EMS Technicians														
TOTAL														
					TOTAL BENEFITS AND REDUCTIONS									



ASSPP Cost Report Template: Exhibit 7 – Schedule C

Exhibit 7 – Schedule C details the cost allocation methodologies employed by the governmental entity.

TEXAS AMBULANCE SERVICES COST REPORT	
COST REPORT for 2012	9-Digit TPI: _____ 0 _____ 10-Digit NPI: 0 _____
Complete Shaded Areas Only	
Cost Allocation Methodologies Employed by the Governmental Entity	
A. If you entered "yes" on Page 12 Line 1.05 and your agency has an approved Cost Allocation Plan (CAP), please provide a copy of the approval letter received from the Cognizant Agency	
B. If you entered "yes" on Page 2, Line 1.06 and 1.09 and your agency has an approved Indirect Cost Rate (IDCR), please provide a copy of the certificate of indirect costs received from the Cognizant Agency	
C. Please provide a list of personnel cost worksheets that support your CAP or IDCR (Examples: Allocation of Personnel Worksheet, Time Distribution Report, Statement of Employee Benefits, etc.)	
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____



ASSPP Cost Report Template: Exhibit 8 – Schedule D

Exhibit – Schedule D is an example of the detail necessary to track the collections efforts made by the governmental entity. Governmental providers are not required to utilize this form, but are required to have a collections policy in place and a way to track uncollectible costs if these costs are included in the Cost Report.

A	B	C	D	E	F	G	H	I	J	K	L	M
TEXAS AMBULANCE SERVICES COST REPORT												
COST REPORT for FFY 2013												
Complete Shaded Areas Only												
Provider									9 digit TPI:		012345678	
Fiscal Year End									10 Digit NPI:		0123456789	
EXAMPLE ONLY												
Exhibit 8 - Schedule D Reasonable Collections Effort Tracking Form												
(1) Proc/Trans ID (Identifier)	(2) Procedure Code Submitted	(3) Procedure Description	(4) Transport Date (Date of Service - DOS)	(5) Insurance Carrier Name	(6) If Medicaid/Medicaid Managed Care - Recipient Number	(7) Units	(8) Charge Amount(s)	(9) Paid Amount(s)	(10) If Uninsured, Billed/Notice Dates Sent to Patient	(11) If Uninsured and Uncollectible Write Off Date	(12) Total Uncompensated Costs	
12345	A0429	BLS -Emergency	10/1/2012	Uninsured	NA	1.000	\$ 840.00	\$ 15.00	1/15/2013 2/15/2013 3/15/2013	NA NA 4/15/2013	\$ 825.00	
78945	A0433	ALS2 -Emergency	11/12/2012	Superior	W23456	1	\$ 435.10	\$ 435.10	NA	NA	\$ -	
25687	A0425	BLS Mileage	11/15/2012	Uninsured	NA	20	\$ 138.80	\$ 90.00	12/15/2012 1/15/2013	NA	\$ -	
10425	A0425	BLS Mileage	12/1/2012	Superior	W23789	25	\$ 525.65	\$ 117.75				
Total All											\$ 825.00	



Reasonable Collection Effort

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

- Collection Agencies--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, it is expected that the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
- Documentation Required--The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.



Collection Fees – Presumption of Uncollectability

When a provider utilizes the services of a collection agency and the reasonable collection effort is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider. When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs.

For example, where an agency collects \$40 from the patient/responsible party, and its fee is 50 percent, the agency keeps \$20 as its fee for the collection services and remits \$20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency (\$40) in the patient's account receivable and records the collection fee (\$20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

Presumption of Noncollectibility

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.



Rate Analysis Mailing Addresses



Regular Delivery

HHSC Rate Analysis

Mail-Code H-400

P. O. Box 149030

Austin, TX 78714-9030

Courier Service / Special Delivery

HHSC Rate Analysis

Brown Heatly Bldg.

Mail Code H-400

4900 North Lamar

Austin, TX 78751