

Ambulance Supplemental Payment Program  
Cost Report  
Frequently Asked Questions  
Updated April 1, 2013

Q. What exactly does it mean for us to “voluntarily agree to certify public expenditures for use as the non-federal share Medicaid payments to the provider listed in this letter?”

A. The form is simply a way to reassure the Centers for Medicaid/Medicare Services that the City is willing to participate in the Ambulance Supplemental Payment Program without coercion by the State.

Q. I would like to request an application to begin this process. I am unsure if we met eligible criteria but would like to review the eligibility requirements. Is there a website that may have these requirements listed?

A. The criteria can be found on the Health and Human Services Acute Care Services Website under Ambulance Services. You may access the website by clicking on the following link: <http://www.hhsc.state.tx.us/rad/acute-care/index.shtml>

Q. I received a letter advising to contact you regarding ambulance supplemental payment program HHSC is administering for governmental ambulance providers. I would like to obtain additional information regarding this program. The letter states this program includes uninsured patients without 3<sup>rd</sup> party coverage, is this program intended to replace private payer payments that do not have insurance?

A. This program is not intended to replace private payer payments. The program is part of the Medicaid Transformation Waiver. Information regarding the waiver may be found on the Health and Human Services website. The following link will provide you will information regarding the Medicaid Transformation Waiver: <http://www.hhsc.state.tx.us/medicaid/MMC.shtml>

Q. In your form letter dated 6/25/2012 you indicate some of the rules for applying for supplemental payments though I still have questions.

- What is a CMS approved cost report, what is the format of this report

A. The CMS approved cost report may be found on the HHSC website. <http://www.hhsc.state.tx.us/rad/acute-care/index.shtml>

- Who certifies the report?

A. The governmental entity is responsible for certifying the cost report each reporting period prior to submission.

- What is the criteria for selection of what ambulance transports are eligible, how are these transports listed and identified to you

A. Please refer to rule §355.8600 - Reimbursement for Ambulance Services for a description of ambulance transports eligible. You may also refer to the Texas Medicaid Provider Procedure Manual (TMPPM) for information regarding the Ambulance program. You may access the TMPPM via the following link:

[http://www.tmhp.com/Pages/Medicaid/Medicaid\\_Publications\\_Provider\\_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx)

- How far back in time can we go with these transports

A. The ambulance cost report is effective the first day of the month after the providers request is approved. It is based on a federal fiscal year and cost data is based on periods of service for the applicable federal fiscal year. Partial year cost reports may apply for any given year based on approval of the provider's application approval.

Q. Will the approved Ambulance providers be able to retro the cost report data as it states in the 1115 waiver and as hospitals do?

A. No. Based on the current ambulance rule, the ambulance cost report is effective the first day of the month after the providers request is approved.

Q. How does HHSC define an uninsured patient? Is this a patient that we classify as a "self-pay account" due to the patient reporting they have no insurance and/or a patient that does not respond to billing company requests for insurance information (both will be classified in a self-pay category).

A. The definition of uninsured may be found in the Cost Report instructions posted to the HHSC Website. You may access the information by utilizing the following link:

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

Q. How does HHSC define a "unit of service"? Is this total # of EMS calls or total # of EMS transports? Other?

A. Unit of service--A unit of service is based on one or more allowable ambulance services provided to a client by all modes of approved transportation as specified in the Ambulance program rules in 15 TAC Chapter 354, Subchapter A (relating to Ambulance Services).

Q. If an ambulance services provider identifies a patient as uninsured, but the patient makes a nominal payment on their account (e.g. the patient pays \$5 of a \$500 charge), is that entire account removed from the UC calculation?

A. No, the UC Tool calculation allows for the reduction of nominal payments made by patients.

Q. What will ambulance service providers need to provide to the state to demonstrate that they are following the hospital guidelines related to the number of notices issued to a patients before they can be deemed that patient as uninsured?

A. HHSC is has developed and included a worksheet in the ambulance tool to assist providers in meeting criteria on allowable cost associated with uncompensated care. HHSC suggest the provider's establish a collection policy to include the following:

- The uncompensated cost must be related to covered services;
- The provider must be able to establish that reasonable collection efforts were made and cost were uncollectible;
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

To be considered a reasonable collection effort, a provider's effort to collect amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicaid patients.