Texas Health and Human Services Commission (HHSC)

Ambulance Services Supplemental Payment Program (ASSPP) for Governmental Entities

Cost Report Training for FFY 2015
Please download the presentation for today’s session from the HHSC website:


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.
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

Acute Care Services

Hospital and Clinic Services

Long-Term Services and Supports

Managed Care Services

Medicaid Administrative Claiming

Time Study
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 Cost Reporting Information

Cost Report Instructions Excel Template

Ambulance Services Contacts

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 liability for care services.

If you have questions regarding Ambulance Services 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.

Contact List:

-AMBULANCE SERVICES
-AMBULANCE SERVICES PROVIDER

Methodology / Rules

The Ambulance Services program rules are located at Title 1 of the Texas Administrative Code, Part 15, Chapter 355, 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 5501, and Divisions 21, Rule 5509.

The fee schedules and any periodic adjustment(s) to the fee schedules are published in bimonthly messages contained in provider Remittance and Status (R&S) reports, Medicaid Bulletin articles, web postings, provider manuals, fee schedule or other provider notifications.
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
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/
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.
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.
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).
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 (TMPPPM) 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.
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.
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
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.
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.
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)

<table>
<thead>
<tr>
<th>FFY /DY</th>
<th>Report Service Period (1115 Waiver)</th>
<th>Report Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFY 2015/DY4</td>
<td>10/01/2014 – 09/30/2015</td>
<td>03/31/2016</td>
</tr>
<tr>
<td>FFY 2016/DY5</td>
<td>10/01/2015 – 09/30/2016</td>
<td>03/31/2017</td>
</tr>
</tbody>
</table>

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](http://www.hhsc.state.tx.us/rad/acute-care/index.shtml)

FFY – Federal Fiscal Year/DY – Demonstration Year
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 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/
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.
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.

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

Applies 3/1/2012 – 9/30/2016
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.
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
Costs related to administrative functions include:

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

§355.105(b)(2)(B)(xii)(I) & (II)
HHSC Central Office Admin Support  Daily Time Sheet

EMPLOYEE NAME: Marium DeMarco

DATE: 10/31/11

<table>
<thead>
<tr>
<th>TIME (hh:mm)</th>
<th>Duties</th>
<th>Cost Centers by Department (Enter time in minutes)</th>
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<tbody>
<tr>
<td>8:00 AM</td>
<td>Payroll</td>
<td>HR-1000: 90</td>
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<td>9:00 AM</td>
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<td>Legal-2000: 60</td>
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<tr>
<td>9:30 AM</td>
<td>Accounting</td>
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<td>10:00 AM</td>
<td></td>
<td>Finance-3000: 45</td>
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<tr>
<td>10:30 AM</td>
<td>Meeting EMS</td>
<td>EMS-2000: 45</td>
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<tr>
<td>12:30 PM</td>
<td>Travel Back to Office</td>
<td>Fire 5000: 45</td>
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<tr>
<td>1:00 PM</td>
<td>Lunch</td>
<td>PD-6000: 0</td>
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<tr>
<td>2:00 PM</td>
<td>Voucher Processing</td>
<td>*Shared Admin costs</td>
</tr>
<tr>
<td>3:00 PM</td>
<td>AMB Waiver Issues</td>
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<tr>
<td>3:30 PM</td>
<td>Annual Leave / Vacation</td>
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Total Minutes per Cost Center

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<tr>
<th>Department</th>
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<th>Total Minutes</th>
<th>Alloc. %</th>
<th>Alloc. Time</th>
<th>Total Time</th>
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<tr>
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<td>HHSC-2000</td>
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<tr>
<td>Finance</td>
<td>HHSC-3000</td>
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<td>EMS</td>
<td>HHSC-4000</td>
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<td>100</td>
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<tr>
<td>PD</td>
<td>HHSC-6000</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>Shared Admin</td>
<td>HHSC-7000</td>
<td>120</td>
<td>36</td>
<td>120</td>
<td>480</td>
</tr>
</tbody>
</table>

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

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.

§355.102(f)(1)
Allowable employee benefits are reported as either:

- Salaries and wages- Benefits \textit{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

§355.103(b)(1)(A)(iii)(III)(e-)
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
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

§355.105(b)(2)(B)(viii)
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

§355.103(b)(2)(B)(ii)
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

§355.103(b)(12)(A)
Allowable Costs – Travel Costs

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

| In-State or Out-of-State Meals and Lodging | •Refer to the GSA’s federal [Domestic Maximum Per Diem Rates](#), effective Oct. 1, 2015. If the city is not listed, but the county is listed, use the rate of the county. For areas not listed (city or county), the rates are: Lodging In-State: up to $85 •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) |
| In-State or Out-of-State Non-Overnight Meals | Not to exceed $36 |
| Automobile Mileage | 57.5 cents per mile (Sept. 1 – Dec. 31, 2015) |
| Aircraft Mileage | $1.29 per mile (Sept. 1 – Dec. 31, 2015) |
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](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

<table>
<thead>
<tr>
<th>Applicable Period (s)</th>
<th>Rates (in cents per mile)</th>
<th>Source(s)</th>
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<tr>
<td>2015 Jan. 1 – Dec. 31, 2013</td>
<td>57.5</td>
<td>IR-2014-114</td>
</tr>
<tr>
<td>2014 Jan. 1 – Aug. 31, 2014</td>
<td>56</td>
<td>IR-2013-95</td>
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<tr>
<td>2013 Jan. 1 – Dec. 31, 2013</td>
<td>56.5</td>
<td>IR-2012-85</td>
</tr>
<tr>
<td>2011 July 1 – Dec. 31, 2011</td>
<td>55.5</td>
<td>IR-2011-69</td>
</tr>
</tbody>
</table>

Allowable vs. Unallowable Costs

Memberships, Subscriptions, Lobbying, Contributions, & Donations

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

<table>
<thead>
<tr>
<th>Allowable</th>
<th>Unallowable</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Professional association dues" /></td>
<td><img src="image" alt="Lobbying or campaign contributions" /></td>
</tr>
<tr>
<td><img src="image" alt="Dues or fees to maintain professional accreditation" /></td>
<td><img src="image" alt="Civic organizations" /></td>
</tr>
<tr>
<td><img src="image" alt="Non-professional organizations" /></td>
<td></td>
</tr>
</tbody>
</table>

§355.103(b)(11)
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

§355.105(b)(2)(B)(xv)
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 ≥ $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.
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.

§355.103(b)(7)(C)(iii)
OTHER AMBULANCE ASSETS


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.

§355.103(b)(7)(C)(iii)
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)

§355.103(b)(7)(C)
## HHSC Emergency Medical Services Mileage Log

### Vehicle Information
- **Make**: Chevy
- **Model**: Suburban
- **Year**: 2011

### Trip Log
<table>
<thead>
<tr>
<th>Driver</th>
<th>Passengers</th>
<th>Purpose of Trip</th>
<th>Beginning Odometer Reading</th>
<th>Ending Odometer Reading</th>
<th>Total Mileage</th>
<th>Program Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Huggins</td>
<td>Asst. Chief Moorad</td>
<td>Fin. Meeting - EMS Budget</td>
<td>10000</td>
<td>10005</td>
<td>5</td>
<td>EMS</td>
</tr>
<tr>
<td>Chief Huggins</td>
<td>None</td>
<td>Fire Call</td>
<td>10005</td>
<td>10025</td>
<td>20</td>
<td>Fire</td>
</tr>
<tr>
<td>Chief Huggins</td>
<td>None</td>
<td>Fire Call w/EMS</td>
<td>10025</td>
<td>10042</td>
<td>17</td>
<td>Fire/EMS</td>
</tr>
<tr>
<td>Chief Huggins</td>
<td>Asst. Chief Moorad</td>
<td>EMS ConfAustin</td>
<td>10042</td>
<td>10065</td>
<td>23</td>
<td>EMS</td>
</tr>
</tbody>
</table>

### Legend

<table>
<thead>
<tr>
<th>Department</th>
<th>Cost Center</th>
<th>Cost Center</th>
<th>Mileage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Office</td>
<td>HHSC-1000</td>
<td>HHSC-1000</td>
<td>0</td>
</tr>
<tr>
<td>EMS</td>
<td>HHSC-2000</td>
<td>HHHC-2000</td>
<td>36.5</td>
</tr>
<tr>
<td>Fire</td>
<td>HHSC-3000</td>
<td>HHSC-3000</td>
<td>28.5</td>
</tr>
<tr>
<td>Police</td>
<td>HHSC-4000</td>
<td>HHSC-4000</td>
<td>0</td>
</tr>
<tr>
<td>XXXXXXXXXX</td>
<td>HHHC-XXXXXX</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total       | 65          | |         |
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

§355.103(b)(6)(A)
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

§355.103(b)(6)(B)
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

§355.105(b)(2)(B)(xv)
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:

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

Corrections 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.
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.
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.
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

Informal

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
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
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.
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.
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.
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.
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.
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.
### 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.

<table>
<thead>
<tr>
<th>Certification of Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Computable Expenditures submitted to the Texas HHSC for FY 12</th>
<th>$0</th>
</tr>
</thead>
</table>

**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**

1. 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.

2. The expenditures included in this statement are based on the actual cost of recorded expenditures.

3. 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 nonfederal share 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).

4. The expenditures on this cost report have not been claimed on any other cost report.

5. 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.

6. 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.

7. 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.

8. 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.

**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
- Other Agent/Representative (describe)

Subscribed and sworn before me, a notary public in

**M.O.**

**A.G.**

**E.G.**

**Commission Expires**
ASSPP Cost Report Template: Exhibit 5 – Schedule A

Exhibit 5 identifies allowable depreciation expenses incurred by the provider related to Medicaid, Medicaid Managed Care and Uncompensated Care. This Exhibit will identify depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this Exhibit must come from a depreciation schedule maintained by the provider in accordance with appropriate accounting guidelines established by the provider and/or the parent organization of the provider. For depreciation expenses, the straight line method should be used. Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

<table>
<thead>
<tr>
<th>Description</th>
<th>Month/Year Placed in Service</th>
<th>Years of Useful Life</th>
<th>Cost</th>
<th>Prior Period Accumulated Depreciation</th>
<th>Depreciation for Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>VEHICLES:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
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.
Exhibit 7 – Schedule C details the cost allocation methodologies employed by the governmental entity.

<table>
<thead>
<tr>
<th>Cost Allocation Methodologies Employed by the Governmental Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. If you entered &quot;yes&quot; 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.</td>
</tr>
<tr>
<td>B. If you entered &quot;yes&quot; 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.</td>
</tr>
<tr>
<td>C. Please provide a list of personnel cost worksheets that support your CAP or IDCR.</td>
</tr>
<tr>
<td>(Examples: Allocation of Personnel Worksheet, Time Distribution Report, Statement of Employee Benefits, etc.)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>
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.

### Example Only

**Exhibit 8 - Schedule D Reasonable Collections Effort Tracking Form**

<table>
<thead>
<tr>
<th>(1) Proof Trans ID Identifier</th>
<th>(2) Procedure Code Submitted</th>
<th>(3) Procedure Description</th>
<th>(4) Transport Date (Date of Service = COS)</th>
<th>(5) Insurance Carrier Name</th>
<th>(6) Denial Code</th>
<th>(7) Units</th>
<th>(8) Charge Amount(s)</th>
<th>(9) Paid Amount(s)</th>
<th>(10) Date Uninsured, Unpaid Notice Sent to Patient</th>
<th>(11) Date Uninsured and Uncollectible Notice Sent to Patient</th>
<th>(12) Total Uncompensated Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345</td>
<td>A0429</td>
<td>BLS - Emergency</td>
<td>10/1/2012</td>
<td>Uninsured</td>
<td>NA</td>
<td>1.000</td>
<td>$840.00</td>
<td>$15.00</td>
<td>1/15/2013 (2/15/2013)</td>
<td>NA</td>
<td>3/15/2013 (4/15/2013)</td>
</tr>
<tr>
<td>78945</td>
<td>A0433</td>
<td>ALS2 - Emergency</td>
<td>11/11/2012</td>
<td>Superior</td>
<td>W23456</td>
<td>1</td>
<td>$435.10</td>
<td>$435.10</td>
<td>NA</td>
<td>NA</td>
<td>3/15/2013 (4/15/2013)</td>
</tr>
<tr>
<td>25687</td>
<td>A0425</td>
<td>BLS Mileage</td>
<td>11/19/2012</td>
<td>Uninsured</td>
<td>NA</td>
<td>20</td>
<td>$138.80</td>
<td>$90.00</td>
<td>12/15/2012 (1/15/2013)</td>
<td>NA</td>
<td>1/15/2013 (1/15/2013)</td>
</tr>
<tr>
<td>10425</td>
<td>A0425</td>
<td>BLS Mileage</td>
<td>12/1/2012</td>
<td>Superior</td>
<td>W23789</td>
<td>25</td>
<td>$255.65</td>
<td>$117.75</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Total All** $835.00
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