Payments for Government Ambulance Transportation Services

Qualified in-state government ambulance transportation service providers are reimbursed for the actual incurred costs of providing ambulance services to eligible Medicaid beneficiaries. Each provider must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid ambulance transportation services. The CMS approved Medicaid cost report form 2552-10 or the non-hospital government ambulance cost report form is due from ambulance providers five months after the end of the provider's fiscal year. An initial settlement will be processed within eighteen months of receiving an approved cost report. A final settlement will be processed within twenty-four months of receiving the approved cost report. The payments will be paid to each provider in an amount based on the provider's reconciled costs for providing ambulance transportation services to Medicaid recipients, less amounts already paid to the provider for ambulance transportation services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods approved by the office. Government providers are required to comply with cost allocation principles found in OMB Circular A-87. In instances where cost allocation principles in OMB A-87 conflict with CMS 15-1, government providers must always use the OMB A-87 principles. For purposes of these payments, effective for services provided on or after January 1, 2011, costs shall be calculated as follows:

A. For hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent hospital cost report on file with the office. Hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

B. For non-hospital-based governmental ambulance transportation providers, costs will be calculated using the most recent CMS-approved cost report on file with the office. Non-hospital-based governmental transportation providers will submit the Indiana Medicaid Freestanding Governmental Ambulance Provider Cost Report that is prepared in accordance with a cost reporting methodology developed by the office that complies with OMB Circular A-87 and utilizes the Federal Transit Administration (FTA) Uniform System of Accounts, or other accounting system determined to be appropriate by the office. Cost reports must also comply with Medicare reasonable cost principles. Non-hospital-based provider cost reports must be submitted to the office no later than the last day of the fifth month following the provider's fiscal year end.

Payments will be the amounts calculated under Step Four of the following formula:

Step One: Determine the amount of each provider's charges and Medicaid reimbursement for claims incurred during the provider's fiscal year and adjudicated to a paid status through the MMIS.

Step Two: Determine the amount of each provider's reconciled costs for the provider's fiscal year for providing ambulance transportation services for Medicaid eligible persons. Cost for the provider's fiscal year will be calculated by multiplying the provider's charges identified in Step One by the cost-to-charge ratio from the cost report on file with the office corresponding to the fiscal year under consideration.

Step Three: Subtract the Medicaid reimbursement amount determined in Step One from the cost calculated in Step Two. If Medicaid reimbursement exceeds cost calculated in Step Two, an overpayment has been made. The office will recover the overpayment in compliance with the requirements of section 1903(d)(2) of the Social Security Act.

Step Four: If the amount calculated in Step Three is greater than zero, the provider will receive a payment equal to the amount calculated in Step Three multiplied by the Federal Medical Assistance Percentage (FMAP) rate for Indiana in effect at the time of the payment.

Community Mental Health Rehabilitation Services

Payment will be based upon the lower of the provider's submitted charge or the OMPP maximum allowance for the procedure billed. Maximum allowances are established by the Department of Mental Health based upon a review of like charges by similar providers throughout the State. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Mental Health Rehabilitation Services. The agency's fee schedule rate was set as of 7-1-2010 and is effective for services provided on or after that date. All rates are published on the agency's website at www.indianamedicaid.com.