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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

1. AMBULANCE-
Ambulance Transportation services are medically necessary when provided by an ambulance provider under the Medicaid program in accordance with the following as described in Attachment 3.1-A.1, paragraph 23a.

Payment to private providers will be set as a percentage of the Medicare Fee Schedule in effect as of January 1 of each year. The percentages will be applied as indicated in paragraph 23 (A). Interim payment to governmental providers will be set at the same level as private providers and will be cost reconciled to equal the cost of services provided during the fiscal period beginning July 1, 2009 through June 30, 2010, and for subsequent 12 month fiscal periods. Cost will be determined by the Division of Medical Assistance using a CMS approved cost identification process in accordance with 2 CFR Part 225 and the CMS Provider Reimbursement Manual. Cost for each governmental provider will be identified and compared to the interim payment, based on this comparison, additional payment or recovery of payment will be made to assure that the total of payment equals cost. Governmental and private ambulance transportation providers' interim rates are listed on Page 1a.

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A. Direct Medical Services Payment Methodology

Effective July 1, 2009 Ambulance Services fees will be based on the following percentages of the Medicare Fee Schedule:

a. Ground Mileage, Per Statue Mile will be 45%
b. Advanced Life Support, Non-Emergency, Level 1 will be 30%
c. Basic Life Support, Non-Emergency, Level 1 will be 33%
d. Advanced Life Support, Emergency will be 35%
e. Basic Life Support, Emergency will be 22%
f. Conventional Air Services, One Way (Fixed Wing) will be 16%
g. Conventional Air Services, One Way (Rotary Wing) will be 14%
h. Advance Life Support, Level 2 will be 24%
i. Fixed Wing Air Mileage per Statue Mile will be 45%
j. Rotary Wing Air Mileage, Per Statue Mile will be 54%

Fee changes for codes not covered by Medicare that Medicaid currently covers, such as Non-Emergency Transportation will be based on the forecasted Gross National Product (GNP) Implicit Price Deflator.

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 of the State Plan. These rates will be adjusted July 1st of each year.

The Ambulance Transportation Fee Schedule is published on the North Carolina Department of Health and Human Services, Division of Medical Assistance (DMA) Website located at http://www.ncdhhs.gov/dma/fee/fee.htm.

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B. Direct and Indirect Allowable Cost Methodology

The Division of Medical Assistance (DMA) uses a cost based methodology for governmental Ambulance Transportation providers which consist of a cost report and reconciliation.

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To determine the Medicaid-allowable direct and indirect costs of providing Medicaid-eligible emergency transportation for governmental providers, the following steps are performed:

(1) Direct costs for direct medical services include payroll costs, EMS service contracted, communications, rental cost equipment/vehicles, EMS travel, vehicle maintenance/operations/repairs; materials and supplies that can be directly charged to direct medical services.

These direct costs are accumulated on the provider's annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation in accordance with the principles in 2 CFR Part 225 and the CMS Provider Reimbursement Manual.

(2) Total direct costs for direct medical services from Item B 1 above are reduced on the cost report by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.

(3) Indirect costs are determined using the provider's annual central service cost allocation plan. A double step-down allocation requiring sequential ordering of benefiting departments is used to distribute indirect costs among central services and other departments that receive benefits. Only Medicaid-allowable costs are certified by providers. North Carolina adheres to the CMS approved cost identification process described on this page.

(4) Net direct costs and indirect costs are combined.

(5) An average cost per trip is calculated by dividing net direct and indirect costs by total transports. Transports are transportation of a patient for medically necessary treatment. Trips are empty ambulance en route to a call or returning from a transport. Mileage is only applied for medically necessary ground transportation outside the county's base area.

(6) Medicaid's portion is calculated by multiplying the results from Item B 4 above by the total number of Medicaid transports.

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C. Annual Cost Report Process

For Ambulance transportation listed in Paragraph 23a.1 during the state fiscal year, each governmental ambulance provider must complete an annual cost report. The cost report is due on or before November 30th following the reporting period.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by the Division of Medical Assistance or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Division, may be subject to withhold penalties for non-compliance. A 20 percent withhold of Medicaid payments will be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to the Division of Medical Assistance and has received a written approval from the Division of Medical Assistance. The withholding of monies will continue until the Medicaid cost report filing requirements have been satisfied. Once, all requirements have been satisfied withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

The primary purposes of the governmental cost report are to:

(1) Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology

(2) Reconcile annual interim payments to total CMS-approved, Medicaid - allowable costs using a CMS approved cost allocation methodology.

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D. The Cost Reconciliation Process

The cost reconciliation process must be completed within twelve months of the end of the reporting period covered by the annual Ambulance Transportation Cost Report. The total Medicaid-allowable scope of costs based in accordance with 2 CFR Part 225 and the CMS Provider Reimbursement Manual methodology are compared to the Ambulance Transportation Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the 2 CFR Part 225 and the CMS Provider Reimbursement Manual approved scope of costs. Any modification to the scope of cost, cost allocation methodology procedures requires approval from CMS prior to implementation.

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E. The Cost Settlement Process

If a provider's interim payments exceed the provider's certified cost for Ambulance Transportation provided to Medicaid clients, the provider will remit the excess federal share of the overpayment at the time the cost report is submitted. The federal share will be returned via CMS-64 Report.

If the certified cost of an ambulance transportation provider exceeds the interim payments, the Division of Medical Assistance will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.