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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 26-0002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355 (300)
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

July 31, 2026

Melanie Bush
Deputy Secretary of Medicaid
Division of Health Benefits
2001 Mail Service Center
1985 Umstead Drive
Raleigh, NC 27699-20014

Re: North Carolina State Plan Amendment (SPA) 26-0002

Dear Deputy Secretary Bush:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Medicaid State Plan Amendment (SPA) TN 26-0002, with a requested effective date of July 1, 2026. This amendment proposed to update School Based Service by expanding eligible provider types and covered services as well as updating various payment methodologies. This SPA also intends to add clarifying language to confirm state compliance with audit standards.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 440.110, 42 CFR 440.50(a), 440.60(a), 440.130(b), 440.130(c), 440.130(d). This letter informs you that North Carolina Medicaid SPA TN 26-0002 was approved on July 31, 2026 with an effective date of July 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the North Carolina State Plan.

If you have any questions, please contact Leilani Ochai at (410) 786-5009 or via email at Leilani.Ochai1@cms.hhs.gov.

Sincerely,

Nicole McKnight
Acting Director, Division of Program Operations

Enclosures

cc: Kathryn Horneffer, NC DHHS
Ashley Blango, NC DHHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26 — 0002

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
~~42 CFR 440.110~~ 42 CFR 440.110, 42 CFR 440.50(a), 440.60(a), 440.130(b), 440.130(c), 440.130(d),1905(r) of the Social Security Act.

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 27 $ 1,826,686
b. FFY 28 $ 1,844,953

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Attachment 3.1-A.1 pg 7d - 7e~~
~~Attachment 4.19-B, Section 6, pg 2-7~~
Attachment 3.1-A.1 Pages 7d-7f
Attachment 4.19-B Section 6, Pages 2- 11

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A.1 pg 7d - 7f.4
~~Attachment 4.19-B, Section 6, pg 2-7~~
Attachment 4.19-B, Section 6, pg 2-6

9. SUBJECT OF AMENDMENT

School Based Services

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED: Secretary

11. SIGNATURE OF STATE AGENCY OFFICIAL: DocuSigned by:

12. TYPED NAME
Jay Ludlam

13. TITLE
Deputy Secretary

14. DATE SUBMITTED 02/13/26 | 11:28 AM EST

15. RETURN TO
Office of the Deputy Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

FOR CMS USE ONLY

16. DATE RECEIVED
February 24, 2026

17. DATE APPROVED
July 31, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2026

19. SIGNATURE OF APPROVING

20. TYPED NAME OF APPROVING OFFICIAL
Nicole McKnight

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

7-28-26-State authorized pen and ink change to update Box 5 and 7
7/30/2026 - State authorized pen and ink change to update Box 8.

Instructions on Back

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

(8) Medicaid Services Provided in Schools (Local Education Agencies)

School-Based Services (SBS) are Medicaid-covered health services provided to a Medicaid beneficiary by or through a Local Education Agency (LEA) and are included under one or more of the categories in Section 1905(a) of the Social Security Act, and EPSDT services. SBS are provided in accordance with state law and policies, and listed in one of the following documents:

- Individualized Education Program (IEP)
- Section 504 accommodation plan (34 C.F.R. §104.36)
- Individual Health Plan (IHP)
- Behavior Intervention Plan (BIP)
- Other written plan of care

A beneficiary shall receive services delivered in the least restrictive environment consistent with the nature of the specific services and the physical and mental condition of the beneficiary.

Covered Services
The SBS benefit includes medically necessary evaluation, diagnostic, and treatment services that are covered under North Carolina's Medicaid program when provided by or through a LEA. These services are necessary to correct or ameliorate physical or behavioral illnesses or conditions. Covered school-based services include:

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders provided by licensed practitioners within the scope of practice as defined under state law and in accordance with 42 CFR §440.110.

- Behavioral health services recommended by a physician or other licensed practitioner operating within their scope of practice under state law and regulation, and provided by a:
  Licensed Psychologist (LP);
  Licensed Psychological Associate (LPA);
  Licensed Clinical Mental Health Counselor (LCMHC);
  Licensed Clinical Mental Health Counselor Associate (LCMHCA);
  Licensed Clinical Social Worker (LCSW);
  Licensed Clinical Social Worker Associate (LCSWA);
  School Psychologist (SP);
  School Psychologist Intern;
  Licensed Marriage and Family Therapist (LMFT);
  Licensed Marriage and Family Therapist Associate (LMFTA);
  Licensed Clinical Addiction Specialist (LCAS);
  Licensed Clinical Addiction Specialist Associate (LCASA);
  Licensed Physician Assistant (PA);

Nurse Practitioner (NP), including Psychiatric Mental Health Nurse Practitioner (PMHNP);
Licensed Behavior Analyst;
Licensed Assistant Behavior Analyst;
Behavior Technician;
Medical Doctor (MD);
Doctor of Osteopathic Medicine (DO); or
other licensed practitioner operating within their scope of practice under state law and regulations or provided by staff under the supervision of a licensed practitioner.

Behavioral health services are provided in accordance with 42 CFR §§ 440.130(d) or 440.50(a) and include psychological testing; clinical observation; clinical assessment; medication management; crisis services (assessment, referral, and direct treatment); therapy; and counseling services.

- Research-Based Behavioral Health Treatment (RB-BHT) services are research-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary. Research-Based Behavioral Health Treatment demonstrates clinical efficacy in treating ASD, prevents or minimizes the adverse effects of ASD, and promotes, to the maximum extent possible, the functioning of the beneficiary. RB-BHT services include: adapting environments to promote positive behaviors and learning while reducing negative behaviors; applying reinforcement to change behaviors and promote learning; teaching techniques to increase positive behaviors, build motivation, and develop social, communication, and adaptive skills; using typically developing peers to teach and interact with individuals with ASD; and applying technological tools to change behaviors and teach.

  RB-BHT services are provided by a Licensed Qualified Autism Service Provider (LQASP) as defined under state law and regulations and a Certified Qualified Professional (C-QP) or a paraprofessional under the supervisions of an LQASP and within the scope of practice as defined under state law and regulations and in accordance with 42 CFR § 440.130(c).

- Nursing services provided pursuant to a written treatment plan developed by a licensed Registered Nurse (RN) based on a written order as required by the North Carolina Board of Nursing. Nursing services provided by a Licensed RN or delegated to a Licensed Practical Nurse (LPNs) operating within the scope of practice as defined under state law and regulations and covered under 42 CFR §440.60(a).

- Vision and hearing screenings administered in accordance with 42CFR § 440.130(b) by a licensed registered nurse (RN), licensed practical nurse (LPN), licensed audiologist, or licensed speech/language pathologist working within the scope of practice as defined under state law and regulations.

MEDICAL ASSISTANCE
STATE: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

Additional EPSDT services may be provided by or through a LEA to the extent they are coverable under Medicaid, consistent with the federal and state requirements and provider qualification standards established in the State Plan. All covered services must be provided in accordance with treatment plans that meet standards and requirements defined in state policy.

Federally recognized tribes or Indian Health Services are exempt from the above requirements as they are governed by Federal Regulations and/or equivalent tribal code.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

(4) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of School-based Medicaid services. The agency's fee schedule rate was set as of July 1, 2026 and is effective for services provided on or after that date. All rates are published on the NC Medicaid Division of Health Benefits (DHB) website at: https://ncdhhs.servicenowservices.com/fee_schedules

(5) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.

(6) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid beneficiaries, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid beneficiaries. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.

(7) School-based Medicaid services are services that are medically necessary and provided by a Local Education Agency (LEA) to Medicaid beneficiaries in accordance with an Individualized Education Program (IEP), a section 504 Accommodation Plan pursuant to 34 CFR§104.36, a Behavior Intervention Plan (BIP), or an Individual Health Plan (IHP) or other written treatment plan. Covered services include the following as described in Attachment 3.1-A.1:

a. Physical Therapy
b. Occupational Therapy
c. Speech/Language Pathology
d. Audiology Therapy
e. Behavioral Health Services
f. Nursing Services
g. Vision and Hearing Screenings

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified healthcare professional that have been approved under Attachment 3.1-A/B of the Medicaid State Plan.

A. Direct Medical Services Payment Methodology

The Division of Health Benefits (DHB) will use a cost-based reconciliation methodology for reimbursement to Local Education Agencies (LEAs). This methodology will consist of interim payments, cost reporting, time study, and reconciliation. If interim payments exceed Medicaid-allowable costs, the excess will be recouped.

The interim payment to LEAs for covered services are based on the physician fee schedule methodology as outlined in Attachment 4.19-B, Section 5.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

The interim payment to LEAs for nursing services is based on the private duty nursing schedule as outlined in Attachment 4.19-B, Section 8. The interim payment for nursing services has 3 components, each established on a 15-minute unit fee. The interim rate for RN Services and LPN Services are established by using the national average hourly salary for RNs and LPNs based on data from the U.S. Department of Labor. The fee per 15-minute unit is then derived from the average hourly salary for Registered Nurse (RN) and Licensed Practical Nurse (LPN).

The interim payment to LEAs for outpatient specialized therapies (physical therapy, occupational therapy, speech-language pathology, and audiology therapy) and behavioral health services is based on fee schedules published on the NC Medicaid Division of Health Benefits (DHB) website at: https://ncdhhs.servicenowservices.com/fee_schedules.

All interim payments are provisional and will be reconciled to actual, Medicaid-allowable costs in accordance with the CMS approved cost-allocation methodology.

B. Data Sources for Determining Costs

Data collected to support the cost determination of providing services will be included on the annual School Based Services (SBS) Cost Reports received from LEA. SBS Cost Reports will be completed utilizing the following data sources:

1. North Carolina Department of Public Instruction (DPI) Unrestricted Indirect Cost Rate (UICR);
2. Random Moment Time Study (RMTS) Activity Code 4.b (Direct Medical Services – IEP), Activity Code 4.c (Free Care or Direct Medical Service pursuant to other medical plans of care), and Activity Code 10 (General Administration); and
3. Medicaid Enrollment Ratios for LEAs
    a. Medicaid IEP Enrollment Ratio and
    b. Medicaid Enrollment Ratio for all other plans of care.

C. Cost Reconciliation Methodology

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid beneficiaries in the LEA, the following steps are performed:

1. Allowable Direct Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A.1. Total direct costs for direct medical services are reduced on the cost report by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs. The School Based Services (SBS) Cost Report contains the scope of cost and methods of cost allocation that have been reviewed by the Centers for Medicare & Medicaid Services (CMS).

The sources of these financial data will be audited records kept at the LEA level.

a. Direct Medical Services
   Non-federal cost pool for allowable providers consists of:
   i. Salaries;
   ii. Benefits;
   iii. Medically-related purchased services; and
   iv. Medically-related supplies and materials

b. Time Study Participants: Every employee or contractor for whom an LEA plans to claim Federal reimbursement must participate in the time study. The only exception is for direct service contractors who spend 100% of their time on Medicaid covered direct medical services that are delivered to students where medical necessity has been established.

   These direct service contractors are not eligible to have their costs included on the MAC cost report and receive MAC reimbursement since they spend 100% of their time delivering Medicaid covered direct medical services to students where medical necessity has been established. 100% Medicaid covered direct service contractors are defined as non-LEA employees who have a contract to provide Medicaid covered direct medical services to students where medical necessity has been established. To be considered a 100% direct service contractor, the contract or expected duties must only include the provision of Medicaid covered direct eligible services to students where medical necessity has been established. If the contract or expected duties includes activities that are not Medicaid covered direct medical services or are provided to students for which those medical necessity has not been established for those Medicaid covered direct eligible services, the contractor should be included in the time study. DHB will consider the contract documenting only Medicaid reimbursable services to be the appropriate documentation for excluding a contractor from the time study. The contract must clearly outline that the provider is contracted only to provide Medicaid covered direct medical services that are delivered to

students where medical necessity has been established and they do not perform any other activities for the school district. This does not include individuals such as parents or other volunteers who receive no compensation for their work; this would include in-kind "compensation". For purposes of this implementation plan, individuals receiving compensation from LEAs for their services are termed "LEA staff". All staff will be reported into one of two cost pools: a Direct Service and Administrative Services Providers" cost pool and an "Administrative Services Provider Only" cost pool. The two cost pools are mutually exclusive, i.e., no staff should be included in both pools. The following provides an overview of the eligible categories in each cost pool.

c. Cost Pool 1 (Direct Service & Administrative Service Providers)
- Licensed Audiologist
- Licensed Speech / Language Pathologist
- Licensed Speech / Language Pathologist Assistants
- Licensed Occupational Therapists
- Licensed Occupational Therapy Assistants
- Licensed Physical Therapists
- Licensed Physical Therapy Assistants
- Licensed Registered Nurses, RN
- Licensed Practical Nurses, LPN
- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA)
- Licensed Clinical Mental Health Counselor (LCMHC)
- Licensed Clinical Mental Health Counselor Associate (LCMHCA)
- Licensed Clinical Social Workers (LCSW)
- Licensed Clinical Social Worker Associate (LCSWA)
- Licensed School Psychologist
- Licensed School Psychology Intern
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Marriage and Family Therapist Associate (LMFTA)
- Licensed Clinical Addiction Specialist (LCAS)
- Licensed Clinical Addiction Specialist Associate (LCASA)
- Licensed Physician Assistant (PA)
- Licensed Nurse Practitioner (NP)
- Licensed Psychiatric Mental Health Nurse Practitioner (PMHNP)
- Licensed Behavior Analyst
- Licensed Assistant Behavior Analyst
- Behavior Technician

- Licensed Medical Doctor (MD)
- Licensed Doctor of Osteopathic Medicine (DO)

Cost Pool 2 (Administrative Service Providers Only)

- School Social Workers
- School Counselors
- School Early Identification Personnel
- Early Intervention/Special Education Placement
- Special Education – Support Technicians
- Pupil Support – Technicians
- Special Education Administrators
- Pupil Support Services Administrators
- Bilingual Specialists &Assistants
- Health Services Special Education Teachers
- Interpreters & Interpreter Assistants
- Program Specialist
- Other groups/individuals that may be identified by the LEA as participating in an administrative activity but whose job title does not appear on this list.

Staff with job titles in either cost pool 1 or 2, are not automatically included in the time study. An LEA must determine whether they meet all requirements above and if they are less than 100% federally funded. Individuals that are known to be 100% federally funded at the time of the staff pool certification will be excluded from the time study. All criteria must be met in order to be included in the time study.

The two universes of time study participants and associated cost pools are mutually exclusive and the only direct costs that can be claimed under Medicaid related to this program are derived from the two cost pools described above. A sufficient number of medical services personnel will be sampled to ensure time study results that will have a confidence interval of at least 95 percent within a precision of plus or minus five percent overall.

At the beginning of each quarter, participating LEAs submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMTS time study. This list of names is subsequently grouped into job categories (that describe their job function), and from that list all job categories are assigned into one of two “cost pools” for each LEA participating in the time study.

By including an individual on the Participant List, the LEA verifies that the participant:

- Participates in either administrative and/or direct services activities that are Medicaid reimbursable.
- Is not paid 100% by Federal funds
- Is not a contractor that spends 100% of their time delivering Medicaid covered direct medical services to students where medical necessity has been established

When the SBS Program coordinator submits the Participant List, they also provide:

- The participant email address
- Participant schedule (may be based on shifts)

Vacant Positions

The Participant List may include vacant positions that are planned to be filled during the reporting quarter. If a vacant position is filled during the quarter, the individual will complete the time study (if sampled), and actual costs incurred for the position during the quarter are eligible to be reported. If a vacant position is not filled during the quarter, then any sampled time study moments are considered invalid. If a position becomes vacated during the quarter and is later filled with a direct replacement, the direct replacement will complete the time study (if sampled), and the proportional costs incurred for both the original participant and direct replacement are eligible to be reported.

For any new positions that are created after the participant selection is completed for a particular time study period, the position/individual would be included in the universe for the next quarters time study.

2. Allowable Indirect Costs: Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate (UICR) to its net direct costs. North Carolina LEAs use predetermined fixed rates for indirect costs. The Department of Public Instructions (DPI) is the cognizant agency for the LEAs and approves unrestricted indirect cost rates for school districts for the US Department of Education. Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate:

a. Apply the NC DPI UICR applicable for the dates of service in the rate year.
b. The UICR is the unrestricted indirect cost rate calculated by NC DPI.

3. Time Study Percentages: The time study results are utilized to determine the amount or percent of time spent by school district personnel doing Medicaid reimbursable activities. For quarterly MAC claims, the % Time Claimable is only for that quarter. For end of year cost settlement for direct services, it is an average, by code, for all 4 quarters The sampling period is defined as the three-month period comprising each quarter of the Federal Fiscal Year calendar. A time study is performed for each of the quarters listed below:

    a. Quarter 1 = October 1 – December 31
    b. Quarter 2 = January 1 – March 31
    c. Quarter 3 = April 1 – June 30
    d. Quarter 4 = July 1 – September 30

The net direct costs for each service are calculated by applying the direct medical services percentage from the CMS-approved time study to the adjusted direct costs from Item (C)(1) above ("Allowable Direct Costs"). A time study that incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, all other medical services, and general and administrative time. This time study will ensure that there is no duplicate claiming relative to claiming for administrative costs. The RMTS methodology will utilize a single cost pool for direct medical services, which includes all eligible staff and other medical service providers. Every employee or contractor for whom an LEA plans to claim federal reimbursement must participate in the time study. The only exception is for direct service contractors who spend 100 percent of their time on Medicaid reimbursable activities. 100% direct service contractors are defined as non-LEA employees who have a contract to only provide Medicaid reimbursable services. The RMTS will generate the Direct Medical Services time study percentages; one for Direct Medical Services pursuant to an IEP and one for all other Direct Medical Services. The two Direct Medical Services time study percentages will be applied to only those costs associated with direct medical services to generate a Direct Medical Services cost amount for services provided pursuant to an IEP and a Direct Medical Services cost amount for all other direct medical services.

4. Medicaid Ratio Determination: Two distinct direct service Medicaid ratios will be established for each participating LEA. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students.

    a. Medicaid Enrollment Ratio for Other Plans of Care: Medicaid's portion of total net costs for all other services is calculated by multiplying the Direct Medical Services cost amount by the ratio of Medicaid-enrolled students to total students. The DPI enrollment file will be matched against the Medicaid enrollment file, to determine the percentage of those that are enrolled in Medicaid. Both

enrollment files will use data as of December 1 of each year. The numerator will be the number of Medicaid enrolled students (per FERPA, who have parental consent to release information to Medicaid), as established by the individuals matched between the DPI enrollment file and the Medicaid enrollment file, and the denominator will be the total number of students enrolled in the LEA, as established by the DPI enrollment file.

b. Medicaid IEP Ratio: Medicaid's portion of total net costs for IEP covered services is calculated by multiplying the Direct Medical Service cost amount by the ratio of the total number of Medicaid-enrolled students with an Individualized Education Program (IEP) to the total number of students with an IEP. The students with an IEP will be identified using the Department of Public Instruction's (DPI) Every Child Accountability Tracking System (ECATS) as of December 1 of each year which is the same data source and date of DPI's federal Child Count Report data. This data will be matched against the Medicaid enrollment file which will use data as of December 1 of each year to determine the percentage of students with an IEP enrolled in Medicaid. The numerator will be the number of Medicaid enrolled students with an IEP (per FERPA, who have parental consent to release information to Medicaid) and the denominator will be the total number of students, with an IEP.

5. Total Medicaid Reimbursable Cost for Direct Services: The resulting Medicaid allowable costs for direct services from both the IEP MER and all other plans of care MER are combined to determine total direct services costs for reconciliation.

D. Certification of Funds Process

On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. LEAs are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

E. Annual Cost Report Process

For Medicaid services listed in Paragraph 7a-g provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report must be submitted in a timely manner.

The primary purposes of the cost report are to:

1. Document the provider's total Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile annual interim payments to its total Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual School Based Services (SBS) Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBS Cost Reports are subject to desk review by Division of Health Benefits or its designee.

F. The Cost Reconciliation Process

The cost reconciliation process must be completed in a timely manner. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's 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 CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

G. The Cost Settlement Process

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid beneficiaries, the provider will remit the federal share of the overpayment at the time the cost report is submitted. The Division of Health Benefits will submit the federal share of the overpayment to CMS within 60 days of identification in accordance with 42 CFR 433 subpart f.

If the actual, certified costs of a LEA provider exceed the interim payments, the Division of Health Benefits will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

H. Audit Documentation

The State Medicaid agency and any contractors used to help administer school-based Medicaid services are aware of Federal regulations listed below for audits and documentation, and will provide documentation needed to support school-based claims.

1. 42 CFR 431.107 Required provider agreement.
2. 42 CFR 447.202 Audits.
3. 2 CFR 200.302 Financial management and standards for financial management systems.