Table of Contents

State/Territory Name Utah

State Plan Amendment (SPA) #: 25-0009

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
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

November 17, 2025

Nate Checketts
Interim Director
Division of Integrated Healthcare
Utah Department of Health and Human Services
PO Box 143101
Salt Lake City, UT 84114-3101

Re: Utah State Plan Amendment (SPA) 25-0009

Dear Director Checketts:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0009. This amendment proposes modifications to coverage and reimbursement policies for medically necessary services delivered by Local Education Agencies (LEAs).

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR §440.130. This letter informs you that Utah Medicaid SPA TN 25-0009 was approved on November 17, 2025, with an effective date of July 1, 2025.

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

If you have any questions, please contact Tyler Deines at (202) 260-6048 or via email at Tyler.Deines@cms.hhs.gov.

Sincerely,

Wendy Hill Petras, Acting Director
Division of Program Operations

Enclosures

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: 25-0009

2. STATE: UT

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, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Section 1902(a)(30)(A) of the Social Security Act
42 CFR §440.130

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 1,400,000
b. FFY 2026 $ 5,600,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Page 29(a)(1) through 29(a)(8) of the ATTACHMENT 4.19-B~~
Page 2 of Attachment #4b to Attachments 3.1-A & B
Pages 29(a)(1) - 29(a)(7) of Attachment 4.19-B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Page 29(a)(1) through 29(a)(8) of ATTACHMENT 4.19-B~~
Page 2 of Attachment #4b to Attachments 3.1-A & B (TN: 21-0019)
Pages 29(a)(1) - 29(a)(4) of Attachment 4.19-B (TN: 21-0019)
Pages 29(a)(5) - 29(a)(7) of Attachment 4.19-B (TN: 24:0004)
Page 29(a)(8) of Attachment 4.19-B (DELETED) (TN: 21-0019)

9. SUBJECT OF AMENDMENT
School-Based Payments and Services - This amendment expands services within the school-based services program.

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Tracy S. Gruber

13. TITLE
Executive Director, Utah Dept of Health & Human Services

14. DATE SUBMITTED
June 2, 2025

15. RETURN TO
Craig Devashrayee
Utah Department of Health & Human Services
Division of Integrated Healthcare
cdevashrayee@utah.gov

FOR CMS USE ONLY

16. DATE RECEIVED
June 2, 2025

17. DATE APPROVED
November 17, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Wendy Hill Petras

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

22. REMARKS
Blocks 5, 7, and 8: Pen and ink changes approved by the state on 11/14/2025.

Instructions on Back

MEDICALLY NECESSARY SERVICES (Continued)

Medically necessary services not otherwise provided under the State Plan but available to EPSDT (CHEC) eligibles (Continued)

Diagnostic, Preventive, Rehabilitative Services (42 CFR 440.130)

A. Early intervention services are diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers up to age four with disabilities.

1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, or communication deficits; and
2. Information and skills training to the family to enable them to enhance the health and development of the child.

B. Skills Development Services

EPSDT Services Provided by Local Education Agencies

A. Medicaid provides direct coverage to eligible recipients pursuant to EPSDT for services furnished in the school-setting, in accordance with section 1905(a) of the Social Security Act. Under EPSDT, the state must provide all 1905(a) coverable benefits/services to individuals under the age of twenty-one in accordance with regulations at 42 CFR 440. Services must be determined medically necessary by the state. Medicaid eligible individuals up to the age of 21, receiving covered services in a school setting, must have a valid IEP, Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.

LEA Responsibilities

1. LEAs shall ensure that all service providers act within the requirements of proper licensure or certification.

2. LEAs shall ensure that all unlicensed/uncertified providers requiring supervision are properly supervised.

3. LEAs shall ensure that licensed/certified supervising providers assume professional liability for unlicensed/uncertified providers rendering covered Medicaid services.

4. LEAs shall ensure that proper documentation of rendered services is created and maintained to ensure that all compliance requirements are met.

Service Exclusions

1. Services are not covered when the service is educational or academic in nature.

2. Services are not covered when the service is considered to be social, vocational, or extracurricular in nature.

MEDICALLY NECESSARY SERVICES (Continued)

Medically necessary services not otherwise provided under the State Plan but available to EPSDT (CHEC) eligibles (Continued)

Diagnostic, Preventive, Rehabilitative Services (42 CFR 440.130)

A. Early intervention services are diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers up to age four with disabilities.

1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, or communication deficits; and
2. Information and skills training to the family to enable them to enhance the health and development of the child.

B. Skills Development Services

EPSDT Services Provided by Local Education Agencies

A. Medicaid provides direct coverage to eligible recipients pursuant to EPSDT for services furnished in the school-setting, in accordance with section 1905(a) of the Social Security Act. Under EPSDT, the state must provide all 1905(a) coverable benefits/services to individuals under the age of twenty-one in accordance with regulations at 42 CFR 440. Services must be determined medically necessary by the state. Medicaid eligible individuals up to the age of 21, receiving covered services in a school setting, must have a valid IEP, Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.

LEA Responsibilities

1. LEAs shall ensure that all service providers act within the requirements of proper licensure or certification.

2. LEAs shall ensure that all unlicensed/uncertified providers requiring supervision are properly supervised.

3 LEAs shall ensure that licensed/certified supervising providers assume professional liability for unlicensed/uncertified providers rendering covered Medicaid services.

4. LEAs shall ensure that proper documentation of rendered services is created and maintained to ensure that all compliance requirements are met.

Service Exclusions

1. Services are not covered when the service is educational or academic in nature.

2. Services are not covered when the service is considered to be social, vocational, or extracurricular in nature.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

2. LEAs will continue to submit claims for Medicaid covered services rendered but will not be paid for claim charges. All claims will be submitted to Medicaid with a $.00 charge. LEAs will only be paid through the monthly interim payment.

C. Data Capture for the Cost of Providing School Based Skills Development Services

Data capture for the cost of providing SDS will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:

   a. SDS cost reports received from LEAs;

   b. Utah State Board of Education (USBE) Unrestricted Indirect Cost Rate (UICR);

      i. The unrestricted indirect cost rate is derived from costs having to do with administrative, overhead maintenance and other support services. Staff included on the LEA's staff pool list are not paid from these areas.

      ii. LEAs are specifically instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures. This ensures that there is no duplication of costs for indirect rates.

      iii. When a USBE-calculated, unrestricted indirect cost rate is not available, school districts will use a de minimis rate in accordance with 2 CFR 200.414(f). School districts with a USBE-calculated, unrestricted indirect cost rate must use the calculated rate and cannot choose the de minimis rate.

   c. Random Moment Time Study (RMTS)

      i. Direct Medical IEP activity code is used for direct medical services covered as part of an IEP under IDEA, and not covered on another medical plan of care, also known as a Document of Medical Necessity (DMN).

      ii. Direct Medical IEP activity code is accounted for in the annual cost settlement report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

      iii. Direct Medical Services pursuant to other medical plans of care activity code is used for direct medical services covered on a plan of care other than an IEP.

         I. Direct Medical Services, other than an IEP activity code, is accounted for in the annual cost settlement report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

      iv. General Administration is accounted for in both the quarterly Medicaid Administrative Claim as well as the annual Cost Reconciliation and Cost Settlement.

         I. General Administrative is a General Administrative Overhead Factor and is calculated to determine the amount of time that is eligible for reimbursement in the MAC Claim. General Administration is distributed to the reimbursable code based on the percentage of total time as dictated by the Random Moment Time Study.

         II. General administrative is also accounted for in the annual cost report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

v. The resulting direct medical service percentages will be specific to each cost pool and reflected as a statewide average.

d. LEA specific Medicaid Enrollment Ratio (MER):

i. Medicaid IEP Ratio: For the purposes of the annual cost reconciliation and cost settlement process, the Medicaid Enrollment Ratio (MER) is referred to as the Medicaid IEP Ratio. This IEP Ratio is unique to each participating LEA and is used to apportion the Total Direct Medicaid Service costs between Medicaid and non-Medicaid. The ratio will be calculated based on a December 1 student count with the numerator reflecting the total number of students with a covered medical service in their IEP that are Medicaid-enrolled and the denominator reflects the total number of students with a covered medical service in their IEP. This ratio will be applied to the calculation to determine the reimbursement level for services provided to students with an IEP/IFSP. The IEP/IFSP reimbursement uses the percentage of time spent annually and utilizes the Activity Code 4B results.

ii. Medicaid Enrollment Ratio for Other Medical Plans of Care: The Medicaid Enrollment Ratio for Other Medical Plans of Care will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to medical plans of care other than an IEP/IFSP. The names, student numbers, and birthdates of all students from the USBE Enrollment Count Report (currently October 1st) are matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid-enrolled students, and the denominator will be the total number of students. The Medicaid Enrollment Ratio for Other Medical Plans of Care will be calculated for each LEA on an annual basis. This ratio will be applied to the calculation to determine the reimbursement level for services provided to students with medical necessity documented in a method other than an IEP/IFSP. This reimbursement uses the percentage of time spent annually and utilizes the Activity Code 4C results.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable 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 (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs in Utah Administrative Code. These direct costs will be calculated on a LEA specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

   Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. These direct costs are accumulated on the annual School Based Skills Development Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The 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 source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the State of Utah. Costs will be reported on a cash basis.

   a. Medically related purchased services include contracted services. LEAs report the amounts they pay to contracted providers as salaries. Benefits are not reported by the LEA for contracted staff.

      i. The USBE's Unrestricted Indirect Cost Rate is multiplied by the sum of the LEA's total regular staff salaries and the total contracted salaries.

   b. Any expenditures that are fully offset for using federal funds will be removed from the cost report. Expenditures that are partially offset by federal funds will be reduced by the amount of the offset. Only the portion of expenditures paid for with state or local funds is included in the calculation of the Medicaid Direct Medical Service costs. Providers of Medicaid Direct Medical Service costs make up this non-federally offset cost pool.

      Allowable costs for this provider pool consist of:
      i. salaries;
      ii. benefits;
      iii. medically-related purchased services; and
      iv. medically-related supplies and materials.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific Unrestricted Indirect Cost Rate (UICR) to its adjusted direct costs. Utah LEAs use predetermined fixed rates for indirect costs. Utah State Board of Education (USBE) has, in cooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by LEAs in Utah. Pursuant to the authorization in 34 CFR § 75.561(b), USBE approves unrestricted indirect cost rates for LEAs for the DOE, which is the cognizant agency for LEAs. When a USBE-calculated, unrestricted indirect cost rate is not available, school districts will use a de minimis rate in accordance with 2 CFR 200.414(f). School districts with a USBE-calculated, unrestricted indirect cost rate must use the calculated rate and cannot choose the de minimis rate.

   Indirect Cost Rate

   a. Apply the Utah State Board of Education Cognizant Agency UICR applicable rate for the dates of service in the rate year.

   b. The UICR is the unrestricted indirect cost rate calculated by the Utah State Board of Education.

   To ensure non-duplication of costs, LEAs are instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures on the annual cost report.

3. Time Study Percentages: A time study separately approved by HHS (outside the state plan process) must be approved before claiming and drawing down FFP for eligible services. This is captured by using a Random Moment Time Study (RMTS) methodology, and is used to determine the percentage of time that medical service personnel spend on IEP/IFSP, on other medical plans of care, or where medical necessity has been otherwise established direct medical services, general and administrative time, and all other activities to account for 100 percent of time to assure that there is no duplicate claiming.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

4. Medicaid IEP Ratio Determination: A Medicaid ratio 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 IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to an IEP. The names, gender, and birthdates of students with an IEP identifying a covered service will be identified from the December 1 Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid enrolled students with an IEP identifying a covered service and the denominator will be the total number of students with an IEP identifying a covered service. The IEP ratio will be calculated for each LEA participating in the SDS program on an annual basis. The IEP MER represents the number of Medicaid-enrolled students (per FERPA who have parental consent to release information to Medicaid) with an IEP in the LEA (or other claiming entity) in the numerator and the total number of students with an IEP (which should all be verifiable in an audit) in the LEA (or other claiming entity) as the denominator. The Utah Department of Health and Human Services maintains the student files and match used to calculate the rates for audit purposes.

    b. Medicaid Enrollment Ratio for Other Medical Plans of Care: The Medicaid Enrollment Ratio for Other Medical Plans of Care will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to medical plans of care other than an IEP/IFSP. The names, student numbers, and birthdates of all students from the USBE Enrollment Count Report (currently October 1st) are matched against the Medicaid enrollment file to determine the percentage of those who are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid-enrolled students and the denominator will be the total number of students. The Medicaid Enrollment Ratio for Other Medical Plans of Care will be calculated for each LEA on an annual basis. This ratio will be applied to the calculation to determine the reimbursement level for services provided to students with medical necessity documented in a method other than an IEP/IFSP. This reimbursement uses the percentage of time spent annually and utilizes the Activity Code 4C results.

5. Contracted costs: LEAs can include contracted service costs for and contracted clinicians that were included on the Staff Pool List for the RMTS process. The contracted service costs represent the amounts charged to the LEA by the contractor or contracting agency and may include the costs associated with the clinician and any overhead incurred by the contractor that is charged back to the LEA. This cost does not include any overhead or other indirect costs incurred by the LEA to support the contracted clinician.

    a. Contracted service costs for direct medical services will be a separate line item in the cost report with the application of the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.

    b. Contracted service costs for direct medical services and administrative services are part of the RMTS and the allocation to direct medical and administrative percentages, the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.

    c. The LEA's Unrestricted Indirect Cost Rate is applied to contracted service costs to reflect the overhead and administrative costs incurred by the LEA to support the contracted service clinician and are non-duplicative of any agency indirect costs charged to the LEA by the contractor.

6. Total Medicaid Reimbursable Cost: The previous steps will result in a total Medicaid reimbursable cost for each LEA for Direct Medical Services on an IEP and provision of Direct Medical Services to students with medical necessity established in a manner other than an IEP/IFSP.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

Step 1. The Direct Service Personnel Costs (Salaries + Fringe Benefits + Contract Costs) will be added to the Direct Service Non-Personnel Costs (Materials and Supplies + Depreciation) to determine the Total Direct Services Costs.

Step 2. The Total Direct Services Costs will then be multiplied by the Direct Medical Services Percentage (as determined by the RMTS and applied to the 2 Direct Medical cost pools on a statewide basis) to determine the Total Direct Medicaid Services Costs.

Step 3. The Total Direct Medical Services Costs will be multiplied by the Unrestricted Indirect Cost Rate to determine the total Indirect Costs.

Step 4. The Direct Medical Services Costs will be added to the Indirect Costs to determine the Total Allowable Costs.

Step 5. The Total allowable Costs will be multiplied by the Medicaid Enrollment IEP Ratio (calculated by each LEA) to determine the Total Medicaid Reimbursable Costs.

Step 6. Reconciliation process: The Total Medicaid Interim Payments will be subtracted from the Medicaid Reimbursable Costs to equal the Total Cost Settlement.

Step 7. Balancing process: Each LEA account will be balanced to address overpayment or underpayment. A balance payment will be issued to each LEA in an underpayment status and each LEA in an overpayment status will be invoiced for the balance. When an LEA's interim payments are less than the calculated total allowable costs, the balance will be paid out to the LEA. When the interim payments exceed the calculated total allowable costs, the balance will be recouped from the LEA.

E. Certification of Funds Process

Each LEA certifies on an annual basis an amount of the interim payments received during the previous federal fiscal year. In addition, each LEA certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal 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.

F. Annual Cost Report Process

Each LEA will complete an annual cost report for all SDS delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than one year after the close of the quarter ending June 30.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

a. The primary purpose of the cost report is to:

i. document the LEA's total Medicaid allowable scope of costs for delivering SDS, including direct costs and indirect costs, based on cost allocation methodology procedures.

b. Cost reports will be subjected to a comprehensive review process prior to their use in the calculation of the interim rates.

i. The review will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SDS program are aware of federal regulations listed below for audits and documentation and will provide documentation for MERs and any other documentation needed to support SDS claims.

I. 42 CFR 431.107 Required provider agreement.
II. 45 CFR 447.202 Audits.
III. 45 CFR 75.302 Financial management and standards for financial management systems.

c. Cost reports will be used to reconcile its interim payments to its total Medicaid- allowable scope of costs based on cost reconciliation methodology procedures.

i. The reconciliation will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. The annual SDS Cost Report includes a certification of funds statement to be completed, certifying the LEA's actual, incurred costs/expenditures. All filed annual SDS Cost Reports are subject to a desk review by the Division of Integrated Healthcare (DIH) or its designee.

G. The Cost Reconciliation Process

The total CMS-reviewed, Medicaid allowable scope of costs based on CMS-reviewed cost allocation methodology procedures are compared to the LEA's Medicaid interim payments for school health services 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-reviewed scope of costs, the CMS-reviewed cost allocation methodology procedures, or its 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 review from CMS prior to implementation; however, such review does not necessarily require the submission of a new state plan amendment.

H. The Cost Settlement Process

1. For services delivered for a period covering July 1st, through June 30th, the annual SDS Cost Report is due no later than one year after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than two years after the fiscal year end.

a. Actual costs will be used to determine whether the LEA has an under or overpayment. Actual costs will be calculated for the school year and will then be compared to the interim payments made during that same school year.

2. If an LEA's interim payments exceed the actual, certified costs of the provider for SDS to Medicaid clients, the provider will return the federal share of an amount equal to the overpayment.

3. If the actual, certified costs of a LEA for SDS exceed the interim Medicaid payments, DIH will pay the federal share of the difference to the LEA 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.

a. The Division of Integrated Healthcare will issue a notice of settlement within 60 days following the completion of the settlement determination that denotes the amount due to or from the provider.