Table of Contents

State/Territory Name: WI

State Plan Amendment (SPA) #: 25-0014

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

August 19, 2025

William Hanna, Medicaid Director
Division of Medicaid Services
Wisconsin Department of Health Services
1 W. Wilson St
Madison, WI 53701

Re: Wisconsin State Plan Amendment (SPA) – 25-0014

Dear Director Hanna:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 25-0014. This amendment proposes adding additional coverage and payment details for delivering school-based services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter informs you that Wisconsin's Medicaid SPA TN 25-0014 was approved on August 18, 2025, effective July 1, 2025.

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

If you have any questions, please contact Mai Le-Yuen at 312.353.2853 or via email at mai.le-yuen@cms.hhs.gov.

Sincerely,

Nicole McKnight, Acting Director
Division of Program Operations

Enclosures

cc: Alexandra Merfeld, DHS

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 — 0014

2. STATE: WI

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
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
1905(r)(5), 42 C.F.R. § 440.50, 42 C.F.R. § 440.100, 42 C.F.R. § 4

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 25 $ 5,700,000
b. FFY 26 $ 22,800,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
3.1-A Supplement 1 - pgs. 1.d, 1.e.
3.1-B Supplement 1 - pgs. 1.d, 1.e.
4.19-B - pgs. 16.d., 16.e-1-4, 16.e-5-11 (new)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
3.1-A Supplement 1 - pgs. 1.d, 1.e.
3.1-B Supplement 1 - pgs. 1.d, 1.e.
4.19-B - 16.d., 16.e-1-4 (05-0015)

9. SUBJECT OF AMENDMENT

Expanding care plans that can be used to document medical necessity for school-based services, adding additional covered SBS.

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:

Signed by: Nathan Bellhorst

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
William Hanna

13. TITLE
Medicaid Director

14. DATE SUBMITTED
5/28/2025

15. RETURN TO
Allie Merfeld
State Plan Amendment Coordinator Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR CMS USE ONLY

16. DATE RECEIVED
May 28, 2025

17. DATE APPROVED
August 18, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING

20. TYPED NAME OF APPROVING OFFICIAL
Nicole McKnight

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

22. REMARKS

Instructions on Back

4.b. EPSDT Other Services, continued

4. School Based Services

Medicaid 1905(a) benefits can be furnished by or in schools when services are medically necessary, such as when identified as medically necessary in a treatment plan (e.g., Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established).

All services delivered in the school setting and as part of the Medicaid school-based program must be ordered/recommended by, as well as provided/rendered by, practitioners who meet all state licensing and scope of practice requirements, all Federal Medicaid statutes, regulations and requirements, and who are outlined in the state plan.

Services in a school-based setting must be performed by qualified practitioners as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440.

Covered services include the following and must be provided in accordance with the corresponding benefit pages in the approved state plan:

- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Services are prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.
  - Physical therapy services are furnished by or under the direction of a qualified physical therapist who meets the Medicare Conditions of Participation.
  - Occupational therapy services are furnished by or under the direction of a qualified therapist who meets the Medicare Conditions of Participation.
  - Services for individuals with speech, hearing, and language disorders include diagnostic, screening, preventive, or corrective services furnished by or under the direction of a speech pathologist or audiologist in accordance with 42 CFR 440.110;
- Private duty nursing services in accordance with 42 CFR §440.80 must be provided by a registered nurse or licensed practical nurse, and provided under the direction of the member's physician.
- Diagnostic, screening, preventive, and rehabilitative services in accordance with 42 CFR §440.130.
- The following other licensed practitioner services (OLP) provided by licensed practitioners within the scope of practice as defined under State law and in accordance with 42 CFR §440.60:
  - Nursing services performed by a licensed practical nurse or registered nurse and services delegated by a registered nurse to a licensed practical nurse or unlicensed assistive personnel to whom nursing acts may be delegated and who has received appropriate training from and is supervised by a registered nurse, with the exception of private duty nursing which must be delivered by a registered nurse or licensed practical nurse, as noted above.
  - Behavioral Treatment Services provided by the following provider types:
    - Behavioral Treatment Licensed Supervisor
    - Behavioral Treatment Therapist
    - Behavioral Treatment Technician
    - Focused Treatment Licensed Supervisor
    - Focused Treatment Therapist

- Personal care services (as known as attendant care services) authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a service plan approved by the State, performed by qualified individuals and coverable under 42 CFR §440.167;
- Physician services relevant to the recipient's medical needs, including evaluation and management services, screens and referrals for treatment of health needs; treatment; medication management; and explanations given of treatments, therapies and physical or mental conditions to family members or school district or LEA staff performed by a physician or other provider operating within the scope of their practice, as defined under 42 CFR §440.50;
- Dental services including oral evaluations, oral assessments, application of fluoride, and dental sealants and other minimally invasive dental services when performed by licensed practitioners within the scope of practice as defined under state law and coverable as dental services under 42 CFR §440.100;

When services are provided under the direction of a licensed therapist, the licensed must:

- See the beneficiary at the beginning of and periodically during treatment;
- Be familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- Have continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- Assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- Spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- Maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

4.b. EPSDT Other Services, continued

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- Physician services relevant to the recipient's medical needs, including evaluation and management services, screens and referrals for treatment of health needs; treatment; medication management; and explanations given of treatments, therapies and physical or mental conditions to family members or school district or LEA staff performed by a physician or other provider operating within the scope of their practice, as defined under 42 CFR §440.50;
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- Assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- Spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- Maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

28. Medicaid-Covered Services included in Medicaid-eligible Students' Individualized Education Programs (IEPs) and other plans in which medical necessity has been established Provided by Local Education Agencies

Overview

This section of the plan describes how:

1. The Department establishes rates for interim Medicaid reimbursement,
2. Local education agency (LEA) providers identify total allowable Medicaid costs, including the Federal and non-Federal share of expenditures for Medicaid-covered services provided by Medicaid- qualified providers, and
3. The Department reconciles interim payments to total allowed cost as reported on the CMS reviewed cost reports for direct medical services and specialized transportation services.

This section of the plan applies only to Medicaid-covered services identified in the child's treatment plan.

Payment for Medicaid-Covered Services included in Medicaid-eligible Students' IEPs or other plans in which medical necessity has been established Provided by LEAs

LEA providers shall be reimbursed on an interim basis and those payments shall retrospectively be reconciled to cost. Sections A and B cover the interim payment process. Sections C through F cover the process for certification and reconciliation.

Interim Payment for Covered Services Provided by LEA Providers

A. Before July2007, statewide rates will be set on an interim basis using the July 2004 school year's reimbursement updated for inflation at a rate not to exceed the qualified economic offer (QEO) annual rate. In negotiating teacher's contracts, the QEO identifies the minimum offer required by state statute that a local school district may make to avoid binding arbitration on salaries and fringe benefits.

B. After July 2007, LEA specific rates will be set on an interim basis using the LEA 's most recent cost information updated to the current year for inflation at a rate not to exceed the QEO.

Identification of Total Allowed Cost

C. Data Capture for the cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

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

   a. School Based Services cost reports received from LEAs;

   b. Wisconsin Department of Public Instruction (DPI) Unrestricted Indirect Cost Rate (UICR);

      The Unrestricted Indirect Cost Rate methodology is approved by the United States Department of Education (USDOE). The Wisconsin Department of Public Instruction (DPI) works with USDOE to gain approval for the methodology and then calculates rates for school districts each fiscal year.

      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. Some LEAs do not have a calculated DPI UICR)\. For those that do not have one calculated, a de minimis rate, consistent with 2 CFR 200.414(f), will be charged to Medicaid. All LEAs with a calculated UICR will use their calculated rate.

   c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services), Activity Code 4C ((Free Care or Direct Medical Services pursuant to other medical plans of care), and Activity Code 10 (General Administration):

      i. Direct Medical IEP activity code (4B) is used for direct medical services covered as part of an IEP under IDEA, and not covered on a other Medical Plan of Care.

         a. 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.

ii. Direct Medical Services pursuant to other medical plans of care activity code (4C) is used for direct medical services covered on a plan of care other than an IEP.

a. 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.

iii. General Administration code 10 is accounted for in both the quarterly Medicaid Administrative Claim as well as the annual Cost Reconciliation and Cost Settlement.

a. General Administrative code 10 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.
b. General administrative code 10 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.

iv. 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 Fall Student count with the numerator reflecting the total number of students with an IEP that are Medicaid enrolled and the denominator reflects the total number of all students with an 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 utilize 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, gender, and birthdates of all students from the DPI Enrollment 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 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 utilize the Activity Code 4C results.

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, excluding transportation personnel. 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 Wisconsin School-based 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 approved 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 Wisconsin 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.

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

      b. Medicaid Direct Medical Service costs are funded by the state and local dollars. Any expenditures that are fully paid for using federal funds will be removed from the cost report. Expenditures that are partially funded by federal funds will be reduced by the amount of federal funds. 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 funded 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

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its adjusted direct costs. Wisconsin LEAs use predetermined fixed rates for indirect costs. Wisconsin Department of Public Instruction has, in cooperation with the United State Department of Education (ED), developed an indirect cost plan to be used by LEAS in Wisconsin. Providers 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.

   Indirect Cost Rate

   a. Apply the Wisconsin Department of Public Instruction Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.

   b. The Wisconsin Department of Public Instruction UICR is the unrestricted indirect cost rate calculated by the Wisconsin Department of Public Instruction.

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, 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. The RMTS methodology will utilize four cost pools in total. Two cost pools are for direct medical services and one cost pool for administrative activities.

   a. The first cost pool is the SBS Group 1 cost pool and includes individuals are eligible to bill direct medical services. Eligible positions included in this cost pool are:

      - Attendant Care Service Providers / Personal Care,
      - Delegated Nursing Services Providers,
      - Licensed Counselor,
      - Licensed Social Worker,

- School Social Worker, LPNs, and
- Registered Nurses.
- Marriage and Family Therapists
- Board Certified Behavior Analysts
- Registered Behavior Technicians

b. The second cost pool is the SBS Group 2 cost pool and includes individuals are eligible to bill direct medical services. Eligible positions included in this cost pool are:

- Audiologist,
- Audiology Assistants,
- Occupational Therapists,
- Certified Occupational Therapy Assistants,
- Physical Therapists,
- Physical Therapy Assistants,
- Psychologists and assistants,
- Speech-Language Therapists and
- Speech-Language Therapy Assistants.
- Physicians
- Dentists
- Dental Hygienists

c. The third cost pool is the MAC cost pool and includes individuals whose primary duties are administrative in nature. These individuals are not eligible to bill direct medical services. Staff included in the cost pool are not included on the annual cost report and the time study results for this cost pool are not included as part of any calculations for the annual cost reconciliation and cost settlement process. Examples of staff that are eligible to be included in this cost pool are:

- Principals
- Assistant Principals
- Special Education Teachers
- Program Coordinators
- Program Aides
- Directors and Assistant Directors of Special Education
- Interpreters, and
- Support Personnel

d. Staff cannot be included in more than one cost pool. If an individual performs job duties that correspond to more than one cost pool, the individual must be added to the cost pool that corresponds with their primary job responsibilities.

e. Participants from both pools complete time studies for three sample periods. In order to ensure consistent sampling, a precision of +/- 2% with a 95% confidence level is used. The weighted average of those three sample period time studies will be used to determine the percentage of time spent on the provision of Medical Services to students with an IEP/IFSP and time spent on the provision of Medical Services to students with medical necessity established in a manner other than an IEP/IFSP

f. The RMTS will generate three Direct Medical Services time study percentages; one for SBS Group 1 Cost Pool, one for the SBS Group 2 Cost Pool and one for SBS Group 3 Cost Pool. Each Direct Medical Services time study percentage will be statewide averages. The direct medical services costs and time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the State of Wisconsin and CMS.

A. 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 pool 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 and birthdates of students with an IEP will be identified from the Fall 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 and the denominator will be the total number of students with an IEP. The IEP ratio will be calculated for each LEA participating in the SBS program on an annual basis.

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, and birthdates of all students from the dpi Enrollment 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 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 utilize the Activity Code 4C results.

B. 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 are subjected to the same factors that are applied to the LEA's direct medical service personnel costs (salaries and benefits) including the Direct Medical Services RMTS percentage, the LEA's Unrestricted Indirect Cost Rate, and the LEA's Medicaid IEP Ratio.

b. 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.

C. 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.

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.

Methodology for Determining Specialized Transportation Cost

E. Transportation is reimbursed only on days when a covered Medicaid service was provided pursuant to an IEP and only if specialized transportation is listed as a service in the I EP.

Each LEA provider shall report to the Department, on an annual basis, the total allowed costs incurred for Specialized Transportation services using the following steps.

1. Each LEA will use the CMS-approved cost report to accumulate annually direct cost, which will which will include some personnel cost, contracting cost, and specialized transportation vehicle depreciation, fuel, insurance, and repairs and servicing costs necessary for the provision of school-based I EP transportation services.
2. Total specialized transportation cost will be determined by multiplying cost identified under Step I by one plus the cognizant agency's unrestricted indirect expenditure (cost) rate.]fa provider does not have an unrestricted indirect cost rate, the provider does not have any Medicaid-allowable indirect costs associated with specialized transportation services.
3. Medicaid's portion of specialized transportation cost will be identified by multiplying the results of Step 2 by the ratio of the total number of one-way Medicaid specialized transportation trips pursuant to the IEP over all one-way specialized transportation trips that were provided. The provider is responsible to maintaining one-way trip documentation.

F. Cost Reconciliation and Cost Settlement

Each LEA provider shall be required to do all of the following activities:

1. Each LEA provider must complete annually the CMS-approved cost report for direct medical services and specialized transportation. It will contain total cost incurred to provide Medicaid- covered services to Medicaid beneficiaries, including the Federal and non-Federal share of incurred cost. This cost report will be filed with the Department by March 31, 2007 for 2005- 2006 state fiscal year, and the December 31 following the end of the state fiscal year for all future years. The Department will inform the provider of whether there has been an over- or underpayment.

2. The LEA provider is required to keep, maintain and have readily retrievable financial records that fully identify or support its allowable costs eligible for FFP in accordance with Federal and Wisconsin Medicaid records requirements. The LEA provider is also required to participate in statewide time studies conducted by the Department.

3. The LEA provider shall paid at cost. Using the reconciled cost as reported on the CMS-approved cost report, any settlement amount will be identified. LEA providers shall be required to reimburse overpayments of interim payments. If the interim payments underpay an LEA provider, the Department will reimburse the provider up to its cost. All costs will be settled no later than 24 months after the close of the applicable state fiscal year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

4. Special Rule for Cost Reconciliation and Cost Settlement

   Applicable to the Fiscal Year July 2005-June 2006

   For the fiscal year July 2005 - June 2006 only, cost reconciliation will be performed in accordance with a methodology submitted by the Department and approved by CMS.

G. Department's Responsibilities

1. The Department shall assure that it utilizes the CMS-approved scope of cost as reflected in the CMS-approved cost report. For costs that were reported using invoices instead of object codes, the State will assure by 7/1/07 all cost be reported using object codes. The changes in coding will be made in consultation with CMS. The Department shall review future changes in the DPI WUFAR and Special Education Fiscal Report project codes and other data and procedures as they occur to assure that costs included in cost reports are consistent with CMS-approved cost categories. Whenever there is a change in the object codes used in the cost report, the State will seek approval from CMS. This action may or may not result in the required submission of a state plan amendment. The Department shall conduct time studies that meet CMS guidelines for approved Administrative Claiming Time Studies to determine that percentage of time that school staff spend on activities related to the provision of Medicaid allowable medical services.

2. As part of the financial oversight responsibilities, the Department shall develop review procedures for the certified expenditures that include procedures for assessment of risk that expenditures and other information submitted by the LEAs is incorrect. The financial oversight of all LEA providers shall include reviewing the allowable costs in accordance with the scope of cost approved by CMS. The scope of allowed cost approved by CMS was adjusted for services provided on or after 7/1/2009.

If the Department becomes aware of potential instances of fraud, misuse, or abuse, it shall perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.

"Federal Auditing and Documentation Requirements and any contractors used to help administer any part of the school services program are aware of federal regulations listed below for audits and documentation:

i. 42 CFR § 431.107 Required provider agreement

ii. 42 CFR § 447.202 Audits

iii. 45 CFR § 75.302 Financial management and standards for financial management systems."