Table of Contents

State/Territory Name: Illinois

State Plan Amendment (SPA) #: 21-0008-CP

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

September 27, 2024

Elizabeth Whitehorn
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763-0001

Re: Illinois State Plan Amendment 21-0008

Dear Director Whitehorn:

Enclosed please find a corrected approval package for the Illinois State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0008. This SPA, which adds a new reimbursement methodology for school-based health services (SBHS) and expands SBHS under the EPSDT benefit, was originally approved on April 18, 2023. The approval package sent to Illinois included the following error:

- One page in the original approval package for IL 21-0008 was not accurate. The footer for Appendix to Attachment 3.1-A, Page 3(A) reflected the incorrect approved SPA number and incorrect superseded SPA number. The footer information for Page 3(A) should be TN: 21-0008, Superseded: 09-001.

The enclosed corrected package contains the original signed letter, the CMS-179, the original SPA pages and corrected SPA page.

If you have any questions, please contact Courtenay Savage at 312-353-3721 or via email at Courtenay.Savage@cms.hhs.gov .

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2024.09.27 15:31:23 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Annet Godiksen
Kati Hinshaw

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

April 18, 2023

Theresa Eagleson
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
3rd Floor
Springfield, IL 62763-0001

Re: Illinois State Plan Amendment (SPA) 21-0008

Dear Ms. Eagleson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0008. This amendment provides a new reimbursement methodology for school-based health services (SBHS) and expands SBHS under the EPSDT benefit.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Illinois Medicaid SPA 21-0008 was approved on April 18, 2023, with an effective date of July 1, 2021.

If you have any questions, please contact Courtenay Savage at 708-567-2048 or via email at Courtenay.Savage@cms.hhs.gov.

Sincerely,

[redacted]

Digitally signed by James G. Scott -S
Date: 2023.04.18 09:12:55 -05'00'

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Kelly Cunningham
Mary Doran
Annet Godiksen
Kati Hinshaw

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER	2. STATE:
21-0008	ILLINOIS

3. PROGRAM IDENTIFICATION:
Title XIX of the *Social Security Act* (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE:
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

[ ] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.130

7. FEDERAL BUDGET IMPACT
a. FFY 2021 - $2,750,000
b. FFY 2022 - $9,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Appendix to Attachment 3.1-A Pages 3; 3(A); 3(A)(1), 3(A)(2) 3(A)(3)
Attachment 4.19-B, Page 42, Pages 42(A) - 42(K), Page 43

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Appendix to Attachment 3.1-A Pages 16(G) - 16(F)
Attachment 4.19-B, Pages 42 & 43
Appendix to Attachment 3.1-A Pages 3 & 3(A)

10. SUBJECT OF AMENDMENT:
School Based Health Services – Expansion and Cost Settlement

11. 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
[X] OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Theresa Eagleson

14. TITLE: Director of Healthcare and Family Services

15. DATE SUBMITTED

16. RETURN TO:
Department of Healthcare and Family Services
Bureau of Program and Policy Coordination
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2021

18. DATE APPROVED: April 18, 2023

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by James G. Scott -S
Date: 2023.04.18 09:13:26 -05'00'

21. TYPED NAME: James G, Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS:
4/17/23: Illinois authorized pen and ink changes to Boxes 8 and 9.

FORM CMS-179 (07/92)

Instructions on Back

04/09 3. OTHER LABORATORY AND X-RAY SERVICES

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

4a. SKILLED NURSING FACILITIES (OTHER THAN SERVICES IN AN INSTITUTION FOR MENTAL DISEASES) FOR INDIVIDUALS 21 YEARS OF AGE OR OLDER

A preadmission screening assessment is required.

4b. EARLY AND PERIODIC SCREENING AND DIAGNOSIS TREATMENT SERVICES

Clients shall be referred for dental screenings beginning at age 2 if the client is not in the continuing care of an enrolled dental provider.

All medically necessary diagnosis and treatment services will be furnished to EPSDT (Healthy Kids) clients to treat conditions detected by periodic and inter-periodic screening services even if the services are not included in the State Plan.

In addition to services provided under this State Plan, covered Medicaid (Section 1905(a) of the *Social Security Act*) services for individuals under age 21 include: case management, personal care services, Christian Science nurse and respiratory care services.

Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments, including organ transplants which are “medically necessary”, to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

A. School Health Services Program Benefits

Medicaid 1905(a) benefits can be furnished to Medicaid eligible student beneficiaries that require medical or mental/behavioral health services identified as medically necessary in an Individualized Education Program (IEP), Individualized Family ServicePlan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established. Furthermore, any 1905(a) benefit/service covered in the community can be performed in a school-based setting.

Services in a school-based setting must be performed by qualified practitioners as setforth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440 and/or Illinois state law. All eligible recipientsmust be allowed the freedom of choice to receive services from any willing and qualified practitioner. Beneficiaries shall receive services delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client. Participation by Medicaid-eligible recipients is optional.

1. School Health Personal Care Attendant/Aide Services

   Definition:

   School Health Personal Care Attendant/Aide services are available to a Medicaid-eligible beneficiary under theage of 21 for whom the services are medically necessary and documented in an IEP/IFSP, other medical plans of care, or other service plan approved by the state.

   Services:

   School Health Personal Care Attendant/Aide services are medically necessary and provided in accordance with 42 CFR 440.167. Personal Care attendants/aides provide a range of human assistance services to support Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADLs) which enables individuals to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself

   Providers:

   School Health Personal Care Attendant/Aide Services must be provided by a qualified provider in accordancewith 42 CFR § 440.167, who is 18 years or older and has been trained to provide thepersonal care services required by the client, and who is not legally responsible member of the individual's family.

2. Developmental Rehabilitative Therapy

   Definition:

   Developmental Rehabilitative Therapy includes orientation and mobility services provided, through the Early Intervention Program or School-Based Program to a child identified as having a developmental delay or other related disabilities in order to correct deficits in the child's cognitive, social or emotional, adaptive, communication, psychomotor development or physical functioning, including visual and hearing. These treatments are recommended bya physician or other licensed practitioner of the healing arts, within their scope of practice, under State law for maximum reduction of physical or mental disability and restoration to the child's best possible functional level. Deficits are revealed through comprehensive screening, examination and evaluation.

Services:
Orientation and Mobility services are rehabilitative services related to the evaluation, diagnosis, and treatment of a student who is blind or visually impaired to attain systematic and safe orientation and movement within their environment through sensory integrative techniques. Orientation and Mobility services also include direct assistance with the selection, acquisition, training, and use of an assistive technology device. It would also include provision of instruction to parents and to caregivers in assisting them in maintaining a daily therapeutic regimen related to regaining the child's progress.

Providers:

Developmental Rehabilitative Therapy is provided by professionals who are credentialedby the Department of Human Services as a Part C EI Service System Developmental Therapists. In the school setting for IEPs and other medical plans of care, services are provided by Licensed Orientation and Mobility Specialists Licensed by the Academy forCertification of Vision Rehabilitation and Education Professionals.

3. Specialized Transportation

Definition:

Specialized transportation services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the transportation services are medically necessary anddocumented in an IEP/IFSP.

Services:

Services must be provided on the same date of service that a Medicaid covered service,required by the student's IEP/IFSP, is received. Transportation must be on a specially adapted school bus to and/or from the location where the Medicaid service is received.

All specialized transportation services provided must be documented in a transportationlog.

Providers:

Transportation services include direct services personnel, e.g. bus drivers, aides etc. employed or contracted by the school district.

05/19 4c. FAMILY PLANNING SERVICES

Medically necessary fertility preservation services for individuals of child bearing age are limited to office visits, pelvic ultrasounds, sperm and oocyte cryopreservation and storage, medications/injectables and laboratory testing.

01/14 4d. TOBACCO CESSATION COUNSELING SERVICES FOR PREGNANT WOMEN

1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; or*

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

*described if there are any limitations on who can provide these counseling services.

2) Provided: ☑ No limitations ☐ With Limitations

Tobacco cessation counseling services for pregnant women shall include four (4) individual face-to-face counseling sessions per quit attempt, with a maximum of three (3) quit attempts per calendar year.

5.a. PHYSICIANS' SERVICES

Covered services, when performed by fully licensed residents, are limited according to the following conditions:

- that the resident provides services within a Family Practice Residency Program approved by the Department and accredited by the LCGME (Liaison Committee on Graduate Medical Education).
- that the resident provides services within a Family Practice Residency Program recognized by Medicare as either a Free Standing Program or a Provider Based Program.
- that, in those instances where the resident provides services within a Provider Based Family Practice Residency Program, such services will be covered only through a related provider (hospital).

01/93 In order for a physician's services to be covered for children under age 21, the physician must:

1) Be certified in pediatrics or family practice by the medical specialty board recognized by the American Board of Medical Specialties; or
2) Be employed by or affiliated with a federally qualified health center; or
3) Have admitting privileges at a hospital; or
4) Be a member of the National Health Service Corps; or
5) Document a current, formal consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in 1) for the purpose of specialized treatment and admission to a hospital; or

Special Rehabilitation Services and Non-emergency Transportation Services Provided by Local Education Agencies

A. Reimbursement Methodology for School-Based Health and Related Services

School-based services, known as School-Based Health Services (SBHS) in Illinois, are delivered by the school districts, Special Education Cooperatives (Co-ops) and K-12 educational institutions (herein after referred to as "providers" for this section of the State Plan), and these can include the following Medicaid 1905(a) services:

1. Physicians Services
2. Nursing Services
3. School Health Aide Services
4. Psychology Services
5. Counseling Services
6. Social Work Services
7. Orientation, Mobility, and Vision Services
8. Speech-Language Services
9. Audiology Services
10. Occupational Therapy (OT)
11. Physical Therapy (PT)
12. Registered Behavioral Technician services
13. Specialized Transportation
14. EPSDT Services

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified health care professional that have been approved under Attachment 3.1-A and Attachment 3.1-B of the Medicaid state plan.

B. Direct Medical Payment Methodology

All school districts, Special Education Cooperatives and K-12 educational institutions will be paid on a cost basis. District specific provider costs were collected from the participating school districts, Special Education Cooperatives and K-12 educational institutions calculate cost-based rates for each district and for each billable service. Each of the 850+ participating LEAs will have their own cost-based rates for each billable service. Cost based rates were calculated for each 1905(a) service. The total reported annual cost was divided by the reported number of annual service hours to create a cost per hour for each service. The state entered these service rates for each participating LEA in the MMIS system. Those cost-based rates will be used for interim payments for services LEAs will submit to the state MMIS system for processing and payment. As districts submit claims on a regular basis to the MMIS system, these LEA specific cost-based rates will be used to make interim claim payments to each LEA. Districts will only receive interim payments for services submitted to the MMIS system that will be paid out at the district specific rates. These interim payments will be utilized for each participating LEA during the annual cost reconciliation process.

On an annual basis a district-specific cost reconciliation to the final and audited cost report and cost settlement for all over and under payments will be processed. Under payments will be paid out to the districts and overpayments will be recouped directly from the school districts. The state will process all overpayments at the time the cost reports are finalized and process those adjustments on the next CMS-64. The state will then recoup any overpayments directly from the districts by withholding future interim payments until the overpayment has been fully recovered. Likewise, any underpayments will be processed by the state at the time the cost reports are finalized and make the entire underpayment directly to the district. All participating public school districts and public Special Education Cooperatives will complete this process annually.

The service rates are also published within the claiming system for LEAs to reference as well. LEAs are required to maintain all service documentation and to provide support documentation for the services that have been submitted for payments. The amount paid from interim rates will be settled annually through the cost settlement process.

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 captured utilizing the following data:
   a. School-Based Health Services cost reports received from school districts, Co-ops, and K-12 educational institutions;
   b. Illinois State Board of Education (ISBE) Unrestricted Indirect Cost Rate (UICR);
   c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services), Activity Code 4C (Free Care or Direct Medical Service pursuant to other medical plans of care) and Activity Code 10 (General Administration):
      i. Direct Medical Services RMTS percentage
      ii. Free Care RMTS percentage
   d. School district, Co-ops, and K-12 educational institutions specific Medicaid Ratios:
      i. Medicaid Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) Ratio
      ii. Medicaid Ratio for Other Medical Plan(s) of Care

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. Costs are included in accordance with 2 CFR 200 and 45 CFR 75. Costs for transportation personnel are reported as defined in Section E. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnellisted in the descriptions of the covered Medicaid services delivered by school districts, Co-ops,and K-12 educational institutions, excluding transportation personnel. These direct costs will be calculated on a district-specific level and will be reduced byany 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 Health 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), but the state maintains ultimate responsibility to follow all federal cost rules, regulations and claiming processes.

   The source of this financial data will be audited Chart of Account records kept at the school district, Co-ops, and K-12 educational institutions level. The Chart of Accounts is uniform throughout the state of Illinois. Costs will be reported on a cash basis.

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

   b. 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.

2. 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.

3. Indirect Costs: Indirect costs are determined by applying the school district's specific UnrestrictedIndirect Cost Rate (UICR) to its adjusted direct costs. Illinois public school districts and Co-ops use predetermined fixed rates for indirect costs. Illinois State Board of Education (ISBE) has, incooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by school districts and Co-ops in Illinois. ISBE approves unrestricted indirect cost rates for school districts for the DOE, which is the cognizant agency for school districts. 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.

   When an ISBE calculated unrestricted indirect cost rate is not available, school districts will usethe statewide average rate. School districts with a ISBE calculated unrestricted indirect cost ratemust use the calculated rate and cannot choose the statewide average indirect cost rate.

   Indirect Cost Rate

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

   b. The UICR is the unrestricted indirect cost rate calculated by the Illinois 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.

4. Time Study Percentages: After the state receives a CMS approval letter for the time study implementation guide (TSIG) to run the RMTS, a time study will be 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. When the participant is providing a direct medical services, as part of their response, they will indicate how medical necessity has been established (IEP/IFSP, other plans of care) and that will determine which direct service code the moment is assigned to. The RMTS methodology will utilize two distinct cost pools; one cost pool for Direct Medical Services which includes all eligible staff except School Health Aides Providers and one also for Direct Medical Services staff but only to include School Health AideProviders. The average of the 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, other medical plans of care or where medical necessity has been otherwise established and applied statewide. All regular school days are part of the RMTS universe.

RMTS Sampling Periods

Effective on 7/1/2023: The sampling period is defined as follows for the SBHS Program:

- Sample Period 1 = mid-August – December 31*
- Sample Period 2 = January 1 – March 31
- Sample Period 3 = April 1 – June 30
- Sample Period 4 = July 1 – mid-August** (the summer sample period)

*the time study period will begin with the first regular school day when any participating district returns from the summer break and will continue until the end of December
**no time study will be generated. The sample period will run from the day after the last regular school day until the day before the first regular school day for any participating district.

Effective until 6/30/2023 the sample periods are defined as:

- Sample Period 1 = October 1 – December 31
- Sample Period 2 = January 1 – March 31
- Sample Period 3 = April 1 – June 30
- Sample Period 4 = July 1 – September 30***

***no time study was conducted during this period

Below the job categories in each of the cost pools is outlined based on the current eligible provider job categories.

Direct Service Cost Pool
The following positions that are eligible to bill direct medical services in the IDHFS Policies and Rules include:

- Registered Nurse;
- Licensed Practical Nurse;
- Licensed Clinical Psychologist (LCP);
- School Psychologist;
- Licensed Clinical Professional Counselor (LCPC);
- School Social Worker;
- Licensed Clinical Social Worker (LCSW);
- Licensed Marriage and Family Therapist (LMFT);
- Speech Language Pathologist;
- Speech Language Pathology Assistant (SLPA);
- Audiologist;
- Occupational Therapist;
- Certified Occupational Therapy Assistant (COTA);
- Orientation and Mobility Specialists;
- Physical Therapist;
- Physical Therapy Assistant (PTA);
- Hearing and Vision Screeners
- Orientation and Mobility Specialist; and
- Registered Behavior Technician

Other Direct Service Personnel Cost Pool
The following positions that are eligible to bill direct medical services in the IDHFS Policies and Rules include:

- School Health Aides

The RMTS will generate the Direct Medical Services time study percentages; one for Direct Medical Services pursuant to an IEP/IFSP and one for Direct Medical Services pursuant to other medical plans of care. There is one Direct Medical Services percentage pursuant to an IEP/IFSP for each cost pool and that cost pool percentage is used statewide. There is also one Direct Medical Services percentage pursuant to other medical plans of care for each cost pool and that cost pool percentage is used statewide as well. The two Direct Medical Service time study percentages will be applied to only those costs associated with direct medical services to generate a Direct Medical Service cost amount for services provided pursuant to an IEP/IFSP and a Direct Medical Services cost amount for services provided pursuant to other medical plans of care for each cost pool. 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 Illinois and CMS.

5. Medicaid Enrollment Ratio for direct services Determination: Two distinct Medicaid ratios will be established for each participating school district. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students for each participating LEA or Special Education Cooperative.

    a. Medicaid IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the MedicaidDirect Medical Service costs pursuant to an IEP/IFSP. The names, gender, and birthdates ofstudents with an IEP/IFSP will be identified from the ISBE Special Education Enrollment Count Report (currently December 1st) 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 special education students with a medical service on their IEP/IFSP and the denominator willbe the total number of enrolled special education students with a medical service on their IEP/IFSP The IEP ratio will be calculated for each district/Co-op or K-12 educational institutions participating in the SBHS program on an annual basis. Since Special Education Cooperatives provide medical staff and services to their member LEAs, the student counts for the Special Education Cooperatives will be the sum of those of their member districts. The average of their member districts will be calculated to determine their Medicaid IEP Ratio. For a Special Education Cooperative the formula is defined as the total number of Medicaid enrolled special education students with a medical service on their IEP/IFSP from all their member districts and the denominator will be the total number of enrolled special education students with a medical service on their IEP/IFSP from all their member districts. 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.

    b. Medicaid Enrollment Ratio for Other Medical Plans of Care: The Medicaid Enrollment Ratiofor 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 ISBE Enrollment Count Report (on October 1 of each year 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 district/Co-op or K-12 educational institutions participating in the SBHS program on an annual basis. For Co-ops, the student counts will be the sum of those of their member districts for the numerator and denominator. 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.

6. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each school district, Co-ops, or K-12 educational institutions for Direct Medical Services.

E. Specialized Transportation Services Payment Methodology

Providers will be paid on a cost basis. Providers will be reimbursed interim rates for SBHS Specialized Transportation services at the lesser of the provider's billed charges or the statewide enterprise interim rate. Interim payments are paid at the district specific rate. Federal matching fundswill be available for interim rates paid by the State. An interim rate for transportation is calculated for each school district. The school district will bill for allowable transportation services using that rate as a basis to determine the interim reimbursement. Just as with the other allowable services, the state will calculate annually a transportation rate based on previous year cost reports, for each participating LEA and Co-op that will be used for interim billing through the year. The rate is provided to each LEA for billing purposes. At the end of the fiscal year, transportation services are included in the annual cost settlement process. Specialized transportation can only be billed on the day the student receives another Medicaid eligible service. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

School based specialized transportation is defined as a medically necessary service (as outlined in the IEP/IFSP of an enrolled Medicaid beneficiary) provided in a specially-adapted vehicle that has been physically-adjusted or designed (e.g., wheelchair lifts, ramps, etc.,) to accommodate special needs children in the school-based setting. Note: The presence of only an aide(s) (on a non-adapted bus/vehicle) or seat belts does not make a vehicle specially-adapted.

Transportation may be claimed as a Medicaid service when the following conditions are met:

1. Specialized transportation is specifically listed in the IEP/IFSP as a required service;
2. The child required transportation in a specially adapted vehicle to serve the needs of an individual with an IEP/IFSP disability;
3. A Medicaid eligible service is provided on the day that the specialized transportation is billed;and
4. The service billed only represents the costs associated with the one-way trip on the specially adapted transportation for direct medical services as listed in the IEP/IFSP.

The specialized transportation cost-pool will include only those costs below associated with the specialized transportation program described below and allocate those costs based on allowable Medicaid 1-way trips.

Transportation costs included on the Cost Report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs (other than the interim payments), resulting in net costs for transportation. The Cost Report includes costs for the following:

1. Bus Drivers
2. Mechanics & Mechanic Assistants
3. Substitute Drivers
4. Fuel & Oil
5. Repairs & Maintenance
6. Rentals
7. Insurance
8. Purchased Professional Transportation Services
9. Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district, Co-ops, and K-12 educational institutions level. The Chart of Accounts is uniform throughout the State of Illinois. Costs will be reported on a cash basis.

Special education transportation costs include those for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities(Illinois State Board of Education, Department of Education).

Costs for specialized transportation must be reported in one of two, mutually exclusive cost pools; Specialized Transportation Only or Not Only Specialized Transportation.

- Specialized Transportation Only Costs: school districts, Co-ops, or K-12 educational institutions should report costs in this cost pool only when they are able to discretely account for these costs within their financial records AND when the personnel and non-personnel expenditures being reported under this category are 100% dedicated to the provision of a specialized transportation trip. Costs reported as Specialized Transportation Only would be apportioned to the Medicaid program through the application of the Medicaid One Way Trip Ratio only.
- Not-Only Specialized Transportation Cost: school districts, Co-ops, or K-12 educational institutions should report costs in this cost pool when they cannot discretely identify the specialized transportation costs from their general transportation costs AND when specialized transportation personnel or equipment are used to provide transportation services for both specialized transportation and general transportation students. For example, if a bus modified for the purposes of providing specialized transportation services is also used to transport a general education student(s), the personnel and non-personnel costs must be reported as Not-Only Specialized Transportation. Costs reported as Not-Only Specialized Transportation costs will be apportioned to the Medicaid program first through the application of the Specialized Transportation Student Ratio to identify the portion of costs associated with the provision of the specialized transportation services and subsequently by the application of the Medicaid One Way Trip Ratio.

The two ratios are defined as follows:

- Specialized Transportation Student Ratio: The Specialized Transportation Student Ratio is required when a district reports "not only specialized transportation" costs. This ratio determines the percentage of students with specialized transportation as prescribed in their IEP receiving specialized transportation services in a district and therefore the portion of costs associated with the provision of specialized transportation services. The numerator of the Specialized Transportation Student Ratio will be the count of all students with specialized transportation prescribed in their IEP. The denominator of the Specialized Transportation Student Ratio will be the total number of all students receiving transportation services in the LEA. This would include students receiving both specialized transportation per their IEP and all other students receiving transportation services.

  The formula for the Specialized Transportation Student Ratio is presented below:

  $$\frac{\text{ALL Students with Specialized Transportation in their IEP}}{\text{ALL Students receiving Transportation Services in the District}}$$

  The application of the Specialized Transportation Student Ratio to the Not-Only Specialized Transportation Cost Pool results in the exclusion of any costs associated with transportation services for any students that are not receiving Specialized Transportation services per an IEP. The remaining costs following the application of this ratio are associated with the provision of transportation services for only those students receiving Specialized Transportation per their IEP.

  NOTE: If a district reports costs as Specialized Transportation Only, as defined above, the Specialized Transportation Student Ratio would not be applicable.

- Medicaid One Way Trip Ratio: The Medicaid One Way Trip Ratio is used to allocate the Medicaid allowable specialized transportation costs from the total specialized transportation costs reported by the district. The numerator for the Medicaid One Way Trip Ratio will be the total number of allowable (as defined above) specialized transportation one-way trips for Medicaid enrolled IEP/IFSP students. The denominator for this ratio will be the total number of one-way trips for all students using the specialized transportation vehicles (Medicaid enrolled and non-Medicaid enrolled students). The source for the trip counts reported in the numerator and denominator will be district vehicle/bus logs or equivalent documentation.

The formula for the Medicaid One Way Trip Ratio is presented below:

Allowable Specialized Transportation One Way Trips for Medicaid Enrolled Students with Specialized Transportation in their IEP

All Specialized Transportation One Way Trips for All Students with Specialized Transportation in their IEP

The denominator for this ratio should be inclusive of all one-way trips for all students included in the numerator of the Specialized Transportation Student Ratio.

The application of the Medicaid One Way Trip Ratio to the Specialized Transportation Only Cost Pool and the Not Only Specialized Transportation Cost Pool (following the application of the Specialized Transportation Student Ratio) will result in the identification of the costs for Specialized Transportation one-way trips for Medicaid enrolled students with Specialized Transportation in their IEP.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal year. In addition, each provider 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. Providers will complete a Certification of Public Expenditures (CPE) form.

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.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due 365 days after the close of the quarter ending June 30. The primary purposes of the cost report are to:

1. Document the provider's total Medicaid allowable scope of costs for deliveringschool health services, including direct costs and indirect costs, based on cost allocation methodology procedures; and

2. Reconcile its interim payments to its total Medicaid-allowable scope of costs based on federal cost allocation methodology procedures. The process will follow the cost principles as outlined in 45 CFR 75. The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to a desk review by The Department or its designee.

H. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual SBHS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider'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-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.

I. The Cost Settlement Process

For services delivered for a period covering July 1st, through June 30th, the annual SBHS Cost Report is due 365 days after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than June 30th (24 months after the fiscal year end).

If a provider's interim payments exceed the actual, certified costs of the provider for school health services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school health services exceed the interim Medicaid payments, The Department will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

The Department shall issue a notice of settlement that denotes the amount due to or from the provider.

J. Awareness of Federal Audit and Documentation Regulations:

The Illinois Department of Healthcare and Family Services and any contractors used to help administer any part of the SDS program are aware of federal regulations listed below for audits and documentation:

- 42 CFR § 431.107 Required provider agreement
- 45 CFR § 447.202 Audits
- 45 CFR § 75.302 Financial management and standards for financial management systems