DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

July 14, 2010

Andrew Allison, PhD
Executive Director
Kansas Health Policy Authority
Landon State Office Building
900 S.W. Jackson, Room 900N
Topeka, Kansas 66612

Dear Dr. Allison:

On June 26, 2009, the Centers for Medicare & Medicaid Services (CMS) received Kansas State Plan Amendment (SPA) transmittal #09-07, which proposes to amend the reimbursement methodology for school based services to provide for payment of reconciled cost to Local Education Agencies (LEAs).

Based on the information provided, I am pleased to inform you that SPA 09-07 is approved as of July 13, 2010 with an effective date of July 1, 2009. Enclosed is a copy of the CMS 179 form as well as the approved pages for incorporation into the Kansas State plan.

I appreciate the significant amount of work that your staff dedicated to getting this SPA approved and the cooperative way in which we achieved this much-desired outcome. If you have any questions concerning this SPA please contact Narinder Singh or Mandy Hanks at (816) 426-5925 or Narinder.Singh@cms.hhs.gov.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Barbara Langner, Ph.D.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #09-07

2. STATE: Kansas

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2009

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:

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 $ 5,821,247
b. FFY 2010 $23,284,989

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, #4.b., Page 2
Attachment 4.19-B, #4.b., Pages 2b to 2g (New Pages)
Attachment 3.1-A, #4.b., Pages 4 & 5
Attachment 3.1-A, #4.b., Pages 6-10 (New Pages)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, #4.b., Page 2
Attachment 3.1-A, #4.b., Pages 4 & 5

10. SUBJECT OF AMENDMENT:
Local Education Agencies (LEAs)

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: Andy Allison, PhD. is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
for Andy Allison, PhD.

14. TITLE:
Acting Executive Director of the Kansas Health Policy Authority

15. DATE SUBMITTED:
January 13, 2010

16. RETURN TO:
Andy Allison, PhD.
Kansas Health Policy Authority
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 26, 2009

18. DATE APPROVED: July 13, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS:

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

- **School-Based Services (SBS)**
  - Services to children listed on either the child's Individualized Education Program (IEP) or the child's Individualized Family Services Plan (IFSP) including:

Specialized Transportation:

a. Description: Specialized transportation of a child to/from a site to receive medically appropriate and necessary services, including transportation of a caretaker or attendant when medically necessary and including transportation to/from a school setting to receive such services.

b. Qualifications: Specialized transportation to and from school may be claimed as a Medicaid service if the following conditions are met:
Specialized transportation is specifically listed in the IEP as a required service; the child required transportation in a vehicle adapted to service the needs of an individual with a disability; a medical service is provided on the day that specialized transportation is billed; and, the service billed must only represent a one-way trip.
Services must be provided by an enrolled specialized transportation provider within the guidelines described in the Kansas Medical Assistance Program medical benefits brochure and the Kansas Medical Assistance Provider manual, or a Medicaid-enrolled SBS provider.

c. Limitations: Specialized transportation is covered only when it is necessary to receive another Medicaid service, and the need for both the Medicaid service and the transportation are specified in the IEP/IFSP. Similar transportation would be required if the child was not in a school setting.

Nursing Services:

a. Description: Nursing services include but are not limited to: health screenings (i.e., an evaluation of a child that may include but is not limited to developmental, psychological, speech and language, occupational and physical assessment therapy assessment); vision services (i.e., an evaluation of a child's vision status, the making of referrals for medical or other attention); initial and ongoing assessments; communication with physicians; medication set-up and administration; invasive procedures treatment and evaluation of wounds; individualized teaching of care procedures; and other services designed to provide for maximum reduction of physical or mental disability and restoration of a

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

recipient to this best possible functional level. All services must be provided in accordance with 42 CFR §440.60 or 42 CFR §440.130(d).

b. Qualifications: Nursing services provided in accordance with 42 CFR §440.60 must be provided by a qualified nurse, such as a Registered Nurse (RN), Licensed Practical Nurse (LPN), Advanced Practice Nurse (APNs) certified by the Kansas Department of Health and Environment . Nursing services provided in accordance with 42 CFR §440.130(d) must be provided by a qualified nurse, such as an RN, LPN, or APN, or though delegated services in accordance with the Kansas Department of Health and Environment by individuals who have received appropriate training from an RN or APN.

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Occupational Therapy:

a. Description: Identification of children with service needs; evaluation of the nature, extent, and degree of the need for services; improving, developing, or restoring functions impaired or lost through illness and injury; improving ability to perform tasks for independent functioning when functions are impaired or lost; provision of therapy services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

designed to correct deficits or delays; and preventing, through early intervention, initial or further impairment or loss of function, provided in accordance with 42 CFR 440.110(b) .

b. Qualifications: Occupational therapy services must be provided by occupational therapists licensed by the Kansas State Board of Health Arts and/or the Kansas State Department of Education or occupational therapist assistants/aides/interns under the direction of such licensed occupational therapists, in accordance with 42 CFR 440.110(b).

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Physical Therapy:

a. Description: Identification of children with service needs; evaluation of the nature, extent, and degree of the need for services; services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems; provision of therapy services designed to correct deficits or delays; and obtaining, interpreting, and integrating information appropriate to care planning, provided in accordance with 42 CFR 440.110(a).

b. Qualifications: Physical therapy services must be provided by physical therapists licensed by the Kansas State Board of Healing Arts and/or by the Kansas State Department of Education or physical therapist assistants/aides/interns under the direction of such licensed occupational therapists, in accordance with 42 CFR 440.110.(a).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Speech, Language and Hearing Services:

a. Description: Identification of children with service needs, including children with hearing loss or with speech or language disorders; evaluation of the nature, extent, and degree of the need for services, including the referral for medical or other professional attention for the rehabilitation of speech or language disorders or the amelioration of hearing; provision of amelioration activities, such as language amelioration, auditory training, speech (lip) reading, hearing evaluation and speech conversation; provision of speech or language services for the habilitation or prevention of communicative disorders; determination of the need for group and individual amplification; hearing aid services; and provision of therapy services designed to correct deficits or delays, provided in accordance with 42 CFR 440.110(c).

b. Qualifications: Speech, language, and hearing services must be provided by speech language pathologists or audiologists licensed by the Kansas State Department of Health and Environment and/or the Kansas

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

Department of State Education or speech language pathologist assistants/aides/interns and audiologist assistants/aides/interns under the direction of such licensed speech language pathologists or licensed audiologists, in accordance with 42 CFR 440.110(c).

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Counseling Services:

a. Description: Identification of children with service needs; determination of the nature, extent, and degree of the need for services; and provision of services to assist the child and/or parents in understanding the nature of the child's development, disability, and/or special needs; health and behavior interventions to identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of the child's development, disability, and/or special needs, provided in accordance with 42 CFR §440.60(a).

b. Qualifications: Counseling services must be provided by or under the direction of a qualified licensed counselor in accordance with 42 CFR §440.60(a).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Social Work Services:

a. Description: Identification of children with service needs; determination of the nature, extent, and degree of the need for services; provision of services to assist the child and/or parents in understanding the nature of the child's development, disability, and/or special needs; health and behavior interventions to identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of the child's development, disability, and/or special needs; and provision of services to support the child's social and emotional needs, provided in accordance with 42 CFR §440.60(a).

b. Qualifications: Social work services must be provided by or under the direction of a qualified licensed social worker in accordance with 42 CFR §440.60(a).

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Limitations
"Kan Be Healthy" School-Based Services (SBS) (continued)

- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Psychological Services:

a. Description: Evaluation of a child for the purpose of determining the need for specific psychological, health or related services, including the administering psychological tests and other assessment procedures and the interpreting testing and assessment results; services for obtaining, integrating and interpreting information about child behavior and conditions related to learning and functional needs; services for planning and managing a program of psychological services; and assessment of the effectiveness of the delivered services toward achieving goals and objectives of the child's IEP/IFSP, provided in accordance with 42 CFR §440.60(a).

b. Qualifications: Psychological services must be provided by or under the direction of a qualified licensed psychologist in accordance with 42 CFR §440.60(a).

c. For situations where another licensed practitioner (OLP) bills for services provided by unlicensed support personnel, all of the following conditions must be met by the OLP in order to bill Medicaid:

- The OLP must assume professional responsibility for the service provided to the beneficiary by the unlicensed support personnel;
- The OLP must provide some portion of the service (or test), which is billed to Medicaid (for example: interpreting the results of the performed test);
- The OLP must be practicing within the scope of the applicable State's Practice Act for which the OLP is licensed.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

A. Reimbursement Methodology for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

School-based Services (SBS) are delivered by Local Education Agencies (herein after referred to as "providers" for this section of the State Plan), and include the following Medicaid services identified in an Individualized Family Service Program or Individualized Education Program under the Individuals with Disabilities Education Act (IDEA):

1. Specialized Transportation
2. Nursing Services
3. Occupational Therapy
4. Physical Therapy
5. Speech, Language and Hearing Services
6. Counseling Services
7. Social Work Services
8. Psychological Services

B. Direct Medical Payment Methodology

Effective with dates of service on or after July 1, 2009, providers will be reimbursed on a cost basis. Providers will be paid interim rates for school-based direct medical services on a per unit basis. On an annual basis, a provider-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes. Direct medical services may be encounter-based or in 15-minute unit increments. Fee-based reimbursement for a specific service for a period is an interim payment, pending the completion of cost reconciliation and cost settlement for that period.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

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 Health Services cost reports received from LEAs;
   b. Kansas Department of Education (KDE) Unrestricted Indirect Cost Rate (ICR);
   c. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services) and Activity Code 3100 (General Administration);
   d. LEA-specific IEP Ratios.

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 provider-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 Kansas 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).

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

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 Kansas. Costs will be reported on a cash or accrual basis, depending on the district.

a. Direct Medical Services

Non-federal cost pool for allowable providers consists of:

i. Salaries;

ii. Benefits;

iii. Medically-related purchased services; and

iv. Medically-related supplies and materials.

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

   Apply the Kansas Department of Education Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.

   The Kansas Department of Education UICR is the unrestricted indirect cost rate calculated by the Kansas Department of Education.

3. Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on 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 appropriate time study results will be applied to the direct medical services cost pool. The direct medical services costs and time study results will be maintained by the State of Kansas. The use of CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per OMB Circular A-87 cost allocation requirements.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

4. IEP Ratio Determination: A provider-specific IEP Ratio will be established for each participating LEA. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students.

   The names and birthdates of students with a health related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid.

   The numerator of the rate will be the students with an IEP that are eligible for Medicaid and the denominator will be the total number of students with an IEP.

5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

   After CMS-approved time study results have been produced for at least four consecutive quarters, the Kansas Health Policy Authority (KHPA) will submit for CMS review and approval a proposed methodology for documenting (backcasting) prior period claims by applying the valid time study results for purposes of adjusting the prior period claims. Reported expenditures must be reasonable, allowable, and allocable, and must be adjusted, if necessary, to comport with the guidelines specified in the CMS-approved time study.

E. Specialized Transportation Services Payment Methodology

Effective with dates of service on or after July 1, 2009, providers will be paid on a cost basis. Providers will be reimbursed interim rates for School-based Specialized Transportation services at the statewide enterprise interim rate. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Specialized Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required services;
2. The child required specialized transportation in a vehicle adapted to service the needs of an individual with a disability;

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

3. A medical service is provided on the day that specialized transportation is billed; and
4. The service billed only represents a one-way trip.

Specialized transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Depreciation

The source of these costs will be audited Chart of Accounts data kept at the LEA level. The Chart of Accounts is uniform through the State of Kansas. Costs will be reported on a cash or accrual basis, depending on the district.

Specialized 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.

When LEAS are not able to discretely identify the specialized transportation cost from the general education transportation costs, a specialized transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the LEA. This rate will be based on the *Total IEP Special Educations (SPED) Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation.* The result of this rate (%) multiplied by the *Total School LEA Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

the total number of *SPED IEP One Way Trips.* This data will be provided from bus logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each fee reimbursed 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 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 Settlement Process

Each provider will complete an annual cost report for all school-based services delivered during the previous state fiscal year covering July 1 through June 30. The cost report must be filed no later than 6 months after the end of the fiscal period (December 31). The primary purposes of the cost report are to:

1. Document provider's total CMS-approved, Medicaid allowable scope of costs for delivering school-based services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and
2. Reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

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

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Methods and Standards for Establishing Payment Rates (Continued)

provider's Medicaid interim payments for school-based 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 the 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.

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

If the actual, certified costs of a provider for school-based services exceed the interim Medicaid payments, KHPA 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.

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