Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

School-Based Skills Development Services

Division of Integrated Healthcare

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Table of Contents

Introduction

School-based skills development services are Medicaid-covered medically necessary diagnostic, preventative, and treatment services. These services include therapeutic interventions designed to ameliorate motor impairments, sensory loss, communication deficits, and/or psycho-social impairments. These services are specifically designed to enhance a student's health and functional abilities and/or prevent further deterioration. They are necessary for the student to benefit from special education.

General information, pertaining to Utah Medicaid providers and Medicaid billing, is located in the Section 1: General Information provider manual on Utah Medicaid's website.

1 Program standards

1-1 Authority

The Medicaid Catastrophic Coverage Act of 1988, Section 411(k)(12) permits Medicaid to pay for Medicaid covered services included in a Medicaid eligible recipient's Document of Medical Necessity (DMN) when services are medically necessary and are covered in the Medicaid State Plan, for students who are 3 to under 21 years old.

1-2 Definitions

The following definitions apply to this program:

Administrative fee: The fee assessed to cover costs incurred by the Department of Health and Human Services to administer the Medicaid program.

Clean claim: A claim that can be processed as submitted without obtaining any additional information from the provider of the service or from a third party.

Document of Medical Necessity (DMN): A document approved by the Utah State Board of Education as a medical plan of care used to demonstrate a student's need for medical services in the school environment during school hours. This document must state the following: the medical need, the medical diagnosis, a start and end date, the scope of the service, the frequency of the service, and the duration of the service. The document must be signed and dated by a provider whose licensure allows.

Examples of DMNs include but are not limited to the following: IEP, IFSP, 504 plan, health plan, Behavior Intervention Plan, prescribed services.

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, designed to ensure Medicaid eligible recipients from birth through age twenty have access to needed medical care.

Federal financial participation (FFP): The federal share of Medicaid payments authorized and directed under Section 1903(a) of the Social Security Act.

HIPAA: The federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information, and help the healthcare industry control administrative costs.

Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP): A written plan for a student with a disability developed and implemented in accordance with the Utah State Board of Education Special Education Rules.

Local Education Agency (LEA): The Utah school districts, the Utah Schools for the Deaf and Blind (USDB), and all Utah public charter schools that are established under state law that are not schools of an LEA.

Maximum allowable costs: The percentage of costs incurred by the LEA to deliver covered skills development services to the Medicaid population.

Medicaid administrative claiming (MAC): is a means by which the states' LEAs are able to claim partial reimbursement for administrative activities that support and ensure the integrity and delivery of Medicaid services provided both within the school setting and through coordination with community Medicaid providers.

Medically necessary service: A service that is reasonably calculated to prevent, diagnose, or cure conditions in the recipient that endanger life, are causing suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap, and there is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

Paraprofessional: An individual who is not a licensed healthcare provider; however, has been trained to perform certain healthcare tasks under the supervision of a licensed medical or behavioral professional.

Related services: Developmental, corrective, and other supportive services required to assist a student with a disability to benefit from special education. Related

services are identified in the Individuals with Disabilities Education Act (IDEA), Part B Regulations, 34 CFR Section 300.34. Not all related services are considered medically necessary.

Skilled nursing services: School-based skills development services provided to medically fragile students who require continuous, one-to-one skilled nursing throughout their school day, in accordance with a physician or other qualified healthcare professional's order.

Special education: Instruction which is specially designed to meet the unique needs of a student with a disability.

State match: The current percentage of the State's share of Medicaid expenditures as defined in 42 CFR 433.10.

Utah Health Information Network (UHIN): a nonprofit, broad-based coalition of Utah healthcare insurers, providers, and others, including local government entities that provides a private and secure gateway for electronic data exchanges.

1-3 Program eligibility

1. LEAs may bill Medicaid for covered services rendered to students when the LEA is an enrolled provider with Utah Medicaid and has a current, signed contract and provider agreement with the Department of Health and Human Services.
2. LEAs may bill Medicaid for covered services rendered to students, if all of the following criteria are met:
    a) The student is Medicaid eligible and is between the ages of 3 and 21.
        i. The LEA may check Medicaid eligibility by sending a student list to the school-based program manager, using the Eligibility Lookup Tool at www.medicaid.utah.gov, or by calling 1-801-538-6155 or 1-800-662-9651, and following the prompts.
    b) The student must have a Medicaid-covered service specified in their DMN and receive these services from a qualified provider.

2 Scope of services

The direct services outlined in this section must be rendered in accordance with a provider order, except personal care. The student's DMN may be used as the provider order if the information stated includes the provider's recommendation for services, the scope, frequency, duration of services, and the provider's signature and date.

LEAs not wanting to use the DMN as a provider order must complete a provider order separate from the DMN.

2-1 Covered direct services

The following direct care services must be rendered by a provider whose scope of license legally allows them to do so, or by a paraprofessional under the supervision of a provider whose scope of license legally allows them to supervise the rendered service.

1. School-based skills development services Include:
    a) Evaluation and assessment for the purpose of identifying and documenting a special education student's health related service need.
        i. Both initial evaluations and assessments, along with re-evaluations and assessments, are covered by Medicaid, as long as the evaluated and/or assessed service results in DMN placement.
        ii. Evaluations and assessments that do not result in DMN placement for the evaluated or assessed service are not covered by Medicaid.
    b) Motor skills development services are rehabilitative, active or restorative therapies designed to enhance a student's fine and gross motor skills including muscle coordination and strength, ambulation, range of motion, grasp and release, and oral motor functioning. Examples of these services are occupational therapy and physical therapy.
        i. Motor skills development services may be provided in an individual or group setting.
    c) Communication skills development services are speech, language, and hearing services designed to enhance a student's ability to communicate through the development of functional expressive speech, functional use of adaptive equipment and devices, or improved oral-motor functioning. An example of this service is speech language pathology or hearing screenings.
        i. Speech, language, and hearing services may be provided in an individual or group setting.
    d) Personal care

i. The following services must be performed under proper supervision per the Final Supervision and Licensure Appendix 3 and in accordance with Utah Code section 58-1-307 and Admin Code R156-31b-701b. The student's DMN may serve as the service plan for personal care services.

1 Activities of Daily Living (ADLs) such as: toileting, hand washing, eating, and bathing
2 Administer over-the-counter medications according to the manufacturer/FDA directions
3 Administer prescription ointments per a licensed health care provider order/prescription
4 Administer non-controlled medications per a licensed health care provider order/prescription
5 Administer medication through tubes per a licensed health care provider order/prescription
6 Administer eye/ear drops: prescribed or over the counter
7 Administer gastrostomy tube feeding: changing empty bags and clipping/unclipping the feeding line to the port (but not replacing a port)
8 Tasks related to stoma care, including pouch changes, measuring intake and output, and skin care around the stoma area
9 Changing a catheter bag
10 Oxygen management: assisting with applying nasal cannulas, adjusting the flow of O2 within prescribed parameters, and the temporary removal of O2 tubing to facilitate ADLs
11 Measure and record electronic vital signs (such as pulse oximeter or blood pressure) and take weights and temperatures
12 Perform routine ventilator respiratory care but may not adjust settings
13 Clean established trach tubes and routine surface suctioning but may not provide deep suctioning

14 Nail care: clipping and filing toe and fingernails (for non-diabetic individuals)

ii. Personal care services shall not be performed as a group service; however, one or more students may be served one-at-a-time sequentially.

e) Skilled nursing

i. Skilled nursing services require the provider to have appropriate licensure per the Final Supervision and Licensure Appendix. In addition to the services stated under the personal care section, these providers may render the following in accordance with their licensing and training as outlined in Utah Code section 58-1-307 and Admin Code R156-31b-701a:

1 Routine respiratory care, including management of ventilator settings
2 Standard tracheotomy care includes cleaning and suctioning, whether surface or deep suctioning
3 IV management
4 Evaluations and assessments (RNs only)
5 Emergency interventions
6 Seizure monitoring
7 Asthma management
8 Diabetes management
9 Scoliosis screening
10 Vision screening
11 Hearing screening
12 Height and weight screening

ii. Nursing services that are considered observational or stand-by in nature are not covered.

iii. Skilled nursing services must be in accordance with a prescribed provider order and be stated in the student's plan of care. The order may be signed by a physician or other qualified healthcare professional.

iv. For information regarding other qualified healthcare professionals, refer to the *All Providers General Information Section 1 Manual*.

f) Behavioral health services are designed to mitigate behaviors such as aggression, self-abuse, property destruction, severe non-compliance or withdrawal when, and to the extent, those behaviors significantly impact a student's ability to benefit from special education. Examples of these services include behavioral redirection, counseling, and psychological services.

i. Behavioral health services may be provided in an individual or group setting.

g) Vision and hearing adaptation services are (necessitated by a student's absence or loss of vision and/or hearing) are specifically designed adaptation training services to develop/enhance a student's functional abilities to assist him or her to benefit from special education. Examples of these services are orientation and mobility as well as aural/auditory rehabilitation.

2. Telehealth

a) Utah Medicaid covers medically necessary, non-experimental, and cost-effective services provided via telehealth. Telehealth is a two-way, real-time interactive communication to facilitate contact directly between a student and a provider. This electronic communication uses interactive telecommunications equipment that includes, at a minimum, audio and video equipment that complies with HIPAA and UHIN privacy and security standards for telehealth.

i. Covered telehealth services include but are not limited to the following:

1 Consultation services
2 Evaluation and management services
3 Mental health services

ii. Reporting requirements for provided telehealth services are the same as those provided when the student is present (in person).

iii. There are no geographic restrictions for telehealth services.

iv. Providers at the originating site receive no additional reimbursement for the use of telehealth services.

For more information regarding telemedicine, please refer to Utah Medicaid's Section 1: General Information provider manual.

3. Service categories and service plans
    a) Services that may be stated in a student's DMN as a category, i.e., social skills, transition skills, functional skills, daily living skills, self-help, etc., must be broken down. The Medicaid covered services to be rendered must be stated.
        i. Example: if social skills services include behavioral interventions, the LEA can state "behavior" as the covered service in the DMN.
    b) Services that may be stated in a student's DMN as a plan, i.e., health plan, must be broken down. The Medicaid covered services to be rendered must be stated.
        ii. Example: If a DMN states, "health plan", but the actual service to be rendered is speech, then the DMN should say "speech".

4. Credentials and supervision
    a) The Supervision and Licensure Appendix 3 outlines the licensure, certification, and other credentials required to deliver and/or supervise the delivery of Medicaid covered school-based skills development services.

2-2 Non-covered services/activities

1. The following services and activities are outside of the scope of the school-based skills development services and are not reimbursable under this program:
    a) Durable and non-durable medical equipment (including assistive technology devices), appliances, and supplies. When medically necessary, these items are available to a Medicaid eligible student through other programs and enrolled providers.
    b) Services provided prior to the implementation (or subsequent to the expiration) of a student's DMN.
    c) Medicaid covered services, which are not specified in a student's DMN.

d) Services specified in a student's DMN, but the nature or purpose of the activity is:

i. Academic or educational and covered under the state's educational "core curriculum" including addition, subtraction, multiplication, letter and sound identification, reading, history, science, and other services that do not meet the criteria of medically necessary services;

ii. To teach consumer and homemaker skills, including, but not limited to, shopping, budgeting, bed making, table setting, vacuuming, dishwashing, and laundry skills;

iii. Extracurricular in nature, including training and participation in regular physical education, recreational and cultural activities, athletics/sports, and special interest/leisure activities;

iv. Any other service that may be appropriate for the DMN, according to the USBE standards, but are not Medicaid covered services as outlined in this manual, (e.g., adapted physical education); or

v. Vocational or job training activities designed to prepare a student to obtain or maintain paid or unpaid employment (such as objectives written to address specific job skills and work habits, use of public transportation, community awareness and access, and following work related directions).

2-3 Service coordination

1. The LEA is responsible to coordinate the provision of school-based skills development services with students' primary and specialty providers.
2. Utah Medicaid providers should be familiar with coverage of preventative, diagnostic, treatment, and outreach services for EPSDT-eligible recipients in order to assist families to appropriately utilize Medicaid benefits available.

3 Service payment

3-1 Billing authority

The LEA, along with the education authority, is solely responsible to ensure that it is legally authorized to submit a claim to Medicaid in accordance with all state and federal laws.

3-2 Claims processing

1. Upon enrollment in the Medicaid program, LEAs will receive instructions and assistance from the Medicaid agency to enable them to submit claims monthly.
2. LEAs must be able to submit claims using HIPAA compliant software using the UHIN tool.
3. Payment will be made to the LEA for students who are Medicaid eligible during the billing period.
4. The LEA is responsible for submitting clean claims to Medicaid and for working through rejected claims with its clearinghouse and/or UHIN when appropriate.
5. Submitted claims must contain the following information:
    a) The names of all (Medicaid) students who received Medicaid covered services during the billing period;
    b) Each student's date of birth and social security number or Medicaid identification number;
    c) The number of units of covered service(s); and
    d) The dates of service during the billing month
6. Providers should not be listed individually on school-based skills development claims.

3-3 Billing codes, usage, limitations, and specifications

1. LEAs must submit claims to Medicaid in order to justify its reported direct care service costs and receive its monthly interim payment.
2. LEAs must use correct CPT/HCPCS codes on claims per the School-Based Skills Development Code List Appendix 1 and the School-Based Skills Development Audiology Code List Appendix 2.
        a) LEAs may only submit claims for dates when a Medicaid covered service is rendered to a student.
3. Billing for time
    a) When submitting the CPT/HCPCS codes for time, the minutes must be rounded. If the resulting time is 0 to less than 8 minutes, do not bill for the time. If the resulting time is 8 to 15 minutes, 1 unit of nursing services may be billed.
            i. The following is an example of rounded minutes when using the T1002 and the T1003 codes: If a nurse rendered services for 34

minutes, bill 2 units. If a nurse rendered services for 39 minutes, bill 3 units.

b) Services billed using CPT/HCPCS codes for time may only be billed for the day that the services are rendered. Partial minutes cannot carry over from one day to the next in order to complete a unit.
    i. The following is an example: 9 minutes of nursing services on Tuesday cannot be added to 6 minutes of nursing services on Wednesday to make one whole 15-minute unit.

c) LEAs may bill for nursing services during transportation using the appropriate code, when deemed necessary. In order to bill for nursing services during transportation, the total nursing minutes stated in the DMN must also include the minutes for transportation. Nursing minutes are billed in 15-minute increments.
    i. Simply stating "transportation" in the DMN, or adding time to transportation in the DMN, is not sufficient. This does not clearly identify the expected time associated with the nursing services, nor does it clearly tie the "transportation" activities to a specific related service.
    ii. Example: If a student receives 2,000 weekly nursing minutes at school, and also receives nursing services on a bus for 30 minutes a day, five days a week, the total time stated in the DMN must be 2,150 in order for the LEA to bill for both services.

3-4 ICD-10 diagnosis codes

1. LEAs will use the full list of ICD-10 diagnosis codes as appropriate for the associated rendered service.
    a) LEAs will include the appropriate ICD-10 diagnosis code on submitted claims to Medicaid.

3-5 State match and administrative fee

1. State match
    a) The LEA will receive a quarterly bill for the estimated state match, pertaining to direct care services. The bill will be sent 45 days prior to the beginning of each

new quarter and payment must be made at least 15 days prior to the start of the quarter.

b) State match requirements for administrative services will be accomplished through certified public expenditures (CPE).

2. Administrative fee
   a) The LEA will receive a bill for the administrative fee 45 days prior to the beginning of the fourth quarter of each state fiscal year. The administrative fee will be calculated as a percentage of the total Medicaid payments. It will include both FFP and state match amounts paid to the LEA for school-based skills development services during the state fiscal year.
      i. The administrative fee is calculated as follows:

Fiscal Year Medicaid Payments	Fiscal Year Administrative Fee
$1-$500,000	3 percent of total
$500,000- $1,000,000	$15,000 + 2 percent of amount exceeding $500,000
Greater than $1,000,000	$25,000 + 1 percent of amount exceeding $1,000,000

3. LEA monthly Medicaid payments will be placed on hold if the state match or the administrative fee is not paid.

4 Documentation

4-1 Documentation requirements

The school-based skills development LEA must maintain sufficient records to fully justify the Medicaid covered services rendered, its claims submitted to Medicaid, and its reported costs.

1. DMN – the DMN must demonstrate the following:
   a) That the student received service(s) pursuant to a DMN which met the requirements in accordance with Chapter 1-4, Program eligibility, of this manual.
   b) That the dates of the DMN cover the billing month on the claim.
   c) That the Medicaid covered services rendered to the student during the month match the services outlined in the student's DMN.

d) That the CPT/HCPCS codes included on a claim are pursuant to a service stated in the DMN.

2. Rendering and supervising providers
   a) The rendering provider(s) met the required licensure, certification, or other criteria described in the Supervision and Licensure Appendix 3 or was supervised by an individual who met the requirements per Appendix 3.
      i. That the rendering provider has signed and dated the documentation of services rendered.
         1 That the signature is handwritten or electronic.
         2 That the signature is legible.
      ii. That the rendering provider and the supervising provider (if applicable) have both signed and dated the documentation of services rendered.
         1 The documentation must clearly state both the rendering and the supervising provider names.
         2 The documentation must clearly indicate who rendered the service.
         3 The documentation must clearly indicate who supervised the service.
      iii. Electronic signatures are acceptable when the LEA has a system to maintain an auditable signature record, and when the LEA has a way to protect against modification of the record after the signature.
         1 The LEA and the person whose name is represented by the electronic signature, are responsible for the authenticity of the signature.
3. Clinical notes
   a) The LEA must maintain clinical documentation to justify the costs reported to Medicaid. The clinical notes must include the following:
      i. The student's name;
      ii. The type of service rendered;
      iii. The date the service was rendered;
      iv. The duration of time spent rendering the service; and
      v. A clinical description of the services rendered:

1 Clinical notes must include the exact activities performed with the student. The exact activities demonstrate how the service was rendered.
2 Clinical notes must be in line with the standards of practice for each rendering and/or supervising provider's specialty.

4. Skilled nursing service documentation must also ensure that the number of 15-minute units on a claim was billed correctly.

4-2 Record retention

1. All documentation pertinent to a claim submitted by the LEA to Medicaid must be kept for a period of five years after the date of payment.
   a) Records must be retained even after a student leaves the LEA.

5 Cost reporting

5-1 Annual direct care cost reports

1. On an annual basis LEAs must submit a report outlining the costs associated with rendering covered direct care services to students that are eligible for this program. The annual reports should include the following information:
   a) Salary and benefits for staff rendering covered direct care services to students.
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Salary and benefit expense may only be included for staff that have participated in the time study and only for the period in which they participate in the time study.
   b) Contracted staff costs for rendering covered direct care services to students
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Contracted staff expense may only be included for contracted staff that have participated in the time study and only for the period in which they participate in the time study.
   c) Costs for allowable materials and supplies used to provide covered direct care services.

5-2 Quarterly administrative cost reports

1. On a quarterly basis LEAs must submit a report outlining the costs associated with administering this program. The quarterly reports should include the following information:
   a) Salary and benefits for staff rendering direct care services to students, as well as the salary and benefits for staff providing administrative support of this program.
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Salary and benefit expense may only be included for staff that have participated in the time study and only for the period in which they participate in the time study.
   b) Contracted staff costs for providing administrative support of this program.
      i. This expense should be broken out to reflect the percent of the expense that is funded through state/local funds, IDEA, or other federal funds.
      ii. Contracted staff expense may only be included for contracted staff that have participated in the time study and only for the period in which they participate in the time study.
   c) Other costs including:
      i. Staff travel and training costs;
      ii. Staff professional dues and fees; and
      iii. Materials and supplies.

6 Random moment time study

1. The random moment time study is a mechanism for identifying and categorizing Medicaid administrative and direct care activities performed by LEA employees. This serves as the basis for developing claims for the costs of administrative activities that may be properly reimbursed under Medicaid. It is also used to calculate the maximum allowable cost for the annual cost reconciliation for direct care services.

2. Participating Utah LEAs must participate in the time study for three periods per year. The first period is from mid-August to December 31 and the second period is from January 1 to June 30. The third period is the summer period, beginning July 1 and ending mid-August. No time study will be generated during the summer period. 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 LEA. An average of the two (2) previous sampling periods' time study results will be used to calculate claims for the summer sampling period. No Medicaid funding will be available to an LEA for a quarter in which it failed to complete an approved time study.
3. LEAs must work with the Department's time study vendor to enroll time study participants into three categories:
   a) **Paraprofessionals**– Included in this category are paraprofessionals, interveners, and any other aides that provide covered direct care services
   b) **Clinical providers** – Included in this category are the following:
      Physical therapists
      Physical therapy assistants
      Physical therapy aides
      Occupational therapists
      Occupational therapy assistants
      Occupational therapy aides
      Orientation and mobility specialists
      Psychologists
      Social workers
      Hearing specialists
      Audiologists
      Audiology aides
      Speech and language pathologists
      Speech language technicians
      Speech language pathology aides
      RNs or LPN physicians
      Other qualified healthcare professional
      Augmentative/assistive communications teams
      Counselors/mental health practitioners

c) **Administrative staff** – Include staff that support this program, but do not render direct care services. These may include the following:
Special education directors or coordinators
Medicaid coordinators
Special education staff assistants

4. The time study will produce statewide percentages for 3 cost pools associated with the three participant categories. These will be used for the direct care cost settlement and administrative claiming.
   a) The paraprofessional and clinical provider time studies will result in separate direct care service percentages.
   b) The paraprofessional, clinical provider, and administrative staff time studies will result in separate administrative activity percentages.
5. The LEA must ensure an 85% compliance rate with the quarterly time study.

7 Medicaid administrative claiming

1. Utah LEAs may claim Medicaid administrative Federal Financial Participation (FFP) for a share of the costs incurred to perform activities which support the proper and efficient operation of the Medicaid program in schools. Some or all of the costs of these administrative activities may be reimbursable at a 50% match rate. The quarterly cost reports will be used to calculate the administrative claim.
   a) The objective of the Medicaid administrative claim is to isolate and identify only those LEA costs that are associated directly with administrative activities that support the provision of Medicaid covered services in the Medicaid program.
   b) The LEA may submit the Medicaid administrative claim to the Department of Health and Human Services through the Department approved process.

7-1 Participation criteria

1. In order for a LEA to claim Medicaid administrative funding, the following criteria must be met:
   a) the LEA must be enrolled as a Medicaid provider;
   b) the LEA must actively bill Medicaid for direct care services;
   c) the LEA must participate in the Department approved time study;

d) the LEA must attend required trainings; and
e) the supported activity must be necessary for the proper and efficient administration of the Medicaid State Plan.

7-2 Cost data

1. Cost data will be submitted by the district quarterly. Calculations from the cost data will be used to support the quarterly administrative claim. The following elements will be used to calculate the administrative claim:
   a) Employee level salary data
      i. This information comes in a quarterly report from the LEA
   b) Employee benefit data
      i. This information comes in a quarterly report from the LEA
   c) Contracted staff costs
      i. This information comes in a quarterly report from the LEA
   d) The district's indirect cost rate
      i. This information is published annually by the USBE
   e) The district's Medicaid discount factor
      i. This is the percentage of the total students in the LEA that are Medicaid eligible
   f) The statewide time study percentages related to Medicaid administrative services for each of the staff cost pools
      i. This includes the teachers and paraprofessionals, clinical providers, and administrative staff
2. This will be calculated separately for each of the three staff cost pools and then will be combined and reduced by 50% to isolate the federal share of the administrative FFP.
3. The Department will then pay the LEAs for the administrative claim.

8 Direct care payment

1. Utah LEAs may claim Federal Financial Participation (FFP) through Medicaid for a share of the costs incurred to render covered direct care services to Medicaid eligible students.

a) Medicaid's regulations prohibit payments to governmental agencies in amounts which exceed an agency's costs to provide a service. LEAs, as governmental entities, are not allowed to make a profit.

2. The objective of the direct care payment reimbursement process is to isolate and identify only those LEA costs that are associated directly with rendering Medicaid covered direct care services.
3. A cost settlement is used to assure LEAs are reimbursed for the maximum allowable cost.
4. All reported costs and payments are subject to a review and takeback process per Utah Code 26b-1-213 and Administrative Rule R414-1-14.

8-1 Maximum allowable cost

1. The maximum allowable cost is calculated using the annual cost report data for direct care costs. The following elements will be used to calculate the maximum allowable cost:
   a) Employee level salary data
      i. This information comes in a quarterly report from the LEA
   b) Employee benefit data
      i. This information comes in a quarterly report from the LEA
   c) Contracted staff cost
      i. This information comes in a quarterly report from the LEA
   d) The district's indirect cost rate
      i. This information is published annually by the USBE
   e) The LEA's Medicaid IEP student ratio
      i. This ratio is for purposes of the annual cost settlement and is applied to the calculation for determining the reimbursement level for services provided to students with an IEP/IFSP.
      ii. This is calculated by dividing the number of Medicaid eligible students in an LEA, with a Medicaid covered related service on their IEP/IFSP, by the number of students in the LEA with Medicaid covered related services on their IEP/IFSP.

(# of Medicaid students /w qualified services on IEP)

(Total # of students /w qualified services on IEP)

iii. On an annual basis, each participating LEA must submit to the Department a list of students who have a qualified service on their IEP. Medicaid will request this list from the LEAs on November 1st.

f) The LEA's Medicaid eligibility ratio
   i. This ratio is applied to the calculation to determine the reimbursement level for direct services costs pursuant to DMNs other than IEPs and IFSPs.
      1. This is calculated by dividing the total number of Medicaid eligible students in the LEA by the total number of students enrolled in the LEA.
   ii. The total student enrollment is given to Medicaid by the Utah State Board of Education.
   iii. This ratio is only used for those students whose DMN is not an IEP or IFSP.

g) The statewide time study percentages related to direct care services for each of the direct care staff cost pools.
   i. This includes the teachers and paraprofessionals and clinical providers.

h) This will be calculated separately for each of the two direct care staff cost pools and then will be combined for the total maximum allowable cost for each LEA.

8-2 Interim payment

1. Due to the fact that payment is based on actual costs, interim payments will be made to the LEAs until a cost settlement can be finalized.
2. In advance of the school year, the interim payment is determined by taking the maximum allowable cost calculation from a previous period and applying that as an estimate of the anticipated cost of the coming year.
3. In an effort to minimize a payback situation, the LEAs will select to receive 80% or 90% of the estimated maximum allowable cost to be paid out monthly.

a) At any time during the year, the LEAs may request to reduce the interim payments.
    i. If billing for direct care services decreases during the year, the Department may hold or reduce interim payments in an effort to ensure the estimated maximum allowable cost is still representative of the current situation.

8-3 Cost settlement

1. At the conclusion of the school year, the Department will perform a cost settlement by comparing the interim payments made throughout the year with the actual maximum allowable costs for the year.
    a) If the maximum allowable cost exceeds the interim payments, the Department will pay the difference to the LEA.
    b) If the interim payments exceed the maximum allowable costs, the Department will invoice the LEA for the difference.
    c) If the interim payments are equal to the maximum allowable cost, no action is required.
2. The LEA is responsible to ensure that the Medicaid funds it receives as part of the school-based skills development program are only used to support and enhance the provision of Medicaid-covered services.