NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

JOSH STEIN • Governor
DEVDUTTA SANGVAI • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

SIGNATURE REQUEST MEMORANDUM

TO: Jay Ludlam DS

FROM: Ashley Blango, SPA Manager

RE: State Plan Amendment

Title XIX, Social Security Act
Transmittal #2026-0002

Purpose
Attached for your review and signature is a Medicaid State Plan Amendment (**School Based Services)** summarized below, and submitted on February 9, 2026 with a due date of February 13, 2026.

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Ashley Blango, Kathryn Horneffer, Todd Baustert, Tabitha Evans, Chris Gordon, Melanie Bush

Background and Summary of Request
It is recommended that you sign this State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

The purpose of the revisions to the State Plan Amendment is to will expand from only services provided pursuant to an IEP, IHP, BIP or 504 Plan to include "other written plan"; remove IFSP; expand eligible provider types and services, including Research-Based Behavioral Health Treatment (RB-BHT); update payment methodology including changes to the time study methodology and Medicaid ratio calculation and allow NC Medicaid to apply an administrative fee to be subtracted from the final cost settlement for LEAs; and add clarifying language and edits to confirm state compliance with audit documentation standards, update NC Medicaid nomenclature and links, and example dates for cost settlement process.

The proposed effective date for the SPA is July 1, 2026.

Your approval of this State Plan Amendment is requested. If you have any questions or concerns, please contact me at 919-812-6145.

(8) Medicaid Services Provided by Schools (Local Education Agencies)

School-Based Services (SBS) are Medicaid-covered health services provided to a Medicaid beneficiary by or through a Local Education Agency (LEA) and are included under one or more of the categories in Section 1905(a) of the Social Security Act, and EPSDT services. SBS are provided in accordance with state law and policies, and listed in one of the following documents:

- Individualized Education Program (IEP)
- Section 504 accommodation plan (34 C.F.R. §104.36)
- Individual Health Plan (IHP)
- Behavior Intervention Plan (BIP)
- Other written plan of care

A beneficiary shall receive services delivered in the least restrictive environment consistent with the nature of the specific services and the physical and mental condition of the beneficiary.

Covered Services

The SBS benefit includes medically necessary evaluation, diagnostic, and treatment services that are covered under North Carolina's Medicaid program when provided by or through a LEA. These services are necessary to correct or ameliorate physical or behavioral illnesses or conditions. Covered school-based services include:

- Physical therapy, occupational therapy, speech-language pathology, and audiology therapy provided by qualified practitioners within the scope of practice as defined under state policy and regulations and in accordance with G.S. Chapter 90, Title 21 NCAC, and 42 CFR §440.110.

- Behavioral health services and Research-Based Behavioral Health Treatment (RB-BHT) are provided in accordance with 42 CFR § 440.130(c)-(d). Behavioral health services and RB-BHT provided must be within the scope of practice of qualified providers as defined under state policy and in accordance with G.S. Chapters 90, 90B, and 115C; Title 21 NCAC; the North Carolina State Board of Education general licensure requirements; and 42 CFR §§ 410.53, 410.54, 410.73, and 440.166.

- Nursing services provided pursuant to a written treatment plan developed by a licensed Registered Nurse (RN) based on a written order as required by the North Carolina Board of Nursing. Nursing services must be provided by a Licensed RN or delegated to a Licensed Practical Nurse (LPNs) operating within the scope of practice as defined under state policy and regulations and in accordance with G.S. Chapter 90, Title 21 NCAC and 42 CFR §440.60.

- Vision and hearing screenings administered in accordance with 42CFR § 440.130(b) by a licensed registered nurse (RN), licensed practical nurse (LPN), audiologist, or speech/language pathologist working within the scope of practice as defined under state policy and regulations and in accordance with G.S. Chapter 90 and Title 21 NCAC.

Additional EPSDT services may be provided by or through a LEA to the extent they are coverable under Medicaid, consistent with the federal and state requirements and provider qualification standards established in the State Plan. All covered services must be provided in accordance with treatment plans that meet standards and requirements defined in state policy.

Federally recognized tribes or Indian Health Services are exempt from the above requirements as they are governed by Federal Regulations and/or equivalent tribal code.

(4) Annual fee increases are applied each January 1 based on the physician fee schedule adjustments as set out in Attachment 4.19-B, Section 5, but not to exceed the percentage increase approved by the North Carolina State Legislature. The LEA fee schedule is published on the NC Medicaid Division of Health Benefits (DHB) website at: https://ncdhhs.servicenowservices.com/fee_schedules.

(5) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.

(6) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid beneficiaries, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid beneficiaries. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.

(7) School-based Medicaid services are services that are medically necessary and provided by a Local Education Agency (LEA) to Medicaid beneficiaries in accordance with an Individualized Education Program (IEP), a section 504 Accommodation Plan pursuant to 34 CFR §104.36, a Behavior Intervention Plan (BIP), an Individual Health Plan (IHP), or other written treatment plan. Covered services include the following as described in Attachment 3.1-A.1:

a. Physical Therapy
b. Occupational Therapy
c. Speech/Language Pathology
d. Audiology Therapy
e. Behavioral Health Services
f. Nursing Services
g. Vision and Hearing Screenings

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified healthcare professional that have been approved under Attachment 3.1-A/B of the Medicaid State Plan. Fee schedules for outpatient specialized therapies (physical therapy, occupational therapy, speech-language pathology, and audiology therapy) and behavioral health services are published on the NC Medicaid Division of Health Benefits (DHB) website at: https://ncdhhs.servicenowservices.com/fee_schedules.

A. Direct Medical Services Payment Methodology

The Division of Health Benefits (DHB) will use a cost-based reconciliation methodology for reimbursement to Local Education Agencies (LEAs). This methodology will consist of interim payments, cost reporting, time study, and reconciliation. If interim payments exceed Medicaid-

allowable costs, the excess will be recouped.

The interim payment to LEAs for covered services are based on the physician fee schedule methodology as outlined in Attachment 4.19-B, Section 5.

The interim payment to LEAs for nursing services is based on the private duty nursing schedule as outlined in Attachment 4.19-B, Section 8. The interim payment for nursing services has 3 components, each established on a 15-minute unit fee. The interim rate for RN Services and LPN Services are established by using the national average hourly salary for RNs and LPNs based on data from the U.S. Department of Labor. The fee per 15-minute unit is then derived from the average hourly salary for Registered Nurse (RN) and Licensed Practical Nurse (LPN).

All interim payments are provisional and will be reconciled to actual, Medicaid-allowable costs in accordance with the CMS approved cost-allocation methodology.

B. Data Sources for Determining Costs

Data collected to support the cost determination of providing services will be included on the annual School Based Services (SBS) Cost Reports received from LEA. SBS Cost Reports will be completed utilizing the following data sources:

1. North Carolina Department of Public Instruction (DPI) Unrestricted Indirect Cost Rate (UICR);
2. Random Moment Time Study (RMTS) Activity Code 4.b (Direct Medical Services – IEP), Activity Code 4.c (Free Care or Direct Medical Service pursuant to other medical plans of care), and Activity Code 10 (General Administration); and
3. Medicaid Enrollment Ratios for LEAs
    a. Medicaid IEP Enrollment Ratio and
    b. Medicaid Enrollment Ratio for all other plans of care.

C. Cost Reconciliation Methodology

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid beneficiaries in the LEA, the following steps are performed:

(1) Allowable Direct 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 of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A.1. Total direct costs for direct medical services are reduced on the cost report by any federal grant

payments with a matching requirement resulting in adjusted direct costs for direct medical services.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs. The School Based Services (SBS) Cost Report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The sources of these financial data will be audited records kept at the LEA level.

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) Allowable Indirect Costs: Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate (UICR) to its net direct costs. North Carolina LEAs use predetermined fixed rates for indirect costs. The Department of Public Instructions (DPI) is the cognizant agency for the LEAs and approves unrestricted indirect cost rates for school districts for the US Department of Education. Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate
a. Apply the NC DPI UICR applicable for the dates of service in the rate year.
b. The UICR is the unrestricted indirect cost rate calculated by NC DPI.

(3) Time Study Percentages: The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the adjusted direct costs from Item 2 above. A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, all other medical services, and general and administrative time. This time study will ensure that there is no duplicate claiming relative to claiming for administrative costs. The RMTS methodology will utilize a single cost pool for direct medical services which includes all eligible staff and other medical services providers. Every employee or contractor for whom an LEA plans to claim Federal reimbursement must participate in the time study. The only exception is for direct service contractors who spend 100% of their

time on Medicaid reimbursable activities. 100% direct service contractors are defined as non-LEA employees who have a contract to only provide Medicaid reimbursable services. The RMTS will generate the Direct Medical Services time study percentages; one for Direct Medical Services pursuant to an IEP and one for all other Direct Medical Services. The two Direct Medical Services time study percentages will be applied to only those costs associated with direct medical services to generate a Direct Medical Services cost amount for services provided pursuant to an IEP and a Direct Medical Services cost amount for all other direct medical services.

(4) Medicaid Ratio Determination: Two distinct direct service Medicaid ratios will be established for each participating LEA. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students.

a. Medicaid Enrollment Ratio for Other Plans of Care: Medicaid's portion of total net costs for all other services is calculated by multiplying the Direct Medical Services cost amount by the ratio of Medicaid-enrolled students to total students. The DPI enrollment file will be matched against the Medicaid enrollment file, using Family Educational Rights and Privacy Act (FERPA) directory information, to determine the percentage of those that are enrolled in Medicaid. Both enrollment files will use data as of December 1 of each year. The numerator will be the number of Medicaid enrolled students, as established by the individuals matched between the DPI enrollment file and the Medicaid enrollment file, and the denominator will be the total number of students enrolled in the LEA, as established by the DPI enrollment file.

b. Medicaid IEP Ratio: Medicaid's portion of total net costs for IEP covered services is calculated by multiplying the Direct Medical Service cost amount by the ratio of the total number of Medicaid-enrolled students with an Individualized Education Program (IEP) to the total number of students with an IEP. The students with an IEP will be identified using the Department of Public Instruction's (DPI) Every Child Accountability Tracking System (ECATS) as of December 1 of each year which is the same data source and date of DPI's federal Child Count Report data. This data will be matched against the Medicaid enrollment file using Family Educational Rights and Privacy Act (FERPA) directory information, which will use data as of December 1 of each year to determine the percentage of students with an IEP enrolled in Medicaid. The numerator will be the number of Medicaid enrolled students with an IEP and the denominator will be the total number of students with an IEP.

(5) Total Medicaid Reimbursable Cost for Direct Services: The resulting Medicaid allowable costs for direct services from both the IEP MER and all other plans of care MER are combined to determine total direct services costs for reconciliation. Final cost settlement provided to LEAs may be reduced by an annual NC DHB administrative fee assessed on LEAs. The administrative fee will be used to fund administration of DHB's School Based Services program. The administrative fee will not be used to fund the provision of direct medical services.

D. Certification of Funds Process

On an annual basis, each LEA will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. LEAs are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

E. Annual Cost Report Process

For Medicaid services listed in Paragraph 7a-g provided by schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before March 1 following the reporting period.

Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by the Division of Health Benefits or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Division, may be subject to penalties for non-compliance. A 20% withhold of Medicaid payments will be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to the Division of Health Benefits and has received a written approval from the Division of Health Benefits. The withholding of monies will continue until the Medicaid cost report filing requirements have been satisfied. Once all requirements have been satisfied, withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

The primary purposes of the cost report are to:

(1) Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
(2) Reconcile interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

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

F. 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 School Based Services (SBS) Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments 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.

G. The Cost Settlement Process

EXAMPLE: For services delivered for the period covering July 1, 2026, through June 30, 2027, the annual SBS Cost Report is due on or before March 1, 2028, with the cost reconciliation and settlement processes completed no later than June 30, 2029.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. The Division of Health Benefits will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of a LEA provider exceed the interim payments, the Division of Health Benefits will pay the federal share of the difference (less the annual administrative fee) to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider. Total federal share will not exceed the applicable Federal Financial Participation (FFP) rate.

H. Audit Documentation.

The State Medicaid agency and any contractors used to help administer school-based Medicaid services are aware of Federal regulations listed below for audits and documentation, and will provide documentation needed to support school-based claims.

1. 42 CFR 431.107 Required provider agreement.
2. 45 CFR 447.202 Audits.
3. 45 CFR 75.302 Financial management and standards for financial management systems.