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: **04-04**

2. STATE: **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: **January 13, 2004**

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 '04 $ ~~15 million~~ Ø
b. FFY '05 $ ~~20 million~~ Ø
per letter from state on 6/21/04

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, pages 42, 43

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, pages 42, 43

10. SUBJECT OF AMENDMENT:

School based health services

Illinois (04-04)
Approved: 06/28/04
Effective: 01/13/04

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:

13. TYPED NAME: **Barry S. Maram**

14. TITLE: **Director of Public Aid**

15. DATE SUBMITTED

16. RETURN TO:
Illinois Department of Public Aid
Bureau of Program and Reimbursement Analysis
Attn: Frank Kopel, Chief
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/31/04

18. DATE APPROVED: 06/28/2004

PLAN APPROVED—ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1-13-2004

20. SIGNATURE OF REGIONAL OFFICIAL: Elizabeth Hamilton, Acting ARA

21. TYPED NAME Cheryl A. Harris

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health

23. REMARKS:

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES, OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

01/13/04

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

Reimbursement for each service will be based on the cost incurred by the local education agency (LEA) in providing a 15-minute unit of that service. The cost shall be determined annually by using the uniform cost calculation methodology established by the Department and may include the cost of practitioners, materials and supplies necessary to provide the service, and indirect costs. The value of educational resources will be specifically excluded from the cost determination. All costs must be documented, based on the previous fiscal year's costs and inflated to the midpoint of the current fiscal year, using the most recently published Medical Economic Index available to the Department.

In the event that no historical costs exist for a specific practitioner, the LEA shall estimate the cost of providing the service for the current year, based on the calculation below, using an inflation rate of 0% for Row ~~L~~ N. Following the completion of a school year, a revised cost calculation form must be submitted to the Department using actual costs. Rates will be adjusted in the event of any overstatement of costs.

LEA-specific costs of providing an individual service, other than those for non-emergency transportation, shall be determined for each service, using the following calculation:

A.	Total full time equivalents providing this service.	____	
B.	Total annual hours service providers were required to work	____	
C.	Total annual hours service providers worked on the provision of service, including prep/follow up and face-to-face time	____	
D.	Percent of hours providing this service (quotient of C divided by B)	___%	
E.	Percent of hours service providers worked on the face-to-face provision of this service	___%	
F.	Total annual hours service providers worked on the face to face provision of this direct service. (product of C and E)	____	
G.	Total amount of salaries and benefits paid to relevant service providers	$___	
H.	Total amount of salaries and benefits related to this service (product of D and G)		$____
I.	Cost of non-salary expenses attributable to the provision of this service		$____
J.	Total direct cost of providing service (sum of ~~F and G~~ H, and I)		$____
K.	Indirect cost rate	___%	
L.	Indirect cost of providing service (product of ~~H and I~~ J and K)		$____
M.	Last year's total cost of providing service (sum of ~~H and J~~ J and L)		$____
N.	Inflationary adjustment rate	___%	
O.	Inflationary cost (product of ~~L and K~~ M and N)		$____
P.	Total current cost (sum of ~~K and M~~ M and O)		$____
Q.	Hourly cost of providing this service (quotient of ~~N divided by C~~ P divided by F)		$____
R.	Cost per 15 minute billing unit (quotient of ~~O~~Q divided by 4)		$____

Total hours providing a service reported in row C above must include the sum of face-to-face time as defined in Code H.3.b., as well as preparatory and follow-up time as defined in Code H.3(a) of the Illinois Guide for School-Based Health Services Administrative Claiming.

State ILLINOIS
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES, OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

Direct face-to-face percentage necessary for billable time (row E) shall be an annual determination based on the state-wide average of the most recently available quarter of time study data from the Illinois Guide for School-based Health Services Administrative Claiming and shall equal the practitioner's total time reported under face to face time (time study Code H.3.(b)) divided by the total time reported under practitioner's total hours worked on the provision of this service (sum of time study Code H.3.(a) and time study Code H.3.(b)).

Billable units for nursing services may be billed in 5 minute increments and will be equal to the cost as determined by the methodology described above divided by three.

Costs of providing allowable group services shall be based on the individual calculation above, multiplied by the Medicare Relative Value Unit scale for calendar year 2002.

Special Non-emergency Transportation Services Provided by a Local Education Agency

Reimbursement will be based on the cost incurred by the LEA to transport a disabled child to and from a source of medical service. All costs must be documented, based on the previous fiscal year's documented costs.

Individual round trip costs shall be equal to the total reported special education transportation costs, as reported to the Illinois State Board of Education (ISBE) in the Annual Claim for Pupil Transportation Reimbursement (ISBE Form 50-23). Using this form, or as updated by the ISBE, allowable transportation costs shall equal total reported special education transportation costs reported on line 23C, divided by the total number of special education students reported on line 9, divided the number of days in the LEA's school year. Only qualifying transportation trips may be billed to the Department.

Qualifying transportation trips means the provision of transportation where each of the following conditions are met:

A. Special transportation is necessary for the child's medical condition and is documented in the child's Individual Education Plan,

B. A non-transportation medical service that requires special transportation is provided on the day of the transportation, and

C. The LEA provides special accommodations in providing the transportation service, beyond what is otherwise provided to all students in routine transportation.