DIVISION OF HEALTH BENEFITS

INTRUCTIONS FOR
SCHOOL BASED SERVICES
LOCAL EDUCATION AGENCIES (LEA)
July 1, 2019 through June 30, 2020

Reporting Deadline: **March 1, 2021**

MAILING ADDRESS

DHHS – NC Medicaid
Division of Health Benefits
Attn: Provider Audit Section – John Mathewson
2501 Mail Service Center
Raleigh, NC 27699 – 2501

OVERNIGHT / EXPRESS MAIL ADDRESS

DHHS – NC Medicaid
Division of Health Benefits
Attn: Provider Audit Section – John Mathewson
820 South Boylan Avenue – McBryde South
Raleigh, NC 27603

Rev (10/01/2019)

North Carolina Medicaid Services in Schools - List of Eligible Practitioners

Category of Service	CFR Reference	Social Security Act, Section 1905 Reference	Provider Types	Licensure/Certification Authority
Audiology and Hearing Services	42 CFR §440.110(c)(3)	§1905(a)(11), physical therapy and related services	Qualified audiologist licensed by the state	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Speech Language Services	42 CFR §440.110(c)(1)	§1905(a)(11), physical therapy and related services	Qualified Speech/Language Pathologist licensed by the state	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Speech Language Services			Qualified Speech/Language Assistant under the direction of Licensed Speech Language Pathologist	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Occupational Therapy	42 CFR §440.110(b)	§1905(a)(11), physical therapy and related services	Qualified occupational therapist licensed by the state	North Carolina Board of Occupational Therapy
Occupational Therapy			Qualified Occupational Therapy Assistant licensed by the state and under the direction of Licensed Occupational Therapist	North Carolina Board of Occupational Therapy
Physical Therapy	42 CFR §440.110(a)	§1905(a)(11), physical therapy and related services	Qualified physical therapist licensed by the state	North Carolina Board of Physical Therapy
Physical Therapy			Qualified Physical Therapy Assistant licensed by the state and under the direction of Licensed physical therapist	North Carolina Board of Physical Therapy
Psychological/ Counseling Services	42 CFR §440.60	§1905(a)(6), medical care, or any other type of remedial care	licensure as a practicing psychologist or psychological associate working under the direction of Licensed practicing psychologist	North Carolina State Board of Examiners of Practicing Psychologists
Psychological/ Counseling Services			licensure as a school psychologist	North Carolina Department of Public Instruction
Psychological/ Counseling Services			licensure as a Clinical Social Worker	North Carolina Certification and Licensing Board for Social Work
Nursing Services	42 CFR §440.60	§1905(a)(6), medical care, or any other type of remedial care	Licensure as a Registered Nurse or Licensed Practical Nurse. Delegated staff are school or contracted staff such as teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff or personal care aides.	North Carolina Board of Nursing
Nursing Services	42 CFR §440.130			

INSTRUCTIONS FOR COMPLETING THE 2019-2020 SCHOOL BASED SERVICES COST REPORT

General

Providers shall include a "crosswalk" from the provider's line item accounts on the Working Trial Balance and Payroll Detail to the Cost Reporting lines on Exhibits 6A-6D, Exhibit 7 and Exhibit 8. <u>The Cost Report will be deemed incomplete without a Crosswalk and no settlement shall be issued without a complete cost report</u>.

For the cost report to be accurate, only fill in the shaded areas of the cost report. Also, please be sure to fill in your signature, title, date and contact number at the bottom of Exhibit 1.

Please include an electronic copy of the completed cost report on a CD along with a printed and signed paper copy.

Cost Report Line Number	**Description**

Exhibit 2 - Provider Data

Column C, Line 10:	Enter the **Provider Name**.
Column C, Line 11:	You must enter your **Medicaid Provider Number** as assigned by the NC Division of Medical Assistance. If the Medicaid Provider Number changed during the cost report period, please provide the prior Medicaid provider number.
Column C, Line 12:	Enter your National Provider Identifier (NPI).
Column C, Line 15:	Enter the **County & State**.
Column C, Line 17:	Enter the **name** of the **Business Manager/Finance Director**.
Column C, Line 19:	Enter the **cost report preparer's name**. This should be the contact person if there are questions about the cost report.
Column C, Line 21:	Enter the **contact phone number** for the person who completes the cost report or person in charge of the cost report.
Column C, Line 23:	Enter a **contact email address or website**.
Column C, Line 25-26:	Enter a **contact mailing address**.
Column C, Line 27:	Enter the **city, state, and zip code**. *(Ex. Anytown, NC 33333)*
Column C, Line 29-30:	Enter a **contact street address**.
Column C, Line 31:	Enter the **city, state, and zip code**. *(Ex. Anytown, NC 33333)*

Cost Report Line Number	Description
Column C, Line 30:	Enter the **Type of Time Study** that was conducted. *(Ex. Traditional or Random Moment)*
Column C, Line 32:	Enter the **time period the time study was conducted** that was used to complete the cost report.
Column C, Line 35:	Enter the current year's **Unrestricted Indirect Cost Rate**, which must cover the same period of time as the cost report period.
Column C, Line 37:	Enter the name of the **Cognizant Agency.** *(The cognizant agency that determines the Unrestricted Indirect Cost Rate is the NC Department of Public Instruction.)*
Column C, Line 39:	Enter the **Period of Time** for which the Unrestricted Indirect Cost Rate was approved for. *(Ex. 7/1/2019 to 6/30/2020)*
Column C, Line 41:	Enter the **Date** in which the Unrestricted Indirect Cost Rate was approved. *(Ex. 7/1/2019)*
Column E, Lines 10-11:	Enter the beginning and ending dates of the cost report period.
Column G, line 10:	Enter the date of the cost report submission.

Exhibit 1 - Final Certification Statement

Except for Sections 3 and 4a, each of the sections' information below will automatically fill in from other pages as they are completed.

1. The **Government Agency Name** and the **Mailing Address** field will automatically fill in after **Exhibit 2** has been completed. Verify the information is correct in Section 1.

2. The **Reporting Period** field will automatically fill in after **Exhibit 2** has been completed. Verify the information is correct in Section 2.

3. Enter your **Federal Employer ID Number** in Column L, Line 15.

4a. Indicate **Type of Report** by entering an "X" in the appropriate box.

4b. The **Cost by Component** field automatically fills in from **Exhibit 9**.

Signature and date of the authorized official of the LEA as either the Superintendent or the Chief Financial Officer as to the Certification of the cost report.

Cost Report
Line Number **Description**

Exhibit 3 - Allocation Statistics

Line 16: Enter the **total number of Medicaid students** covered.

Line 17: Enter the **total number of students in the district** during the applicable period.

Line 18: Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Exhibit 4B.

Line 23: ** Enter the **total number of Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) students receiving covered health related services*** (do not include managed care students).

Line 24: ** Enter the **Total number of IEP Students or IFSP Students receiving covered health related services.**

Line 25: **The percentage calculated will carry over to Exhibits 4A and 4C.**

****Covered health related services: speech, occupational or physical therapy, audiology, psychological or nursing services. Please refer to the Clinical Coverage Policy 10C, Local Education Agencies https://medicaid.ncdhhs.gov/providers/programs-services/care-management/local-education-agencies**

****Please include the completed IEP Template from the DHB website for LEAs: http://www.ncdhhs.gov/dma/cost/leareports.htm**

Exhibit 4A - Summary of Cost by Discipline for IEP / IFSP Medical Services

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3, 5, 6B and 6D are completed.

Exhibit 4A - Summary of Cost by Discipline for 504 / BIP / IHP Medical Services

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3, 5, 6B and 6D are completed.

Exhibit 4B - Summary of Cost by Discipline for Administrative Activities

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3, 5, 6B, 6D and 8 are completed.

Exhibit 4C - Summary of Other Non-Personnel Direct Medical Cost

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3 and 7 are completed.

Cost Report
Line Number **Description**

Exhibit 5 - Time Study Results

Column E: Enter the **percentages calculated** from the completed time study for each field. **Enter the percentage in decimal form.** *(Ex. If the percentage from the time study for Direct Medical Services Covered is 23.57%, enter .2357 in Column E)*

The percentage calculated in cell G33 will carry to Exhibit 4A – Summary of Cost by Discipline for IEP / IFSP Medical Services.

The percentage calculated in cell H33 will carry to Exhibit 4A – Summary of Cost by Discipline for 504 / BIP / IHP Medical Services.

The percentage calculated in cell K33 will carry to Exhibit 4B

Be sure to enter the Time Study Results for the Time Study that the LEA participated in for audit period, 07/01/2019 – 06/30/2020.

Exhibit 6A & 6B - Direct Cost by Discipline

General Instructions: **For each type of service, enter all the required information as you move across the rows. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Exhibits 4A and 4B.**

Step 1: Enter provider Accrual Trial Balance totals along the top line of each discipline.

Column G, Line 11:	Enter gross salary from provider's trial balance for Speech Therapy.
Columns O, P, Q, R, Line 11:	Enter employee benefits / contractor payments from provider's trial balance for Speech Therapy.
Column G, Line 23:	Enter gross salary from provider's trial balance for Occupational Therapy.
Columns O, P, Q, R, Line 23:	Enter employee benefits / contractor payments from provider's trial balance for Occupational Therapy.
Column G, Line 35:	Enter gross salary from provider's trial balance for Audiology.
Columns O, P, Q, R, Line 35:	Enter employee benefits / contractor payments from provider's trial balance for Audiology.
Column G, Line 47:	Enter gross salary from provider's trial balance for Physical Therapy.

Cost Report Line Number	Description
Columns O, P, Q, R, Line 47:	Enter employee benefits / contractor payments from provider's trial balance for Physical Therapy.
Column G, Line 59:	Enter gross salary from provider's trial balance for Psychological / Counseling Services.
Columns O, P, Q, R, Line 59:	Enter employee benefits / contractor payments from provider's trial balance for Psychological / Counseling Services.

Step 2: Enter amounts to be removed. If there are adjustments or reductions required due to positions which are fully or partially funded by federal funds or which are required to remove non allowable Medicaid expenses, complete the following.

Column B: Enter the vendor's/employee's **Position Number or Employee ID.**

Column C: Enter the vendor's/employee's **last name.**

Column D: Enter the vendor's/employee's **first name.**

Column E: Enter the vendor's/employee's **job title.**

Column F: Enter who performed the services. ***(Enter either Vendor or Employee)***

Column G: Enter employee's **total gross salary.**

Column H: Enter whether or not the vendor's/employee's salary is **fully funded** by a Federal grant payment(s). **(*Enter either Yes or No)* Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column I.**

Column I: **Do not enter information into this column, this column is automatically calculated.**

Column J: Enter whether or not the vendor's/employee's salary is **partially funded** by a Federal grant payment(s). ***(Enter either Yes or No*) Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Column K: Enter the amount of **Federally Funded salary** (employees only)

Column L: Enter the amount of **State Matched salary** (employees only).

Column M: Enter any other **reductions to the total gross salary** (employees only)

Cost Report Line Number	Description

Column N: **Do not enter information into this column, this column is automatically calculated.**

Column O: Enter the amount of the **employee benefits paid** to the employee.

Column P: Enter the amount of the **employee FICA tax paid** (if not covered under employee benefits).

Column Q: Enter the amount of the **employee Medicare tax paid** (if not listed under employee benefits).

Column R: Enter the amount of **Federally Funded Vendor/Contractor payments**.

Column S: **Do not enter information into this column, this column is automatically calculated.**

Exhibit 6C & 6D - Direct Cost by Discipline - Continuation

General Instructions: **For each type of service, enter all the required information as you move across the rows. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Exhibits 4A and 4B.**

Step 1: Enter provider Accrual Trial Balance totals along the top line of each discipline.

Column G, Line 11: Enter gross salary from provider's trial balance for Nursing Services (RN Services).

Columns O, P, Q, R, Line 11: Enter employee benefits / contractor payments from provider's trial balance for Nursing Services (RN Services).

Column G, Line 29: Enter gross salary from provider's trial balance for Nursing Services (LPN Services).

Columns O, P, Q, R, Line 29: Enter employee benefits / contractor payments from provider's trial balance for Nursing Services (LPN Services).

Column G, Line 46: Enter gross salary from provider's trial balance for Nursing Services (Delegated Services).

Columns O, P, Q, R, Line 46: Enter employee benefits / contractor payments from provider's trial balance for Nursing Services (Delegated Services).

Step 2: Enter amounts to be removed. If there are adjustments or reductions required due to positions which are fully or partially funded by federal funds or which are required to remove non allowable Medicaid expenses, complete the following.

Cost Report Line Number	Description
Column B:	Enter the vendor's/employee's **Position Number or Employee ID.**
Column C:	Enter the vendor's/employee's **last name.**
Column D:	Enter the vendor's/employee's **first name.**
Column E:	Enter the vendor's/employee's **job title.**
Column F:	Enter who performed the services. ***(Enter either Vendor or Employee)***
Column G:	Enter the employee's **total gross salary.**
Column H:	Enter whether or not the vendor/employee is **fully funded** by a Federal grant. ***(Enter either Yes or No)*** **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column I.**
Column I:	**Do not enter information into this column, this column is automatically calculated.**
Column J:	Enter whether or not the vendor/employee is **partially funded** by a Federal Funds. ***(Enter either Yes or No*****) Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**
Column K:	Enter the amount of **Federally Funded salary** (employees only)
Column L:	Enter the amount of **State Matched salary** (employees only)
Column M:	Enter any other **reductions to the total gross salary** (employees only).
Column N:	**Do not enter information into this column, this column is automatically calculated.**
Column O:	Enter the amount of the **employee benefits paid** to the employee.
Column P:	Enter the amount of the **employee FICA tax paid** (if not covered under employee benefits).
Column Q:	Enter the amount of the **employee Medicare tax paid** (if not listed under employee benefits).
Column R:	Enter the amount of Federally Funded Vendor/Contractor payments.
Column S:	**Do not enter information into this column, this column is automatically calculated.**

Providers shall include a "crosswalk" from the provider's line item accounts on the Working Trial Balance and Payroll Detail to the Cost Reporting lines on Exhibits 6A-6D, Exhibit 7 and Exhibit 8. <u>The Cost Report will be deemed incomplete without a Crosswalk and no settlement shall be issued without a complete cost report</u>.

Please include your LEA reconciliation schedule to your General Ledger Working Trial Balance which shows the chart of account codes and amounts to reconcile the cost report cost to the GL or Working Trial Balance. The Crosswalk should also include Sources of funding (State, Local, and Federal) to support the Payroll cost and employee benefits, specifically Federal Funds received directly or as pass through funding.

Cost Report Line Number	**Description**

Exhibit 7 - Other Non-Personnel Direct Medical Cost

General Instructions: **For each type of service, enter all the required information as you move across the rows. The Adjusted Trial Balance totals will carry to Exhibit 4C.**

Step 1: Enter provider Accrual Trial Balance totals along the top line of each cost center.

Column F, Line 12: Enter total for Direct Medical Supplies, Materials, and Other Costs from provider's trial balance.

Column F, Line 22: Enter total for Direct Medical Equipment from provider's trial balance.

Step 2: Enter amounts to be removed. If there are adjustments or reductions required due to costs which are fully or partially funded by federal funds or which are required to remove non allowable Medicaid expenses, complete the following.

Column B: Enter the **trial balance account number.**

Column C: Enter the **trial balance account description.**

Column F: Enter the **trial balance amount.**

Column G: Enter whether or not the cost is **fully funded** by a Federal grant payment(s) ***(Enter either Yes or No*). Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column H.**

Column H: **Do not enter information into this column, this column is automatically calculated.**

Column I: Enter whether or not the cost is **partially funded** by a Federal grant payment(s). **(*Enter either Yes or No.)* Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Cost Report Line Number	Description

Column J: Enter the amount of **Federally Funded cost.**

Column K: Enter the amount of **State Matched cost.**

Column L: Enter any other **reductions to the trial balance**.

Column M: **Do not enter information into this column, this column is automatically calculated.**

Exhibit 8 - Other Cost for Medicaid Administrative Claiming Plan Activities

General Instructions: **For each type of service, enter all the required information as you move across the rows. The Adjusted Trial Balance totals will carry to Exhibit 4B.**

Step 1: Enter provider Accrual Trial Balance totals along the top line of each cost center.

Column F, Line 12: Enter total for Medicaid Administrative Claiming costs from provider's trial balance.

Step 2: Enter amounts to be removed. If there are adjustments or reductions required due to costs which are fully or partially funded by federal funds or which are required to remove non allowable Medicaid expenses, complete the following.

Column B: Enter the **trial balance account number.**

Column C: Enter the **trial balance account description.**

Column F: Enter the **trial balance amount.**

Column G: Enter whether or not the cost is **fully funded** by a Federal grant payment(s). ***(Enter either Yes or No*) Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column H.**

Column H: **Do not enter information into this column, this column is automatically calculated.**

Column I: Enter whether or not the cost is **partially funded** by a Federal grant payment(s). **Enter Yes or No) Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Cost Report Line Number	Description

Column J: Enter the amount of **Federally Funded cost.**

Column K: Enter the amount of **State Matched cost.**

Column L: Enter any other **reductions to the trial balance.**

Column M: **Do not enter information into this column, this column is automatically calculated**.

Exhibit 9 - Reconciliation and Settlement

Column G, Spreadsheet Line 19: Enter the **Total Medical Claims paid.**

When providers file a cost report indicating that an overpayment has occurred, **FULL REFUND** is to be remitted with the report to DHHS Accounts Receivable. This refund should be mailed under separate cover to:

Send Via US Mail To:

DHHS – Controller's Office
Accounts Receivable - NC Medicaid
2022 Mail Service Center
Raleigh, NC 27699-2022

Make checks payable to:
Division of Health Benefits