HEALTH CARE AUTHORITY OF NEW MEXICO

INSTRUCTIONS FOR COMPLETING THE

MEDICAID SCHOOL-BASED DIRECT SERVICES COST REPORT

August 2024

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SCHOOL-BASED DIRECT SERVICES COST REPORT

General

Interim payments will be made to each LEA on an ongoing basis throughout the fiscal year. On an annual basis, a Cost Report and Reconciliation will be completed for each LEA to reconcile the interim payments to its total Medicaid allowable costs/expenditures, including the federal share and the nonfederal share for the fiscal year.

This Cost Report Instruction Guide and related Cost Report template is designed to demonstrate the data that will be collected, compiled, and ultimately calculated by applying time study results to allowable costs. The Cost Report and Instructions demonstrate the calculations. The data and calculations contained herein will be completed in a web-based system that is designed to capture the elements identified in the Excel Schedules for each LEA.

For the Cost Report to be accurate, only the shaded areas of the Cost Report will be completed. The remaining sections will be loaded by other data inputs and information provided in the web-based system. Schedule 1 is used for each LEA to complete its signature, title, date and contact number.

Schedule 1 - Certification of Public Expenditure (CPE)

For Schedule 1, all that is needed is to verify the information is correct prior to the authorized individual's signature, title and contact information. Each of this section's information below will automatically fill in from other pages as they are completed. Schedule 1 should be submitted with the annual cost report.

1. The Government Provider Name and the Address field will automatically fill in as Schedule 2 is completed.

2. The Reporting Period and Medicaid Provider number field will automatically fill in after Schedule 2 has been completed.

3a. Verify the Type of Report that is completed. This should be Full Year Cost Report.

3b. Verify that all information in the Total Computable Expenditure is accurate based on the total on Line 5 of Schedule 9.

Fields H39 & J39: The Cost Report period dates will automatically fill in as Schedule 2 is completed.

Fields C58, I58, C61, I61: Sign/Date Certification and provide Title/Phone number.

Schedule 2 - Provider Data

General demographic information is compiled in this section. Below provides the line numbers and descriptions of the sections that will be completed.

Cost Report Line Number	Description

Column C, Line 10: Enter the Provider Name. (School District/REC)

Column C, Line 11: Enter Medicaid Provider Number as assigned by the NM Human Services Department/Medical Assistance Division for the LEA. If the Medicaid Provider Number changed during the cost report period, please provide the prior Medicaid provider number.

Column E, Line 10: Enter the Cost Report Period Start Date

Column E, Line 11: Enter the Cost Report Period End Date

Column G, Line 10: Enter the Cost Report Submission Date

Column C, Line 17: Enter the County & State.

Column C, Line 19: Enter the name of the Business Manager/Finance Director.

Column C, Line 21: Enter the cost report preparer's name. This should be the contact person if there are questions about the cost report.

Column C, Line 23: Enter the contact phone number for the person who completes the cost report or person in charge of the cost report.

Column C, Line 25: Enter a contact email address.

Column C, Line 27-28: Enter a contact address.

Column C, Line 29: Enter the city, state, and zip code. (Ex. Anytown, NM 87505)

Column C, Line 34: Enter the Type of Time Study that was conducted. (Ex. Random Moment)

Column C, Line 36: Enter the time period the time study was conducted that is applicable for this Cost Report. (Ex. 7/1/2015 – 6/30/2016)

Column C, Line 41: Enter the cost report year's Unrestricted Indirect Cost Rate, which must cover the same period of time as the cost report period.

Column C, Line 43: Enter the name of the Cognizant Agency. (The cognizant agency that determines the Unrestricted Indirect Cost Rate is the New Mexico Public Education Department.)

Column C, Line 45: Enter the Period of Time for which the Unrestricted Indirect Cost Rate was approved for. (Ex. 7/1/2015-6/30/2016)

Column C, Line 47: Enter the Date in which the Unrestricted Indirect Cost Rate was approved. (Ex. 7/1/2015)

Schedule 3 - Cost Allocation Statistics

The Medicaid Eligibility Rate (Lines 14 & 15) is derived based on the process identified in New Mexico's CMS-approved MAC Claiming Guide. HSD will also request the applicable student data for calculation of the IEP ratios (Lines 19,20,24,25, 29, and 30) at that time.

Column H, Line 14: Enter the total number of Medicaid students.

Column H, Line 15: Enter the total students in the district.

Column H, Line 16: Do not enter information into this cell, this value is automatically calculated. The percentage calculated will carry over to Schedule 4A (No-IEP)

Column H, Line 19: Enter the total number of Medicaid Covered students with IEP/IFSPs receiving services.

Column H, Line 20: Enter the total number of IEP/IFSP students receiving services in the LEA

Column H, Line 21: Do not enter information into this cell, this value is automatically calculated. The percentage calculated will carry over to Schedule 4A (IEP), 4B.

Column H, Line 24: Enter the total IEP/IFSP students receiving specialized transportation.

Column H, Line 25: Enter the total students in the LEA receiving transportation.

Column H, Line 26: Do not enter information into this cell, this value is automatically calculated. The percentage calculated will carry over to Schedule 4C.

Column H, Line 29: Enter the total number of Medicaid enrolled IEP/IFSP one-way trips.

Column H, Line 30: Enter the total one-way trips on a specialized vehicle.

Column H, Line 31: Do not enter information into this cell, this value is automatically calculated. The percentage calculated will carry over to Schedule 4C.

Schedule 4A - Personnel Cost Summary (IEP)

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

Schedule 4A - Personnel Cost Summary (No-IEP)

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

Schedule 4B - Non-Personnel Costs Summary

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

Schedule 4C - Special Education Transportation Summary

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Schedules 2, 3, 8A and 8B are completed.

Schedule 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 or Direct Medical Services Covered is 23.57%, enter .2357 in Column E).

*The percentage calculated in cell G32 will carry to Schedule 4A (IEP).
** The percentage calculated in cell H32 will carry to Schedule 4A (No-IEP).

Schedule 6A & 6B - Direct Cost by Discipline

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 Schedule 4A (IEP and No-IEP).

First, enter your Trial Balance totals along the top line of each discipline. (Line 11, 23, 35, 47 and 59 – Columns G, N, O, P and Q).

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

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 vendor's/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). This amount will automatically calculate column I.

Column I: Do not enter information into this column.

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).

Column K: Enter the amount of Federally Funded salary.

Column L: Enter any other reductions to the total gross salary.

Column M: Do not enter information into this column.

Column N: Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

Column O: Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

Column P: Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

Column Q: Enter the amount of Vendor/Contractor payments paid from federal or other excluded funds.

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

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

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 Schedule 4A (IEP and No-IEP).

First, enter your Trial Balance totals along the top line of each discipline. (Line 11, 23, 35, and 47 – Columns G, N, O, P and Q).

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

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 vendor's/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). This amount will automatically calculate column I.

Column I: Do not enter information into this column.

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)

Column K: Enter the amount of Federally Funded salary.

Column L: Enter any other reductions to the total gross salary.

Column M: Do not enter information into this column.

Column N: Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

Column O: Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

Column P: Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

Column Q: Enter the amount of Vendor/Contractor payments paid from federal or other excluded funds.

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

Schedule 7 - Other Direct Medical Cost

Report costs paid by the district for direct medical materials, supplies and other costs used to provide covered services for a single item costing $5000 or less with a useful life of one year or less. Any single item costing more that $5000 will not be included in the cost report. Examples of direct medical services materials, supplies and other costs are provided as Attachment 2, *Examples of Direct Medical Supplies, Materials and other costs.*

The total for this discipline will carry to Schedule 4B.

For each discipline, enter all the required information as you move across each row.

First, enter your Trial Balance total in **Column F, Line 11**.

Next enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

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 the cost is **fully** funded by a Federal grant payment(s). (Enter either Yes or No). This amount will automatically calculate column H.

Column H: Do not enter information into this column.

Column I: Enter whether the cost is **partially** funded by a Federal grant payment(s). (Enter either Yes or No.)

Column J: Enter the amount of Federally Funded cost.

Column K: Enter any other reductions to the trial balance.

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

Schedule 8A and 8B - Specialized Transportation Cost

For each discipline, enter all the required information as you move across each row. The Adjusted Trial Balance totals will carry to Schedule 4C.

To complete Rows 13 to 41 of this Schedule:

First, enter your Trial Balance totals along the top line of each discipline. (Line 13, 22, 30 and 38 – Columns G, P, Q, R, and S).

Next, enter your Reductions to Trial Balance following the instructions below. A Reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

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 Total Gross Salary

Column I: Enter whether or not the vendor's/employee's salary is **fully** funded by a Federal grant payment(s). (Enter either Y or N). This amount will automatically calculate column J.

Column J: Do not enter information into this column.

Column K: Enter whether or not the vendor's/employee's salary is **partially** funded by a Federal grant payment(s). (Enter either Y or N).

Column L: Enter the amount of Federally Funded salary.

Column M: Enter any other reductions to the total gross salary.

Column O: Do not enter information into this column.

Column P: Enter the amount of the employee benefits that are paid from federal or other excluded funds for the employee.

Column Q: Enter the amount of Employer- FICA (if not covered under employee benefits) paid from federal or other excluded funds.

Column R: Enter the amount of Medicare Tax -Employer - (if not listed under employee benefits) paid from federal or other excluded funds.

Column S: Enter the amount of transportation related Vendor/Contractor payments paid from federal or other excluded funds.

Column T: Do not enter information into this column.

To complete Rows 51 to 56 of this Schedule:

Report costs paid by the LEA for Fuel, Repairs and Maintenance, Rentals, Contract, Insurance, and Vehicle Depreciation.

Column B: Enter the Trial Balance Account number

First, enter your Trial Balance totals in Column G. All costs should be reported as LEA-wide costs for all students (general education and special education) with the exception of Vehicle Depreciation. Vehicle Depreciation costs should be reported for only Specialized (Specially Equipped) Transportation.

Next enter your Reductions to Trial Balance following the instructions below. A reduction to Trial Balance occurs when Federal Funds or other Excluded Costs must be backed out.

Column I: Enter whether or not the cost is **fully** funded by a federal grant payment(s) (Enter either Y or N). This amount will automatically calculate column J.

Column J: Do not enter information into this column.

Column K: Enter whether the cost is **partially** funded by a federal grant payment(s). (Enter Y or N.)

Column L: Enter the amount of Federally Funded cost.

Column M: Enter any other reductions, rebates, revenues, non-related activities to the trial balance.

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

Column T: Do not enter information into this column.

Schedule 9 - Settlement

Column F, Line 19: Enter the Total Medical Claims paid.

Column E, Line 30: Enter the end date for the Cost Report period.

Column F, Line 30: Enter the begin date of the approved FFP for the previous year to calculate the applicable FFP for the Cost Report period.

Column G, Line 30: Enter the begin date of the approved FFP for the current year to calculate the applicable FFP for the Cost Report period.

Column F, Line 33: Enter the Medical Federal Financial Participation percentage for the applicable period.

Column G, Line 33: Enter the Medical Federal Financial Participation percentage for the applicable period.

Column F, Line 37: Enter the remaining state share deduction (to be deducted from final settlement) for the applicable period.

Column F, Line 38: This will confirm the cost report settlement. If the value is noted in a parenthesis, this indicates that an overpayment has occurred. Full Refund is to be remitted with the cost report and signed certification page to the New Mexico Health Care Authority/Medical Assistance Division. Make checks payable to: NM Health Care Authority.

This refund should be mailed under separate cover, **via US Mail**, to:

HCA/Medical Assistance Division
School Health Office
Post Office Box 2348
Santa Fe, NM 87504