Guide to Cost Reporting for the Preschool and School Supportive Health Services Direct Service Claiming Programs (SSHSP)

New York Department of Health

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1. Introduction

Effective with the 2011-2012 school year (i.e., October 1, 2011, through June 30, 2012), New York will be implementing an annual cost-based settlement and reconciliation process for its Medicaid Preschool and School Supportive Health Services Program (collectively "SSHSP") delivered by New York Local Education Agencies (LEAs). In NY the LEAs include public school districts and counties. This process ensures that LEAs are reimbursed by Medicaid for all Medicaid-allowable costs associated with the delivery of medically necessary services to Medicaid-eligible Special Education students.

Any public New York LEA may participate in the SSHSP. Each LEA is required to: be enrolled as a New York Medicaid provider, participate in the Random Moment Time Study (RMTS) process, and submit an annual Cost Report. The New York Department of Health (NYDOH) oversees the administration of the SSHSP.

2. Reimbursable Activities in the NY School Supportive Health Services Program

Direct Medicaid reimbursement for certain medical services provided by LEAs is based on a cost based methodology. Medicaid Services are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA). These services include:

- Physical Therapy Services
- Occupational Therapy Services
- Speech Therapy Services
- Psychological Counseling Services
- Skilled Nursing Services
- Psychological Evaluations
- Medical Evaluations
- Medical Specialist Evaluations
- Audiological Evaluation Services
- Specialized Transportation Services

To be reimbursable through the New York Medicaid Program: the need for the service(s) must be documented in the student's IEP; the services must meet the criteria in the approved Medicaid State Plan (TN #09-61); the services must be delivered in accordance with the IEP; the services must be provided by an approved provider type; the provider must participate in the RMTS process; the services must be properly documented; and the student must be eligible for Medicaid services. The LEA must also have submitted interim claims throughout the year for each service type in order for those costs to be reimbursed.

2A. Approved SSHSP Services and Service Provider Types

The NY DOH approved SSHSP services and service provider types are defined in the **NY DOH School Supportive Health Services Program (SSHSP) Manual**. The following section contains the description of each approved SSHSP service and service provider type.

Physical Therapy Services

Physical Therapy Services is a SSHSP covered service, when provided to a Medicaid eligible child, are medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Physical therapy services include but are not limited to:

- Identification of Children with physical therapy needs;
- Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
- Provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems;
- Obtaining, interpreting, and integrating information appropriate to program planning;
- Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including but not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization and therapeutic exercise with or without assistive devices, and
- The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.

Physical therapy services may be provided in an individual or group setting.

Physical therapy services must be provided by:

- A New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State law.

Occupational Therapy Services

Occupational therapy services is a SSHSP covered service, when provided to a Medicaid eligible child, are medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Occupational therapy services include but are not limited to:

- Identification of children with occupational therapy needs;

- Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
- Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation;
- Preventing through early intervention, initial or further impairment, or loss of function;
- Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximum physical and mental functioning of the student in daily life tasks.

Occupational therapy services may be provided in an individual or group setting.

Occupational therapy services must be provided by:

- A New York State licensed and registered occupational therapist qualified in accordance with 42 CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A certified occupational therapy assistant (cOTA) "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State law.

Speech Therapy Services

Speech therapy services is a SSHSP covered service, when provided to a Medicaid eligible child, are medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Speech therapy services include but are not limited to:

- Identification of children with speech disorders;
- Diagnosis and appraisal of specific speech disorders;
- Referral for medical or other professional attention necessary for the habilitation of speech disorders;
- Provision of speech or language services for the habilitation or prevention of communicative disorders;
- Evaluation and application of principles, methods and procedures of measurement, predication, diagnosis, testing, counseling, consultation, rehabilitation and instruction, related to the development of disorders of speech, voice, and/or language; and
- Preventing, ameliorating or modifying speech disorder conditions in children and/or groups of children.

Speech therapy services may be provided in an individual or group setting.

Speech therapy service must be provided by:

- A licensed and registered speech-language pathologist qualified in accordance with 42 CFR 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech-language pathologist (ASHA-certified or equivalent), acting within his or her scope of practice under New York State law.

Psychological Counseling

Psychological counseling is a SSHSP covered services, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Psychological counseling services include:

- Treatment services using a variety of techniques to assist the child in ameliorating behavioral and emotional problems that are sever enough to require treatment.

Psychological counseling services may be provided in an individual or group setting.

Psychological counseling services must be provided by a qualified practitioner within his or her scope of practice in accordance with New York State law and with the qualification requirements of 42 CFR 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations.

Services may be provided by:

- A New York State licensed and registered psychiatrist qualified in accordance with 42 CFR 440.50(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law;
- A New York State licensed and registered psychologist qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law;
- A New York State licensed clinical social worker (LCSW), qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law, under the supervision of such a qualified licensed and registered licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist.

Skilled Nursing

Skilled nursing is a SSHSP covered services, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE).

Skilled nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Skilled nursing services may include:

- Health assessments and evaluations;
- Medical treatments and procedures;

- Administering and/or monitoring medication needed by the student during school hours; and
- Consultation with licensed physicians, parents, and staff regarding the effects of medication.

Skilled nursing services must be provided by:

- A New York State licensed and registered nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice; or
- A New York State licensed practical nurse qualified in accordance with 42 CFR 440.60(1) and other applicable state and federal laws and regulations, acting within his or her scope of practice "under the direction of" a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

Psychological Evaluations

Psychological evaluations are a SSHSP covered service, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a psychological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

Psychological evaluations include but are not limited to:

- Administering psychological tests and other assessment procedures;
- Interpreting testing and assessment results; and
- Evaluation a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services.

Psychological evaluations must be provided by a qualified provider who meets the requirements of 42 CFR 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations.

Services may be provided by:

- A New York State licensed and registered psychiatrist qualified in accordance with 42 CFR 440.50(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed and registered psychologist qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law.

Medical Evaluations

Medical evaluations are a SSHSP covered service, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

A medical evaluation is the recording of:

- Chief complaints;
- Present illness;
- Past medical history;
- Personal history and social history;
- A system review;
- A complete physical evaluation;
- Ordering of appropriate diagnostic tests and procedures; and
- Recommended plan of treatment.

A medical evaluation must be provided by a New York State licensed and registered physician, physician assistant, or nurse practitioner qualified in accordance with 42 CFR 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law.

Medical Specialist Evaluations

Medical specialist evaluations are a SSHSP covered service, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If a medical specialist evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

A medical specialist evaluation is:

- An examination of the affected bodily area or organ system and other symptomatic or related organ systems;
- The ordering of appropriate diagnostic tests and procedures, and the reviewing of the results and reporting on the tests and procedures.

A medical specialist evaluation must be provided by a qualified New York State licensed and registered physician, physician assistant, or nurse practitioner specialist practicing in the related area of specialization within his or her scope of practice under New York State law, in accordance with 42 CFR 440.50(a), 440.60(a) and 440.166(a) and other applicable state and federal laws and regulations.

Audiological Evaluations

Audiological evaluations are a SSHSP covered service, when provided to a Medicaid eligible child, is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). If an audiological evaluation is used to identify a child's health related needs as part of the IEP process, the evaluation is eligible for Medicaid coverage once the evaluation is reflected in the child's IEP.

Audiology evaluation services include but are not limited to:

- Identification of children with hearing loss;
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing; and
- Determination of the child's need for group and individual amplification.

An audiological evaluation is the determination of the range, nature and degree of hearing loss including:

- Measurement of hearing activity;
- Tests relating to air and bone condition;
- Speech reception threshold;
- Speech discrimination;
- Conformity evaluations;
- Pure tone audiometry.

Audiological evaluations must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR 440.60(a) and 42 CFR 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

Special Transportation

Special transportation is a SSHSP covered service for a Medicaid eligible child when it is medically necessary, and included in the IEP as recommended by the Committee on Preschool Special Education (CPSE) or Committee on Special Education (CSE). Special transportation arrangements including an explanation as to how the transporting vehicle has been specially modified to serve the needs of that student with a disability must be identified in the IEP.

Special transportation is provided when a child requires specialized transportation equipment, supports or services because of his/her disability as cited in 34 CFR 300.34(c)(16)(iii) and as clarified in Medicaid Alert, Issue #13-10.

Special transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered service (other than transportation), and both the Medicaid covered service and the need for special transportation are included in the child's IEP. Special transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one way trip.

Special transportation services must be provided by a qualified Medicaid provider. Attendance documentation (bus logs) is required in order to bill Medicaid. In order to receive payment for services provided to a Medicaid recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered.

3. Overview of the Random Moment Time Study (RMTS) Process

The Random Moment Time Study (RMTS) process is a federally approved technique of polling a statistically valid sampling of randomly selected moments (one moment = one minute) that are assigned to randomly selected participants. The RMTS method measures the work effort of the entire group of participants involved in the SSHS Program by sampling and analyzing the work efforts of a randomly selected cross-section of the group. The time study determines the percentage of time that direct medical services staff spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of time, thus assuring that there is no duplicate claiming.

The RMTS is broken into two mutually exclusive cost pools of providers; Direct Service Cost Pool – Therapy Services, Direct Service Cost Pool – All Other Services. The two pools are mutually exclusive, i.e., no staff can be included in more than one pool. The pools include only LEA employees.

The Direct Service Cost Pool – Therapy Services includes all staff who are expected to provide direct therapy services during the time study period (i.e., Physical Therapists, Physical Therapy Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech Therapists, Speech Teachers).

The Direct Service Cost Pool – All Other Services includes all staff who are expected to provide the non-therapy direct services during the time study period (i.e. – Psychologists, Psychiatrists, Registered Nurses, Licensed Clinical Social Workers, etc.).

The State's vendor is the party responsible for maintaining documentation for audit purposes and for calculating the random moment in time study percentages. The RMTS is run annually during the quarters of October to December, January to March, and April to June. The direct medical service percentage is the average from the three quarterly time studies. For the cost reporting period from July 1, 2012 to June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013, and April 2013 to June 2013.

3A. Direct Service Cost Pool – Therapy Services (Providers of Direct Medical Therapy Services)

- Physical Therapists
- Physical Therapy Assistants
- Occupational Therapists
- Certified Occupational Therapy Assistants
- Speech Language Pathologists
- Teacher of Students with Speech and Language Disabilities (TSLD)
- Teacher of the Speech and Hearing Handicapped (TSHH

3B. Direct Service Cost Pool – All Other Services (Providers of Direct Medical Non-Therapy Services)

- Psychiatrists
- Psychologists
- Licensed Clinical Social Workers (LCSW)
- Licensed Master Social Workers (LMSW)
- Registered Nurse
- Licensed Practical Nurse (LPN)
- Physician
- Physician Assistant
- Nurse Practitioner
- Audiologist

3C. Random Moment Time Study (RMTS) Process

There are three quarterly time studies: October 1-December 31, January 1 – March 31, and April 1 – June 30.

Each LEA submits its RMTS staff pool list prior to the time study period. Training is provided to LEA coordinators on the time study process. The time study sample is pulled and each participant responds to his/her sampled moment. The New York RMTS process is a web-based system within which sampled participants respond in narrative form to a few simple questions. They include:

1. Who was with you?
2. What were you doing?
3. Why were you performing this activity?
4. Was the activity regarding a special education student?
5. Was the service provided part of the child's IEP?

Centralized coders then assign the appropriate time study code to the narrative response. At the end of the time study period, the percentages by activity code are calculated.

The RMTS process results in an annual direct medical services time study percentage. The direct medical services costs reported on the annual SSHSP Medicaid Cost Report are allocated to the Medicaid Program based on the applicable direct medical services time study percentage and the applicable Medicaid IEP Ratio for the LEA.

Payroll costs can only be reported on the Annual SSHSP Medicaid Cost Report for staff listed on the LEA time study staff pool lists or for staff that replaced an individual listed on the LEA time study staff pool lists as the staff pool lists are position specific rather than person specific.

Additional details regarding the RMTS process can be found in the NY DOH RMTS Implementation Guide.

4. Annual Data Submission including the SSHSP Medicaid Cost Report

After the end of the school year, school districts and counties will be required to complete the annual SSHSP Medicaid Cost Report. The provider must log into the web-based system, Medicaid Cost Reporting and Claiming System (MCRCS) on an annual basis to enter information including payroll costs for SSHSP direct medical services staff, with such information including allocation statistics like the IEP ratio and the specialized transportation ratios, direct medical services supplies and other material costs. The pages that need to be completed in MCRCS as part of the annual Medicaid cost report are:

Page Name
General and Statistical Information
Annual Payroll Information
Direct Medical Services Materials, Supplies and Equipment
Direct Medical Services Equipment Depreciation
Annual Contractors Costs Information
Annual Tuition Costs
Intergovernmental Agreements
Transportation Payroll Information
Transportation Other Costs
Transportation Equipment Depreciation

Importing and Exporting Data into the System

To expedite the data submission process, the LEA coordinator can organize its data in a spreadsheet using an application such as Microsoft Excel™, and then the LEA can upload its information in a comma separated values (CSV) file.

At the bottom of various pages, including the *Direct Medical and Administrative Services Salary and Benefits Data by Position Page*, there are import/export buttons.

The first step will be to export the template from the system by clicking *Export*. The user will be prompted to click another *Export* button in order to export the file as a CSV file, which is the only available option. The system will then ask the user to *Open* or *Save* the file. It is suggested that you save the file to your desktop so that you can find it easily for upload. Once you have saved the template file, please open it in a spreadsheet application, such as Microsoft Excel™ (below).

You can now enter in the paid hours, salaries/benefits, contracted staff costs, and/or federal funds and other reductions into the spreadsheet. Please do not format any of the cells to currency or as a date. For all currency, please enter decimals only without currency symbols or commas.

Once you are finished editing the template, save your file in the exact same format as the exported file (CSV file). Once saved, you will return to the page for which you are importing the data and click *Browse*. You will choose the CSV file that you just updated and saved on your desktop. You will notice that the path to the file then displays in the field to the left of the *Browse* button. Click *Import*.

If the system detects no errors in your data, it will upload it to the system immediately. If there are errors, you will see them circled in red on the top of the page. You will need to correct all of these errors before the system will allow you to upload any data.

Please see below for common import/export issues.

Troubleshooting: Common Import/Export Issues

Here are some suggestions to avoid common problems that users experience when importing information into the system.

1. The file must be uploaded as a CSV file, the same sort of file format that it was saved as originally. Microsoft Excel™ will often ask you to save the file as a XLS or XLSX. Do not save it as anything other than a CSV file.
2. The cells should not be formatted. Information that is formatted as Currency or Date will not upload into the system correctly. General formatting is preferable. For all currency please enter in decimals only without currency symbols or commas.
3. If the data is sorted, make sure that all users are still in line with the same Row ID they had upon exporting the template, which is found in the first column of the spreadsheet.
4. Do not enter information in any column that did not have a column header when you exported the template. If the LEA coordinator is receiving an error that the application cannot find Column ##, then you need to delete those specified columns. For example, if you get the error, "cannot find Column 19," count out the columns from left to right—the 19th column will be column "S" in Excel ™. Delete that column and attempt to upload your data again.
5. Functions can be used to calculate your data, but before importing the CSV file into the system you will want to turn all functions into values. This is accomplished by selecting the entire worksheet (ctrl + a), copying the worksheet (ctrl + c), and finally pasting the worksheet as values which can be found under Edit>Paste Special (Excel 2003™) or Home>Paste>Paste Values (Excel 2007™).
6. CSV files do not allow for multiple spreadsheets in a single workbook. If you are working in multiple spreadsheets in order to calculate values, those spreadsheets will be deleted once you save the file as a CSV.

4A. General and Statistical Information

This page collects information needed by the system to calculate allocation percentages to apply to specific cost items toward the determination of Medicaid-allowable costs.

Unrestricted Indirect Cost Rate
This percentage has been pre-populated from information provided annually by the New York State Education Department (SED), which serves as the cognizant agency responsible for approving LEA indirect cost rates for the United States Department of Education. This percentage is applied by the system to net direct costs (total costs less amount paid with federal funds) toward calculating the amount of allowable indirect costs. The net direct costs only include Salaries and Benefits as reported on the Annual Payroll Information Page and the Transportation Payroll Information Page, Direct Medical Services Materials, Supplies and Equipment, Direct Medical Services Equipment Depreciation, Transportation Other Costs excluding contracted transportation services, and Transportation Equipment Depreciation. Indirect costs are not applicable to Annual Contract Costs, Annual Tuition Costs, Intergovernmental Agreement Costs, and contracted Transportation Costs.

Counties may use a 10% indirect cost rate to determine Medicaid-allowable indirect costs for the Medicaid Cost Report.

While the provider needs to verify the accuracy of the pre-populated information, changes cannot be made to this field by the provider. If the pre-populated information is incorrect, please contact PCG for assistance.

The application of this percentage is clearly shown on the Cost Summary page of the SSHSP Medicaid Cost Report.

Direct Medical Services- Therapy and Direct Medical Services – All Other Percentage
These percentages will be pre-populated from the quarterly RMTS process with one percentage applicable to costs associated with the Direct Medical Services – Therapy and one percentage applicable to costs associated with the Direct Medical Services – All Other. These percentages are applied by the system to direct medical services - therapy costs and the direct medical services – all other costs as the first allocation method in calculating the amount of allowable direct medical services costs. The application of these percentages is clearly shown on the Cost Summary page.

The Direct Medical Service percentages as well as the RMTS results for Direct Medical Services – Therapy and Direct Medical Services – All Other cost pools from the quarters of October to December, January to March, and April to June are visible on the General and Statistical Information page. The direct medical service percentage is the average from the three quarterly time studies for each cost pool.

Individualized Education Program (IEP) Ratio
The direct service Medicaid eligibility rate, referred to as the Individualized Education Program (IEP) Ratio will be calculated annually and used to apportion cost to the Medicaid SSHS Program. The numerator will be the

number of Medicaid eligible IEP students in the LEA with a direct medical service, as outlined in their IEP. The denominator will be the total number of students in the LEA with an IEP with a direct medical service as outlined in their IEP. Direct medical services are speech therapy, physical therapy, occupational therapy, psychological counseling, skilled nursing, psychological evaluations, medical evaluations, medical specialist evaluations, and audiological evaluations (those services billable under the SSHS program).

For the 2013-2014 school year, the numerator of the IEP ratio used in the cost settlement calculation was the number of unique recipients based on the paid claims data from the MMIS from July 1 through October 31. The denominator was the BEDS Day snapshot. The same calculation methodology is being used for the 2014-2015 school year.

For the 2015-2016 and future school years, the IEP ratio will include the number of unique recipients based on the paid claims data from the MMIS for the full school year as the basis for the numerator. For the 2015-2016 and future school years, the cost settlement calculation will use the total number of students in the LEA with a direct medical service, as outlined in their IEP, at any time during the school year as the basis for the denominator in the IEP ratio.

The IEP Ratio calculation is:

Numerator = Total Number of Medicaid unique recipients with a direct medical service in their IEP
Denominator = Total Number of ALL IEP Students with a direct medical service in their IEP

The application of these percentages is clearly shown on the Cost Summary page of the SSHSP Medicaid Cost Report. The IEP Ratio will be applied to all Direct Medical Service costs including the applicable salary, benefit, materials and supplies, depreciation, contacted services, health related tuition, and intergovernmental agreement contract and health related tuition costs.

Encounters

Local Education Agencies (LEAs) will need to count the number of Individualized Educational Program (IEP) direct medical service encounters delivered per school year. Direct medical services are these services listed in Section 2A of this Guide, excluding Specialized Transportation. An encounter is defined as a documented face-to-face direct medical service visit that was provided pursuant to the recommendations of a student's IEP by a qualified provider listed in Section 2A of this Guide. Consider only face-to-face contact time with the student and qualified provider; do not include pre-session planning or post-session write-up time when counting face-to-face direct medical service encounters.

For example, a student's IEP contains a recommendation that Occupational Therapy services are to be provided for 20-30 minutes/3 times a week for 6 months. Each documented visit in which the student actually received at least 20 minutes of occupational therapy from a qualified provider listed in Section 2A of this Guide would be counted as one encounter.

If a student's IEP contains a recommendation that Speech Therapy services are to be provided for 15 minutes twice a day/3 times a week for 6 months. Each documented visit in which the student actually received at least 15 minutes of speech therapy from a qualified provider listed in Section 2A of this Guide would be counted as one

encounter.

NOTE: The reporting requirement for the Encounter data will begin with reporting periods beginning on or after July 1, 2014. LEAs will not be required to report this data for periods prior to July 1, 2014.

School districts and counties that do not claim for specialized transportation services will only see the Unrestricted Indirect Cost Rate, the Direct Medical Services Percentages, the IEP Ratio, and the Encounters tables on the General and Statistical Information Page. Once a school district or county reports transportation costs on their annual cost report, the two transportation ratios will be activated on the General and Statistical Information Page. All school districts and counties claiming for the specialized transportation service will need to complete the Specialized Transportation Ratio and the Medicaid One Way Trip Ratio. The two transportation related ratios are described below.

Specialized Transportation Ratio

The Specialized Transportation Ratio is used to allocate transportation service costs between specialized transportation services and non-specialized transportation services.

The numerator for this ratio is defined as the total number of Medicaid eligible students receiving Specialized Transportation services per their IEP. The denominator for this ratio should be the total number of all students (Medicaid and non-Medicaid) receiving transportation services.

Numerator = <u>Total number of Medicaid eligible students receiving Specialized Transportation services per their IEP</u>

Denominator = Total number of all students receiving transportation services

The LEA is to report the Total number of Medicaid eligible IEP students receiving Specialized Transportation per their IEP (numerator) and the total number of all students receiving transportation services (denominator).

The date for this ratio will be based on the enrollment as of the first Wednesday in October of that school year.

Medicaid One Way Trip Ratio

The numerator for this ratio is defined as the total number of allowable one way trips for Medicaid IEP students as required in their IEP and as billed through MMIS. Allowable one way trips that are reimbursed by Medicaid are defined as Specialized Transportation in the approved State Plan Amendment (TN#09-61) and require that another Medicaid covered service was provided by the LEA on the day of the trip. The numerator will be based on the total number of paid specialized transportation claims data from the state MMIS system.

The denominator is defined as the total number of one-way trips provided to Medicaid eligible students with specialized transportation documented in the IEP during the cost reporting period. This trip count should include all trips for Medicaid eligible students receiving specialized transportation services as identified in their IEP regardless of whether or not the trip qualified as a Medicaid specialized transportation trip. This data should be based on the bus logs maintained by the LEA.

Numerator = <u>Total Medicaid paid one way trips for specialized transportation services per MMIS</u>
Denominator = Total one way trips for Medicaid eligible students with specialized transportation in their IEP (from bus logs)

The LEA is to report the total number of one-way trips provided to Medicaid eligible students with specialized transportation documented in the IEP (denominator).

The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e., all one way trips provided between July 1 and June 30.

During the desk review process, this amount will be compared to the number of one-way trips paid by Medicaid during the cost-reporting period.

4B. Annual Payroll Information

This page is pre-populated with the name and RMTS job category of each staff person (employee and contracted staff) on the LEA RMTS staff pool lists. The provider can enter the requested payroll information directly into the web-based system or download (export) an Excel spreadsheet, enter the requested payroll information, and upload (import) into the web-based system.

In the event that an employee is shared by more than one district or county, each district or county should report only those salary and benefit costs which they incurred for the employee's services.

This page includes the following data elements, which are discussed in detail below:

- Last Name
- First Name
- (RMTS) Job Category
- Cost Pool
- Staff Employment Status
- District Job Title
- District Employee ID
- Paid Hours (Optional)
- Salaries
- Employee Benefits, such as health insurance, life insurance, retirement, other employee insurance, and other employee benefits paid for by the school district or county
- Federal Funds and Other Reductions

In order to comply with CMS provisions, annual costs must be reported using the accrual basis accounting methodology. The LEA must maintain supporting documentation for all information reported on the annual Medicaid Cost Report.

Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

Direct costing must be used unless otherwise stated in these instructions. Direct costing means that costs incurred for the benefit of, or directly attributable to, a specific service must be charged directly to that particular service. Costs related to each direct medical service must be direct costs. Employee payroll taxes and benefits/insurance costs must be directly associated to the individual employee and cannot be allocated.

Reported costs in this section should be formatted with two decimal places and not rounded to the nearest whole dollar.

If reporting paid hours, number should be formatted with two decimal places and not rounded to the nearest whole hour.

Last Name
This field is pre-populated from information transferred from the RMTS process. The provider needs to verify the accuracy of the pre-populated information, noting any necessary revisions in the LEA cost report supporting documentation file.

First Name
This field is pre-populated from information transferred from the RMTS process. The provider needs to verify the accuracy of the pre-populated information, noting any necessary revisions in the LEA cost report supporting documentation file.

(RMTS) Job Category
This field is pre-populated from information transferred from the RMTS process. While the provider needs to verify the accuracy of the pre-populated information, changes cannot be made to this field by the provider. If the LEA coordinator thinks there is an error in the Job Category field, the LEA coordinator should contact the PCG NY SSHSP Team to compare the information in the system with the staff pool lists submitted by the LEA coordinator.

Staff Employment Status
This is a required field. The provider will need to enter the *Staff Employment Status* (Full Time or Part Time) of the individual from a drop down menu or verify the accuracy of any pre-populated information transferred from the RMTS process, making any necessary revisions. The definitions for full-time and part-time staff are according to each LEA's procedures and processes and each LEA should maintain those definitions in its cost report documentation file. For example, some LEAs consider an aide that works 30 hours per week to be a full- time employee and that is acceptable.

District Job Title
This is an optional field. As such, it is acceptable to be left blank. However, it is recommended that the LEA coordinator enter the participant's District job title. If the District Job Title is pre-populated from the RMTS process, the LEA needs to verify the accuracy of the pre-populated information, making any necessary revisions.

District Employee ID
This is an optional field. As such, it is acceptable to be left blank. This field is for the use of the LEA to assist in identifying staff since there may be more than one staff person with the same name. This field can be used to

easily reconcile costs to the LEA's financial system and Chart of Accounts. **Do not enter Social Security Numbers in this field.**

Paid Hours (Optional)

This is an optional field. Paid hours are requested so that the system can generate benchmarks. These system edits include hourly compensation calculations that will help to verify the reported payroll costs are indeed for a quarter rather than for a full year. This field should be a reflection of the number of paid hours applicable to the payroll costs reported for each staff person. This can also be a reasonable estimate if data is not readily available and does not have to be exact. Remember to include all paid hours, including paid hours associated with payroll costs reported, including summer school, coaching and other extracurricular activities.

The provider should report the total hours that the individual worked during the reporting period. If the staff person is full time (usually meaning 7.5 or 8.0 paid hours per day), then the number of work days in the quarter should be multiplied by the number of hours per day to arrive at the amount reported in this field. The number of days is the number of "teacher" paid days and not the number of "student" days. Paid hours include hours for paid time off (e.g., sick leave or vacation).

Example:

John Doe is a full-time physical therapist with an employment contract for 7.5 hours per day for 180 days during the 2011-2012 school year. During the Fall 2011 semester (i.e., July 1, 2011, through January 25, 2012), there were 95 work days. Thus, the amount reported in the Paid Hours field for John Doe would be 712.5 (7.5 X 95).

Paid Hours for a part-time employee are calculated in the same manner if the person is scheduled to work the same number of hours per day. However, if the part-time employee is paid hourly, the number of paid hours for the reporting period would be reported.

Salaries:

This is a required field, meaning that any individual whose *Staff Employment Status* is "Full Time" or "Part Time" is required to have a value in this field.

The amount reported in this field is the total gross earnings for the individual as paid by the LEA for the reporting period, including regular wages and extra pay, as well as any amounts paid for paid time off (e.g., sick or annual leave), overtime, bonuses, longevity, stipends, cash bonuses, and/or cash incentives. Salaries are those payments from which payroll taxes are (or should be) deducted. Do not include any reimbursements for expenses such as mileage or other travel reimbursements.

Benefits:

Benefits include employer-paid health/medical, life, disability, or dental insurance premiums, as well as employer-paid child day care for children of employees paid as employee benefits on behalf of your staff, retirement contributions, and worker's compensation costs. Report the expended amounts paid by the LEA which are directly associated with each staff member by type of employee benefit.

The following employee benefits can be captured:

- **Employee Insurance**- Amounts for the employer's share of any insurance plans, such as life, health, dental, and accident insurance.

- **Social Security Contributions**- Employer's share of amounts paid by the district for social security. This can include Social Security- OASDI and Medicare-Hospital Insurance.

- **State Retirement System Contributions**- Employer's share of amounts paid by the district for retirement and long-term disability contributions.

- **Tuition Reimbursement**- Amounts reimbursed by the school district to any employee qualifying for tuition reimbursement on the basis of school district policy.

- **Unemployment Insurance**- Amounts paid by the district to provide unemployment insurance for its employees.

- **Workers' Compensation**- Amounts paid by the district to provide workers' compensation insurance for its employees.

- **Other Health Benefits (Employer Paid)**- Amounts paid by the district to provide health benefits, other than insurance, for its current or former employees.

- **Other Employee Benefits (Employer Paid)**- Employee benefits other than those classified above, including fringe benefits such as automobile allowances, housing or related supplements, moving expenses, and paid parking.

Federal Funds and Other Reductions:
If any of the reported payroll costs for the staff person was paid with federal funds (e.g., IDEA federal payments, Title 1 payments, or ARRA payments), then the amount paid with federal funds should be entered in this field. Please be sure that the amount reported in this field does not exceed the total payroll costs reported for the individual since the system will subtract the amount reported in this field from the total payroll costs to result in the amount paid with state/local funds.

4C. Direct Medical Services Materials, Supplies and Equipment

This page collects non-payroll costs other than depreciation expense by direct service. Costs to be reported on this page include direct medical materials, supplies and equipment. Costs reported on this schedule will be subjected to the direct medical services percentage from the RMTS and the LEA IEP Ratio on the Cost Summary Report, as defined in Section 4K, to determine the Medicaid allowable costs.

USER INPUT

Direct Medical Services Materials, Supplies and Equipment

The *Direct Medical Services Materials, Supplies and Equipment Costs* are collected annually through the

completion of the SSHSP Medicaid Cost Report. Allowable materials and supply costs are those used to provide covered direct medical services for a single item costing $5,000 or less. Any single item costing more than $5,000 should be depreciated. See Section 4D for instructions. The following are the CMS approved Direct Medical Services Materials and Supply Costs that can be reported on the annual SSHSP Medicaid cost report.

- Audiometer (calibrated annually), tympanometer
- Auditory, speech-reading, speech-language, and communication instructional materials
- Bandages, including adhesive (e.g., band-aids) and elastic, of various
- Battery testers, hearing aid stethoscopes, and earmold cleaning materials
- Blood glucose meter
- Bmi calculator
- Clinical audiometer with sound field capabilities
- Cold packs
- Cotton balls
- Cotton-tip applicators (swabs)
- Current standardized tests and protocols;
- Diapers and other incontinence supplies
- Disposable gloves (latex-free)
- Disposable gowns
- Disposable suction unit
- Ear mold impression materials
- Electroacoustic hearing aid analyzer
- Electronic suction unit
- Evaluation tools (e.g., goniometers, dynamometers, cameras)
- Eye pads
- Fm amplification systems or other assistive listening devices
- Gauze
- Loaner or demonstration hearing aids
- Materials for nonstandard, informal assessment;
- Materials used to assist students with range of motion
- Mobility equipment (e.g., walkers, wheelchairs, scooters)
- Nebulizers
- Otoscope
- Otoscope/ophthalmoscope with battery
- Peak flow meters
- Physician's scale that has a height rod and is balanced
- Portable acoustic immittance meter
- Portable audiometer
- Positioning equipment (e.g., wedges, bolsters, standers, adapted seating, exercise mats)
- Reflex hammer
- Sanitary pads, individually wrapped (may be used for compression)
- Scales
- Scoliometer
- Slings
- Sound-level meter
- Sound-treated test booth
- Sphygmomanometer (calibrated annually) and appropriate cuff sizes
- Splints (assorted)
- Stethoscope
- Supplies for adapting materials and equipment (e.g., strapping, velcro, foam, splinting supplies)
- Surgipads
- Syringes (medication administration / bolus feeding)
- Technology devices (e.g., switches, computers, word processors, software)
- Test materials for central auditory processing assessment
- Test materials for screening speech and language, evaluating speech-reading and evaluating auditory skills
- Tongue depressors
- Triangular bandage
- Vision testing machine, such as titmus
- Visual reinforcement audiometry equipment and other instruments necessary for assessing young or difficult-to-test children
- Wheelchair

Direct Medical Services Materials, Supplies and Equipment Paid With Federal Funds and Other Reductions:
If any of the costs reported as "Direct Medical Service Material, Supply and Equipment Costs" were paid with federal funds (e.g., IDEA flow-through federal payments, Title 1 payments, or ARRA funds), report the amount of the direct medical services materials/supplies paid from federal funds in this column. The system will subtract the federal amounts from the totals to arrive at the allowable costs paid from state/local funds. Thus, the amount reported in Direct Medical Services Material, Supply and Equipment Costs Federal funds and other reductions cannot exceed the amount reported in Direct Medical Services Material, Supply and Equipment Costs.

Notes: The *Notes* field is an optional field that an LEA can use to include information pertaining to the amounts reported on this schedule.

SYSTEM GENERATED DATA

Provider Category:
All unique values from the *Provider Category* found on *the LEA Payroll Information by Position Page.*

Total Other Costs Net of Federal Funds and Other Reductions:
This is calculated by subtracting the *Direct Medical Services Material, Supply and Equipment Costs Paid with Federal Funds* from the *Direct Medical Services Material and Supply Costs*.

4D. Direct Medical Services Equipment Depreciation Page

This page will allow reporting of the depreciation of capital assets that are used by the client for the medical services. This equipment should be included on the LEA's fixed asset ledger. Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. (Please note this is not market value.)

Allowable depreciation expense for direct medical services includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable. Any single item purchased during the cost-reporting period costing less than $5,000 must be expensed and reported accordingly. Costs reported on this schedule will be subjected to the direct medical services percentage from the RMTS and the LEA IEP Ratio on the Cost Summary Report, as defined in Section 4K, to determine the Medicaid allowable costs

Required detail must be provided for each depreciable asset and each depreciable asset must be assigned its correct estimated useful life.

USER INPUT

Unique Asset ID:

Each LEA will have to provide the unique asset ID assigned to each asset included on the *Direct Medical Services Equipment Depreciation Page*. This will be the number used by the LEA to identify the asset.

Service Type:
This list is populated with the allowable SSHSP direct medical service categories, e.g., Occupational Therapy, Physical Therapy, Audiological Evaluations.

Asset Type:
This list is populated with groups of the most common Asset Types. Please select an Asset Type that most closely categorizes the Medical Service Equipment in question. If you have a piece of equipment that falls under a type that is not listed, please select “Other” in this field and provide a description in the Notes column. Do not combine items under generic descriptions such as "various", “additions" or "equipment". Do not combine items by year purchased (e.g., "2008 computers"). Be specific in providing the description of each depreciable item.

Month/Year Placed in Service:
Enter the date the direct medical service equipment was placed into service. Note this should be the date the item was placed into service and not the date the item was purchased.

Month/Year Removed from Service:
Enter the date the direct medical service equipment was removed from service, if applicable. This is only required if the asses was removed from service prior to the end of its useful life.

Years of Useful Life:
The useful life of each asset is derived from the Asset Type. The number of years of useful life of the claimed asset will populate automatically once the Asset Type is selected. If you have an asset that does not fit into a listed Asset Type category, enter the equipment into the bottom row of the table. The minimum useful lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (Item Number - 061170). Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., Phone: 800-242-2626, Mailing Address: AHPI, Books Division, 737 North Michigan Avenue, Chicago, IL 60611-2615. Please contact Public Consulting Group, Inc., with any questions.

Cost:
Enter the cost of acquiring the asset and preparing it for use. This is the original purchase price for this Medical Service Equipment. This number should be the full amount paid for the equipment regardless of the source of funding. Do not include Goodwill.

Federal Funds and Other Reductions:
This is the amount of Federal funding that was used toward the purchase of this equipment.

Notes:
The notes field is available for the district to provide any additional information about the asset being depreciated. The district must use this field to identify the asset if "Other" is selected for the Asset Type.

SYSTEM GENERATED DATA

Prior Accumulated Depreciation:
This is the amount that the equipment has depreciated since the date of purchase. This is calculated by dividing the *Costs Amount* minus the *Federal Funds Amount* by the *Years of Useful Life* divided by 365, which gives you the average depreciation of the equipment per day for the useful life of the asset. That number is then multiplied by the number of days the piece of equipment has been in service, which is the *Month/Year Placed in Service* subtracted from the *Last Day of the Fiscal Year*.

Depreciation for Reporting Period:
This is the amount that the equipment has depreciated during the current year. This can be calculated by dividing the *Cost Amount* minus the *Federal Funds Amount* by the *Years of Useful Life.* The allowable amount of depreciation will be less if, during the reporting period, the asset became fully depreciated or the asset was placed into or taken out of service. Fully depreciated means that the total accumulated depreciation for the asset is equivalent to the depreciation basis. For cost-reporting purposes, the provider is to claim a full month of depreciation for the month the asset was placed into service, no matter what day of the month it occurred. Conversely, the provider is not to claim depreciation for the month the asset was taken out of service, no matter what day of the month it occurred. For example, if you purchased a depreciable item in December, you would claim six months of depreciation on your cost report for that item (July through December). If you sold an item in March, you would claim nine months of depreciation for that item (July through March).

4E. Annual Contractors Costs Information

This page is for reporting the amounts paid by LEAs to contractors for the provision of IEP direct medical services. The only costs that can be submitted are direct costs incurred by the LEA to purchase services from a non-LEA employed direct medical service provider. These are costs incurred for the benefit of, or directly attributable to, a specific service. Reported costs should be formatted with two decimal places and not rounded to the nearest whole dollar and hour, respectively.

LEAs reporting costs on the *Annual Contractor Costs Information Page* must complete the Contractor Supplemental roster form prior to the certification of the cost report. This supplemental form is necessary to validate the licensure of the contracted practitioners providing the IEP direct medical services.

Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

The MCRCS system will automatically apply the IEP ratio to contract costs in addition to directly employed staff costs and other costs in order to reduce total reported contractor costs to only those contractor costs which are related to services provided to Medicaid eligible students. This calculation is completed on the *Cost Summary Report* in the cost report, as seen in Section 5K of this Guide.

USER INPUT

Service Type:
This field allows the user to select the appropriate approved direct medical service category under the SSHS Program.

Vendor Name:
This field is to be used to identify the name of the entity providing the contracted IEP direct medical service practitioners to the district.

Notes:
This field can be used to provide additional details for the contracted services listed. It is not a required field.

Total Cost:
The amounts identified here should be the gross amounts paid to contractors by the LEA for the provision of IEP direct medical services. The amount reported should be the total amount paid to the vendor(s) and does not need to break out the salaries and benefits paid out by the vendor(s) to their employees.

Federal Funds and Other Reductions:
If any of the contracted service costs were paid for by using federal funding, then it should be entered here. This should be in addition to what is put into *Total Costs.* Additionally, the *Federal Funds and Other Reductions* field should be used to report all offsets to expenses such as revenue received from a contractor for the use of space in a district or county where direct medical services are provided.

SYSTEM GENERATED DATA

Net Contract Expenditures:
This is a calculation that is the *Total Cost* minus the *Total Cost paid with Federal Funding.*

4F. Annual Tuition Costs

This section is used to identify the reimbursable portion of tuition expenditures for approved private schools and other school based out of district providers. Tuition costs associated with public schools and counties must be reported on the Intergovernmental Agreement page, defined in Section 4G of this Guide.

USER INPUT

School:
This field must be used to identify the specific school/program to which tuition was paid. The user should select the name of the appropriate school/program from the drop down list.

Notes:
This field can be used to provide additional information about the school/program to which tuition was paid.

Tuition Cost:
The *Tuition Cost* field should be used to enter the total annual tuition paid to the specific school/program.

Federal Funds and Other Reductions:
The *Federal Funds and Other Reductions* field should be used to enter the portion of the *Tuition Cost* made using Federal Funds. Additionally, the *Federal Funds and Other Reductions* field should be used to report all offsets to expenses such as revenue received from a tuition provider for the use of space in a district or county where direct medical services are provided.

SYSTEM GENERATED DATA

Net Tuition Costs Less Reductions:
This field is calculated by subtracting the amount entered in the *Federal Funds and Other Reductions* field from the amount entered in the *Tuition Cost* field.

Health Related Percentage:
This field will be pre-populated based on the school/program selected in the *School* field. Each school/program will have a distinct health related percentage. This health related percentage will be calculated on an annual basis using annual provider financial reports (CFR forms) submitted to the New York State Education Department (SED).

Health Related Percentage Calculation Methodology
The Health Related Percentage for each tuition based provider will be calculated by PCG using the following methodology:

Applicable codes (from Appendix R *Direct Care Staff*):
225 – Teacher – Speech Certified
315 – Nurse Practitioner/Nursing Supervisor
316 – Licensed Practical Nurse
317 – Registered Nurse
318 – Psychiatrist
320 – Physician
321 – Licensed Psychologist

324 – Licensed Social Worker (LMSW, LCSW)
333 – Occupational Therapist
334 – Physical Therapist
335 – Speech Therapist

Step 1. Select Program Codes from CFR 1.1 which correspond to the approved Program Codes listed in Appendix 3.

Step 2. Select position codes from **CFR-4** which correspond to the above listed codes by cost pool.

Step 3. Add (enter) the *Total Amount Paid* for each applicable Program Code from Step 1 for the positions in Step 2 to get total Direct Care Staff costs for each title.

Step 4. Add the *Total Amount Paid* amounts from Step 3 for the position codes from Step 2 to get the total Direct Care Staff costs by cost pool.

Step 5. Divide *Total Fringe Benefits* (CFR-1.2 Line 20) by Personal Services (CFR-1.2 Line 16) for the applicable Program Codes from Step 1 to get the agency's overall Fringe Benefits Percentage.

$$\frac{\text{Total Fringe Benefits (CFR-1.2 Line 20)}}{\text{Personal Services (CFR-1.2 Line 16)}} = \text{Overall Fringe Benefit Percentage}$$

Step 6. Multiply the Direct Care Staff costs for each cost pool from Step 4 by the Overall Fringe Benefits Percentage from Step 5 to get Fringe Benefits for Direct Care Staff by cost pool.

$$\text{Overall Fringe Benefits Percentage} \times \text{Direct Care Staff Costs - Therapy} = \text{Fringe Benefits Direct Care Staff - Therapy}$$

AND

$$\text{Overall Fringe Benefits Percentage} \times \text{Direct Care Staff Costs - All Other} = \text{Fringe Benefits Direct Care Staff - All Other}$$

Step 7. Add Step 4 and Step 6 to get the Total Direct Care Staff Costs by cost pool.

$$\text{Direct Care Staff Costs - Therapy} + \text{Fringe Benefits for Direct Care Staff - Therapy} = \text{Total Direct Care Staff Costs - Therapy}$$

AND

$$\text{Direct Care Staff Costs - All Other} + \text{Fringe Benefits for Direct Care Staff - All Other} = \text{Total Direct Care Staff Costs - All Other}$$

Step 8. Select positions from **CFR-4A** which correspond to the above listed codes.

Step 9. Add (enter) the *Total Amount Paid* for each applicable Program Code for the positions selected in Step 8.

Step 10. Add the *Total Amount Paid* amounts from Step 9 to get the Total Contract Direct Care Staff Costs by cost pool.

Step 11. Add the Total Direct Care Staff Costs by cost pool from Step 7 and the Total Contract Costs by cost pool from Step 10 to get the total Health Related Direct Costs.

Total Direct Care Staff Costs - Therapy	+	Total Contact Direct Care Staff Costs - Therapy	=	Total Health Related Direct Costs - Therapy

AND

Total Direct Care Staff Costs - All Other	+	Total Contract Direct Care Staff Costs - All Other	=	Total Health Related Direct Costs - All Other

Step 12. Apply the RMTS Direct Medical Service Percentages to the applicable Total Health Related Direct Costs categories from Step 11 (i.e. the RMTS Direct Medical Service – Therapy Percentage to the Total Health Related Direct Costs – Therapy) to get the IEP Health Related Direct Costs.

Total Health Related Direct Costs - Therapy	x	RMTS DMS Percentage Therapy	=	IEP Health Related Direct Costs - Therapy

AND

Total Health Related Direct Costs - All Other	x	RMTS DMS Percentage All Other	=	IEP Health Related Direct Costs - All Other

Step 13. Add the totals from Step 12 to get the Total IEP Health Related Direct Costs.

IEP Health Related Direct Costs - Therapy	+	IEP Health Related Direct Costs - All Other	=	Total IEP Health Related Direct Costs

Step 14. Apply the SED Agency Ratio Value Factor found on CFR-3.2, line 68 (i.e. Administrative Agency Rate) to the costs defined in Step 13 to get the IEP Health Related Administrative Rate.

IEP Health Related Direct Costs	+	SED Agency Ratio Value Factor	=	IEP Health Related Administrative Rate

Step 15. Add Step 13 and Step 14 to get the Total IEP Health Related Costs.

IEP Health Related Direct Costs	+	IEP Health Related Administrative Rate	=	Total IEP Health Related Costs

Step 16. Divide the total IEP Health Related Costs in Step 15 by the "Total Prog/Site Costs" in CFR-1, line 67 for the applicable Program Codes from Step 1 to generate the health related tuition percentage.

Health Related Tuition Expense:
This field is calculated as the product of *Net Tuition Total Costs Less Reductions* times the *Health Related Percentage*. This is the amount that will be used to determine the Medicaid allowable costs for cost settlement.

4G. Intergovernmental Agreements

This page is for collecting the contracted service and tuition cost data related to the intergovernmental relationships between public schools and/or counties. The page will collect data on the transactions, for contracted services and for tuition agreements, between two public school districts, a public school district and a county, or two counties. The intent of this schedule is to clearly identify those transactions that occur between two entities that have the ability to bill Medicaid for reimbursable services and complete annual cost reports under SSHSP. It is anticipated that the statewide, aggregate result of all intergovernmental agreement transactions will result in a net $0.

*NOTE: Contracted service transactions between a public school or county and an outside entity such as a private vendor or a BOCES must be reported on the Annual Contractor Cost page in the cost report (described in **Section 4E** of this Guide). Tuition arrangements between a public school or county and a private entity such as a private school, a 4201 school, or a private preschool agency must be reported on the Annual Tuition Costs page in the cost report (described in **Section 4F** of this Guide).*

The intergovernmental agreement transactions will be broken out in to four categories; Intergovernmental Agreement Contract Expenses, Intergovernmental Agreement Contract Revenues, Intergovernmental Agreement Tuition Expenses, and Intergovernmental Agreement Tuition Revenue. Details on the fields and reporting requirements for each of these categories are provided in the following pages.

LEAs will only be required to initially report their Intergovernmental Agreement Contract and Intergovernmental Agreement Tuition expenses. Following the submissions of all cost reports, DOH's vendor will conduct an analysis of the Intergovernmental Agreement Contract and Intergovernmental Agreement Health Related Tuition costs reported by all LEAs and calculate the respective Intergovernmental Agreement Contract and Intergovernmental Agreement Health Related Tuition revenue offsets. DOH will conduct a review of the calculations completed by its vendor. The revenue offsets will be loaded into the appropriate cost reports for the LEAs. LEAs will be required to review and recertify their cost reports following the computation of the Intergovernmental Agreement Contract and Intergovernmental Agreement Health Related Tuition revenue offsets. Any discrepancies between the expenses reported by one LEA and the revenues received by another LEA, will need to be resolved between the LEAs prior to the recertification of the reports.

LEAs reporting costs on the Intergovernmental Agreement Contract Expenses table must complete the Contractor Supplemental roster form prior to the certification of the cost report. This supplemental form is necessary to validate the licensure of the contracted practitioners providing the IEP direct medical services.

Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

The MCRCS system will automatically apply the IEP ratio to the net Intergovernmental Agreement Contract Costs in order to reduce total reported contractor costs to only those contractor costs which are related to services provided to Medicaid eligible students. This calculation is completed on the *Cost Summary Report* in the cost report, as seen in Section 4K of this Guide.

The MCRCS system will also automatically apply the IEP ratio to the net Intergovernmental Agreement Tuition Costs in order to reduce the total health related tuition costs to only those costs which are related to services provided to Medicaid eligible students. This calculation is completed on the Cost Summary Report in the cost report, as seen in Section 4K of this Guide.

NOTE: It is expected that the net expenses for Intergovernmental Agreement Contract and Tuition costs will be $0 statewide. Upon submission of all cost reports, DOH and its vendor will conduct an analysis of the Intergovernmental Agreement expenses across all LEAs to determine the statewide, net Intergovernmental Agreement expenses.

INTERGOVERNMENTAL AGREEMENT CONTRACT EXPENSE

This table is to be used by LEAs to report the total contract expenses incurred for the purchase of IEP direct medical services provided by other public schools or counties.

USER INPUT

Provider (Paid To):
This field is to be used to identify the name of the entity providing the contracted IEP direct medical service practitioners to the district. The only entities that may be listed in this field are public school districts or counties.

Service Type:
This field allows the user to select the appropriate approved direct medical service category under the SSHS Program.

Total Cost:
The amounts identified here should be the gross amounts paid to contractors by the LEA for the provision of IEP direct medical services. The amount reported should be the total amount paid to the vendor(s) and does not need to break out the salaries and benefits paid out by the vendor(s) to their employees.

Federal Funds and Other Reductions:
If any of the contracted service costs were paid for by using federal funding or require other offsets, then it should be entered here. This should be in addition to what is put into *Total Costs.*

SYSTEM GENERATED DATA

Net Costs Less Federal Funds and Other Reductions:
This is a calculation that is the *Total Cost* minus the *Federal Funds and Other Reductions.*

INTERGOVERNMENTAL AGREEMENT CONTRACT REVENUES

This table is to show the total contract revenues received from other public schools or counties for the provision of IEP direct medical services and the Medicaid Allowable Intergovernmental Agreement Contract Revenue offsets that will be used in the determination of the total Medicaid Allowable Intergovernmental Agreement Contract Expenses. LEAs will not be required to enter any data in to this section as all data will be generated based on the data certified by the LEAs incurring the expenses.

SYSTEM POPULATED DATA

Provider (Paid From):
This field is to be used to identify the name of the entity from which the contract revenue was received for the contracted IEP direct medical services. The only entities that may be listed in this field are public school districts or counties.

Service Type:
This field will identify the appropriate approved direct medical service category under the SSHS Program.

Total Revenue:
The amounts identified here will be the gross amounts received by the LEA for the provision of IEP direct medical services. The amount reported will be the total amount received from the public school or county.

Medicaid Allowable IA Contract Revenues:
This is the calculated revenue offset based on the expenses reported as paid to the LEA. This will be calculated following the initial certification of all cost reports and populated in MCRCS for the LEA to review and recertify. The calculation of the Medicaid Allowable IA Contract Revenues will be conducted as follows:

Example: LEA #1 reports an IA Contract Expense of $2,000 paid to LEA #2 for Occupational Therapy Services.

LEA #1's Medicaid Allowable IA Contract Costs for this transaction will be calculated as:

Provider (Paid To)	Service Type	Expense	Federal Funds and Other Reductions	Net Expenses Less Federal Funds and Other Reductions	LEA #1 IEP Ratio	Medicaid Allowable IA Contract Expense
LEA #2	Occupational Therapy	$2,000	$0	$2,000	50%	$1,000

For this transaction between LEA #1 and LEA #2, the Medicaid Allowable IA Contract Expense would be $1,000. In order to ensure that the revenue offset for LEA #2 is equal to the Medicaid allowable expense being claimed by LEA #1, the revenue offset would be calculated as follows:

Provider (Paid From)	Service Type	Revenue	Federal Funds and Other Reductions	Net Revenue Less Federal Funds and Other Reductions	LEA #1 IEP Ratio	Medicaid Allowable IA Contract Revenue
LEA #1	Occupational Therapy	$2,000	$0	$2,000	50%	$1,000

A similar calculation would be completed for every Intergovernmental Agreement Contract transaction between LEA #2 as the service provider receiving the revenue and all other LEAs purchasing the contract services. When determining the appropriate revenue offsets, the IEP ratio will be based on that of the LEA paying for the services (LEA #1 in the above example). Further, in the event that the LEA incurring the expense reported an amount for Federal Funds and Other Reductions to reduce their expense, a similar reduction will be made to the gross revenue amount.

NOTE: The calculation of the revenue offsets will be an offline calculation. The data in MCRCS will only show the gross revenue amount (equal to the gross expense reported by the LEA incurring the expense) and the Medicaid Allowable IA Contract Revenue resulting from the calculation described above.

INTERGOVERNMENTAL AGREEMENT TUITION EXPENSE

This section is used to identify the reimbursable portion of intergovernmental agreement tuition expenditures for public schools or counties.

USER INPUT

Provider (Paid To):

This field must be used to identify the specific public school or county to which tuition was paid. The user should select the name of the appropriate school/program from the drop down list. This list will only include public schools and counties.

Tuition Cost:
The *Tuition Cost* field should be used to enter the total annual tuition paid to the specific public school or county.

Federal Funds and Other Reductions:
The *Federal Funds and Other Reductions* field should be used to enter the portion of the *Tuition Cost* made using Federal Funds.

SYSTEM GENERATED DATA

Net Tuition Costs Less Federal Funds and Other Reductions:
This field is calculated by subtracting the amount entered in the *Federal Funds and Other Reductions* field from the amount entered in the *Tuition Cost* field.

Health Related Tuition Percentage:
This field will be pre-populated based on the public school or county selected in the *Provider (Paid To)* field. Each public school or county will have a distinct health related tuition percentage. This health related tuition percentage will be calculated on an annual basis using annual provider financial reports (ST-3 forms) submitted to the New York State Education Department (SED). The calculation of the health related tuition percentage follows the methodology outlined under Annual Tuition Costs in Section 4F of this Guide.

Health Related Percentage Calculation Methodology
The Health Related Percentage for each tuition based provider will be calculated by PCG using the following methodology:

Step 1. Select Program Codes from Supplemental Schedules SS-11 and SS-13 which correspond to the approved Program Codes.

Step 2. Select Position Codes from Supplemental Schedules SS-13 which correspond to approved codes by cost pool.

Step 3. Add (enter) the Amount Paid for each applicable Program Code from the positions in Step 2 to get the Direct Care Staff Costs for each title.

Step 4. Add the Total Amount Paid from the position in Step 3 to get the total Direct Care Staff costs by cost pool.

Step 5. Divide Fringe Benefits (SS-11 Line 11) by Salaries (SS-11 Line 2) under the applicable Program Codes to get the agency's Overall Fringe Benefits Percentage.

$$\frac{\text{Total Fringe Benefits (SS-11 Line 11)}}{\text{Salaries (SS-11 Line 2)}} = \text{Overall Fringe Benefit Percentage}$$

Step 6. Multiply the Direct Care Staff costs for each cost pool from Step 4 by the Overall Fringe Benefits Percentage from Step 5 to get the Fringe Benefits for each cost pool.

Overall Fringe Benefits Percentage	X	Direct Care Staff Costs - Therapy	=	Fringe Benefits Direct Care Staff - Therapy
		AND		
Overall Fringe Benefits Percentage	X	Direct Care Staff Costs - All Other	=	Fringe Benefits Direct Care Staff - All Other

Step 7. Add the Fringe Benefits from Step 6 to the Direct Care Staff Costs from Step 4 for each Cost Pool to get the Total Direct Care Staff Cost for each cost pool.

Direct Care Staff Costs - Therapy	+	Fringe Benefits for Direct Care Staff - Therapy	=	Total Direct Care Staff Costs - Therapy
		AND		
Direct Care Staff Costs - All Other	+	Fringe Benefits for Direct Care Staff - All Other	=	Total Direct Care Staff Costs - All Other

Step 8. Apply the RMTS Direct Medical Service Percentages to the applicable Total Direct Care Staff Costs categories from Step 7 (i.e. the RMTS Direct Medical Service – Therapy Percentage to the Total Direct Care Staff Costs – Therapy) to get the IEP Health Related Direct Costs.

Total Direct Care Staff Costs - Therapy	x	RMTS DMS Percentage Therapy	=	IEP Health Related Direct Costs - Therapy
		AND		
Total Direct Care Staff Costs - All Other	x	RMTS DMS Percentage All Other	=	IEP Health Related Direct Costs - All Other

Step 9. Add Totals from Step 8 to get the total Health Related Direct Cost.

IEP Health Related Direct Costs - Therapy	+	IEP Health Related Direct Costs - All Other	=	Total IEP Health Related Direct Costs

Step 10. Apply the School District Unrestricted Indirect Cost Rate (Published by SED) to the costs defined in Step 9 to get the Health Related Indirect Costs.

IEP Health Related Direct Costs	+	SED Approved UICR	=	Total IEP Health Related Indirect Costs

Step 11. Add Step 9 and Step 10 to get the Total Health Related Costs.

IEP Health Related Direct Costs	+	IEP Health Related Indirect Cost	=	Total IEP Health Related Costs

Step 12. Divide the Total Health Related Costs in Step 11 by the Total Direct Care Expenditures (SS-11 Line 13) from the applicable Program Codes to generate the Health Related Tuition Percentage.

Health Related Tuition Expense:
This field is calculated as the product of *Net Tuition Total Costs Less Reductions* times the *Health Related Tuition Percentage*. This is the amount that will be used, in conjunction with the Health Related Tuition Revenue and the LEA IEP Ratio, to determine the Medicaid allowable costs for cost settlement.

INTERGOVERNMENTAL AGREEMENT TUITION REVENUE
This section is used to show the total health related tuition revenues received from other public schools or counties for the provision of IEP direct medical services and the Medicaid Allowable Intergovernmental Agreement Health Related Tuition Revenues that will be used in the determination of the total Medicaid Allowable Intergovernmental Agreement Tuition Expenses. LEAs will not be required to enter any data in to this section as all data will be generated based on the data certified by the LEAs incurring the expenses.

SYSTEM POPULATED DATA

Provider (Paid From):
This field is used to identify the specific public school or county from which tuition was received. This list will only include public schools and counties.

Tuition Revenue:
The *Tuition Revenue* field will be used to show the total annual tuition received from the specific public school or county.

Health Related Tuition Percentage:
This field will be pre-populated based on the public school or county that is completing the cost report (for example the cost report for School District A would have the School District A health related tuition percentage pre-populated in this field). Each public school or county will have a distinct health related tuition percentage. This health related tuition percentage will be calculated on an annual basis using annual provider financial reports (ST-3 forms) submitted to the New York State Education Department (SED). The calculation of the health related tuition percentage follows the methodology outlined under Intergovernmental Agreement Tuition Expense in Section 4G of this Guide.

Medicaid Allowable IA Health Related Tuition Revenue:
This field will show the computed Medicaid Allowable Intergovernmental Agreement Health Related Tuition Revenue that will be used in determining the Total Medicaid Allowable Intergovernmental Agreement Health Related Tuition Cost that is included in the calculation of the cost settlement.

The calculation of the Medicaid Allowable IA Contract Revenues will be conducted as follows:

Example: LEA #1 reports an IA Tuition Expense of $20,000 paid to LEA #2.

LEA #1's Medicaid Allowable IA Health Related Tuition Costs for this transaction will be calculated as:

Provider (Paid To)	Expense	Federal Funds and Other Reductions	Net Expenses Less Federal Funds and Other Reductions	Health Related Tuition Percentage (for LEA #2)	Health Related Tuition Costs	IEP Ratio (LEA #1)	Medicaid Allowable IA Health Related Tuition Expense
LEA #2	$20,000	$0	$20,000	10%	$2,000	50%	$1,000

For this transaction between LEA #1 and LEA #2, the Medicaid Allowable IA Health Related Tuition Expense would be $1,000. In order to ensure that the revenue offset for LEA #2 is equal to the Medicaid allowable expense being claimed by LEA #1, the revenue offset would be calculated as follows:

Provider (Paid From)	Revenue	Federal Funds and Other Reductions	Net Expenses Less Federal Funds and Other Reductions	Health Related Tuition Percentage (for LEA #2)	Health Related Tuition Costs	IEP Ratio (LEA #1)	Medicaid Allowable IA Health Related Tuition Revenue
LEA #1	$20,000	$0	$20,000	10%	$2,000	50%	$1,000

A similar calculation would be completed for every Intergovernmental Agreement Tuition transaction between LEA #2 as the service provider receiving the revenue and all other LEAs purchasing the tuition services. When determining the appropriate revenue offsets, the IEP ratio will be based on that of the LEA paying for the services (LEA #1 in the above example) while the Health Related Tuition Percentage will be based on the LEA providing the services (LEA #2 in the above example). Further, in the event that the LEA incurring the expense

reported an amount for Federal Funds and Other Reductions to reduce their expense, a similar reduction will be made to the gross revenue amount.

NOTE: The calculation of the revenue offsets will be an offline calculation. The data in MCRCS will only show the gross revenue amount (equal to the gross expense reported by the LEA incurring the expense) and the Medicaid Allowable IA Health Related Tuition Revenue resulting from the calculation described above.

4H. Transportation Payroll Information

This page is for reporting payroll information for all transportation services staff, i.e., drivers, mechanics, and substitute drivers (employee and professional purchased services).

Cost reporting by providers should be consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA).

The only costs that can be submitted are direct costs. These are costs incurred for the benefit of, or directly attributable to, a specific service. Employee payroll taxes and benefits/insurance costs must be direct costs attributed to the individual employee and cannot be allocated. Reported costs and hours should be formatted with two decimal places and not rounded to the nearest whole dollar and hour, respectively.

USER INPUT

Last Name:
Enter the participant's last name.

First Name:
Enter the participant's first name.

Job Category:
Enter the participant's Job Category.

Staff Employment Status:
Enter the participant's employments status: full time or part time.

Paid Hours (Optional):
This field should be populated with the total hours that they employee worked for the quarter. If the employee is full time, then the employee's weekly hours should be divided by 5 work days to get their average hours per day. This number is multiplied by the number of days worked in the quarter to calculate the number of *Hours* worked. This is an optional field.

Salaries:
All participants except contractors are required to have a value in this field. These should be the gross earnings summed for the applicable employees as paid by the LEA. The amount reported in this field is the total gross earnings for the individual as paid by the LEA, including regular wages plus any amounts paid for paid time off (e.g., sick or annual leave), overtime, bonuses, longevity, stipends, cash bonuses, and/or cash incentives. Salaries are those payments from which payroll taxes are (or should be) deducted. Do not include any reimbursements for expenses such as mileage or other travel reimbursements.

Benefits:
Benefits include employer-paid health/medical, life, disability, or dental insurance premiums, as well as employer-paid child day care for children of employees paid as employee benefits on behalf of your staff,

retirement contributions, and worker's compensation costs. Report the expended amounts paid by the LEA which are directly associated with each staff member by type of employee benefit.

Please refer to section 4B for how the benefits tie to the chart of accounts.

Federal Funds and Other Reductions:
If any of the employee's compensation was paid for by using federal revenues, then it should be entered here. This should be in addition to what is put into *Employee Salaries*, any benefits columns, or *Purchased Professional Services.*

SYSTEM GENERATED DATA

Gross Compensation Expenditures:
This is a calculation that is a sum of the *Salaries, Retirement, Social Security, Life Insurance, Health Insurance, Other Employee Insurance, and Other Employee Benefits.*

Net Compensation Expenditures:
This is a calculation that is the *Gross Compensation Expenditures* minus *Federal Funds and other reductions.*

4I. Transportation Other Costs

Transportation Other Costs Page
This page collects non-payroll costs for all transportation services other than depreciation expense. Data will be needed for non-personnel transportation services costs incurred in support of direct medical services.

USER INPUT

Lease/Rental:
Report the lease/rental costs of all transportation equipment. If a vehicle lease includes both specialized transportation equipment and non-specialized transportation equipment, report them as "General Transportation Costs" and the cost will be allocated to the Special Education program based upon the vehicle ratio entered in the General and Statistical Information page.

Insurance:
Report the cost for insurance premiums for all transportation vehicles. Costs should be reported with amounts accrued for premiums, modifiers, and surcharges and net of any refunds and discounts actually received or settlements paid during the same cost reporting. If these costs cannot be directly associated to specialized transportation equipment costs, report them as "General Transportation Costs" and the cost will be allocated to the Special Education program based upon the vehicle ratio entered in the General and Statistical Information page.

Maintenance and Repairs:
Report repairs and maintenance include those regular maintenance costs, such as tune-ups, oil changes, cleaning, licenses, inspections, and replacement of parts due to normal wear and tear (such as tires, brakes,

shocks, and exhaust components) for all transportation vehicles. Report maintenance supplies related to specialized transportation vehicles. Major vehicle repairs (such as engine and transmission overhaul and replacement) costing $5,000 or more must be depreciated and reported as "Depreciation – Specialized Transportation Equipment." If these costs cannot be direct costs only for specialized transportation vehicles, report them as "General Transportation Costs" and the cost will be allocated to the Special Education program based upon the vehicle ratio entered in the General and Statistical Information page.

Fuel and Oil:
Report gasoline, diesel, and other fuel and oil costs for all transportation vehicles. If these costs cannot be directly associated only to specialized transportation vehicles, report them as "General Transportation Costs" and the cost will be allocated to the Special Education program based upon the vehicle ratio entered in the General and Statistical Information page.

Contract - Transportation Services:
Report costs of contracted transportation services. This category includes contracts for comprehensive transportation services, inclusive of staff (i.e. bus drivers) and equipment. **Note that these costs will not be eligible for the application of the indirect cost rate.**

Contract - Transportation Equipment:
Report costs of contracted transportation services equipment. This category includes contracts for transportation equipment only. **Note that these costs will not be eligible for the application of the indirect cost rate.**

Federal Funds and Other Reductions:
If any of the costs reported in one of the categories defined above were paid with federal funds (e.g., IDEA flow-through federal payments, Title 1 payments, or ARRA funds), report the amount of the expense paid from federal funds in this column. The system will subtract the federal amounts from the totals to arrive at the allowable costs paid from state/local funds. Thus, the amount reported in Federal Funds and Other Reductions cannot exceed the amount reported for any of the defined other transportation cost categories.

SYSTEM GENERATED DATA

Total Other Transportation Costs Net of Federal Funds and Other Reductions:
This is calculated by subtracting the *Federal Funds and Other Reductions* from the individual Transportation Other Costs categories.

4J. Transportation Equipment Depreciation Page

This page will record depreciation of all transportation equipment that is used at the district or county, not just the equipment used to provide Medicaid reimbursable services. This equipment should be included on the LEAs fixed asset ledger. Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. (Please note this is not market value.)

Allowable depreciation expense for direct medical services includes only pure straight-line depreciation. No accelerated or additional first-year depreciation is allowable. Any single item purchased during the cost-

reporting period costing less than $5,000 must be expensed and reported accordingly.

Required detail must be provided for each depreciable asset and each depreciable asset must be assigned its correct estimated useful life.

USER INPUT

Unique Asset ID:
Each LEA will have to provide the unique asset ID assigned to each asset included on the *Transportation Equipment Depreciation Page*. This will be the number used by the LEA to identify the asset.

Asset Type:
This list is populated with groups of the most common Asset Types, please select an Asset Type the most closely categorizes the Transportation Equipment in question. If you have a piece of equipment that falls under a type that is not listed, please select “Other – please describe” from the drop down list and provide a description in the Notes filed. Do not combine items under generic descriptions such as "various", “additions" or "equipment". Do not combine items by year purchased (e.g., "2008 buses"). Be specific in providing the description of each depreciable item.

Month/Year Placed in Service:
This is the first date that the Transportation Equipment could have been used. This is not to be confused with the date of purchase.

Month/Year Removed from Service:
This is the date that the Transportation Equipment was removed from service. This date is reported only if the asset was removed from service prior to the end of the useful life of the asset.

Years of Useful Life:
This is the estimated useful life of each asset listed on the *Transportation Equipment Depreciation Page*. The LEA is responsible for determining the appropriate useful life for each asset identified based on acceptable industry standards. LEAs may reference the "Estimated Useful Lives of Depreciable Hospital Assets", published by the American Hospital Association (AHA) (Item Number - 061170) for guidance on determining appropriate useful lives of assets. Copies of this publication may be obtained by contacting American Hospital Publishing, Inc., Phone: 800-242-2626, Mailing Address: AHPI, Books Division, 737 North Michigan Avenue, Chicago, IL 60611-2615. Please note that this cost report should not include administrative equipment expense

Cost:
This is the original purchase price for this transportation asset. This number should be the full amount paid for the equipment regardless of the source of funding.

Federal Funds and Other Reductions:
This is the amount of Federal funding that was used toward the purchase of this equipment.

Notes:
This field is to be used by LEAs in providing additional information, as necessary, for the assets listed on this

page. LEAs must provide a description in this field for any asset identified as "Other – please describe" in the Asset Type field.

SYSTEM GENERATED DATA

Prior Accumulated Depreciation:
This is the amount that the equipment has depreciated since the date of purchase. This is calculated by dividing the *Cost* minus the *Federal Funds and Other Reductions* by the *Years of Useful Life* divided by 365, which gives you the average depreciation of the equipment per day for the useful life of the asset. That number is then multiplied by the number of days the piece of equipment has been in service, which is the *Month/Year Placed in Service* subtracted from the *Last Day of the Fiscal Year*.

Depreciation for Reporting Period:
This is the amount that the equipment has depreciated during the current year. This can be calculated by dividing the *Cost* minus the *Federal Funds and Other Reductions* by the *Years of Useful Life of Asset.* The allowable amount of depreciation will be less if, during the reporting period, the asset became fully depreciated or the asset was placed into or taken out of service. Fully depreciated means that the total accumulated depreciation for the asset is equivalent to the depreciation basis. For cost-reporting purposes, the provider is to claim a full month of depreciation for the month the asset was placed into service, no matter what day of the month it occurred. Conversely, the provider is not to claim depreciation for the month the asset was taken out of service, no matter what day of the month it occurred. For example, if you purchased a depreciable item in December, you would claim six months of depreciation on your cost report for that item (July through December). If you sold an item in March, you would claim nine months of depreciation for that item (July through March).

4K. Cost Summary Report

This page provides summaries of all of the data included on all of the pages within the cost report and calculations of the Medicaid Allowable costs to be used in the annual cost settlement calculation. Components of the *Cost Summary Report* include the Direct Medical Services Salary and Benefits Summary by Service Type and Job Category, LEA Information Summary Report, Contract Costs Summary, Tuition Costs Summary, Intergovernmental Agreement Contract Costs Summary, Intergovernmental Agreement Tuition Costs Summary, and Transportation Services Total Costs Summary. Details for each of these tables are provided below.

Direct Medical Services Salary and Benefits Summary by Service Type and Job Category
This table automatically summarizes the direct services payroll data input in to the *Annual Payroll Information Page*. The data in this table is aggregated based on the Service Type and by the Job Category included on the *Annual Payroll Information Page.*

LEA Information Summary Report
The LEA Information Summary Report table illustrates the calculation of the Medicaid Allowable Costs for the direct medical services. The table includes expenditure data such as the salary and benefit costs by Service Type from the *Annual Payroll Information Page*, the other costs by Service Type from the *Direct Medical Services Materials, Supplies, and Equipment Page* and the *Direct Medical Services Equipment Depreciation Page.* The

LEA Information Summary Report also includes Direct Medical Service Percentages, the Unrestricted Indirect Cost Rate, and the IEP Ratio from the *General and Statistical Information Page*.

Contract Costs Summary

The *Contract Costs Summary* table illustrates the calculation of the Medicaid Allowable costs for contacted IEP direct medical services. The table includes the Total Costs, Federal Funds and Other Reductions and Net Costs Less Federal Funds and Reductions by Service Type as reported on the *Annual Contract Costs Page*. The table also includes the IEP Ratio from the *General and Statistical Information Page* and the calculation of the Medicaid Allowable Contract Costs.

Tuition Costs Summary

The *Tuition Costs Summary* table illustrates the calculation of the Medicaid Allowable costs for out-of-district tuition IEP direct medical services. The table includes the Net Health Related Tuition Payments as calculated on the *Annual Tuition Cots Page* and the IEP Ratio from the *General and Statistical Information Page.* The table shows the calculation of the Medicaid Allowable Health Related Tuition Costs.

Intergovernmental Agreements (IA) Contract Costs Summary

The *Intergovernmental Agreements (IA) Contract Costs Summary* table illustrates the calculation of the Medicaid Allowable costs for contracted IEP direct medical services provided through Intergovernmental Agreements. This table shows the Total IA Contract Expense, the IEP Ratio (from the *General and Statistical Information Page*), the calculation of the Medicaid Allowable Contract Costs (Total IA Contract Expense x IEP Ratio), the Medicaid Allowable IA Contract Revenues, and the calculation of the Total Medicaid Allowable IA Contract Costs (Medicaid Allowable IA Contract Costs – Medicaid Allowable IA Contract Revenues).

Intergovernmental Agreements (IA) Tuition Costs Summary

The *Intergovernmental Agreements (IA) Tuition Costs Summary* table illustrates the calculation of the Medicaid Allowable costs for tuition IEP direct medical services provided through Intergovernmental Agreements. This table includes the Total IA Health Related Tuition Expenses, the IEP Ratio (from the *General and Statistical Information Page*), the calculation of the Medicaid Allowable IA Health Related Tuition Costs (Total IA Health Related Tuition Expenses x IEP ratio), the Medicaid Allowable IA Health Related Revenues and the calculation of the Total Medicaid Allowable IA Health Related Tuition Costs (Medicaid Allowable IA Health Related Tuition Expenses – Medicaid Allowable IA Health Related Revenues).

Transportation Services Total Costs Summary

The *Transportation Services Total Costs Summary* table illustrates the calculation of the Medicaid Allowable costs for transportation services. The table includes expenditure data such as the salary and benefit costs from the *Transportation Payroll Information Page* and other costs from the *Transportation Other Costs Page* and the *Transportation Equipment Depreciation Page*. The *Transportation Services Total Costs Summary* table also includes the Unrestricted Indirect Cost Rate, the Specialized Transportation Ratio and the Medicaid One Way Trip Ratio from the *General and Statistical Information Page*.

The sum of the Medicaid Allowable costs from the LEA Information Summary Report, the Contract Costs Summary, the Tuition Costs Summary, the Intergovernmental Agreements (IA) Contract Costs Summary, the Intergovernmental Agreements (IA) Tuition Costs, and the Transportation Services Total Costs Summary

represents the Total Medicaid Allowable costs to be included in the annual cost settlement calculation.

4L. Annual Edits and Certifying the SSHSP Cost Report

Once the information has been reported, the system reviews the information for common errors and will note any edits that require a resolution on the Annual Edits Page of the cost report. Examples of common errors include reporting paid hours and no salaries or contracted compensation, reporting disproportional benefit-to-salary ratios, inclusion of materials, supplies and equipment without corresponding payroll. If one of these common errors is identified, the provider either must make necessary revisions or provide a written explanation as to why the reported information is accurate before they can certify their cost report.

For those edits that result in a revision to the data, the revised information will be reflected in the appropriate cost report page, i.e. a change to the salary reported for a speech therapist to resolve an edit check would be reflected on the Annual Payroll Page for that clinician and subsequently on the Cost Summary Report. Once resolved, these edits will no longer be visible on the Annual Edits Page.

Those edits that have been resolved by a written explanation will be maintained on the Annual Edits Page so that the explanations provided can be reviewed during the desk review process or upon DOH request.

Once the edits/reviews have been resolved or explained, the web-based system generates the cost report from the reported information. The provider then certifies the data and electronically submits the cost report.

4M. Certification of Public Expenditures for the Annual Cost Report

Following the completion of the annual cost report and prior to submission, the LEA will be required to certify the public expenditures used for matching purposes to draw down federal funds related to the Medicaid Direct Service Program. In addition to certifying the accuracy of the public expenditures used for matching purposes, LEAs must also certify that all interim claims, have to the best of their ability and knowledge, been submitted through MMIS.

A brief description of the instructions and the processes to complete the certification of public expenditures (CPE) form is outlined below. The CPE form will be made available to providers within the web based cost reporting template.

Provider Identification Information

The first section of the CPE form includes the Provider Identification Information. The required fields in this section include LEA Name, LEA Address, National Provider Identification (NPI), and Medicaid Provider Number. For the annual CPE submission, these fields will be pre-populated and will not require additional entry by the LEA.

LEA Name: _____

LEA Address: _____

(Street or P.O. Box, city, state, 5-digit zip)

National Provider Identification (NPI): _____

Medicaid Provider Number: _____

Reporting Period

For the annual cost settlement, the Reporting Period will be pre-populated on the CPE form based on the claim period the LEA is certifying for SSHSP Cost Settlement purposes.

HEREBY CERTIFY that for the reporting period: From: _____ To: _____

Section I

For the annual CPE submission, Section I of the CPE form will contain pre-populated information based upon the expenditures reported by the LEAs. This will include Total Expenditures and Total Medicaid Expenditures.

Total Medicaid Expenditures

The Total Medicaid Expenditures are calculated based on the statewide time study results and the Medicaid IEP ratio for each LEA. The Total Expenditures are aggregated for all direct medical service providers in the Direct Service – Therapy and Direct Service –All Other cost pools for the LEA for SSHSP cost settlement purposes. The statewide direct medical service time study results are applied to the Total Expenditures by service type. The resulting amounts are then reduced by the LEA's Medicaid IEP Ratio to calculate the Medicaid expenditures by service type. Transportation costs are aggregated and then discounted first by the specialized transportation ratio, and subsequently by the one-way trip ratio. The sum of these expenditures represents the Total Medicaid Expenditures for the LEA. The Total Medicaid Expenditures is the amount of state and local expenditures that must be certified in order to draw down federal funds reimbursable under the Medicaid SSHS program.

Certification Statement by Officer of the Provider

This section of the form must be reviewed and completed by the LEA's designated signer to officially certify the public expenditures identified in the section above that were used to match the federal funds under the Medicaid program. The LEA must include the following information in this section:

- Signature of Signer
- Title of Signer
- Date
- Printed/Typed Name of Signer
- Address of Signer
- Contact Phone Number
- Fax Number
- Email Address

It is important to note that the only acceptable signers of this form are the LEA's CEO, CFO, or Superintendent. A form signed by a representative of the LEA other than one of these representatives will be rejected and will require the LEA to re-submit the document.

4N. Submitting the Cost Report

The annual Cost Report is submitted by clicking on the "certify" button, which electronically submits the report

to PCG. You then need to print out the Certification of Public Expenditures form, have it signed by an appropriate LEA official, and mail or fax to PCG at the address included on the form. Once the Certification of Public Expenditures form has been received by PCG, the annual Cost Report is considered completed and ready for the desk review/audit, cost reconciliation, and cost settlement processes.

4O. Desk Review Process

The annual reports will be desk reviewed by PCG. LEAs may be requested to answer desk review questions and/or provide copies of documentation to support the information reported on the annual Medicaid Cost Report.

4P. Documentation Requirements

Providers must maintain records that are accurate and sufficiently detailed to substantiate the legal, financial, and statistical information reported on the cost report. These records must demonstrate the necessity, reasonableness, and relationship of the costs (e.g., personnel, supplies, and services) to the provision of services. These records include, but are not limited to, all accounting ledgers, journals, invoices, purchase orders, vouchers, canceled checks, timecards, payrolls, transportation logs, organizational charts, functional job descriptions, work papers used in the preparation of the cost report, trial balances, and cost allocation spreadsheets.

In addition, all enrolled SSHSP Medicaid providers (LEAs) must adhere to the requirements at 18 NYCRR section 504.3 regarding documentation to support Medicaid claims.

During the reconciliation and cost settlement processes, the desk reviewed Medicaid-allowable costs for the LEA's SSHS Program will be compared to the LEA's interim Medicaid payments for SSHS services delivered during the reporting period. If the provider's federal-share costs exceed the provider's interim Medicaid payments, the provider will receive the difference in a lump sum payment. **If the provider's costs are less the provider's interim payments, the provider is required to repay the difference either with a lump sum recoupment payment or through deductions from future payments. Those excess payments will be sent back to CMS.**

4Q. If You Need Help

Please contact PCG for assistance in completing or submitting the New York SSHSP Medicaid Cost Report. Contact information is posted to the Dashboard of the web-based system.

Appendix 1: Glossary of Important Terms

- Local Education Agency (LEA): LEA means a public school or a county that is a Medicaid-enrolled provider of school supportive health services.

- **Contracted Service Costs:** Contracted service costs refer to those costs associated with the purchase IEP direct medical services only by a LEA. Contracted services can be purchased from public schools, counties, private vendors, or BOCES. Costs associated with contracted services purchased from private vendors or BOCES are reported on the Annual Contracted Costs page of the Annual SSHSP Cost Report. Cost associated with contracted services purchased from a public school or a county are reported on the Intergovernmental Agreements page and must also have an equal revenue offset reported by the public school or county providing the contracted service.

- **Tuition Costs:** Tuition costs are those costs associated with the purchase of services through a public school, county, private school, or 4201 school and inclusive of the costs for both IEP direct medical services and education services. Any tuition costs reported will be reduced through the application of the Health Related Tuition Percentage to identify the Health Related Tuition Costs to be included in the computation of the Medicaid Allowable Costs. Costs associated with tuition arrangements between any combination of public school and/or county would be reported on the Intergovernmental Agreement page with an equal revenue offset reported on the cost report of the public school or county receiving the tuition payment.

- **Intergovernmental Agreements:** Intergovernmental Agreements refer to the relationships between two public schools, a public school and a county, or two counties. Intergovernmental Agreements can be for contracted services in which one entity provides IEP direct medical services only for a rate agreed upon by the two entities. Intergovernmental Agreements can also be for tuition arrangements in which educational and IEP direct medical services are provided. It is expected that for every Intergovernmental Agreement expense reported on the cost report of a public school or county (receiving the services) that there is an equal revenue offset entered on the cost report of the public school or county providing the services (receiving the contract or tuition payment). It is anticipated that in the aggregate, the statewide Intergovernmental Agreement expenses result in a net $0.

- **Health Related Tuition Percentage:** The Health Related Tuition Percentage is used on the Annual Tuition Costs Page and the Intergovernmental Agreement Page on the Annual SSHSP Medicaid Cost Report to identify the portion of tuition costs associated with the provision of IEP direct medical services. The Health Related Tuition Percentage is calculated for all applicable private schools, 4201 schools, public schools, and counties. The Health Related Tuition Percentage is calculated based on annual financial reports, either the CFR or the ST-3, submitted to the New York State Education Department.

- **IEP Ratio:** The IEP Ratio is the ratio within the Annual SSHSP Medicaid Cost Report used to apportion the Direct Medicaid Service Costs to the Medicaid program. The ratio is calculated based on the total number of unique Medicaid Eligible Students for the full school year with a SSHSP service in their IEP divided by the Total Number of Students with a SSHSP direct medical service in their IEP at

any time during the school year. This ratio is LEA specific.

- **Specialized Transportation Ratio:** The Specialized Transportation Ratio is the ratio within the Annual SSHSP Medicaid Cost Report used to apportion the transportation costs between specialized transportation and general or not-only specialized transportation. The ratio is based on the total number of Medicaid eligible students with specialized transportation services in their IEP divided by the total number of all students (Medicaid and non-Medicaid) receiving transportation services (specialized and non-specialized) in the LEA.

- **Medicaid One Way Trip Ratio:** The Medicaid One Way Trip Ratio is the ratio within the Annual SSHSP Medicaid Cost Report used to apportion specialized transportation costs to the Medicaid program. The ratio is based on the total number of paid one way specialized transportation trips for Medicaid eligible students with specialized transportation in their IEP divided by the total number of one way trips provided to Medicaid eligible students with specialized transportation in the IEP. The numerator of the ratio is based on data from MMIS while the denominator is based on data from LEA bus logs. The denominator should include all one way trips for Medicaid eligible students with specialized transportation in their IEP regardless of the whether or not the trips met the requirements for specialized transportation (i.e. provided on the same day as another SSHSP covered service).

- **Random Moment Time Study:** The Random Moment Time Study (RMTS) process is a federally approved technique of polling a statistically valid sampling of randomly selected moments (one moment = one minute) that are assigned to randomly selected participants. The RMTS method measures the work effort of the entire group of participants involved in the SSHSP Program by sampling and analyzing the work efforts of a randomly selected cross-section of the group. The time study determines the percentage of time that direct medical services staff spend on direct medical services, general and administrative time, and all other activities to account for 100 percent of time, thus assuring that there is no duplicate claiming. For NY SSHSP, there are two mutually exclusive cost pools; one for therapy services (occupational therapy, physical therapy, and speech therapy) and one for all other services (audiological evaluations, medical evaluations, medical specialist evaluations, psychological counseling, psychological evaluations, and skilled nursing). The RMTS is conducted on a quarterly basis for three quarters of the school year; October – December, January – March, and April – June. The results of the three quarterly time studies are averaged to determine the statewide direct medical service percentages applied to direct costs in the Annual SSHSP Medicaid Cost Report.

- **Unrestricted Indirect Cost Rate:** The Unrestricted Indirect Cost Rate is a LEA specific rate that is applied to direct costs (salaries, benefits, materials and supplies, and depreciation) in the Annual SSHSP Medicaid Cost Report to determine the amount of allowable indirect costs to be included in the calculation of the LEA Medicaid Allowable Costs. For public schools, the Unrestricted Indirect Cost Rate is provided annually by the New York State Education Department (SED), which serves as the cognizant agency responsible for approving LEA indirect cost rates for the United States Department of

Education. For counties, the Unrestricted Indirect Cost Rate is set to 10% as defined in OMB Circular A-87 Attachment A, Section G.

- **Encounters:** An encounter is defined as a documented face-to-face direct medical service visit that was provided pursuant to the recommendations of a student's IEP by a qualified provider. Consider only face-to-face contact time with the student and qualified provider; do not include pre-session planning or post-session write-up time when counting face-to-face direct medical service encounters. This data will not be a required for reporting periods prior to July 1, 2014. LEAs will be required to report this data on the General and Statistical Information Page for all reporting periods beginning on or after July 1, 2014.

  For example a student's IEP contains a recommendation that Occupational Therapy services are to be provided for 20-30 minutes/3 times a week for 6 months. Each documented visit in which the student actually received at least 20 minutes of occupational therapy from a qualified provider would be counted as one encounter.

  If a student's IEP contains a recommendation that Speech Therapy services are to be provided for 15 minutes twice a day/3 times a week for 6 months. Each documented visit in which the student actually received at least 15 minutes of speech therapy from a qualified provider would be counted as one encounter.

Appendix 2: CFR Program Codes for Health Related Tuition Percentage Calculation

The CFR program codes included in the calculation of the Health Related Tuition Percentage include:

CFR Program Code	CFR Program Code Description
9000	School Age – Special Class
9001	School Age – Special Class
9002	School Age – Special Class
9003	School Age – Special Class
9004	School Age – Special Class
9005	School Age – Special Class
9010	School Age – Special Class Half Day
9011	School Age – Special Class Half Day
9100	Preschool – Special Class – over 2.5 hours per day
9101	Preschool – Special Class – over 2.5 hours per day
9102	Preschool – Special Class – over 2.5 hours per day
9103	Preschool – Special Class – over 2.5 hours per day
9104	Preschool – Special Class – over 2.5 hours per day
9106	Preschool – Special Class – over 2.5 hours per day
9115	Preschool – Special Class – 2.5 hours per day
9116	Preschool – Special Class – 2.5 hours per day
9117	Preschool – Special Class – 2.5 hours per day
9118	Preschool – Special Class – 2.5 hours per day
9160	Preschool – Integrated Special Class – over 2.5 hours per day
9161	Preschool – Integrated Special Class – over 2.5 hours per day
9162	Preschool – Integrated Special Class – over 2.5 hours per day
9163	Preschool – Integrated Special Class – over 2.5 hours per day
9165	Preschool – Integrated Special Class – 2.5 hours per day
9166	Preschool – Integrated Special Class – 2.5 hours per day
9167	Preschool – Integrated Special Class – 2.5 hours per day
9190	Preschool – Evaluations
9191	Preschool – Evaluations
9192	Preschool - Evaluations
9260	4201 State Supported Education Program

The complete list of CFR Program Codes can be found at http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/CurrentYear/Cal2013/12013CFRAPPEND.pdf, under Appendix H.

Appendix 3: Contract and Tuition Relationship Matrix

The following pages contain a matrix outlining the various contractual and tuition based relationships that may exist between public and private entities as well as between two public entities. The matrix identifies the relationships along with the identification of the Medicaid billing provider, the impact on the cost report for the entity purchasing the services and the impact on the cost report of the entity providing the service.

	Condition	Who is the Medicaid Biller of Record?	What is the net impact on CPE Cost Report for Provider giving IEP services	What is the net impact on CPE Cost Report for Provider that is receiving IEP services
1	School District A enters into Intergovernmental Agreement to provide education and IEP services to student from School District B or preschool student from County A.	School District B or County A	School District A would need to report a revenue offset equal to the Health Related Tuition costs being captured in the School District B or County A cost report to ensure non-duplication of costs.	School District B or County A would report the total tuition expense paid to School District A on their cost reports. This tuition expense would be reduced by the Health Related Tuition Percentage for School District A to determine the Health Related Tuition Costs. This expense would have an equal revenue offset on School District A's cost report.
2	School District A enters into Intergovernmental Agreement to provide only IEP services to student from School District B or preschool student from County	School District B or County A	School District A would need to report a revenue offset equal to the amount received from School District B or County A for the provision of IEP direct medical services. This will ensure non-duplication of costs. The net impact on CPE costs is $0.	School District B or County A would report the total expense paid to School District A for the provision of IEP direct medical services. This will ensure non-duplication of costs. The net impact on CPE costs is $0.
3	School District A and B share a direct medical worker for IEP services	The School District that is the district of residence for the student receiving the services. For example, if services provided to a School District A student, School District A would be the Medicaid biller.	School District A and B must report only salary paid by district. For example, if the clinician's total compensation is $50,000 and School District A and School District B are each responsible for 50% of that compensation, the School District A cost report would reflect $25,000 and the School District B cost report would reflect $25,000. There is no duplicative claiming in this scenario.	N/A

	Condition	Who is the Medicaid Biller of Record?	What is the net impact on CPE Cost Report for Provider giving IEP services	What is the net impact on CPE Cost Report for Provider that is receiving IEP services
4	School District A pays tuition to a 4201 school or other private school. Tuition costs include education and IEP services.	School District A, as the district of residence, would be the Medicaid biller of record for services provided by the private or 4201 school to a School District A student.	Private or 4201 schools do not complete the CPE Cost Report. Private and 4201 schools are reimbursed by the school districts based on the tuition agreement.	School District A is reimbursed based on the total tuition payment x health related tuition percentage of the private or 4201 school x IEP ratio of School District A. The health related tuition percentage is based on the CFR for the private or 4201 school and the statewide (ROS) RMTS percentages.
5	School District A enters into a contract for only IEP services with a private contractor.	School District A, as the district of residence, would be the Medicaid biller of record for services provided by the private contractor to a School District A student.	Private contractors do not complete the CPE Cost Report. These private contractors are reimbursed based on the contractual agreement with School District A.	School District A is reimbursed the contract costs for IEP direct medical services x the IEP ratio of School District A. School District A would also recognize a revenue offset for a portion of any rental revenues received from the private contractor.

	Condition	Who is the Medicaid Biller of Record?	What is the net impact on CPE Cost Report for Provider giving IEP services	What is the net impact on CPE Cost Report for Provider that is receiving IEP services
6	School District A is contracted with a BOCES program for the provision of IEP direct medical services. School District A incurs either a tuition cost or contract service cost. Regardless of the arrangement, School District A must clearly identify the costs for the provision of IEP direct medical services and include only those costs on their cost report as contracted service costs. School District A cannot include a tuition payment for services provided by a BOCES program on their cost report.	School District A, as the district of residence, would be the Medicaid biller of record for services provided by the BOCES to a School District A student.	BOCES do not complete the CPE Cost Report. BOCES are reimbursed based on the contractual agreement with School District A.	School District A is reimbursed the contract costs for IEP direct medical services x the IEP ratio of School District A. School District A would also recognize a revenue offset for a portion of any rental revenues received from the BOCES.
7	County A enters into a contract to pay tuition to a private school/private preschool agency. Tuition costs include education and IEP services.	County A, as the county of residence, would be the Medicaid biller of record for services provided by the private school/preschool agency to a County A student.	Private schools/private preschool agencies do not complete the CPE Cost Report. The private schools/preschool agencies are reimbursed by County A based on the tuition agreement.	County A is reimbursed the total tuition payment x health related tuition percentage for the private school/preschool agency x IEP ratio for County A. The health related percentage is based on the CFR for the private school/private preschool agency and the statewide (ROS) RMTS percentages.

	Condition	Who is the Medicaid Biller of Record?	What is the net impact on CPE Cost Report for Provider giving IEP services	What is the net impact on CPE Cost Report for Provider that is receiving IEP services
8	County A enters into a contract for only IEP direct medical services with a private contractor.	County A, as the county of residence, would be the Medicaid biller of record for services provided by the private contractor to a County A student.	Private contractors do not complete the CPE Cost Report. These private contractors are reimbursed based on the contractual agreement with County A.	County A is reimbursed the contract costs x the IEP ratio of County A. County A would also recognize a revenue offset for a portion of any rental revenues received from the private contractor.
9	County A is contracted with a BOCES program for the provision of IEP direct medical services. County A incurs either a tuition cost or contract service cost. Regardless of the arrangement, County A must clearly identify the costs for the provision of IEP direct medical services and include only those costs on their cost report as contracted service costs. County A cannot include a tuition payment for services provided by a BOCES program on their cost report.	County A, as the county of residence, would be the Medicaid biller of record for services provided by the BOCES to a County A student.	BOCES do not complete the CPE Cost Report. BOCES are reimbursed based on the contractual agreement with County A.	County A is reimbursed the contract costs x the IEP ratio of County A. County A would also recognize a revenue offset for a portion of any rental revenues received from the BOCES, when applicable.

Note 1: Health Related Percentages: If the servicing contractor/school is providing education and IEP services, the calculated direct care staff costs per CFR must be reduced by two factors: the direct medical percentage (within the health related tuition percentage calculation) and IEP ratio (after the application of the health

related tuition percentage). If a school is providing only IEP services, total costs must be reduced by the IEP ratio. Please see the "Health Related Percentage Calculation Methodology" in the Cost Report Guide (Section 4F) for the detailed steps of this calculation.

Note 2: Intergovernmental Agreements: Intergovernmental Agreements refer to the relationships between two public schools, a public school and a county, or two counties. Intergovernmental Agreements can be for contracted services in which one entity provides IEP direct medical services only for a rate agreed upon by the two entities. Intergovernmental Agreements can also be for tuition arrangements in which educational and IEP direct medical services are provided. It is expected that for every Intergovernmental Agreement expense reported on the cost report of a public school or county (receiving the services) that there is an equal revenue offset entered on the cost report of the public school or county providing the services (receiving the contract or tuition payment). It is anticipated that in the aggregate, the statewide Intergovernmental Agreement expenses result in a net $0.

Note 3: The process for reviewing the Intergovernmental Agreement costs is defined in Section 4G of the Cost Report Guide.