THIS COOPERATIVE AGREEMENT ("Agreement"), dated as of this 6th day of ~~December~~ January 20~~10~~11, between the Department of Social Services of the Human Resources Administration of the City of New York ("HRA" of "the Department"), with offices located at 180 Water Street, New York, New York 10038, and the Department of Health and Mental Hygiene ("DOHMH"), with offices located at 125 Worth Street, New York, New York 10013, (each a "Party", collectively, the 'Parties")

WITNESSETH:

WHEREAS, DOHMH is the official administrator of the Children with Special Health Care Needs/Physically Handicapped Children's Program ("PHCP") designed to provide eligible New York City children up to age 21 with severe physical disabilities, including handicapping dental conditions, with the opportunity for appropriate diagnosis and treatment through an approved provider network; and

WHEREAS, DOHMH provides direct administrative services including, approving initial financial and clinical eligibility for PHCP Medicaid patients ("Clients") which includes authorizing the initiation of orthodontic treatment and billing by New York State Medicaid approved orthodontic providers for over 16,000 new cases yearly ("Program"); and

WHEREAS, DOHMH employs skilled professional medical/dental personnel that have professional education and training in the field of medical care or approporiate medical/dental practice and are in positions that have duties and responsibilities that require those professional medical/dental knowledge and skills for the Program; and

WHEREAS, DOHMH employs direct supporting staff who are directly supervised by the skilled professional medical/dental staff and provide clerical services that are directly necessary for the completion of the professional medical/dental responsibilities and functions of the skilled professional medical/dental staff for the Program; and

WHEREAS, HRA desires to provide funding for direct administrative services including, oversight, quality control and processing of the Program; and

NOW, THEREFORE, the parties hereto agree as follows:

ARTICLE 1. TERM OF PERFORMANCE

1.1 The term of this Agreement shall be for the period from July 1, 2010 through June 30, 2013, (the "Term") unless sooner terminated as provided herein and subjected to the availability of funds.

1.2 This Agreement shall be automatically renewed annually as of July 1, 2013 for three (3) additional one (1) year terms, subject to appropriations, upon the same terms and conditions as set forth herein, unless sooner terminated by either party.

1.3 Either party may terminate this Agreement in accordance with Article 6 herein.

1.4 Unless stated otherwise, all terms and conditions of this Agreement shall only apply to DOHMH's determinations of the eligibility of Clients based on the referrals, as clinically approved by and received from New York State designated clinical Screening and Review Institutions ("SRI").

ARTICLE 2. RESPONSIBILITIES

2.1 DOHMH Responsibilities.

2.1.1 DOHMH via its PHCP staff shall perform quality assurance reviews for Medicaid enrolled children as received from the SRI.

2.1.2 DOHMH shall review case referrals using New York State Medicaid orthodontic coverage criteria for Medicaid and clinical eligibility.

2.1.3 DOHMH shall assign treating orthodontist and notify provider.

2.1.4 DOHMH shall make determinations, on cases referred to DOHMH, regarding a person's eligibility to participate in the Program in accordance with all New York State Department of Health rules and regulations including, but not limited to, Title 10 of the New York Code, Rules and Regulations, Section 85.37 as amended (which is annexed hereto as Attachment B and incorporated herein) and only as they pertain to determinations made by DOHMH upon completion of the screening process. DOHMH shall respond to all administrative fair hearing appeals relating to such determinations.

2.1.5 DOHMH shall issue Medicaid authorization case number for initial treatment and maintain a database that includes patient, provider and authorization number to track and reference patients for quality control and administration purposes.

2.1.6 DOHMH shall provide special clinical assessments to review and coordinate Medicaid orthodontic treatment progress for problem cases, patient transfers and provider reassignments within and outside New York City.

2.1.7 DOHMH shall maintain a system for handling inquires and/or complaints from patients, providers, the public and state and local agencies about program services and eligibility requirements.

2.1.8 DOHMH shall coordinate the review of complex cases including those involving surgery. The orthodontic director shall Chair the Advisory

Committee and monitor its recommendations. The Committee consists of recognized orthodontists and oral and maxillo-facial surgeons in the New York metropolitan area.

2.1.9 DOHMH shall, in cooperation and coordination with the New York State Department of Health, ensure that quality orthodontic treatment is both accessible through an approved provider network and consistent with statewide standards of care to Medicaid eligible enrolled children in New York City.

2.1.10 DOHMH shall maintain separate accounting and reports for the Medicaid orthodontic cases forwarded to DOHMH from the SRI for appropriate action.

2.1.11 DOHMH shall provide relevant materials for program audits relating to Medicaid orthodontic cases received by the Program from the SRI, including:

i. DOHMH's final disposition of referrals of such cases;

ii. Quality of care issues that are referred directly to the Program for administrative action.

2.2 HRA Responsibilities.

2.2.1 HRA shall pay DOHMH for the above referenced services in accordance with Article 4 below.

2.2.2 HRA shall provide reports, documents and other information that will enable DOHMH to perform its duties under this Agreement.

ARTICLE 3. STAFF REQUIREMENTS

3.1 All staff used by DOHMH in fulfillment of this Agreement shall be eligible for reimbursement in accordance with Chapters 11 and 12 of Volume 4 of the New York State Fiscal Reference Manual issued by the New York State Office of Temporary Disability Assistance, Bureau of Financial Services. Copies of which are annexed hereto, and incorporated herein, as Attachment C.

3.2 DOHMH, at a minimum, shall provide the following staff:

3.2.1 One (1) program administrator shall supervise overall program operations including quality assurance;

3.2.2 Two (2) clinical staff shall assign orthodontists, address provider and patient inquiries and/or complaints about quality of care and perform clinical assessment for problem cases, patients transfers and provider reassignments,

3.2.3 Five (5) care coordinators shall process authorizations, answer telephone calls and triage information from patients and providers, produce and transmit case information to referring orthodontist

3.2.4 Five (5) administrative staff shall perform data entry and manage data base

ARTICLE 4. TERMS OF PAYMENT

4.1 DOHMH agrees to accept, as full payment for the services provided pursuant to this Agreement an amount not to exceed $1,347,353.00 for the period July 1, 2010, through, June 30, 2011, based on a budget affixed hereto as Exhibit A-1 and incorporated herein.

4.2 DOHMH agrees to accept, as full payment for the services provided pursuant to this Agreement an amount not to exceed $1,382,138.00 for the period July 1, 2011, through, June 30, 2012, based on a budget affixed hereto as Exhibit A-2 and incorporated herein.

4.3 DOHMH agrees to accept, as full payment for the services provided pursuant to this Agreement an amount not to exceed $1,417,966.00 for the period July 1, 2012, through, June 30, 2013, based on a budget affixed hereto as Exhibit A-3 and incorporated herein.

4.4 DOHMH will forward to HRA documentation in support of Administrative expenses for PHCP including OTPS expenditures such as basic travel, supplies, equipment, informational material and overtime. The documentation should be submitted on a quarterly basis within forty-five (45) days following the end of the quarter. HRA will in turn submit a claim for these expenditures to NYS Office of Temporary Disability Assistance ("OTDA"). Reimbursement to DOHMH will be subject to NYS reimbursement. Upon receipt of reimbursement from NYS OTDA, HRA will forward, and DOHMH agrees to accept as full reimbursement the amount settled by NYS OTDA.

4.5 If claims for reimbursement are made by HRA on behalf of DOHMH pursuant to the Agreement, and such claims are disallowed, then DOHMH shall assume full responsibility for the cost of such services.

4.6 Quarterly Intra-City expenditure reports shall be submitted to:

NYC Human Resources Administration

Finance Office- Bureau of Claims and Reimbursement
Attn: Director
180 Water Street, 9th Floor- Room 907
New York, NY 10038

4.7 The Intra-Agency report shall be signed by the Director of DOHMHs' fiscal department or designee and shall include the following typed language:

" I hereby certify that this invoice is for articles received, services rendered or amounts expended on behalf of the City of New York, that this is correct as to the price and amount, that it is necessary for the proper transaction of the business of the Department, that it was incurred solely for the benefit of the City of New York, that no part of the amount claimed therein has been previously certified, and that the amount is solely for the operation of said Program described in this invoice."

ARTICLE 5. SUPERVISION

In compliance with Administrative Directive 80 ADM-86 of the New York State Department of Social Services, the Commissioner of HRA or his/her designee may require the removal for cause of any employee who performed any work under this Agreement, and may request the retention, reinstatement, or reassignment of any employee who performed any work under this Agreement and who may have been removed. Any employee performing work under this Agreement must report to the Commissioner of HRA or his/her designee and receive all assignments from the Commissioner or his/her designee. For the purposes of this Article, the Commissioner of HRA has named the Commissioner of DOHMH his designee. Furthermore, all records pertaining to this Agreement shall be available for a period of six (6) years and shall be made available for audit by the New York State Department of Social Services, the New York State Audit and Control, and the United States Department of Health and Human Services, and all information pertaining to this Agreement that is exchanged between HRA and DOHMH shall be considered confidential and shall be used only for the intended purposes, with measures to be taken to safeguard the confidentiality of such information to the extent required by applicable State and Federal laws and regulations

ARTICLE 6. TERMINATION

A. The parties shall have the right to terminate this Agreement, in whole of in part, without cause by giving a written notice to all parties within thirty (30) days.

B. In the event the Federal, State or City reimbursement for this Agreement becomes unavailable or is terminated this Agreement shall be deemed terminated immediately.

C. The parties shall have the right to terminate this Agreement, in whole or in part, for good cause by giving thirty (30) days written notice to all parties with opportunity to cure within said thirty (30) days.

D. In the case of termination of this Agreement HRA shall pay all costs and all un-cancellable obligations up to and including the effective date of said termination.

ARTICLE 7. NOTICES

Any notice shall be made to the following or to such other representatives that the Parties designate in writing:

For HRA:

Executive Deputy Commissioner of Finance
New York City Human Resources Administration
180 Water Street Room 1107
New York, New York 10038

With a copy to:

General Counsel
New York City Human Resources Administration
180 Water Street
New York, New York 10038

For DOHMH:

Deputy Commissioner
Health Care Access and Improvement
New York City Department of Health and Mental Hygiene
225 Broadway
New York, NY 10007

With copy to:

General Counsel
Department of Health and Mental Hygiene
125 Worth Street
New York, New York 10003

ARTICLE 8. APPLICABLE LAW

This Agreement shall be governed, construed, applied and enforced in accordance with the laws of the State of New York.

ARTICLE 9. MERGER CLAUSE

This Agreement constitutes the entire understanding of the Parties and merges all prior discussions, agreements or understandings into it. No prior agreement, oral

or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

ARTICLE 10. MODIFICATION

This Agreement may only be modified by a writing signed by authorized representatives of the Parties. It may not be altered, modified, rescinded or extended orally.

ARTICLE 11. NON-ASSIGNMENT CLAUSE

Each Party agrees that it shall not assign, transfer, convey or otherwise dispose of this Agreement except by operation of law, without the prior written consent of the other party.

ARTICLE 12. SUCCESSORS AND ASSIGNS; THIRD PARTY BENEFICIARY

This Agreement shall be binding upon and for the benefit of the Parties hereto and each of their respective successors and permitted assigns and shall be for the sole benefit of the parties hereto.

ARTICLE 13. RECORDKEEPING

All Parties to this Agreement shall maintain for three (3) years from the termination of this Agreement any and all copies of all financial and work reports, and audits, which reflect the services rendered hereunder and fiscal accountability of all monies appropriated and spent thereby, make copies thereof available and submit such copies to any other party hereto upon request.

ARTICLE 14.CONFIDENTIALITY

14.1 All public releases and publications that contain confidential and/or protected information obtained pursuant to this Agreement, including but not limited to written press releases, prepared comments for press conferences or other oral presentations, conference presentations, letters, and analytic, journal, newspaper and magazine articles, shall be submitted to each Party's representative (the signatories of this Agreement) for review prior to dissemination or submission of the material. Should this review indicate the need for modifications, the Parties shall make the modifications and resubmit the documents for final approval. If the Parties are still unable to reach an agreement, the Parties will develop a mutually agreed upon disclaimer to include in the public release or publication.

14.2 The Parties agree to hold confidential all protected client specific information obtained pursuant to this Cooperative Agreement, and to abide by the provisions of New York State Social Services Law; New York State Public Health Law Article 27F; New York State Mental Health Laws; New York

State Public Officers Laws; and all applicable federal and state laws and regulations.

14.3 Any disclosure of HIV-related information shall have the following written statement accompany it:

"*This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general quthorization for the release of medical or other information is not sufficient authorization for further disclosure.*"

14.4 The provisions of this Article 12 shall remain in full force and effect following termination of this Cooperative Agreement.

ARTICLE 15. CIVIL RIGHTS

The Parties agree that, in the prosecution of this Agreement, they shall comply with the Civil Rights Act of 1964 as amended by Executive Order 11246, 41 C.F.R Part 60, Section 504 of the Rehabilitation Act of 1973 and 45 C.F.R. Parts 84 and 85.

This Cooperative Agreement may be executed in counterparts, all of which counterparts, when taken together, shall be deemed a fully executed instrument.

IN WITNESS WHEREOF, the parties hereto have caused this Cooperative Agreement to be duly executed as of December __, 2010.

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

By: _____

Name: _____

Title: Chief Operating Officer/ Executive Deputy Commissioner

NEW YORK CITY HUMAN RESOURCES ADMINISTRATION

By: _____

Name: Vincent Pullo

Title: Acw

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

DOMINIC DOMINGO,ESQ
Notary Public, State of New York
No. 02DO6058476
Qualified in KINGS County
Commission Expires JUNE 19, 2011

On this 21st day of December, 2010, before me personally came Patsy Yang, to me know and known to me to be the Chief Operating Officer of the New York City Department of Health and Mental Hygiene and the same person who executed the foregoing document, and he acknowledged that he executed the foregoing document on behalf of the City of New York and the Department of Health and Mental Hygiene pursuant to the authority vested in him for the purpose herein mentioned.

Notary Public

STATE OF _____)
: SS.:
COUNTY OF _____)

On this 6th day of January, 2011 before me personally came Vincent Pullo, to me know and known to me to be the ACCO of the City of New York Human Resources Administration and the same person who executed the foregoing document, and she/he acknowledged that she/he executed the foregoing document on behalf of the City of New York Human Resources Administration pursuant to the authority vested in her/him for the purpose herein mentioned.

Sharon C James
Notary Public

SHARON C. JAMES
Commissioner of Deeds
City of New York No. 2-13026
Commission Expires April 1, 2012

Exhibit A-1
Orthodontic Program Intra-City Budget
July 1, 2010 - June 30, 2011

Personnel Services	Civil Service Title	Head Count	Number of Staff	Average Salary	Average Percent of Time	Total Budget
Full-Time						
	Attending Dentist (HMH)	1	1	$145,438	100%	$145,438
	Associate Staff Analyst	2	2	$73,878	100%	$147,756
	Public Health Advisor	3	3	$38,111	100%	$114,333
	Public Health Assistant	1	1	$31,996	100%	$31,996
	PAA	0.65	1	$47,357	65%	$30,782
	Secretary	2	2	$36,595	100%	$73,190
Part-Time						
	Dentist	0	1	$135,852	100%	$135,852
	College Aide	0	2	$12,466	100%	$24,932
Sub-Total Personnel Services		9.65	13			**$704,279**
Fringe Benefits @ 51%						**$359,182**
Total Personnel Services						**$1,063,461**
Other Than Personnel Services				Unit Cost		
Supplies	Object Code 100		13	$700		$9,100
Computer Supplies	Object Code 199		13	$434		$5,642
Office Furniture	Object Code 314		13	$500		$6,500
Computer Equipment Maintenance	Object Code 332		13	$1,604		$20,852
Rental of Misc Equipment	Object Code 412		13	$316		$4,108
Local Travel	Object Code 451		13	$600		$7,800
Telecommunication Maintenance	Object Code 602		13	$600		$7,800
Space	Object Code 602		13	$8,500		$110,500
Total Other Than Personnel Services						**$172,302**
Total Direct						**$1,235,763**
Indirect @ 9.03%						**$111,589**
Total Intra-City Budget						**$1,347,353**

Exhibit A-2
Orthodontic Program Intra-City Budget
July 1, 2011 - June 30, 2012

Personnel Services	Civil Service Title	Head Count	Number of Staff	Average Salary	Average Percent of Time	Total Budget
Full-Time						
	Attending Dentist (HMH)	1	1	$149,801	100%	$149,801
	Associate Staff Analyst	2	2	$76,094	100%	$152,189
	Public Health Advisor	3	3	$39,254	100%	$117,763
	Public Health Assistant	1	1	$32,956	100%	$32,956
	PAA	0.65	1	$48,778	65%	$31,706
	Secretary	2	2	$37,693	100%	$75,386
Part-Time						
	Dentist	0	1	$139,928	100%	$139,928
	College Aide	0	2	$12,840	100%	$25,680
Sub-Total Personnel Services		9.65	13			**$725,407**
Fringe Benefits @ 51%						**$369,958**
Total Personnel Services						**$1,095,365**
Other Than Personnel Services				Unit Cost		
Supplies	Object Code 100		13	$700		$9,100
Computer Supplies	Object Code 199		13	$434		$5,642
Office Furniture	Object Code 314		13	$500		$6,500
Computer Equipment Maintenance	Object Code 332		13	$1,604		$20,852
Rental of Misc Equipment	Object Code 412		13	$316		$4,108
Local Travel	Object Code 451		13	$600		$7,800
Telecommunication Maintenance	Object Code 602		13	$600		$7,800
Space	Object Code 602		13	$8,500		$110,500
Total Other Than Personnel Services						**$172,302**
Total Direct						**$1,267,667**
Indirect @ 9.03%						**$114,470**
Total Intra-City Budget						**$1,382,138**

Exhibit A-3

Orthodontic Program Intra-City Budget

July 1, 2012 - June 30, 2013

Personnel Services	Civil Service Title	Head Count	Number of Staff	Average Salary	Average Percent of Time	Total Budget
Full-Time						
	Attending Dentist (HMH)	1	1	$154,295	100%	$154,295
	Associate Staff Analyst	2	2	$78,377	100%	$156,754
	Public Health Advisor	3	3	$40,432	100%	$121,296
	Public Health Assistant	1	1	$33,945	100%	$33,945
	PAA	0.65	1	$50,241	65%	$32,657
	Secretary	2	2	$38,824	100%	$77,647
Part-Time						
	Dentist	0	1	$144,125	100%	$144,125
	College Aide	0	2	$13,225	100%	$26,450
Sub-Total Personnel Services		9.65	13			**$747,170**
Fringe Benefits @ 51%						**$381,057**
Total Personnel Services						**$1,128,226**
Other Than Personnel Services				Unit Cost		
Supplies	Object Code 100		13	$700		$9,100
Computer Supplies	Object Code 199		13	$434		$5,642
Office Furniture	Object Code 314		13	$500		$6,500
Computer Equipment Maintenance	Object Code 332		13	$1,604		$20,852
Rental of Misc Equipment	Object Code 412		13	$316		$4,108
Local Travel	Object Code 451		13	$600		$7,800
Telecommunication Mainteance	Object Code 602		13	$600		$7,800
Space	Object Code 602		13	$8,500		$110,500
Total Other Than Personnel Services						**$172,302**
Total Direct						**$1,300,528**
Indirect @ 9.03%						**$117,438**
Total Intra-City Budget						**$1,417,966**

ATTACHMENT B

TITLE 10 OF THE NEW YORK CODE RULES AND REGULATIONS SECTION 85.37

Section 85.37 - Time limits within which determinations shall be made

PRIOR APPROVAL FOR CARE AND SERVICES

85.37 Time limits within which determinations shall be made. (a) All decisions on requests for prior approval must be made and all required notices shall be sent by the New York State Department of Health to the requesting provider and, where required, to the medical assistance patient-recipient, within 21 calendar days of receipt of such requests by the New York State Department of Health; except that in cases where prior approval requests for dental care are received in area offices outside the five boroughs of New York City and a clinic examination is necessary, the required notices above shall be transmitted within 30 calendar days of receipt of such requests by the respective upstate area office.

(b) In the event prior approval requests must be returned to the requesting provider for submission of additional information, the calendar day limit in subdivision (a) of this section will be tolled from the day the request is returned to the provider until the day the request plus additional information is returned to the New York State Department of Health.

(c) In the event the prior approval request and the requested additional information from the provider is received on a Thursday or Friday which occurs after the 19th calendar day referenced in subdivision (b) of this section, two additional working days may be added to the 21-calendar day limit specified in subdivision (a) of this section.

(d) If a determination is not made and transmitted in accordance with provisions in subdivisions (a)-(c) of this section, the New York State Department of Health shall, within two working days from the expiration of the time limits set forth in subdivisions (a)-(c) of this section, notify the requesting provider and patient-recipient of such fact and of the patient's-recipient's right to request a fair hearing to determine whether the prior approval request should be approved.

ATTACHMENT C

CHAPTERS 11 AND 12 OF VOLUME 4
OF
THE NEW YORK STATE FISCAL REFERENCE MANUAL
ISSUED BY
THE NEW YORK STATE OFFICE OF TEMPORARY DISABILITY ASSISTANCE,
BUREAU OF FINANCIAL SERVICES

Chapter 11: MA Eligibility Determ./Auth./ Payments (F4)

Introduction *11-2*

Description *11-2*

Types of Employees Assigned to the F4 Function *11-4*

Types of Costs Allocated to the F4 Function *11-4*

Claiming of F4 Costs on the LDSS 2347B-2 "Schedule D-4 Calculation for Medical Assistance Eligibility Determination/authorization/ Payment Cost Shares" ... *11-7*

INTRODUCTION

This Chapter describes the F4 Medical Assistance (MA) Eligibility/Determination/Authorization and Payment function, and the types of employees and costs that can be coded to the function.

DESCRIPTION

The MA Eligibility Determination/Authorization and Payments function includes all direct transactions for determining Title XIX MA eligibility. This function also includes all other activities undertaken for the MA program except MA Policy Planning/Administrative activities defined by function code F5.

In general, MA eligibility staff determines client eligibility based on client needs and resources and provides clients with the information necessary to reach a decision on provider care, and then authorize the care.

The MA eligibility activities may include, but are not limited to the following areas:

- ***New certifications*** - The early stage of processing a new MA application or reopening an MA case includes all work prior to the decision of MA eligibility and work associated with processing an MA application, and opening or denying an applicant after an eligibility determination has been made.
- ***Recertifications*** - This work is associated with recertifying an existing MA-Only case, including that work prior to and subsequent to determining or re-establishing eligibility for MA.
- ***MA Undercare Change/Undercare Maintenance*** - This work involves determining if a change in an MA case's circumstances affects the case category (FP or FNP) or the case eligibility. It includes all undercare work following a determination such as updating case data on the Welfare Management System (WMS).
- ***MA claims processing*** - While most MA program expenditures are processed at the state level through a fiscal agent, there are some MA expenditures that the local districts may still process. One example is payment of medical insurance premiums.

The Schedule D-4 has been revised, starting with the original claim submission for July 2003, to include certain administrative costs related to the Working Disabled Buy-In Program. This program is also known as the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD Program). The Working Disabled Buy-In program provides health care insurance to disabled people to enable them to work. To be eligible to take part in this Working Disabled Buy-In program participants must meet the following criteria:

- Be at least 16 years of age but under the age of 65 to participate in the program,
- The person must otherwise have been eligible for benefits under the SSI program except that earnings were in excess of the allowable limit,
- Net available income must not exceed 250% of Federal Poverty Level (FPL) for an one or two person household,
- Resources cannot exceed $10,000, and

- The participant must contribute to the cost of medical assistance in accordance with the premium structure defined in law.

OR

- Be at least 16 years of age but under the age of 65 and employed,
- The participant must have been eligible under the basic coverage group but lost their eligibility because their medical condition improved to the point that they were no longer disabled as SSI defines the term,
- No longer in receipt of medical assistance because they are no longer eligible for SSI disability benefits or disability issuance benefits under the Social Security Act,
- Continues to have a severe medically determinable impairment,
- Contributes to the cost of medical assistance in accordance with the premium structure, and
- Their employment consists of working at least forty hours per month at minimum wage.

Under the premium structure participants in the Working Disabled Buy-In program with net available income less than 150% FPL will have 0% as their premium. Participants with net available income between 150% and 250% FPL will have 7.5% of Net Unearned Income and 3% of Net Earned Income as their premium amounts. The administrative costs for the Working Disabled program are reimbursed at 50% federal share and 50% state share with the exception of A-87 costs that are funded 50% federal share and 50% local share. These costs are not exempt from the local district administrative cost cap.

The Schedule D-4 also reports State Child Health Plus (SCHIP) Program Medicaid expansion administrative costs. The State Child Health Plus provides low-income children who are currently uninsured with health care coverage. These administrative expenditures are associated with the new Medicaid cases arising from the outreach efforts made to provide full Medicaid coverage to children who are 15 to 19 years of age at the 100% federal poverty line and children who are 6 to 19 years of age at the 133% federal poverty line. The administrative costs for this program are reimbursed at 65% federal and 35% state. They are exempt from the local district administrative cost cap.

In addition, the Schedule D-4 reports costs related to contractual agreements between the local social services districts and their early intervention agencies that act on behalf of the local district to identify and assess the health care needs of infants and toddlers eligible for the Child/Teen Health Plan

Activities reported in the F4 function may include:

- Administration and supervision of personnel assigned to work on the Medical Assistance Program.
- Resource investigations related to Medical Assistance cases. These costs are exclusive of the activities in the F10 Fraud and Abuse function.
- Caseworker activities.
- Support activities including accounting, legal, and clerical services, which are clearly identified as benefiting the F4 function.
- Outreach and other administrative activities related to the Medicaid expansion because of the State Child Health Insurance Plan (SCHIP).
- WMS MA administrative activities.

The F4 function should specifically exclude the following costs, which should be coded to the F5 function:

- Medical Assistance Policy Planning/Administration activities eligible for federal reimbursement of 75%.
- Professional Medical Contract activities eligible for 75% federal reimbursement.
- WMS MA administrative activities.
- Travel related to Professional Medical staff.

Types of Employees Assigned to the F4 Function

The following staff should be coded to the F4 function:

- Personnel who determine eligibility for MA-Only clients.
- MA resource investigation workers not included in the F10 Fraud and Abuse function.
- Administrative and supervisory personnel engaged in directing activities of the MA program. These staff members would be included in the F4 function only if they do not have the skilled professional medical education or training to qualify for coding to the F5 MA Policy Planning/ Administration function.
- Clerical and stenographic who support the employees listed above.
- Other units, which are clearly identified as providing support only to F4 coded staff including accounting, legal, and MA systems and procedures staff.
- Personnel who perform outreach activities and screening of low-income children for the State Child Health Plus (SCHIP) program. Such costs should be identified as F4.3

Staff devoted full time to Medical Assistance activities for Indians should be coded F4.1. This category is eligible for 100% state reimbursement on the RF-3, Section B (Additional State Aid for Indian Activities).

Full time staff who are performing personal care services on a full time basis should be coded F4.2.

Where an employee is assigned to more functions than the F4 function, a percentage of the individual's time should be counted in each applicable function. Instructions on the completion of time studies to distribute an individual's salary and person count among functions appear in Chapter 4 of this manual.

Types of Costs Allocated to the F4 Function

Costs charged to the MA eligibility function may include the following:

- Salary costs charged for employee time and effort devoted specifically to the MA F4 function.
- Non-salary costs, including, but not limited to, materials, equipment, MA transportation costs paid to a client or his/her attendant, and other expenditures specifically needed for performing F4 coded activities. Non-salary costs for this function would also include any non-salary costs related to SCHIP outreach.
- Overall overhead costs allocated on the Schedule D to the F4 function from the F40 function;
- DSS overhead costs allocated on the Schedule D to the F4 function from the F20 function;

- Welfare Management System (WMS) costs allocated to the Medical Assistance Program from the WMS Worksheet. (See Chapter 17 of this manual for more information on allocating WMS costs to the benefiting programs.);
- A-87 city-wide indirect DSS costs allocated on the Schedule D to the F4 function from the overhead functions; and
- MA eligibility determination costs identified from results of the I/CM-RMS as costs benefiting the MA Program are transferred to this function. Beneficial costs represent F1 coded eligibility activity for both TANF and Safety Net recipients that are shared with the F4 MA function. These costs are transferred from Schedule D-1 to Schedule D-4. (See Chapters 8 and 21 for further information on the I/CM-RMS process.)
- F2 coded MA health-related service costs for activities that are identified by the Services Random Moment Study (SRMS) percentages. These activities include MA eligibility determinations and re-determinations, MA case management activities, referrals of children for services included in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Also included are referrals for services provided to MA eligible adults and children not covered by EPSDT or case management. This activity also includes the provision of assistance in arranging for, transporting to, or implementing physical and mental health care services and plans. These costs are transferred from the Schedule D-2 to the Schedule D-4. (See Chapters 9 and 23 of this manual for more information on the SRMS process.)
- Directly identified costs related to staff that directly provides personal care services to MA recipients.
- MA Family Planning costs determined by using the MA Family Planning percentage calculated by the local district on a quarterly basis from the Medical Assistance Statistical Report (MR-0-36).
- Contracts with designated early intervention agencies (object of expense code 18.3) that act on behalf of the local district to identify and assess the health care needs of infants and toddlers eligible for the Child/Teen Health Plan. Such costs should be identified as F4.3
- Medical transportation costs. Certain medical transportation expenditures must be claimed as administrative costs rather then assistance costs, the following are the guidelines on which costs are claimable under what group.
    - All transportation services furnished by a provider to whom a direct vendor payment can be made are claimable for reimbursement as assistance costs. A provider is any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency. If there is no provider agreement in place then the transportation expenditures must be claimed as administrative costs.
    - All non-vendor transportation payments should be claimed for reimbursement as administrative costs.

      These non-vendor payments include, but are not limited to the following:
        - Reimbursement to recipients for medical transportation,
        - Costs of meals and/or lodging enroute to and from medical care, and while receiving medical care,

- Costs of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary,
- Costs of bus and subway tokens/passes purchased from the local transportation authority by the local department for distribution to recipients, and
- Payments made to a party that is not the provider of the transportation service.

MA Federal Participation Percentages

There are two percentages to identify the federal participation of MA costs. These are the Medical Assistance Federally Participating Percentage (MA-FP) and the Safety Net Beneficial Federal Participation Percentage (SN-FP).

The Medical Assistance Federally Participating Percentage (MA-FP%) is calculated by the local district on a quarterly basis from information contained in the same MR-0-36 report used to calculate the MA Family Planning percentage. This MA-FP% is applied to F4 coded MA Eligibility and Family Planning costs. This percentage is used to determine how much of the F4 costs can be claimed for federal participation. Since some of the MA cases are federally non-participating (FNP) cases, the administrative costs of the MA program are apportioned between the MA-FP and the MA-FNP reimbursement categories using this percentage.

The MA Federal Participation percentage is provided by the Bureau of Financial Services (BFS) on a quarterly basis, and applied to SN Beneficial costs transferred from the Schedule D-1 to the Schedule D-4 (in section 3 of the Schedule D-4).

Local Share Medicaid Takeover Plan

New York State will cap the local share of Medicaid, including administrative costs as of January 1, 2006. As enacted, the law establishes calendar year 2005 as the base period with annual increases of 3.5% for calendar year 2006, 3.25% for calendar year 2007, and 3.00% for calendar year 2008 and each year thereafter. This modest growth rate is applied in a non-compounded manner and converted to State fiscal year amounts. The State Department of Health (DOH) has calculated district-specific estimated local share cap amounts for State Fiscal Years 2005/06 and 2006/07 using the 2005 base period. Starting January 1, 2006 the local districts will pay equal weekly payments based on the calculated amount for SFY 2005/06. Starting April 1, 2006, the local districts will pay equal weekly payments based on the SFY 2006/07 amount. The DOH will compute the calendar year 2005 amounts using the actual expenditures and adjustments by June 30, 2006 and promulgate final annual (and weekly) State fiscal year caps for SFY 2005/06 and SFY 2006/07. This will result in the establishment of the final cap and an adjustment in payment amounts. Further, a reconciliation of the estimated and final cap amounts will be completed no later than December 30, 2006. The local districts should continue to complete the medical assistance claim schedules showing local shares of their expenditures. These costs will be compared to the capped amount to determine under or over reimbursement for the period of the claim.

The DOH will notify the local districts of hte results as these milestones are reached.

Commencing Janaury 1, 2008, districts will have the option of the using a sales tax intercept methodology to meet their cap allocations. The law provides specific local resolution language which much be delivered by certified mail to the Department of Health no later than September 30, 2007 if a district wishes to utilize

the sales tax methodology. Districts **cannot** rescind this decision. Effective January 1, 2008, local district Medicaid cap payments ot the State, at the option of the local district government, will be based on:

- The capped local contribution methodology; or
- A fixed percentage of local sales tax revenue based on the 2006/07 capped contribution and local sales tax base.

CLAIMING OF F4 COSTS ON THE LDSS 2347B-2 "SCHEDULE D-4 CALCULATION FOR MEDICAL ASSISTANCE ELIGIBILITY DETERMINATION/AUTHORIZATION/ PAYMENT COST SHARES"

The Schedule D-4 is used for the distribution and claiming of F4 coded MA administrative expenditures transferred from the Schedule D, F1 coded MA Beneficial administrative costs transferred from the Schedule D-1, and F2 coded MA Health Related administrative costs transferred from the Schedule D-2. MA Eligibility, Family Planning, Personal Care costs, Child Health Plus, Early Intervention Program contracts, and related A-87 costs are identified along with applicable federal participation rates and federal, state, and local shares.

Instructions for Schedule D-4

The Schedule D-4 is completed and submitted monthly. All districts must complete sections 1, 2, and 3. Section 3 should be completed first since some numbers computed in that section are carried to the other sections. It is important to note that calculated negative numbers must be replaced by zeros on the Schedule D-4. Negative numbers cannot be entered. Also, please note that the Medical Assistance Statistical Report (MR-0-36) has been reporting small numbers (usually negative) for the Title XXI State Child Health Plus program. As this program has ended, do not report these numbers. Any necessary adjustments to allocation percentages should be taken against the largest result.

Section 1 - Calculation of Federal, State and Local Shares

Line 1 - Total MA Costs

Column 1 Total

Enter the total Medical Assistance Eligibility Determination/ Authorization/Payment amount from Schedule D, line 23, column 4.

Column 2 Title XIX MA Eligibility

Subtract from the amount in column 1, the sum of the amounts in columns 3, 4, 5, and 6, and enter the result in column 2 of line 1.

Column 3 Title XIX Family Planning

Subtract the amount in column 4 (Personal Care) from the amount in column 1 (Total). Multiply this result by the Medical Assistance Family Planning percentage, and enter the product in column 3, line 1.

The MA-Family Planning percentage is calculated on a quarterly basis from the Medical Assistance Statistical Report (MR-0-36). The MR-0-36 report used is dated for the middle month of the preceding quarter. For example, February's MR-0-36 report is used to calculate the Family Planning Percentage for claims submitted by the district for April, May, and June. If this report is unavailable, the local district should use the latest MR-0-36 report they have on file.

The calculation is determined from the Grand Total Section of the MR-0-36 report. The sum of the Grand Total beneficiary counts for Family Planning and Child/Teen Health Plan(C/THP) Family Planning is the numerator. The sum of the beneficiary counts for the Family Planning, C/THP, C/THP Family Planning, and All Other Services is the denominator.

Total beneficiaries listed on the MR-0-36 report represent an unduplicated recipient count. In other words, a recipient may have been included in more than one aid category, but is included only once in the total. Therefore, the total amount reported on the MR-0-36 report should **not** be used as the denominator in this calculation.

Column 4 Title XIX Personal Care

Enter those costs included in column 1 which are identified for any full time Personal Care staff who have been assigned to Function F4.2.

Column 5 Title XXI State Child Health Plus

Subtract the amount in column 4 (Personal Care) from the amount in column 1 (Total). Multiply this result by the State Child Health Plus percentage, and enter the product in column 5, line 1. If you have staff and other costs solely devoted to this program, and directly identifiable to this activity, then report those costs here and do not use the percentage method above. Only one method can be used to report these costs.

The State Child Health Plus percentage is calculated on a quarterly basis from the Medical Assistance Statistical Report (MR-0-36). The MR-0-36 report used is for the middle month of the quarter of the preceding quarter. For example, February's MR-0-36 report is used to calculate the State Child Health Plus percentage for claims submitted by the district for April, May, and June. If this report is unavailable, the local district should use the latest MR-0-36 report they have on file.

The calculation is determined from the Grand Total Section of the MR-0-36 report. The beneficiary count for the **Child 6-18 (133% FPL)** category is the numerator. The beneficiary counts for the Total of All Beneficiaries is the denominator.

Total beneficiaries listed on the MR-0-36 report represent an unduplicated recipient count. In other words, a recipient may have been included in more than one aid category, but is included only once in the total. Therefore, the total amount reported on the MR-0-36 report should be used as the denominator in this calculation.

Column 6 Working Disabled Buy-In Program

Subtract the amount in column 4 (Personal Care) from the amount in column 1 (Total). Multiply this result by the Working Disabled Buy-In percentage, and enter the product in column 6, line 1. If you have staff and other costs solely devoted to this program, and directly identifiable to this activity, then report those costs here and do not use the percentage method above. Only one method can be used to report these costs.

The Working Disabled Buy-In percentage is calculated on a quarterly basis from the Medical Assistance Statistical Report (MR-0-36). The MR-0-36 report used is for the middle month of the quarter of the preceding quarter. For example, August's MR-0-36 report is used to calculate the Working Disabled Buy-In percentage for claims submitted by the district for October, November and December. If this report is unavailable, the local district should use the latest MR-0-36 report they have on file.

The calculation is determined from the Grand Total Section of the MR-0-36 report. The total beneficiary counts for the aid category "Medicaid Buy-In-Disabled" and the aid category "Medicaid Buy-In-Medically Improved" should be added together and the result will be the numerator. These two aid categories will have three age groups of 0-20, 21-64, and 65+. Due to the design of the MR-0-36 report the age group 65+ is included within the list, however this age group is not eligible for either program. If a beneficiary count does appear in this age group it should not be include with either the numerator or denominator counts. Please use the total counts for each category. The beneficiary counts for the Total of All Beneficiaries is the denominator.

Total beneficiaries listed on the MR-0-36 report represent an unduplicated recipient count. In other words, a recipient may have been included in more than one aid category, but is included only once in the total. Therefore, the total amount reported on the MR-0-36 report should be used as the denominator in this calculation.

Line 2 MA Federal Participating (MA-FP) Percentage

Enter in column 1 the MA Federal Participating percentage.

This percentage is determined on a quarterly basis using the Grand Total Section of the Medical Assistance Statistical Report (MR-0-36). This is calculated by dividing the number of beneficiaries in the total column (for the aid category subtotal labeled "FP Total Title XIX Recipient") by the number of beneficiaries in the total column of the Grand Total line.

Due to a special 1115 demonstration project most MA recipients are consider to be federally eligible so that the MA-FP rate should be in the very high nineties percentages or may be one hundred percent.

The local districts will use the MR-0-36 report from the middle month of the previous quarter to calculate this percentage. If this report is unavailable, the local district should use the latest MR-0-36 report they have on file.

Line 3 Expenditures Eligible for Federal Participation

Multiply each amount entered on line 1, columns 2 and 3 by the percentage on line 2, column 1 and enter the results on this line in the appropriate column. Bring down the amounts on line 1, columns 4, 5, and 6 to the respective columns of this line. Add the amounts in columns 2, 3, 4, 5, and 6 together and enter the result in column 1, line 3.

Line 4 MA Health Related Costs Transferred From Schedule D-2

Enter in columns 1 and 2 of this line the amount reported on Schedule D-2, section 1, line 12, column 6 for Title XIX MA Health Related Services.

Line 5 TANF/Family Assistance Beneficial Costs transferred from Schedule D-1

Enter in columns 1 and 2 of this line the result of adding together the TANF/Family Assistance and the Safety Net MOE Beneficial MA activity amounts reported on Schedule D-1, section 1, line 7, column 2 and column 3 respectively.

Line 6 Safety Net Beneficial Costs eligible for Federal Funding

Enter in columns 1 and 2 of this line the amount taken from section 3, line 1, column 3 of this schedule. This is the amount of the Safety Net (SN) MA Beneficial Activity Costs transferred from Schedule D-1, section 1, line 7, column 6, that is eligible for federal funding.

Line 7 Total MA Costs Eligible for Federal Financial Participation

For columns 1 through 6, add the amounts on lines 3 through 6 together, and enter the results in the appropriate columns. For line 7, the sum of the amounts in columns 2, 3, 4, 5, and 6 should equal the total of lines 3, 4, 5 and 6, for column 1.

Line 8 Federal Share

Multiply the amounts reported on line 7, columns 2, 4, and 6 by 50% and enter the results in the appropriate columns. Multiply the amount on line 7, column 5 by 65% and enter the result in the respective column. Multiply the amount on line 7, column 3 by 90% and enter the result in the respective column. Add columns 2, 3, 4, 5, and 6 together and enter the result in column 1.

Line 9 SN Beneficial Costs from Schedule D-1, State Funded

Enter in columns 1 and 2 of this line the Balance amount from section 3, line 1, column 4 of this schedule. This is the amount of the SN MA Beneficial Activity Costs transferred from Schedule D-1 that is eligible for state funding only.

Line 10 Early Intervention Program Contracts

As there is only federal reimbursement available for Early Intervention Program Contract expenditures the local districts will perform a three-part calculation to determine the non-federal share of these costs. First, multiply the total of the contracts listed in object of expense code 18.3 of the Schedule LDSS-923 Summary by the MA-Federal Participating (MA-FP) Percentage from line 2 above. Multiply this result by 50 percent to determine the federal share received on line 8-Federal Share. Subtract this federal share amount from the total amount of the contracts and enter that amount in columns 1 and 2 of this line.

Line 11 Balance

For each column, enter the result of adding together the amounts on lines 1, 4, 5, 6 and 9 and subtracting the amounts on lines 8 and 10 from that sum. The sum of columns 2, 3, 4, 5, and 6 together should equal the result of adding together the amounts on column 1, lines 1, 4, 5, 6, and 9, and subtracting the amounts on column 1, lines 8 and 10 from that result.

Line 12 State Share

Multiply the amounts reported on line 11, columns 2 through 4 by 50 percent, and enter the results in the appropriate columns. For columns 5 and 6, bring down the amount on line 11 in the respective column. Add the amounts in columns 2, 3, 4, 5, and 6 together and enter the result in column 1. Please note that there is thirty-five percent state share reimbursement for the Child Health Plus program that is outside the state administrative cost cap.

Line 13 Local Share

For columns 3, 4, 5, and 6, enter the result of subtracting the amount on line 12 from the amount on line 11. For column 2 enter the result of adding together the amount on line 10 and the amount on line 11 and subtracting from that result the amount on line 12. The sum of the amounts in columns 2, 3, 4, 5, and 6 should equal the result of subtracting the amount on line 12, column 1 from the amount on line 11, column 1 and adding the amount on line 10, column 1.

Section 2 - A-87 Costs

Line 1 Total MA A-87 Costs

Column 1 Total

Enter in column 1 the Medical Assistance Eligibility A-87 costs reported on Schedule D, line 29, column 4.

Column 2 Title XIX MA Eligibility

Subtract the amounts in columns 3, 4, 5, and 6 of this line from column 1 and enter the result here.

Column 3 Title XIX Family Planning

Multiply the remainder of column 1 less the amount in column 4 by the Medical Assistance Family Planning percentage, and enter the result here. (The Family Planning Percentage is determined in section 1 above.)

Column 4 Title XIX Personal Care

Multiply the amount in column 1 of this line by the result of Title XIX MA - Personal Care Costs divided by Total Medical Assistance Eligibility costs. The amounts used for this calculation are taken from line 1 of section 1 above.

Column 5 Title XXI State Child Health Plus

Multiply the remainder of the amount in column 1 of this line less the amount in column 4 by the Medical Assistance State Child Health Insurance Plus (SCHIP) percentage, and enter the result here. (The SCHIP percentage is determined in section 1 above.)

Column 6 Working Disabled Buy-In Program

Multiply the amount in column 1 of this line by the Medical Assistance Working Disabled Buy-In percentage, and enter the result here. The Working Disabled Buy-In percentage is determined in section 1 above.

The sum of the amounts columns 2, 3, 4, 5, and 6 should equal the amount in column 1.

Line 2 MA Federal Participating Percentage

Enter the MA Federal Participating percentage as determined in section 1, line 2 above.

Line 3 Costs Eligible for Federal Participation

Multiply the amounts entered on line 1, columns 2, and 3 by the percentage on line 2, column 1, and enter the results in the appropriate columns. Bring down the amounts from line 1, columns 4, 5, and 6 to the respective columns of this line. Add together the amounts in columns 2, 3, 4, 5, and 6 and enter the sum in column 1.

Line 4 Costs From Schedule D-2

Enter in columns 1 and 2 the amount reported on Schedule D-2, section 2, line 10, column 6 for Title XIX-MA Health Related Services.

Line 5 TANF/Family Assistance Beneficial Costs from Schedule D-1

Enter in columns 1 and 2 of this line the result of adding together the TANF/Family Assistance and the Safety Net MOE Beneficial A-87 amounts reported on Schedule D-1, section 2, line 7, column 2 and column 3 respectively.

Line 6 SN Beneficial Costs from Schedule D-1, Federally Funded

Enter in columns 1 and 2 of this line the amount from section 3, line 2, column 3 of the Schedule D-4. This is the amount of the SN Medicaid Beneficial Activity A-87 costs transferred from Schedule D-1, section 2, line 7, column 6 that is eligible for federal funding.

Line 7 Total A-87 Costs Eligible for Federal Financial Participation

Enter in the appropriate columns the results of adding together the amounts on lines 3 through 6. The sum of the amounts in columns 2, 3, 4, 5, and 6 should equal the sum of the amounts in lines 3 through 6 in column 1.

Line 8 Federal Share

Multiply the amounts reported on line 7, columns 2, 4, and 6 by 50%, and enter the results in the appropriate columns. Multiply the amount reported on line 7, column 5 by 65%, and enter the result in column 5. Multiply the amount reported on line 7, column 3 by 90%, and enter the result in column 3. Add the amounts in columns 2, 3, 4, 5, and 6, and enter the sum in column 1.

Line 9 SN Beneficial Costs from Schedule D-1, Locally Funded

Enter in columns 1 and 2 of this line the amount from section 3, line 2, column 4 of this schedule. This is the amount of the SN MA Beneficial Activity A-87 costs transferred from Schedule D-1, section 2, line 7, column 6, that is only locally funded.

Line 10 Total Local Share

Enter the result of adding together the amounts on lines 1, 4, 5, 6 and 9, and subtracting line 8 from that sum for each column. The sum of the amounts on line 10, columns 2, 3, 4, 5, and 6 should equal the sum of the amounts in column 1, on lines 1, 4, 5, 6, and 9 less the amount on line 8.

There is no state share funding of A-87 Costs for any program.

Section 3 - Federal Funding of Safety Net Beneficial Costs

The MA portion of the SN beneficial costs is transferred from the Schedule D-1 to the Schedule D-4 and a portion of these transferred costs is federally reimbursable. This section determines the amount of federal funding for SN Beneficial costs.

Line 1 Total Costs

Column 1 SN Beneficial Costs

Enter the amount from Schedule D-1, section 1, line 7, column 6.

Column 2 Safety Net FP%

Column 2 should contain a federally participating percentage used to determine federal funding of SN beneficial costs. The Bureau of Financial Services provides this percentage to local districts. This percentage is calculated from the most current quarterly MA Eligibility Statistical Report. This report has eight (8) categories of assistance: Default FNP, Old HR, SN w/o Dep, Veterans, Public Home, Alien (FP), Alien (FNP), and Pub Shel. The federal participation percentage is the result of dividing the total number of recipients in Old HR, SN w/o Dep, and Veterans by the total number of eligibles in Safety Net.

Column 3 Federal Funding

Multiply the amount in column 1, line 1, section 3 by the percentage in column 2, line 1, and enter the result in column 3. Carry this amount to section 1, line 6, columns 1 and 2.

Column 4 Balance

Subtract the amount in column 3 from the amount in column 1 of line 1, and enter the result in this column. Carry this amount to line 9, columns 1 and 2 in section 1 of this schedule.

Line 2 - A-87 Costs

Column 1 SN Beneficial Costs

Enter the amount from Schedule D-1, section 2, line 7, column 6.

Column 2 FP%

Enter the FP% from line 1, column 2, section 3 of this schedule.

Column 3 Federal Funding

Multiply the amount in column 1, line 2, section 3 by the percentage in column 2, line 2, and enter the result here. Carry this amount to line 6, columns 1 and 2 of section 2 of this schedule.

Column 4 Balance

Subtract the amount in column 3 from the amount in column 1 of this line, and enter the result in this column. Carry this amount to line 9, columns 1 and 2 of section 2 of this schedule.

LDSS-2347-B2 (Rev. 10/08)

Schedule D-4
Calculation of Medical Assistance Eligibility
Determination/Authorization/Payments Cost Shares

New York State — Office of Temporary and Disability Assistance

Section 1: Calculation of Federal, State and Local Shares — MONTH: — DISTRICT:

ITEM	TOTAL (1)	TITLE XIX MA ELIGIBILITY (2)	TITLE XIX FAMILY PLANNING (3)	TITLE XIX PERSONAL CARE (4)	STATE CHILD HEALTH PLUS (5)	WORKING DISABLED (6)
1. Total MA Costs						
2. Federal Participating Percentage	%					
3. Expenditures Eligible for FFP						
4. Costs from Schedule D-2						
5. TANF Beneficial Costs from Schedule D-1						
6. Safety Net Beneficial Costs from Schedule D-1 Federally Funded						
7. Total MA Costs Eligible for FFP						
8. Federal Share						
9. Safety Net Beneficial Costs from Schedule D-1 State Funded						
10. Early Intervention Program Contracts						
11. Balance						
12. State Share						
13. Local Share						

LDSS-2347-B2 Reverse (10/08)

Schedule D-4

Calculation of Medical Assistance Eligibility Determination/Authorization/Payments Cost Shares

Section 2 - A-87 Costs

Item	Total (1)	Title XIX MA Eligibility (2)	Title XIX Family Planning (3)	Title XIX Personal Care (4)	State Child Health Plus (5)	Working Disabled (6)
1. Total MA A-87 Costs						
2. Federal Participation Percentage	%					
3. Costs Eligible for Federal Participation						
4. Costs from Schedule D-2						
5. TANF Beneficial Costs from Schedule D-1						
6. Safety Net Beneficial Costs from Schedule D-1 Fed. Funded						
7. Total A-87 Costs Eligible for FFP						
8. Federal Share						
9. Safety Net Beneficial Costs from Schedule D-1 Local Funded						
10. Total Local Share						

Section 3: Federal Funding of Safety Net Beneficial Costs

Item	SN Beneficial Costs (1)	Safety Net FP % (2)	Federal Funding (3)	Balance (4)
1. Total Costs		X	=	
2. A-87 Costs		X	=	

Chapter 12: Medical Assistance Policy Planning/Administration (F5)

Introduction *12-2*

Description *12-2*

Types of Employees Assigned to the F5 Function *12-2*

Types of Costs Allocated to the F5 Function *12-4*

Claiming of F5 Costs on the LDSS 2347B-3 "Schedule D-5 Calculation of Medical Assistance Policy Planning/Administration Cost Shares" *12-4*

INTRODUCTION

This chapter describes the Medical Assistance Policy Planning/Administration function, the types of employees assigned to this function, and the types of costs assigned to this function.

DESCRIPTION

The Medical Assistance Policy Planning/Administration function (F5) encompasses administrative aspects of the Title XIX MA program which require professional medical analysis and judgment from skilled professional medical personnel. The direct salaries and fringe benefits of skilled professional medical personnel and their direct support staff are eligible for 75% federal reimbursement. Non-salary expenditures for travel of skilled professional medical personnel and direct support staff, expenditures related to Medical Professional Contracts identified for the Medical Assistance program are also eligible for 75% federal reimbursement.

The costs for staff of other public agencies performing the F5 function activities may be eligible for 75% federal reimbursement. The activities provided must be directly related to the administration of the Medical Assistance Program, and employee education and work requirements specified below must be met. As documentation for the 75% federal participation, there must be a written agreement between parties which verifies these requirements are met.

There is a 90% federal share available for F5 activities related to Family Planning including overhead costs.

A 50% federal share is available for the amounts claimed in the F5 function which do not qualify for either 75% or 90% federal reimbursement. These amounts include non-salary costs other than those specified previously, and overhead costs allocated to the F5 function.

The federal shares noted above are applied to the portion of F5 costs which are federally participating. This portion is determined by the application of the Federal Participating percentage (FP%) described in the previous chapter on the F4 function.

TYPES OF EMPLOYEES ASSIGNED TO THE F5 FUNCTION

The employees assigned to this function include skilled medical personnel and their direct supporting staff.

The skilled professional medical personnel must have professional education and training in the field of medical care or appropriate medical practice. The phrase, professional education and training, means the completion of a two year or longer program leading to an academic degree or certificate in a medically related profession. This qualification is demonstrated by possession of a medical license, certificate, or other document from a recognized national or state medical licensing or certifying organization. It also can be documented by a degree in a medical field issued by a college or university certified by a professional medical organization.

Skilled professional medical personnel eligible for coding to the F5 function include physicians, dentists, nurses, medical or psychiatric health workers, hospital or public health administrators, or other specialized personnel in the field of medical care.

Medical Social Workers must have a Master of Social Work (MSW) degree. As part of the course work for the Master's degree, a specialization (track or concentration) in clinical practice, health care practice, other medical application, or the equivalent.

The equivalent requirements are met in the following situations:

- The social worker completed the graduate degree at a school that offered health care or medical specializations, but the social worker formally concentrated in another area. The social worker would qualify if he/she completed as many health courses as would be required for concentrations in health care.
- The social worker completed a graduate program that offered concentrations, but none distinctly in health care or medical applications. The transcript must show at least as many credits received in health care as would be required for any of the concentrations offered. For example, if a minimum of four courses is required for any concentrations, the transcript must show completion of at least four courses in health or medical applications.

Their work in administering the Title XIX MA program must require professional medical knowledge and skills. A documented employer-employee relationship must exist between the local social services agency and the skilled professional medical personnel and their direct support staff.

Experience in the administration, direction, or implementation of the medical assistance program is not considered the equivalent of professional training in a medical field or medical knowledge and skills.

Duties of skilled professional medical personnel may include the following:

- Planning the scope of the MA program;
- Determining medical care to be delivered including the responsibility for determining the level of institutional care patients require, also securing nursing home beds appropriate for the medical needs of patients;
- Acting as a liaison on the medical aspects with providers of services and other agencies that provide medical care;
- Furnishing expert medical opinions for the adjudication of administrative appeals;
- Reviewing complex medical billings;
- Providing technical assistance and drug abuse screening on pharmacy billings;
- Participating in medical review or independent professional review team activities including conducting, researching, and evaluating the delivery of medical services;
- Assessing the necessity for and adequacy of medical care and services provided, as in a utilization review; and
- Assessing, through case management activities, the necessity for and adequacy of medical care and services for individual recipients.

Other staff eligible for F5 coding include those who directly support skilled professional medical personnel in the MA Policy Planning/Administration function. Support staff is the general description for secretarial, stenographic, and clerical staff, administrative assistants, and other sub-professional staff in work assignments necessary for the completion of professional responsibilities and functions of skilled professional

medical staff. The skilled professional medical staff must directly supervise the support staff's work for support staff to be coded to the F5 function.

TYPES OF COSTS ALLOCATED TO THE F5 FUNCTION

The costs chargeable to the MA Policy Planning/Administration function may include the following:

- Direct salary and fringe benefits for employee time and effort devoted specifically to the MA Policy Planning and Administrative function by the types of employees assigned to the F5 function as described above.
- Medical Professional Contracts which are personal service contracts between the local social services district and a skilled professional medical person (not an organization) performing policy, planning, and administration activities. In this case, the skilled professional medical person is not on the local social services district payroll. These costs are reported under object of expense code 18.1.
- The costs for staff of other public agencies performing the F5 function provided that the specific requirements for 75% federal reimbursement are met, and documented in a written agreement between the parties.
- The costs of travel for F5 coded staff.
- Salary and Non-salary Overall Overhead costs allocated to the F5 function from the F40 function.
- Salary and Non-salary DSS Overhead costs allocated to the F5 function from the F20 function.

The above types of costs also include an MA Family Planning component through the application of the Family Planning Percentage to F5 costs. Please refer to the previous chapter on F4 costs for a description of this percentage, and how it is calculated.

All other non-salary costs incurred to perform the MA Policy Planning/ Administration function should be coded F4 and claimed for 50% federal reimbursement on Schedule D-4.

MA Policy Planning/Administration staff training costs are reported in the F6 function.

CLAIMING OF F5 COSTS ON THE LDSS 2347B-3 "SCHEDULE D-5 CALCULATION OF MEDICAL ASSISTANCE POLICY PLANNING/ADMINISTRATION COST SHARES"

The Schedule D-5 is used for distribution and claiming of MA Policy Planning/Administration, and MA Family Planning expenditures. Federal reimbursement is available at 75% (50% on overhead costs) on allowable federally participating amounts of the MA Policy Planning/Administration expenditures. Federal reimbursement is available at 90% for all federally participating MA Family Planning amounts including Family Planning amounts identified for Overhead functions.

A-87 city-wide costs are also eligible for Federal reimbursement of 50% on MA Policy Planning/Administration amounts, and 90% on Family Planning amounts

Instructions for the Schedule D-5

Each month the local districts must complete Sections 1, 2, and 3 of the Schedule D-5

Section 1 - Calculation of Federal, State and Local Shares of Administrative Costs

Line 1

Column 1 Total Salary and Non-Salary Expenditures

Enter the result of adding together the amounts from Schedule D, column 5, lines 5 (Total Salaries and Fringe Benefits) and 15 (Non-Salary Costs Assigned to Function).

Column 2 Family Planning

Multiply the MA Family Planning percentage calculated by the district for the preparation of this month's Schedule D-4 times the amount in column 1, line 1. Enter the result in column 2, line 1.

Column 3 Planning/Administration

Enter the result of subtracting the amount in column 2, line 1 from the amount in column 1, line 1.

Line 2 Federal Participating Percentage (FP%)

Enter the FP% from Schedule D-4, section 1, column 1, line 2.

Line 3 Expenditures Eligible for FP

Multiply the amounts entered on line 1, columns 2 and 3, by the FP% on line 2, and enter the results on line 3 in the respective columns. Add the amounts in line 3, columns 2 and 3 together and enter the result in column 1, line 3.

Line 4 Federal Share

Multiply the amount entered on line 3, column 2 by 90%, and the amount entered on line 3, column 3 by 75%, and enter the results in the respective columns. Add the amounts in line 4, columns 2 and 3 together and enter the result in column 1, line 4.

Line 5

Column 1 Total Overhead Costs

Enter in line 5, column 1 the result of subtracting the line 1, column 1 amount above from the amount on Schedule D, column 5, line 23 (Total Salary & Non-Salary Expenses).

Column 2 Family Planning

Multiply the MA Family Planning percentage calculated by the district for the preparation of this month's Schedule D-4 times the amount in column 1, line 5. Enter the result in column 2, line 5.

Column 3 Planning/Administration

Enter the result of subtracting the amount in column 2, line 5, from the amount in column 1, line 5.

Line 6 FP Amount

Multiply the amounts entered on line 5, columns 2 and 3, by the FP% on line 2, and enter the results on line 6 in the respective columns. Add the amounts in line 6, columns 2 and 3 together and enter the result in column 1, line 6.

Line 7 Federal Share

Multiply the amount on column 2, line 6 by 90%, and the amount entered on column 3, line 6 by 50%, and enter the results in the respective columns. Add the amounts in columns 2 and 3 together and enter the result in column 1, line 7.

Line 8 Total Federal Share

Add the amounts in columns 2 and 3 for lines 4 and 7 together and enter the results in the respective columns on line 8. Add the amounts in line 8, columns 2 and 3 together and enter the result in column1, line 8.

Line 9 Balance After Federal Share

Enter in each column the result of subtracting line 8 from the total of lines 1 and 5.

Line 10 State Share

Multiply the amounts in columns 2 and 3 by 50% and enter the results in the respective columns. Add the amounts in line 10, columns 2 and 3 together and enter the result in column 1, line 10.

Line 11 Local Share

Enter in each column the result of subtracting line 10 from line 9.

Section 2 - Calculation of A-87 Costs

Line 1

Column 1 Total A-87 Costs

Enter the amount from Schedule D, column 5, line 29.

Column 2 Family Planning

Multiply the MA Family Planning percentage calculated by the district for preparation of this month's Schedule D-4 times the amount in column 1, line1. Enter the result in column 2, line 1.

Column 3 Planning/Administration

Enter the result of subtracting the amount in column 2, line 1 from the amount in column 1, line 1.

Line 2 Federal Participating Percentage (FP%)

Enter the percentage from section 1, column 1, line 2 of this schedule.

Line 3 Expenditures Eligible for FP

Multiply the amounts entered on line 1, columns 2 and 3 by the FP% percentage on line 2, column 1. Enter the results on this line in the appropriate columns. Add the amounts in columns 2 and 3 on this line together, and enter the result in line 3, column 1.

Line 4 Federal Share

Multiply the amount reported on line 3, column 2 by 90%, and enter the result on this line in column 2. Multiply the amount reported on line 3, column 3 by 50%, and enter the result on this line in column 3. Add the amounts in columns 2 and 3 together, and enter the result in column 1.

Line 5 Local Share

Subtract the amounts in line 4 from the amounts in line 1 for all columns, and enter the result in the appropriate columns. The sum of the amounts in columns 2 and 3 should equal the result of subtracting line 4, column 1 from line 1, col

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DISTRICT	SCHEDULE D-5 Calculation of Medical Assistance Policy Planning/ Administration Cost Shares		MONTH

SECTION 1- CALCULATION OF FEDERAL, STATE and LOCAL SHARES of ADMINISTRATIVE COSTS

	PROCEDURE	COL. 1 TOTAL	COL. 2 Family Planning	COL. 3 Planning/Administration
1	Schedule D, Column 5, (Total of Lines 5 and 15)			
2	FP% (From Schedule D-4, Line 2)	%		
3	FP Amount (Line 1 x Line 2)			
4	Federal Share (90% x Line 3, Col. 2 ,and 75% x Col. 3)			
5	Overhead Costs Sch. D, Col. 5, (Line 23 less lines 5 and 15)			
6	FP Amount (Line 2 x Line 5)			
7	Federal Share (90% x Line 6, Col. 2, and 50% x Col.3)			
8	Total Federal Share (Add Lines 4 and 7)			
9	Balance			
10	State Share			
11	Local Share			

Section 2.-**Calculation of A-87 Costs**	TOTAL	Family Planning	Planning/Administration
1. Schedule D, Column 5, Line 29			
2. FP% (From Schedule D-4, Line 2)	%		
3. FP Amount (Line 1 x Line 2)			
4. Federal Share (90% x Line 3, Col. 2, and 50% x Col. 3)			
5. Local Share			