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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 95 LCM-94

Date: August 15, 1995

Division: Management Support
and Quality
Improvement

TO: Local District Commissioners

SUBJECT: Questions and Answers from the May 3, 1995 Teleconference on
Changes to the Local District Claiming Schedules

ATTACHMENTS: Teleconference Questions and Answers

On May 3, 1995 the Bureau of Local Financial Operations and the Office of Human Resource Development presented a training session discussing changes to the fiscal claim schedules. During the training session we discussed changes to the schedules which were effective with the April, 1995 claims. For a listing of the claim forms see 95 LCM 26.

At the teleconference, participants were encouraged to ask questions regarding changes made to the claiming schedules. Attached are the questions posed as a result of the teleconference along with the answers.

If you have any questions please call Roland Levie (Regions I-IV) at 1-800-343-8859, ext. 4-7549, User ID #FMS001 or Marvin Gold (Region V) at (212) 383-1733, User ID #0FM270.

Stephanie O'Connell
Acting Director
Office of Financial Management

Local District Claiming Changes
Effective April, 1995
Teleconference Questions and Answers

1. Q) Does the Schedule K, line 3c IVE JD/PINS foster homes include Therapeutic Foster Boarding Homes (TFBH)?

A) Payments to IV-E JD/PINS included in a Therapeutic Foster Care program would be claimed on line 1 of Section I of the new Schedule K (Reimbursement Claim for Child Care Expenditures). Therapeutic Boarding Homes are subject to the maintenance, service and administrative breakout requirements. Please note that Therapeutic Foster Care should not be included with IV-E JD/PINS Foster Home amounts claimed on Section 2, line 3c of the Schedule K.

2. Q) How are Administrative expenditures for Therapeutic Foster Boarding Homes claimed?

A) Therapeutic Foster Care administrative costs should be coded under the F-2 function and claimed on the Schedule D-2. The appropriate SSRR percentages which distinguish between IVE and CW should be used.

The enhanced State reimbursement that previously provided start up costs related to Therapeutic Foster Care is not available at this time.

3. Q) What are the actual Federal Regulations that indicated that there is no Federal reimbursement for the Services Component of Foster Care?

Federal Regulations, 45 CFR 1356.6(c)(3) do not provide for the IVE reimbursement of Title XX type expenditures. Unallowable expenditures include the costs of social services provided to the child, the child's family or foster family which provide counseling or treatment to ameliorate or remedy personal problems, behaviors or home conditions. In various Federal reviews of claim under Title IV-E, Federal officials determined that a portion of the monies being paid to providers were actually for services outside of those allowed under IV-E. Therefore, the Services Component is required to be identified as FNP.

4. Q) When will the claiming system be available to enter the 4/95 claims?

A) The changes to the RF-2A package claims have been available on production since May 30, 1995. The RF-2 claims were available since June 21, 1995. The RF-3 and RF-6 packages are still in development.

5. Q) Is a Supplemental claim required for Transitional Foster Care on the Schedule K for the period of January to March 1995?

A) No, there is no requirement for Local Districts to submit a supplemental claim for Transitional Foster Care for the period of 1/1/95 to 3/31/95. Funding is now through the State Offices of Mental Health and Mental Retardation and Developmental Disabilities. A separate cover will be sent to identify the claiming requirements.

6. Q) How is Retroactive Managed Care claiming performed?

There is a procedure to obtain additional state aid for managed care services provided 4/94-3/95 and locally paid and claimed in various categories on the prior version Schedule E (which didn't provide for the enhanced reimbursement available during this period). Managed Care provided, and amounts reported on various lines of the previous Schedule E for the 4/94 - 3/95 period, should be identified and adjusted on the revised (4/95) Schedule E to line 17 in the appropriate columns. Expenditures identified for managed care are reported on line 17, column 1. Cancellations and refunds applicable to managed care services provided during this period are entered in column 2. Net expenditures (column 1 less column 2) are entered in column 3, with the appropriate FP and FNP categories being identified in column 4-11. The additional state aid for managed care is reported on line 33 of the revised Schedule E. Column 3 is the total of line 33, columns 4-11. Enter on line 33, columns 4 and 7, the results of multiplying line 17, columns 4 and 7 by 1.55%. Enter on line 33, columns 5 and 6, the results of multiplying line 17, columns 5 and 6 by .31%. Enter on line 33, columns 8-11, the results of multiplying line 17, columns 8-11 by 3.09%.

The local district should also complete the Schedule DSS-3922 "Financial Summary for Special Projects." On the DSS-3922, enter the Month/Year as 4/94-3/95. This is the period in which the managed care services were provided and claimed on the previous version of the Schedule E. The Project Name should be "Managed Care 94-95". Under Object of Expense, line 12, enter the title "Managed Care." Also enter on line 12, in the Total Expenditures and State share columns, the amounts from the attached revised (4/95) Schedule E, line 33, column 3. Line 12 amounts should be carried down to Section E, Project Totals.

Submit the DSS-3922 and supporting Schedule E to:

NYS DSS
BLFO 8C - PA Claims
40 N. Pearl St.
Albany, NY 12243

Local Districts should be careful to identify refunds and cancellations which apply to expenditures made under a managed care program and report them on line 17.

The above information also appears in Fiscal Reference Manual, Volume II, Chapter 3, pages 43 and 44.

It is necessary to complete the above adjustment for the 4/94 - 3/95 period on a DSS-3922 as an adjustment for managed care appearing on the revised (4/95) Schedule E cannot be completed on the Automated Claiming System (ACS) for the 4/94 - 3/95 period.

7. Q) Will Managed Care expenditures be displayed on the BICS Composite Rolls?
 - A) There is currently no payment type in WMS for Managed Care. BICS therefore, cannot display Managed Care expenditures on the Schedule E Composite Roll.
8. Q) Can a new payment type be added to WMS for Managed Care?
 - A) Paying Medical Assistance expenditures through BICS is rare. The Division of Medical Assistance has requested that we decrease the number of MA related pay types. Over a period of time we will determine the need for adding new payment types to WMS for managed care.
9. Q) When will SSRR be discontinued and the Random Moment Study (RMS) used for allocating Services administrative costs?
 - A) We still need to assess the impact of replacing SSRR with the RMS given Federal issues still pending and the State's Services Block Grant.
10. Q) When will Local Districts receive the actual pre-printed claim forms?
 - A) All the newly revised claim forms should have now been received. If any forms are missing please call the Forms and Publications Unit at 432-2505.
11. Q) Why is Service Type 8C (Respite Services Preventive) displayed on the BICS Composite Schedule K?
 - A) Service Type 8C is currently being displayed on the BICS Composites under Foster Care. Foster Care Respite can be provided to Foster Care values 8A, 8B, and 8D. The 8C service type is a preventive service and should be claimed on line 15, Other Services, in the Preventive column on the Schedule G. We will initiate a system change to correct the BICS Composites and the BICS Category logic. In the interim, districts should manually adjust the composites.

12. Q) How is Service Type 40 Therapeutic Foster Care displayed on the BICS Composites?
- A) Service Type 40 is to be used as a direct services component. The direct service component is of course not used by BICS to determine Foster Care claiming and is part of the BICS specification logic. The Therapeutic Foster Care Value (40) should be used in conjunction with a normal Foster Care Purchase of Service type of 61-75. Service Type 40 would not be authorized on a POS line and thus would not be part of the BICS claiming logic for Foster Care.
13. Q) If an RF-9 and a DSS-3922 are both required for Long Term Care for 4/1/94 to 3/31/95 retroactive claiming, wouldn't this result in double claiming?
- A) Since the RF-9 version in effect until 3/31/95 did not provide for enhanced funding for expenditures with a period of service of 4/1/94 to 3/31/95, a manually prepared claim is required. A DSS-3922 "Financial Summary for Special Projects" is used to identify the additional Local District share while the attached RF-9 is used only as backup documentation.
14. Q) What are the memo entries on the bottom of the Schedule H for?
- A) Federal reporting requirements on the Quarterly Expenditure Report (QER) require the reporting of an overpayment collected in the current month which is related to payments made in a prior quarter. Prior quarter Overpayment amounts included on the Schedule H, line 17, column 5 (Transitional IVA Day Care) and 7 (At Risk Day Care) should be reported in the boxes on the bottom of the Schedule H. For example, an overpayment made to an At Risk Day Care Service provider in March, 1995 is reported on the March, 1995 Schedule H. A collection is made on the improper overpayment in June, 1995 and is reported on the June, 1995 Schedule H as a refund. The amount of the overpayment should be footnoted on the bottom of June, 1995 Schedule H, in the "At Risk" column.
15. Q) Does the Composite Roll provide the breakout for prior quarter overpayments on the new version of the Schedule H?
- A) Currently the BICS Composites Rolls do not provide the breakouts for prior quarter overpayments. We will explore the possibility of having the BICS Composites identify overpayments separately. Until that change is made overpayments must be identified manually.
16. Q) How are supplemental claims for the Schedule K handled when the rates for the Maintenance component, Administrative component, and Services component are built into the system?
- A) The rates for the three components for original and supplemental claims are coded in the Automated Claiming System for Schedule K claiming. This alleviates districts from having to enter the rate with each claim. For supplemental claims, the Automated Claiming System also provides for the direct data entry of the rates. This allows districts to modify the rate if a retroactive rate change is required. BLFO will inform the districts of revised rates for retroactive periods, if necessary.

17. Q) What is the difference between line 17 (Managed Care) and line 33 (Additional State Aid Managed Care) on the new version of the Schedule E?
- A) Line 17 on the Schedule E is used for reporting the expenditures, refunds and cancellations of Managed Care for the claim period. Line 33, columns 3-11 is used to report the enhanced State share for Managed Care. Please refer to the Fiscal Reference Manual, Volume II, Chapter 3, pages 38-51 for MA claiming instructions on Schedule E.
18. Q) Could more information be provided on the Federal Allocation for the Child Care and Development Block Grant?
- A) Child Care and Development Block Grant (CCDBG) program funds are granted to New York State on a federal fiscal year basis. CCDBG subsidy funds are allocated on the following basis: fifty percent for New York City and fifty percent for social services districts outside of New York City. CCDBG program funds are subject to an annual federal allocation. Depending upon federal appropriation, and reauthorization of the CCDBG Act, it is possible that allocations to social services districts may vary in subsequent years. Due to the growth in the subsidy programs, no reallocation of funds is anticipated to meet expenditures in excess of district allocations. Further information on CCDBG funding appears in 95 LCM-43 issued 4/24/95.
19. Q) On the back of the RF-3, Section B, line 2, should Schedule D, line 3 be divided by Schedule D, line 23 or should Schedule D, line 23 be divided by Schedule D, line 3?
- A) Referring to FRM, Volume II, Chapter 3, page 198 updated 5/10/95, the RF3 State Charge claim instructions for Section B, line 2 indicates the amount found on Schedule D, line 23, total column is divided by the amount found on line 3, total column of the Schedule D (i.e., line 23 total/line 3 total). Line 23 is the numerator and line 3 is the denominator. This ratio should normally be greater than 100%. When the percentage is applied to the F1.1 and F4.1 coded salaries, the resulting amount should factor in salaries plus fringe benefits, non salary costs and applicable overhead costs for those individuals who devote full time to Eligibility/Income Maintenance activities.

The RF3 (4/95 revision) appearing in the FRM should also indicate in Section B, line 2 that the Schedule D, line 23 total column is divided by the Schedule D, line 3 total column.

20. Q) Is the backup to the Division for Youth (DFY) expenditures still required?
- A) The DFY still requires detailed backup for all JD/PINS expenditures claimed. To assist in this requirement the BICS Composites are being modified to provide for the display of the client name on the Schedule H, as is currently performed for the Schedule K. However, as a result of concerns expressed by local districts to DFY, DFY will be reviewing this issue.
21. Q) Are there any changes necessary to desk aids or the Title XX disk?
- A) There are no modifications necessary to any fiscal desk aid or to the Title XX disk.
22. Q) Have services expenditures with an eligibility code of 04 (EAF) been modified to be displayed correctly on the Schedule H BICS Composites?
- A) At the time of the teleconference it was our understanding that the numerous problems with EAF claiming had been corrected. However, payments with a suffix code of E used in conjunction with a JD/PINS code is still displayed as Schedule K Undetermined. These payments should be claimed on the Schedule H on line 10 (EAF JD/PINS Foster Care) or line 11 (EAF JD/PINS Foster Care Tuition). This problem has been corrected on May 1995 composites.
23. Q) What is the procedure for moving the services component for Foster Care from the Schedule K to the Foster Care line on the Schedule H?
- A) If the case is authorized for EAF, the expenditures would be claimed on the Schedule H in the first instance. If the case is later determined eligible for EAF after appearing on Schedule K it is also possible to receive Federal funding for the service component of Foster Care by shifting the service component amount from the Schedule K to the Schedule H. With supplemental claims, this is accomplished by entering a negative amount in the FNP column in Section I of the Schedule K and entering a corresponding positive entry on the EAF-Foster Care line of the Schedule H.
24. Q) When will the claiming of Foster Care coded eligibility category 02 with a Suffix of E be corrected?
- A) The problem with Suffix E payments has been corrected.
25. Q) Wasn't there another method to derive the three required breakouts for the Schedule K?
- A) There were various methods that could have been deployed to derive the required breakouts on the Schedule K. The method chosen is thought to be the least cumbersome for districts. With the Automated Claiming System providing the percentages and calculations, the completion of the form is less burdensome.

26. Q) Could there be more information provided related to the training cap?

A) The 1995-96 State Budget proposal requires that DSS implement a training cap on Local districts not to exceed \$5 million.

This information on the training cap will be provided once the State budget details are available.

27. Q) Do we at BLFO really believe that we can simplify the claiming process?

A) One goal of the claiming redesign task force is to utilize information that is already available in WMS and BICS to derive and calculate the required financial information. Attaining this goal will relieve local districts of the duplicate data entry of information when it is available in other systems.

The claiming process may also be impacted as Federal and State budget initiatives move forward. Review of the claiming process will be part of those initiatives. Any suggestions that local districts have simplifying the process at any time should be forwarded to the Bureau of Local Financial Operations.

28. Q) Can any Third Party Health Insurance premiums paid to Health Maintenance Organization (HMO) on behalf of an MA eligible client be claimed as managed care and thus receive the higher rate of reimbursement?

A) Yes. Medical Assistance expenditures furnished to eligible persons enrolled in any Health Maintenance Organization (HMO) should be claimed as managed care on line 17 of the Schedule E.

29. Q) Are IV-E JD/PINS placed in an Out of State Facility for Therapeutic Foster Care claimed as JD/PINS?

Per current policy, the Division for Youth will not pay for out of state placements. If the Local Districts have paid for these services they are reimbursable by DSS but then must be applied to the Foster Care Cap. The expenditures should be claimed on line 1 IV-E JD/PINS under FP on section I, column 2 of the new version of the Schedule K.

30. Q) Are any changes required to the State Foster Care Cap worksheets related to the changes to the Schedule K?

No changes were required to be made to the Foster Care Cap worksheet.