

Chapter Four
Medicaid Eligibility

1. Background	4-2
EPSDT Requirements	4-3
2. Determining Eligibility for Medicaid	4-4
Title IV-E Eligible	4-4
Non Title IV-E Eligible	4-4
Required Documentation for Non Title IV-E	4-5
Supplemental Security Income	4-6
Recertification for Medicaid	4-6
Discharge from Care and Continuous Coverage.....	4-7
3. WMS System Instructions	4-8
Title IV-E Eligible	4-8
Non Title IV-E Eligible	4-8
Medicaid Eligibility Budgeting Logic (MBL).....	4-9
Supplemental Security Income	4-11
Continuous Coverage for Case Type 13	4-11
Changing Case Type 13 to Case Type 20 and Vice Versa	4-11
4. Explanation of Eligibility Programs	4-12
Expanded Eligibility	4-12
SSI-Related Budgeting.....	4-12
Excess Income Program.....	4-12
Child Health Plus B	4-13
Family Health Plus.....	4-13
5. Special Circumstances	4-14
Interstate Compact for the Placement of Children.....	4-14
NYS Child Placed Out of State	4-14
Out-of-State Child Placed in NYS	4-17
Minor Parent Placed with a Child.....	4-18
Pregnant Women.....	4-19
OCFS Youth (Juvenile Justice Population)	4-19
Child Placed in OMH/OMRDD Residential Program	4-20
OMH (District Code 97).....	4-20
OMRDD (District Code 98)	4-21
Medicaid Managed Care	4-22
Other Special Eligibility Instructions.....	4-25
Children on Trial Discharge	4-25
Undocumented/Illegal Immigrants	4-25
Third Party Health Insurance	4-25
Communication and Foster Care Placement Transitions	4-27
6. Sample Instructions	4-28
Application Turnaround Document (APTAD) LDSS-3209	4-28
NYS Medicaid Citizenship/Immigration Status.....	4-31

1. Background

This chapter is designed to assist social services staff in determining, documenting, and authorizing Medicaid (MA), also known as Child Health Plus A (CHPlus A), but referred to in this document as Medicaid, for children in foster care. Title XIX of the Social Security Act provides Medicaid for families with dependent children and for aged, certified blind, and disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.

Determining eligibility for Medicaid is crucial to ensure that children in foster care have access to health care and related case management services. The delivery of and payment for health care services will vary depending on whether the child is placed in the direct care of Commissioner of the Local Department of Social Services (LDSS), the Commissioner of the Office of Children and Family Services (OCFS) or placed in a child care agency. Health care services for children in direct care are generally provided via Medicaid fee-for-service basis using the Common Benefit Identification Card (CBIC). However, the local social services commissioner may opt to enroll the child in a Medicaid managed care health plan.

Children placed in a child care agency may have health care services reimbursed by Medicaid through a Medicaid per diem payment made to the child care agency. Except for certain services that existing policy specifies as directly billable to Medicaid, health care providers bill the child care agency directly for services provided to these children and the child care agency makes payment to the health care provider directly for rendered services. Entry into the Welfare Management System (WMS) Principal Provider Subsystem is essential to assure that the child care agency is paid the Medicaid per diem. All of the medical services provided to children placed in child care agencies that do not have a Medicaid per diem should be billed to Medicaid directly by the Medicaid enrolled service provider. Regardless of the way in which services are provided, the vast majority of children in foster care depend on Medicaid for payment of health care services.

Children in foster care who are determined ineligible for Medicaid should be evaluated for other forms of health care coverage, specifically Child Health Plus B (CHPlus B) and Family Health Plus (FHPlus). Children who are Medicaid eligible do not qualify for Child Health Plus B or Family Health Plus. This includes any continuous coverage period.

 **Note:** The WMS Principal Provider Subsystem provides control of cases of Medicaid recipients who are in need of long-term care from various facilities such as child care facilities, nursing homes, psychiatric centers, hospitals, and assisted living providers. The system tracks, by service date, the placement and discharge of a specific recipient into and out of each facility, associates the facility ID with a provider type, and tracks the amount of income owed by the recipient toward the cost of medical care. Children in foster care placed in a child care facility generally do not contribute toward the cost of medical care. Lists of recipients in the Principal Provider Subsystem are sent to the current provider of record on a monthly roster. Appropriate entries into the Principal Provider Subsystem are necessary to ensure facilities are paid a per diem. The child care agency's MMIS provider ID code must be entered on the Principal Provider Subsystem. This ID code may be obtained directly from the child care agency or from the MMIS Inquiry Menu on WMS. To ensure that health care services are available via Medicaid fee-for-service basis when a child is discharged from a child care agency, the discharge date must be entered on the WMS Principal Provider Subsystem.

EPSDT Requirements

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) is a federally required Medicaid benefit that includes a specific set of health care and administrative services for children from birth through age twenty. New York State's Medicaid program for children and adolescents offers the following EPSDT [otherwise known in New York State as Child Teen Health Program (C/THP)] services:

- Comprehensive health supervision visits in accordance with medically accepted standards and periodicity schedules;
- Medically necessary health care screening, diagnostic, and treatment services covered by federal Medicaid statute; and
- Assistance to eligible children and their parents or guardians in effectively obtaining medically necessary screening, diagnostic, and treatment services, including transportation to covered services.

EPSDT (C/THP) is administered by the LDSS. LDSS staff or their designees, including Medicaid managed care plans, are responsible for informing families with children about EPSDT (C/THP) services, the advantages of preventive health care, offering assistance in locating providers, scheduling examinations, coordinating care, and arranging transportation. Each LDSS has an individual or unit that coordinates these benefits.

When the LDSS places Title IV-E eligible children in foster care outside of New York State, please be aware that the receiving state's Medicaid plan may not cover a service which is covered under New York State's Medicaid program. The LDSS should request that the receiving state provide coverage of the needed service under the rubric of EPSDT.

State regulation (18 NYCRR 507.1) requires annual written notification of C/THP services to be provided to foster parents, or the institution, group residence, group home, or agency boarding home where the Medicaid eligible child resides, within 60 days of acceptance into foster care as well as upon request, the names and locations of providers offering examinations, diagnosis, and treatment to children eligible for C/THP. These informing requirements can be met by using either existing New York State Department of Health (NYS DOH) written materials or those approved by NYS DOH as part of the State review of LDSS C/THP plans.

Examples of NYS DOH approved materials include:

- C/THP Brochure (#0575) and C/THP Fact Sheet (Order Form for C/THP Brochure which can be faxed to: (518) 486-2361); Note: 03 OMM/ADM-2 related to Mail-in Renewal (Recertification) advises LDSS to include CTHP information in the renewal package that is mailed to Medicaid recipients by the LDSS when Medicaid recertification is due. Whether or not the LDSS follows this mail-in Medicaid recertification process for children in foster care, annual dissemination of the CTHP information fulfills the State regulatory requirement for annual written CTHP informing.
- Booklet DSS-4148B – “What You Should Know About Social Services Programs” (http://www.otda.state.ny.us/directives/2003/INF/03INF09_4148B.pdf)

LDSS staff responsible for C/THP informing must coordinate their efforts with all personnel involved in arranging for health care services for children in foster care.

2. Determining Eligibility for Medicaid

A Medicaid application must be completed for each child upon entry into foster care or when custody is transferred to the Commissioner of Social Services. An eligibility determination must be completed within 30 days of application. This chapter is intended to provide eligibility policy and system instructions for three primary categories:

- Title IV-E Eligible Foster Care Children
- Non Title IV-E Eligible Foster Care Children
- Foster Care Children Receiving Supplemental Security Income (SSI)

Use the Initial Foster Child Eligibility Checklist as the first step to determine eligibility for Title IV-E funding. (*See Chapter One for information on determining Title IV-E eligibility.*)

Title IV-E Eligible

Children in foster care who meet the requirements of Title IV-E are automatically eligible for Medicaid coverage. For all other children in foster care, eligibility for Medicaid must be determined using specific eligibility standards for children in foster care as issued by the NYS DOH. Once a child has been determined eligible for Title IV-E, Medicaid coverage must be authorized on WMS. (*See Section 3, WMS System Instructions.*) In all cases, Medicaid must be authorized for 12-month segments upon Title IV-E determination. (*See Chapter One for instructions on authorizing Title IV-E.*)

If it is determined that a child in foster care is no longer Title IV-E eligible, the LDSS must redetermine Medicaid eligibility using the specific eligibility methodology for non Title IV-E children in foster care as issued by the NYS DOH.

Non Title IV-E Eligible

If the child is *ineligible* for Title IV-E, eligibility must be determined using the specific eligibility methodology for non Title IV-E children in foster care as issued by the NYS DOH. In all cases, Medicaid for non Title IV-E children in foster care must be authorized for 12-month periods. Determine eligibility according to the following criteria:

1. The child must be a U.S. citizen, national, Native American or be in satisfactory immigration status. "Satisfactory immigration status" means an immigration status that does not make the individual ineligible for benefits under the applicable program. Qualified immigrants and persons permanently residing in the U.S. under color of law (PRUCOL) are said to be in satisfactory immigration status. (*See Section 6 for NYS Medicaid Citizenship/Immigration Status*). Illegal or undocumented immigrants and non-immigrants can be provided Medicaid only for the treatment of emergency medical conditions if found otherwise eligible. Undocumented children may be eligible for CHPlus B (*See Section 5 for Undocumented/Illegal Immigrants*). A woman with a medically verified pregnancy is not

required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

2. The case is generally a household of one. If the child is pregnant, the household size is 2 - one plus unborn (EDC – Expected Date of Confinement). If a minor parent is placed with a child(ren), the household size is 2 or higher. *(See Section 5 for Minor Parent Placed with a Child.)*
3. The child’s income is compared to the higher of the following:
 - Medicaid level (“Medically Needy”) for one or two or higher if appropriate
 - Public Assistance Standard of Need (“PA SON”); or
 - Foster Care Board Rate,¹ or
 - Federal Poverty Level (FPL) based on the child’s age.

 **Note:** Medicaid Automated Budget and Eligibility Logic (MBL) will automatically compare the child’s income/resources to the appropriate level.

Required Documentation for Non Title IV-E

A signed Application for Services (LDSS-2921) with the necessary information to establish the Medicaid case must be filed in the Medicaid record. A notation in the Medicaid record should be made when the following required documentation is in the Services record:

- Date of birth
- Residency
- Social Security Number (SSN)
- Current income
- Citizenship *(See Section 6 for NYS Medicaid Citizenship/Immigration Status.)*
- Third party health insurance *(See Section 5 for Third Party Health Insurance.)*

 **Note:** A SSN number must be provided. Documentation of the SSN is required only when the SSN cannot be confirmed through current verification or validation procedures. Documentation of an application for SSN continues to be required when appropriate. Refer to GIS 03 MA/008.

¹The Foster Care Board Rate is either the (1) the institution rate or (2) the payment made to foster parents based on the child’s age and service needs.

Supplemental Security Income

Children in foster care who are in receipt of Supplemental Security Income (SSI) benefits are automatically eligible for Medicaid. Therefore, it is not necessary to do an eligibility determination. In most instances, an MA/SSI case will already be opened on WMS. If not, the LDSS may use the State Data Exchange (SDX), or other documentation from the Social Security Administration (SSA), to confirm that a child in foster care is an SSI recipient and to open an MA/SSI case (case type 22). In most instances, a case type 22 (MA/SSI) for a child in receipt of SSI will be opened systemically (generated through WMS) via the Auto/SDX process. In instances when a case is not opened systematically, the local district must open a case type 22 (MA/SSI) for a child in receipt of SSI.

Individuals who receive Medicaid based on eligibility for SSI are recertified for Medicaid based on recertification for SSI. SSI recipients do not need to be reauthorized annually. SSI authorization is open-ended until December 31, 2049. Local districts use the SDX to confirm that an SSI recipient continues to be eligible and, therefore, Medicaid eligible. The SSI program does not require that a child be permanently disabled; a child with a severe disability that is expected to last at least one year may qualify for SSI benefits. Therefore, LDSS must pursue SSI for disabled children determined ineligible for Title IV-E foster care with the SSA. Disabled children who are eligible for Title IV-E but lose eligibility during a placement should be referred to the SSA for a determination of SSI eligibility.

If during the Title IV-E eligibility process, it has been determined that Title IV-E is more cost beneficial, the LDSS must advise the SSA of that decision. Based on the child's circumstances, the SSA may suspend or discontinue the child's SSI payment. Upon discharge, the child should be referred to the SSA for appropriate action. The SSI benefit level for children in foster care is the "living with others" level.

 **Note:** Auto SDX updates the WMS database with information concerning participation in the Federal SSI program. The information is received via daily tape processes from the SSA through the SDX. The information received from the SDX is used by the Auto SDX subsystem to both update WMS and create and maintain MA-SSI cases for Medicaid. For MA-SSI cases, the Auto SDX establishes an active case, updates client information including the loss of SSI eligibility, and closes the case if the client dies. If a client becomes ineligible for SSI, Stenson procedures determine continued Medicaid eligibility. If one individual on a multi-individual Medical Assistance case loses SSI eligibility, the individual appears on a report sent to LDSS.

Recertification for Medicaid

A recertification for Medicaid is a determination to continue or discontinue Medicaid based upon the eligibility of the recipient at the time of recertification. The criteria for recertification remain the same as for the initial Medicaid eligibility determination. In all cases, Medicaid for Title IV-E and non Title IV-E eligible children must be authorized for 12-months. (*See Chapter One for instructions on authorizing Title IV-E.*) All factors relating to eligibility, as outlined in this chapter, are re-evaluated at each recertification.

Discharge from Care and Continuous Coverage

When both Title IV-E and non Title IV-E eligible children are discharged from foster care, the Medicaid case should be referred for a separate determination. Once an eligibility determination has been made, LDSS must send a notice to the caretaker or the child (if discharged independently) regarding Medicaid eligibility status.

If the child is determined ineligible, or if eligibility cannot be determined, the child continues to receive up to 12 months of Medicaid under continuous coverage provisions. Continuous coverage, regardless of any changes in income or circumstances, applies to children in foster care up to the age of 19 who were found fully eligible for Medicaid. Medicaid should be provided for 12 months from the date of the last positive determination or re-determination of Medicaid eligibility or until the child's 19th birthday, whichever is sooner.

Continuous coverage for children who have been discharged does not apply in the following circumstances:

- Child has moved out of state;
- Child is incarcerated;
- Child is deceased;
- Child is an undocumented/illegal immigrant or a non-immigrant (i.e., short-term visa holder; student; tourist) seeking coverage for emergency medical treatment (*see Section 5 for Undocumented/Illegal Immigrants*);
- Child is in receipt of Medicaid from another district;
- Child refuses Medicaid continuous coverage; or
- Child is eligible with a spenddown (*see Section 4 for Excess Income Program*);
- Currently in receipt of assistance; and
- Eligible for continuous coverage in new district.

Continuous coverage for a Title IV-E eligible (ADC/FC - case type 13) and non Title IV-E (Medicaid - case type 20) case is supported by WMS. WMS calculates and displays a Continuous Save Date (CSD), as appropriate. At the end of the continuous coverage period, the Medicaid case will fall into a recertification cycle. The Medicaid continuous coverage policy applies regardless of the length of time a child is in foster care.

If continuous coverage applies and a child in foster care was previously in a facility that received a Medicaid per diem, then a Common Benefit Identification Card (CBIC card) must be issued. To generate a CBIC card, enter an "N" in the 'Card Code' field on screen 5 of the LDSS 3209 (turnaround document). After data entry a card without a photo will be issued. The card will be sent to the address on record listed on the authorization (LDSS-3209). *It is important that the LDSS update the child's discharge address to facilitate access to health care.*

When a child is determined eligible for Title IV-E, loses Title IV-E eligibility, or when a Title IV-E eligible child is discharged from foster care, WMS systemically supports the changing of a case type 13 to a case type 20 and vice versa without closing and opening a subsequent case. (See OCFS GIS-03-#005 or DOH GIS 03 MA/010.)

3. WMS System Instructions

A case must be opened appropriately on WMS to authorize Medicaid coverage. The following provides instruction to authorize Medicaid for Title IV-E and Non Title IV-E eligible children. LDSS staff should refer to the Worker's Reference Manual (WRM) for further details.

 **Note:** The Services eligibility code, as outlined in the previous chapters, will be reflected on the Services Authorization form (LDSS-2970) based on the Services Financial Eligibility Determination.

Once the appropriate sections of the Application for Services (LDSS-2921) have been completed and the necessary documents have been collected (or a note has been placed in the Medicaid case record that the documents are in the Services case record) then the initial instructions for processing of a Medicaid application include the following:

1. Perform Application Registration (App. Reg.) on WMS;
2. Review WMS Clearance;
3. Complete a budget using the Medicaid Automated Budget and Eligibility Logic (MBL) for Non Title IV-E; and
4. Complete mandatory fields on the Application Turnaround Document (APTAD LDSS-3209) and submit to Data Entry Unit or complete Full Data Entry. (*See Section 6, Sample Instructions.*)

Title IV-E Eligible

If the child is found eligible for Title IV-E, generate Medicaid coverage by opening an ADC/FC non-services case type 13 on WMS.

Non Title IV-E Eligible

If the child is found *ineligible* for Title IV-E and eligible for Medicaid, coverage is authorized by opening a non-services Medicaid case (case type 20) on WMS.

Medicaid Eligibility Budgeting Logic (MBL)

To determine Medicaid eligibility, a MBL budget must be completed as follows:

From WMS System Menu Screen, select '02 MA Budget Calculation.'

- From the MA Budget Calculation Menu:
 - Select Function 1 (Budget Record – Current)
 - Enter: Registry No. (or case number if available)
 - Transmit

- On the MA Budget Record Screen:
 - Enter: BUDGET TYPE - 01 (LIF/ADC Related)
 - Enter: CASE NAME, NUMBER, OFFICE, UNIT, WORKER (as assigned by LDSS)
 - Enter: TRAN - Transaction type:
 - 02 – Opening
 - 05 – Change
 - 06 – Recertification
 - 09 – Open/Close
 - 10 – Reopening
 - Enter: EFFECTIVE PER. – Effective period “FROM” the first of the month of MA eligibility “TO” the end of the twelfth month (1 year authorization)
 - Enter: CA – Number in case as 01 or 02 (for minor parents)
 - Enter: EEC – Expanded Eligibility Code (EEC) “B” (“B” is the code used to calculate eligibility for children 1-5, 6-18 and 19 & 20 year olds living with families, infants birth to one year, and pregnant women).
 - Enter: EDC1 – Expected Date of Confinement (for pregnant women)
 - Enter: FUEL TY – Fuel Type of 0 – heat is included in shelter costs
 - Enter: SHELTER TY – Shelter type – 18 (unlimited)
 - Enter: AMOUNT – Foster Care Board Rate [all amounts on MBL are entered including dollars and cents with no decimals (e.g., \$212.12 is entered at 22212)]
 - Enter: Child's income, if any
 - EARN INC – Earned Income (consider student earned income disregard or placing income in an irrevocable trust):
 - Enter: LN – Line number of the child '01'
 - Enter: EID – Earned Income Disregard of '06'
 - Enter: SRC – Earned Income Source code '01'– wages (for other codes see WMS Code Card Index)
 - Enter: PER - Period
 - 3 – Weekly
 - 4 – Bi-Weekly
 - 5 – Semi-Monthly
 - 6 – Monthly
 - 7 – Bi-Monthly
 - 8 – Quarterly
 - 9 – Yearly
 - Enter: T – Time Code of 'F'
 - Enter: GROSS – Gross Earned Income
 - U INC – Unearned Income (consider placing income in an irrevocable trust):
 - Enter: LN – Line number of the child '01'
 - Enter: SR – Unearned Income Source (see WMS Code Card Index)
 - Enter: P – Period (see above)
 - Enter: Amount: Unearned Income Amount
 - RESCS – Child's resources, if applicable (consider 96 ADM-16 regarding an irrevocable trust):
 - Enter: LN – Line number of the child '01'
 - Enter: CD – Resource Code (see WMS Code Card Index)
 - Enter: RES VAL – Resource Value

Transmit to get Medicaid output screen.

The Medicaid output screen will display an asterisk next to either the PA STD (PA SON) or MA LEVEL. MBL compares the child’s income (and resources, if appropriate) to the level that has the asterisk. If the foster child’s income exceeds these levels, the Expanded Eligibility/FHP Screen will be displayed noting “eligible” or “ineligible” at the Federal Poverty Level (FPL) appropriate for each age group.

The earned income of any child under the age of 21 (22 years if SSI-Related) who is attending school and employed may be disregarded depending on his/her status. The following chart indicates in what situations the income is disregarded.

TREATMENT OF EARNED INCOME OF STUDENTS		
Type	Full-time Employment	Part-time Employment*
ADC-Related Full-time Student	Disregarded - Up to 6 months per calendar year, countable thereafter	Disregarded
Part-time Student	Countable	Disregarded
SSI-Related Regularly Attending Student	Income, up to \$1,340 per month but not more than \$5,410 per calendar year, is disregarded.	

*Summer employment is considered part-time.

The treatment of resources varies by category. In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19 if income is compared to and below the appropriate poverty level and for children 19 and 20 who are eligible for FHPlus. If a child over age one has income in excess of the appropriate poverty level, resources are considered. The following chart indicates in what situations resources are disregarded.

TREATMENT OF RESOURCES			
Type	Medically Needy	Expanded	FHPlus
Pregnant Women Child Under 1	Disregarded	Disregarded	NA
Child over 1, but under 19	Countable If excess, determine eligibility for Expanded	Disregarded	NA
Child 19 or 20	Countable If excess, determine eligibility for FHPlus	NA	Disregarded

Supplemental Security Income

An SSI recipient's Medicaid coverage is authorized on case type 22. A financial eligibility determination is not necessary for SSI recipients.

Continuous Coverage for Case Type 13

Continuous coverage processing is applicable to case type 13. WMS will calculate and display a Continuous Save Date (CSD) for case type 13 as appropriate. (For a complete explanation of the continuous coverage logic, see the February 9, 1999 Dear WMS/CNS Coordinator letter [Attachments I & II] and the March 2, 1999 Coordinator letter [last page]).

When the case type is changed from 13 to 20 and the Transaction Type is 06, or when the case type is changed from 20 to 13, it is considered a re-determination of eligibility: a new CSD will be calculated for that transaction if the Individual Categorical Code is 01-09, 13, 15, 26, or 43-48. The CSD will be set equal to one full year from the Medicaid Coverage from-date or the first day of the Transaction month, whichever is greater.

Changing Case Type 13 to Case Type 20 and Vice Versa

To facilitate the transitioning of Title IV-E foster care to non Title IV-E foster care or to Medicaid, and vice versa, WMS allows case type 13 to be changed to case type 20, and case type 20 to be changed to case type 13, during an Undercare transaction.

Case Level Reason Code Y61 (NO LONGER Title IV-E Eligible) must be entered when the case type is changed from 13 to 20 at Undercare; when Y61 is entered the Transaction Type must be 05 (Undercare Maintenance) or 06 (Recertification), the case type must be changed from 13 to 20, and the Notice Indicator must be 'N.'

Case Level Reason Code Y62 (CHILD Title IV-E Eligible) must be entered when the case type is changed from 20 to 13, and the Notice Indicator must be blank.

4. Explanation of Eligibility Programs

This section applies to children in foster care who are certified blind or disabled or ineligible for Medicaid using the budgeting methodology for children in foster care. **Eligibility for these programs requires a thorough and comprehensive knowledge of Medicaid eligibility policies and WMS system instructions.** For further instruction on determining eligibility, refer to the Medical Assistance Reference Guide (MARG).

Expanded Eligibility

If the income of children in foster care who are under the age of 19 or pregnant, exceeds the higher of the MA level, the PA level, or foster care board rate, their income is then compared to the applicable percentage of the Federal Poverty Level according to age. Pregnant women, infants, and children under age 19 cannot spend down to their applicable percentage of the FPL to achieve eligibility. If their income exceeds the appropriate FPL, income in excess of the higher of the MA level, the PA level, or the foster care board rate, is considered available to meet the cost of medical care and services. (*See section below, Excess Income Program.*)

SSI-Related Budgeting

SSI-related budgeting is used to determine eligibility for children who are certified blind or disabled and are not in receipt of Supplemental Security Income. For further instruction on SSI-related eligibility, refer to the Medical Assistance Reference Guide (MARG)

Excess Income Program

If a child is not fully eligible for Medicaid and needs services not covered under CHPlus B, the excess income program should be considered. When the available income of the foster child is greater than the MA Level, PA Level, or the foster care board rate, whichever is higher, the excess of the applicable level is considered available to meet the cost of medical care and services.

 **Note:** Children who have income in excess of the FPL must spend down to the Medicaid level or the foster care board rate, whichever is higher, to be eligible for any Medicaid coverage.

To become eligible for Medicaid, the child must either:

1. Incur medical expenses equal to or greater than their excess income; or
2. Pay the amount of the excess income directly to the local district.

There are two methods of applying excess income: (1) on a monthly basis for Medicaid coverage of outpatient care; and (2) on a six-month basis for Medicaid coverage for acute inpatient care in a medical facility. The use of medical expenses to offset excess income is known as “spenddown.” The direct payment of excess income to the local district is known as “pay-in.”

Child Health Plus B (CHPlus B)

Children under the age of 19 years who do not meet the eligibility requirements for Medicaid, including citizenship/immigration status, may be eligible for CHPlus B. Depending on financial circumstances, the CHPlus B program is either fully subsidized or requires payment of premiums for those determined eligible. Although the benefits are more limited in scope than those under Medicaid, they are comparable to benefits available under some private health insurance plans. Unlike most private health insurance plans, there are no co-payments under CHPlus B. Clients can enroll either directly with a CHPlus B insurer or obtain assistance with this process through facilitated enrollers in the community. Once enrolled, clients are provided with a list of local health care providers. Participating health care providers include independent clinicians, group practices, community health centers, and practitioners operating under managed care arrangements or plans. To obtain assistance or information related to CHPlus B, a toll-free hotline is available: 1-800-698-4543. Information is also available on the NYS DOH website: <http://www.health.state.ny.us/chplus/index.htm>.

Family Health Plus (FHPlus)

Children in foster care ages 19 and 20 who are not Medicaid eligible may receive health coverage through the FHPlus program. Children in foster care eligible for FHPlus (19- and 20-year-olds) are opened as case type 24 (Family Health Plus). FHPlus has specific financial eligibility criteria which must be met to qualify for coverage. FHPlus never involves payment of health care premiums and there are no co-payments. To be eligible for FHPlus, gross countable income must be no more than 150% of the FPL. There is no resource test for FHPlus eligibility. Children in foster care with third party health insurance are not eligible for FHPlus except in limited instances. The benefits under FHPlus are more limited in scope than those under Medicaid, but they are comparable to those available under some private health insurance plans. Providers who participate in FHPlus predominantly operate under managed care arrangements. Individuals can enroll in FHPlus either through facilitated enrollers in the community or through the LDSS. There is no spenddown provision for FHPlus to obtain assistance or information related to FHPlus, a toll-free hotline is available: 1-877-9FHPLUS. Information is also available on the NYS DOH website: <http://www.health.state.ny.us/fhplus/index.htm>.

5. Special Circumstances

Interstate Compact for the Placement of Children

The Interstate Compact for the Placement of Children (ICPC) is a uniform law in all 50 states, the District of Columbia, and the Virgin Islands that governs the placement of children across state lines for the purposes of foster care, adoption, residential placement, and discharge from foster care to parents/relatives. All states currently participate in the Interstate Compact for the Placement of Children. Puerto Rico does not participate in the Compact but does have an Interstate Compact Office which forwards information.

 **Note:** NYS LDSS of fiscal responsibility certifies the Title IV-E status and sends the outcome to the NYS ICPC Office, which forwards it to the Puerto Rico ICPC Office. Puerto Rico ICPC office forwards the information to the responsible local Puerto Rican entity.

Under existing law, it is a violation to place a foster care child out of state before the ICPC placement approval is complete. This includes a home study to assess whether the out-of-state placement is in the best interests of the child.

The ICPC has an option for a priority request for out-of-state placement. This involves a court order. The ICPC placement approval decision must occur within 20 business days of the request. These requests are limited to particular circumstances: the child in foster care is to be discharged to a relative within the second degree, and the child is less than two years of age; or the child is currently in an emergency foster care setting; or the child is to be discharged to a party with whom he/she spent substantial time in the past. ICPC placement approvals in these circumstances generally occur within time frames specified in existing ICPC law.

The following sections outline the differences in Medicaid eligibility.

NYS Child Placed Out of State:

Title IV-E Eligible

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides that effective October 1, 1986, the state in which a Title IV-E eligible child resides will be responsible for providing Medicaid, even when the foster care payments are made by New York State.

When a Title IV-E eligible child is placed in another state, the following steps must be taken:

1. NYS LDSS submits the ICPC request package to the OCFS ICPC office for review. This includes the Title IV-E eligibility documentation.
2. OCFS ICPC reviews the request for applicability to ICPC law, completeness, and consistency. If the ICPC request is incomplete, the request is held or returned to the sending LDSS for correction. If the request is complete, it is forwarded to the receiving state ICPC office, which performs a similar review and forwards the request to the appropriate receiving state entity for a home study and a recommendation for approval or disapproval.

3. Receiving state completes the home study and makes a recommendation. The recommendation is forwarded to the receiving state ICPC office. The Interstate Compact Placement Request (form ICPC-100a) is forwarded to the NYS OCFS ICPC office. NYS OCFS ICPC office reviews the home study and recommendation and forwards it to the requesting LDSS. If LDSS makes the placement, LDSS notifies NYS OCFS on the Interstate Compact Report on Child's Placement Status (form ICPC 100b) that placement has been made. NYS OCFS ICPC forwards the placement notification to the receiving state to initiate services and supervision.
4. Medicaid is usually authorized from the date of placement for ICPC approved cases in the receiving state. Prior to this, Medicaid for Title IV-E eligible foster care children continues to be the responsibility of NYS.
5. When applicable, LDSS also notifies the voluntary agency that placed the Title IV-E eligible child that the Medicaid per diem to that agency is being discontinued.
6. Once the LDSS has been notified that the receiving state will be opening a Medicaid case for the foster child, the Medicaid case in NYS is closed. Federal Medicaid regulation specifies that two states cannot have open Medicaid cases at the same time.

If an LDSS or foster parents need assistance in identifying the appropriate agency in their state or in opening a Medicaid case in another state for a Title IV-E eligible child, contact the NYS OCFS ICPC Office at (518) 473-1591 for information on Interstate Compact Coordinators in other states.

When the receiving state's Medicaid plan does not cover a service that is covered under New York State's Medicaid program, the LDSS should request that the receiving state provide coverage under the EPSDT rubric, and the receiving state is responsible for payment of that service.

Re-determination: The LDSS in NYS remains responsible for the re-determination of Title IV-E eligibility for children placed in another state. As long as the child remains Title IV-E eligible, the state in which the child resides remains responsible for providing Medicaid.

Loss of Title IV-E Eligibility: If it is determined that a child in foster care residing out of state loses Title IV-E eligibility, the state of residence will no longer be responsible for providing Medicaid. The LDSS in NYS that placed the child will then be responsible for arranging for access to health care for the duration of the time the child remains in foster care. (*See Section below, Non Title IV-E Eligible*).

Discharge: When a Title IV-E eligible child, residing in another state, is discharged from foster care and continues to reside in that state, the child is no longer automatically eligible for Medicaid in the state in which s/he resides. Therefore, as part of the discharge plan, LDSS should ensure that the discharged child has access to appropriate medical services by assisting in the application process for Medicaid or other medical benefits available in that state. If upon discharge, the child returns to NYS to reside, the LDSS should assist in applying for Medicaid or other medical benefits in NYS. (*See Section 2 for Discharge from Care and Continuous Coverage.*)

Non Title IV-E Eligible

Medical care for non Title IV-E eligible children placed out of state is the responsibility of the LDSS in NYS. LDSS is responsible for arranging for the child to receive medical care. Medicaid eligibility must be determined. (See Section 2, *Determining Eligibility for Medicaid*.)

To provide the child with medical care, the local district can choose one of the following methods:

- The Medicaid eligible child obtains health care from Medicaid providers enrolled in NYS Medicaid. The health care provider bills the Medicaid Management Information System (MMIS) directly.

For out-of-state providers to bill NYS Medicaid, they must apply and be enrolled in the NYS Medicaid Program. Once the out-of-state provider is approved and enrolled, claims are submitted to the NYS MMIS for payment. NYS cannot require out-of-state providers to enroll in the NYS Medicaid Program. Practitioners, including physicians, pharmacies, dentists, medical equipment, and supply houses, should contact the NYS DOH Bureau of Medicaid Enrollment, Office of Medicaid Management, 99 Washington Avenue, Suite 611, Albany, New York 12210; telephone (518) 486-9440 to request an MMIS Enrollment Package.

Institutional providers (hospitals, clinics, home health agencies) should contact the Bureau of Medical Review and Payment's Enrollment Unit, 99 Washington Avenue, Suite 800, Albany, New York 12210; telephone (518) 474-8161 for an MMIS Enrollment Package.

- For children who are not eligible for Medicaid, the foster parent sends the medical bills to the district of fiscal responsibility in NYS*; or
- The foster parents pay the medical bills and are reimbursed by the LDSS.*

*Medicaid cannot pay these bills.

Re-determination: The placing district in NYS is responsible for the recertification of Medicaid for children in foster care placed out of state. All factors relating to the child's eligibility, as outlined in this chapter, must be re-evaluated at recertification. In all cases, Medicaid for non Title IV-E eligible children must be authorized for 12 months.

Discharge: When a non Title IV-E foster child, residing in another state, is discharged from foster care and continues to reside in that state, the child is no longer eligible for NYS Medicaid. Therefore, as part of the discharge plan, LDSS should ensure that the discharged child has access to appropriate medical services by assisting in the application process for Medicaid or other medical benefits available in that state. If, upon discharge, the child returns to NYS to reside, continuous coverage provisions apply to those children who have been receiving NYS Medicaid. (See Section 2 for *Discharge from Care and Continuous Coverage*.)

Out-of-State Child Placed in NYS:

Title IV-E Eligible

The LDSS where the child is placed authorizes Medicaid for a Title IV-E eligible child from another state placed in NYS. Since Title IV-E foster children are automatically Medicaid eligible, no financial eligibility determination is necessary. The placing state continues the foster care board payment.

When a child from another state is placed in foster care in New York State and is eligible for Title IV-E, the following steps should be taken:

1. The placing state sends an ICPC package to the NYS OCFS ICPC Office. OCFS ICPC Office sends a copy to the appropriate LDSS contact for processing (i.e., approval of home study) and Medicaid authorization. Title IV-E eligibility verification and documentation and Third Party Health Insurance (TPHI), if any, must be included in the ICPC package.
2. LDSS completes the Application for Services (LDSS-2921) for the case record and authorizes Medicaid once the child is placed.
3. LDSS notifies the appropriate Title IV-E state agency in the placing state that Medicaid has been authorized by NYS.

Re-determination: The placing state remains responsible for the re-determination of Title IV-E eligibility for children placed in NYS. As long as the child remains Title IV-E eligible, NYS remains responsible for providing Medicaid. In all cases, Medicaid must be authorized for 12 months upon Title IV-E re-determination. LDSS must verify the child's residence and continuing eligibility for Title IV-E foster care payments with the placing state.

Loss of Title IV-E Eligibility: If it is determined that a foster care child from another state is no longer Title IV-E eligible, NYS will no longer be responsible for providing Medicaid. The placing state that has custody of the child must notify NYS of the loss of Title IV-E eligibility. The LDSS in NYS must close the Medicaid case, and the placing state will be responsible for arranging for the child to receive medical care. (*See section below, Non Title IV-E Eligible.*)

Discharge: When a Title IV-E eligible foster child from another state is discharged from foster care and continues to reside in NYS, the child is no longer automatically eligible for Medicaid. The Medicaid case should be referred for a separate determination based on circumstances of the child's living arrangements. LDSS should send a notice to the caretaker or the child (if discharged independently) regarding Medicaid eligibility status. If the child is determined ineligible, or if eligibility cannot be determined, the child receives Medicaid under continuous coverage provisions for the balance of the 12 months from the date the child was last determined Medicaid eligible, or until the child is 19 years old, whichever occurs first. If, upon discharge, the child returns to the placing state to reside, the Medicaid case must be closed since the child is no longer living in NYS.

Non Title IV-E Eligible

For a non Title IV-E eligible child, the placing state arranges for the child to receive medical care. The placing state makes the arrangements with the foster parents directly or with the child care agency or LDSS.

Discharge: When a non Title IV-E eligible child is discharged from foster care and remains in NYS, LDSS should facilitate an application for health care coverage in NYS, under Medicaid, CHPlus B, FHPlus or other public program, if available.

Minor Parent Placed with a Child

Title IV-E Eligible

In instances where the minor parent is Title IV-E eligible and retains legal custody of the child, Medicaid is authorized for the minor parent and the child (no separate Medicaid determination is necessary).

In instances where the minor parent is Title IV-E eligible and the child is residing in the same household as the minor parent but is not in the legal custody of the minor parent, a Medicaid determination must be done for the child. The child will not be Title IV-E eligible since the child is still residing with the minor parent. When doing a budget for a non Title IV-E eligible child of a Title IV-E eligible minor parent in foster care, the child's Medicaid eligibility is determined following usual procedures. A child born to a mother who is a Medicaid recipient, is eligible for Medicaid for one year, until the end of the month in which the child's first birthday occurs.

 **Note:** If a Title IV-E eligible minor parent is placed with his/her infant out-of-state for foster care, then the state of residence becomes responsible for authorizing Medicaid for the minor parent and the infant.

 **Note:** Due to system edits, an unborn cannot be placed on an ADC/FC case type 13; therefore, when an infant is born to a Title IV-E eligible pregnant minor in foster care, a separate Medicaid case type 20 will be opened systemically. If appropriate, add the infant to the minor parent's case type 13. When adding the infant to the minor parent's case type 13, be sure the infant's case type 20 is closed first. A stacking problem will occur if the infant is added to the case type 13 before closing the case type 20. The stacking of coverage will truncate the newborn's Medicaid coverage on WMS and claims will be rejected under these circumstances.

Non-Title IV-E Eligible

If a non Title IV-E eligible minor parent is placed with his/her child and retains custody of that child, a MA determination is necessary for the minor parent and child. The income of the minor parent and child are compared to the MA Level for two, the PA level, or the minor parent's foster care board rate plus any additional allowances for the child, whichever is highest, or the applicable Federal Poverty Level. If the child is not residing with the minor parent, Medicaid eligibility for the child must be determined separately.

Pregnant Women

A woman determined eligible for Medicaid for any day during her pregnancy remains eligible for Medicaid for the duration of her pregnancy and until the end of the month in which the 60th postpartum day occurs, regardless of any changes in the family's income, resources or household composition. This eligibility is granted in all instances where a Medicaid application is made prior to the end of the pregnancy and the pregnant woman is determined eligible for Medicaid. At the end of the 60-day postpartum period, eligibility should be re-evaluated.

A woman with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

 **Note:** A child born to an eligible pregnant woman will remain eligible for Medicaid until the end of the month in which the child turns age one. When a woman applies for Medicaid within three months after giving birth and it is determined that she was eligible at the time of birth, the infant is eligible for this one-year extension.

 **Note:** Use case type 22 (MA-SSI) for a minor parent or the minor parent's child if eligible for Medicaid based solely on receipt of SSI and case type 20 for the non-SSI recipient.

OCFS Youth (Juvenile Justice Population)

All foster care placements require that legal custody be awarded to the Commissioner of the Local Department Social Services (LDSS) or the Commissioner of the State Office of Children and Family Services (OCFS). Only OCFS youth placed in Title IV-E eligible settings may, if found otherwise eligible, receive Medicaid. These include OCFS residential care facilities and OCFS foster care boarding homes that have been designated as meeting Title IV-E requirements, as well as children in OCFS custody who are placed in voluntary foster care agencies. Residential care facilities that meet the Title IV-E requirements for public institutions are those that are 25 beds or less and non-secure.

Once it is determined that the OCFS youth is placed in an eligible setting, an application for Title IV-E and Medicaid will be forwarded to the LDSS of fiscal responsibility by the OCFS Federal Resource Unit (FRU). OCFS is responsible for providing sufficient information to the LDSS to determine Medicaid eligibility. Medicaid eligibility is determined as outlined in this chapter. OCFS notifies LDSS of placement changes, status changes, and discharges while the child remains in care. Medicaid cards for children placed with OCFS, like voluntary child care agencies that have a Medicaid per diem, are not issued under normal circumstances.

 **Note:** Entry into the WMS Principal Provider Subsystem is essential to ensure the child care agency is paid the Medicaid per diem. The principal provider ID Code for all OCFS operated facilities is 01431745.

Re-determinations: A recertification for Medicaid is a determination to continue or discontinue Medicaid based upon the eligibility of the recipient at the time of recertification. In all cases,

Medicaid must be authorized for 12 months upon Title IV-E re-determination. (*See Chapter One for instructions on authorizing Title IV-E.*) Medicaid for non Title IV-E eligible children is recertified every 12 months. All factors relating to eligibility, as outlined in this chapter, are re-evaluated at each recertification.

Discharge: OCFS is responsible to notify the LDSS if the child has been discharged from care and the child’s current address. The Medicaid case should be referred for a determination based on circumstances of the child’s new living arrangements. LDSS should send a notice to the caretaker or the child if discharged independently regarding Medicaid eligibility. If the child is not eligible for Medicaid, continuous coverage provisions apply, if appropriate.

Continuous Coverage: Medicaid continuous coverage applies to all Medicaid eligible children, including the Medicaid eligible OCFS Youth.

Juvenile Delinquents Placed in Voluntary Agencies: The OCFS Commissioner may opt to place a child in the care of a voluntary foster care agency. When this occurs, the Medicaid determination is handled like any other foster care placement.

Third Party Health Insurance: It is OCFS policy to make every effort to determine if a youth placed in custody has third party health insurance. Available TPHI information will then be forwarded to LDSS by OCFS FRU for entry into WMS. (*See section below on Third Party Health Insurance.*)

Child Placed in OMH/OMRDD Residential Program

OMH (District Code 97)

The Office of Mental Health (OMH) is responsible for providing care to persons with mental illness, as defined in Mental Hygiene Law. The following facilities are operated or certified by OMH:

- *Psychiatric Centers (PC)* – NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in PCs.
- *Family Care (FC)* – NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in State Operated Family Care (SOFC) facilities. Local districts are responsible for determining Medicaid eligibility for children placed in Voluntary Operated Family Care (VOFC) facilities.
- *Residential Treatment Facilities for Children and Youth (RTF)* – NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in RTFs.
- *Community Residence (CR)* – Generally, NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in State Operated Community Residences (SOCR). Local districts are responsible for determining Medicaid eligibility for children in a Voluntary Operated Community Residence (VOCR).
- *Family Based Treatment (FBT)* – NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in FBTs.

- *Teaching Family Community Residences (TFCR)* – NYS DOH in conjunction with OMH is responsible for determining Medicaid eligibility for children placed in TFCRs.

OMRDD (District Code 98)

The Office of Mental Retardation and Developmental Disabilities (OMRDD) is charged with the responsibility of caring for persons who are mentally retarded and/or have developmental disabilities as defined in Mental Hygiene Law. The following facilities are operated or certified by OMRDD:

- *Developmental Centers (DC)* – NYS DOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for children placed in DCs.
- *Small Residential Units (SRU)* – NYS DOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for children placed in SRUs.
- *Family Care (FC)* – NYS DOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for children placed in State or Voluntary Operated Family Care homes.
- *Community Residence (CR)/Individualized Residential Alternatives (IRA)* – NYS DOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for “621” eligible individuals in State Operated Community Residence (SOCRs) and State Operated Individualized Residential Alternatives (SOIRAs). Local districts are responsible for determining Medicaid eligibility for individuals in VOCRs and VOIRAs and non-621 individuals in SOCRs and SOIRAs.

 **Note:** Individuals are considered 621 eligible if they (1) are discharged from a psychiatric center operated by OMH or a developmental center operated by OMRDD (including stays in Family Care); and (2) have spent five or more continuous years in these facilities. The 621 status can be verified by contacting the appropriate Psychiatric Center or Developmental Center medical records office.

- *Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)* – NYS DOH in conjunction with OMRDD is responsible for determining Medicaid eligibility for 621 eligible individuals in State or Voluntary Operated ICF/DDs. Local districts are responsible for determining Medicaid eligibility for non-621 eligible individuals in State or Voluntary Operated ICF/DDs.

When a child is placed in a living arrangement where NYS DOH, in conjunction with either OMH or OMRDD, is responsible for determining Medicaid eligibility, the local district Medicaid case must be closed promptly so that OMH or OMRDD can establish the necessary coverage. If the local district’s case type 13 or case type 20 is not closed promptly, OMH or OMRDD will open a case in conflict (i.e., overlaying the county case). When the local district case is subsequently closed, stacking problems can result which will cause the child to appear as not eligible for Medicaid.

Medicaid Managed Care

Social services districts may opt to enroll their direct care foster care population into Medicaid managed care. LDSSs are required to indicate in their Medicaid managed care contracts, whether the respective locality plans to enroll direct care foster care children in Medicaid managed care. Districts are also required to submit to the NYS Department of Health, a “Foster Care Enrollment Plan” which describes the policies and processes that will be used to enroll direct care foster care children in Medicaid managed care.

Please note that children who are placed with voluntary child care agencies and OCFS-operated facilities are not eligible to participate in managed care, and it is the responsibility of the LDSS to disenroll such children from Medicaid managed care upon placement with a voluntary child care agency or OCFS-operated facility.

Enrollment of Direct Care Foster Care Children in Medicaid Managed Care: If an LDSS Commissioner chooses to enroll direct care foster care children in Medicaid managed care, a WMS Prepaid Capitation Enrollment must be entered into the WMS PCP Subsystem for each respective direct care child. Please refer to the next section, Medicaid Managed Care Auto-Assignment, for a description of systems entries that will prevent auto-assignment of children in foster care into Medicaid managed care.

Medicaid Managed Care Auto-Assignment: Medicaid managed care policy requires that individuals residing in counties that operate mandatory Medicaid managed care programs choose a managed care plan within 60 days of notice by New York Medicaid Choice (i.e., NYC, Nassau and Suffolk County enrollment program) or the respective LDSS. Individuals who do not choose a plan within 60 days are auto-assigned to a plan.

Social service districts are provided with periodic reports of Medicaid recipients who will be auto-assigned to a Medicaid managed care plan. These reports must be reviewed to identify children in foster care and to determine if enrollment in a Medicaid managed care plan is appropriate. It is the responsibility of district staff to ensure that children in foster care are not auto-assigned to a Medicaid managed care plan by either selecting a plan for the respective child, in accordance with the approved Foster Care Enrollment Plan that describes policy and procedures for enrollment of children in foster care in Medicaid managed care; or by processing necessary systems entries on WMS to prevent auto-assignment of such children.

Auto-assignment is prevented, as appropriate, by the following systems entries:

- Auto-assignment will not occur if children are authorized as Medicaid eligible ADC/FC case type 13.
- Auto-assignment will also not occur for children who are placed with voluntary child care agencies and OCFS-operated facilities that are paid a Medicaid per diem rate. In this case, entry of “R” (i.e., roster) in the Card Code Field on the LDSS-3209 prevents auto-assignment.

Where the preceding methods (i.e., case type 13; Card Code “R”) do not apply, systems code 90 (Managed Care Excluded) and code 91 (Managed Care Exempt) can be entered, as appropriate, in the WMS Restriction and Exceptions Subsystem to prevent auto-assignment:

- Systems code 90 will prevent auto-assignment and voluntary enrollment in a Medicaid managed care plan.
- Systems code 91 will prevent auto-assignment but will allow voluntary enrollment in a Medicaid managed care plan.

 **Note:** Entry of Code 90 and Code 91 can be changed by ending the existing code and entering the new code.

Upon discharge of children from foster care, district staff should determine if changes should be made to coding entered in the WMS Restriction and Exception Subsystem.

Medicaid Managed Care Enrollment Lock-In Requirements: In counties where lock-in provisions apply, individuals may choose to change Medicaid managed care plans during the first 90 days of enrollment. However, lock-in requirements, with certain exceptions, preclude individuals from changing Medicaid managed care plans after the initial 90-day enrollment period. Individuals are, therefore, locked into enrollment in their respective plan for a period of 12 months, including the initial 90-day enrollment period.

Direct care foster care children are exempt from mandatory managed care enrollment requirements. Direct care foster care children are enrolled in Medicaid managed care plans at the discretion of the local commissioner. And, at the discretion of the local commissioner, these children could be disenrolled from a managed care plan, based on their exempt status, and subsequently enrolled in another managed care plan.

Disenrollment of Foster Care Children from Medicaid Managed Care: Social service districts may opt to enroll direct care foster care children or continue a pre-existing enrollment in a Medicaid managed care. Districts may also opt to disenroll direct care foster care children from Medicaid managed care and provide services through the Medicaid fee-for-service program. The district managed care contracts indicate whether the locality plans to enroll direct care foster care children in Medicaid managed care.

Children in foster care who are placed in the care of voluntary child care agencies and OCFS-operated facilities are not eligible to participate in Medicaid managed care. Such children must be disenrolled from Medicaid managed care.

Appropriate processing of prospective and retroactive disenrollments is important because the Medicaid Management Information System (MMIS) denies payment of Medicaid per diem rates to voluntary child care agencies and OCFS-operated facilities, and certain Medicaid fee-for-service claims, for children who continue to be inappropriately enrolled in Medicaid managed care following foster care placement.

Disenrollment of children who are in the direct care of the LDSS Commissioner are to be processed prospectively, unless there are special circumstances (i.e., urgent medical need) that would warrant a retroactive disenrollment.

Disenrollment of children in foster care who are placed in the care of voluntary child care agencies or OCFS-related facilities may be processed retroactively. In such instances, district staff would retroactively disenroll the child back to the first day of the month of entry into the foster care agency/facility. In processing such disenrollments, district staff shall make

adjustments as necessary to allow the child's Medicaid managed care plan to retain capitation for the retroactive month if the plan was at risk for providing Medicaid managed care benefit package services for any part of that month. Therefore, it is important to ensure that Medicaid managed care plans are paid the monthly capitation payment, prior to processing retroactive disenrollments. Additionally, Medicaid managed care plans must be notified in writing of retroactive disenrollments.

 **Note:** To disenroll children in foster care who are enrolled in Medicaid managed care through the provision of guaranteed eligibility, it is necessary to first change the "Guarantee Thru Date" to the last day of the month prior to the month of disenrollment. As an example, the guarantee date would need to be changed to 10/31/03 to disenroll a foster care child effective 11/1/03. This is done through a change line (CL) transaction on the Prepaid Capitation Plan (PCP) subsystem. Guaranteed eligibility, with certain exceptions, applies if an individual becomes ineligible for Medicaid during the first six months of enrollment in a Medicaid managed care plan. Guaranteed eligibility means that these individuals would remain enrolled in the respective Medicaid managed care plan for a period of no longer than six months from their respective effective date of enrollment. However, Medicaid managed care plans would not be entitled to monthly capitation payments for children who are placed in foster care, following the effective date of disenrollment from Medicaid managed care, regardless of the number of months of guaranteed eligibility that would otherwise be available to the respective child.

Timely Processing of Medicaid Eligibility Determinations and Recertifications: Medicaid eligibility determinations and recertifications need to be completed in a timely manner to ensure that no inappropriate lapse in Medicaid eligibility occurs; and to ensure that appropriate Medicaid managed care capitation payments, Medicaid per diem and Medicaid fee-for-service payments are processed in a timely manner.

Medicaid Managed Care Enrollment upon Discharge from Foster Care: In mandatory Medicaid managed care programs, Medicaid eligible children who are discharged from foster care would be enrolled in their family's Medicaid managed care plan, unless the child is determined to be exempt or excluded from mandatory enrollment requirements. Children who are exempt from Medicaid managed care mandatory enrollment requirements may voluntarily enroll in Medicaid managed care. The LDSS or New York Medicaid Choice (i.e., NYC, Nassau and Suffolk County enrollment program) would provide the head of household with information regarding enrollment options for exempt children.

In counties that operate voluntary Medicaid managed care programs, the LDSS would, when appropriate, provide the head of household with information regarding Medicaid managed care enrollment options.

Other Special Eligibility Instructions

Children on Trial Discharge

A Medicaid eligibility re-determination based on the child's new living arrangements must be completed when a child is placed on a trial discharge for more than seven days based on the child's new living arrangements. If the child is found eligible for Medicaid, a new authorization with a new continuous save date is issued. If the child is determined ineligible for Medicaid, then continuous coverage provisions apply, if appropriate. In cases where the child is ineligible for Medicaid including continuous coverage, then LDSS should facilitate an application for CHPlus B, or FHPlus, whichever is appropriate.

Undocumented/Illegal Immigrants

If otherwise eligible, a child in foster care cannot be denied Medicaid coverage for treatment of an emergency medical condition because of his/her immigration status. The term emergency medical condition is defined as: "a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part." Medicaid is available for emergency services provided to an otherwise eligible immigrant from the time that the individual is first given treatment for an emergency medical condition until such time as the medical condition requiring emergency care is no longer an emergency. The decision whether or not the medical treatment is for an emergency medical condition must, in all cases, be made by a physician. The form DSS-3955 "Certification of Treatment of Emergency Medical Condition" must be completed by the attending physician. Medicaid cases opened for emergency services only would have a Medicaid Coverage Code of 07 – Emergency Services Only.

Foster children who are determined ineligible for Medicaid due to the fact that they are an undocumented/illegal immigrant should be referred to CHPlusB, as there is no citizenship requirement.

 **Note:** A woman with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

Third Party Health Insurance

Third Party Health Insurance (TPHI) includes health, hospital, and/or accident insurance policies. Medicaid eligibility must always be determined for children in foster care regardless of the existence of TPHI. Insurance benefits should be applied to the fullest extent to ensure that Medicaid is the payor of last resort. When the LDSS verifies that a foster child is in receipt of TPHI, it is important to enter this information on WMS by completing the Third Party Data Sheet (DSS-4198) or by making a referral to the TPHI resource person, if available. This will prevent payment of medical bills by Medicaid until the TPHI has made and/or rejected payment. It is also important that the worker remove from WMS any TPHI that is no longer in effect to allow

unrestricted payment of medical bills by Medicaid. The date the insurance policy was terminated should be verified by the insurance company.

Instructions for completing the Third Party Data Sheet (DSS-4198):

Section I: Client Identification Information (Complete all items)

- Enter: Case Name (Last, First)
- Enter: Case Number
- Enter: Recipient's Last Name
- Enter: First Initial (FI)
- Enter: CIN (Client Identification Number)
- Enter: Relationship to Policyholder (REL)

Section II: Essential Insurance Information

- Enter: Insurance Company Name
- Enter: Insurance Code (INC CD) – (see “Claiming Address Report” for list of Insurance Company Codes)
- Enter: Policy Number (may enter Social Security Number of policy holder if unknown)
- Enter: Group Number (if known)
- Enter: Coverage
 - From: Date insurance became effective – if unknown, enter 3 months prior to date of initial eligibility
 - To: Date insurance terminated – leave blank if insurance is still in effect
- Check box(es) of appropriate health insurance coverage – at least one box must be checked
- Policy Source – check appropriate policy source
- Enter: Policy Holder's Name (Last, First)
- Enter: Sex (Policy Holder)
- Enter: Zip Code that corresponds to Insurance Code – (see “Claiming Address Report”)

Section IV: Preparer Information – sign, date, and send to Data Entry Unit for entry into WMS.

Communication and Foster Care Placement Transitions

To ensure ongoing Medicaid coverage during foster care placement transitions, particularly with foster care placement moves between counties, and at foster care discharge, assigned LDSS staff must communicate changes of placement status and initiate related system entries in a timely way.

It is essential to coordinate the openings and closings of Medicaid cases and related system entries to prevent stacking issues, which could result in truncating Medicaid coverage. In addition, if staff fails to communicate a current address upon discharge, Medicaid notices will be issued to an incorrect address. As a result, the Medicaid recipient will not be informed to take the necessary action to ensure Medicaid recertification, and Medicaid coverage will be interrupted.

6. Sample Instructions

Application Turnaround Document (APTAD) LDSS-3209

Below is a list of required screens and fields on the LDSS-3209 for purposes of authorizing Medicaid for children in foster care. The instructions apply to coding options and coding descriptions for required fields within the necessary applicable screens. The required screens to be completed are 1, 2, 3, and 5. Instructions for application registry and instructions for completing the required fields with the applicable codes in the appropriate screens for CT 20 and CT 13 to authorize Medicaid are as follows:

Application Registry

1. From WMS Main Menu select 04 – WMS Application Registry Menu
2. Select 1 – Initial Application Registry
3. Fill in as many fields as possible – information will be pulled into the Full Data Entry workbook screens. The **minimum** fill entries are:
 - a. Application Date
 - b. Unit and/or Worker Number
 - c. Case Type
 - i. 13 – ADC/FC
 - ii. 20 – MA Only
 - d. Language
 - e. Street Address, City, State, Zip
 - f. First Name
 - g. Last Name
 - h. Date of Birth (MMDDYYYY)
 - i. Sex

Case Opening - Full Data Entry

1. Complete Authorization LDSS-3209 as follows and submit to Data Entry Unit
- OR -
2. From WMS Main Menu select 07 – N-S Data Entry & Disposition
3. Select function A – Full Data Entry and enter Registration Number/Version Number – (e.g. 561213/01)

For help in authorizing a case see the Worker Reference Manual (WRM) section titled “Establishing a Case.”

Using the WMS Non-Services Code Card Index to assist – enter the following:

Screen 1

1. Transaction Type (TRANS TYPE)
 - a. 02 – opening
 - b. 10 – reopening
2. Reason Code (CASE REAS CODE)
 - a. 070 – Living Below Agency Standards (MA Only)
 - b. 098 – DSS Custody (ADC/FC Only)
 - c. 097 – OCFS Custody (ADC/FC Only)
3. Authorization Period (AUTH PERIOD) – Using the 1st day of the month of determination, authorize the case for 12 months.
4. MA cases (Case Type 20) may be backdated 3 months from the application date to cover outstanding medical bills prior to the application date, if determined eligible for that period (based upon the child's circumstances prior to placement).
5. Case Number – will be assigned by LDSS
6. PA/FS CODE (ADC/FC Only)
 - a. 02 – Do Not Authorize - Declined to Participate for Food Stamps
7. IV-D Indicator (IV-D IND) (ADC/FC Only)
 - a. Y – IV-D Case
 - b. N – Not a IV-D Case
8. The remainder of the fields will be pulled from the Application Registry.

Screen 2

1. Pregnancy/Parenting Codes (PRG PAR)
 - a. 1 – Pregnant Teen
 - b. 2 – Teen Parent
 - c. 3 – Neither Pregnant Nor Parenting
 - d. 4 – Other TASA (Teenage Services Act)
2. Social Security Number Codes (SSN CD)
 - 1 – SSN Present
 - 2 – SSN Applied for
 - 3 – SSN Applied for and denied
 - 4 – SSN Not Applied for
3. Fill in SSN if known and not entered at App. Reg.
4. Marital Status (MS) (See WMS Code Cards for additional codes)
 - 1 – Married
 - 2 – Single
5. Client Identification Number (CIN) – Fill in ASSIGN or the CIN if known

Screen 3

1. Relationship Code (REL)
 - a. 01 – Applicant
 - b. 02 – Son
 - c. 03 – Daughter
 - d. 20 – Sister/Brother
2. Individual Categorical Code (CAT CODE)
 - a. 07 – Removed by Court Order (ADC/FC and MA-Medically Needy)
 - b. 53 – Continuous Coverage – LIF Child 0 Up to 19

Child's Age and Income	Category	Continuous Coverage Code
Infant under 1 @ 100% FPL	44	54
Infant under 1 between 100% & 200% FPL	45	55
Age 1-5 133% FPL	46	54
Age 6-18 100% FPL	47	54
Age 6-18 between 100% & 133% FPL	60	67

3. State & Federal Charge Codes (ST/FED) (See WMS Code Cards)
4. CTHP Referral Status Codes – not required at opening but required for individual <21 at recertification
5. Veteran Status (VET STAT) (MA Only – See WMS Code Cards for additional codes)
 - a. 9 – Not a Veteran
6. Race (place Y in the appropriate category)
 - a. H – Hispanic or Latino
 - b. I – Native American Indian or Alaskan Native
 - c. A – Asian
 - d. B – Black or African American
 - e. P – Native Hawaiian or Pacific Islander
 - f. W – White
7. Citizenship/Alien Indicator (CIT) (See WMS Code Cards for additional codes)
 - a. C – Citizen

Screen 4

1. No entries required unless Screen 3 Citizenship Indicator is other than “C – Citizen” (See WMS Non-Services Code Card Index)

Screen 5

1. Individual Disposition Status (IND STAT)
 - a. 07 – Active
2. Coverage Code (COV CODE) (See WMS Code Cards for additional codes)
 - a. 01 – Full Coverage
 - b. 30 – Managed Care Full Coverage
 - c. 02—Outpatient

- d. 06—Provisional Eligibility Excess Income
- 3. MA Coverage Dates FROM-TO will be system generated or can be entered.
- 4. Principal Provider Codes (PRIN PROV)
 - a. 00 – No Principal Provider
 - b. 10 – Child Care Facility (an entry should be made in Principal Provider Subsystem)
- 5. Card Code
 - a. N – No Photo
 - b. P – Photo
 - c. R – Roster (Childcare Facility)
 - d. X – Omit Name (no card)

Screen 6 – No entry necessary

Screen 7 – No entry necessary

Screen 8 – No entry necessary

Screen 9 – No entry necessary

To access the WMS Non-Services Code Card Index:

- Go the Health Department web site: <http://www.health.state.ny.us>.
- On the same line as the address click on the down arrow and the dropdown box is displayed. Left click on the address: <http://sdssnet5/>.
- On the next screen left click on the OTDA choice. At the bottom of the dark blue section on the left of the returned screen at SEARCH type in “wms code cards” and left click GO. On the returned screen, click on the top choice – WMS Code Card Index. The returned information displayed is divided into screens (Screen 1, Screen 2, etc.). All information that is needed to fill out each WMS field is recorded on the Code Cards under the matching screen number. These cards are updated frequently and provide the most updated list of WMS codes for each input screen.

New York State Medicaid – Citizenship/Immigrants

To be eligible for NYS Medicaid benefits, an individual must be a citizen, national, Native American (N.A.), or must fall into one of many immigration categories. Applicants must show proof of identity, date of birth, residency, and satisfactory immigration status. “Satisfactory immigration status” means an immigration status that does not make the individual ineligible for benefits under the applicable program.

An individual with satisfactory immigrant status will fall under one of the following categories:

- Legal Permanent Resident (Green Card)
- Asylee
- Refugee
- Amerasian
- Cuban/Haitian Entrant
- Withholding of Deportation
- Conditional Entrant
- Parolee at least one year
- Native American born in Canada who is at least 50% Native American
- Some battered immigrants and/or children
- Order of supervision
- Stay of Deportation
- Voluntary Departure
- Deferred Action Status
- Suspension of Deportation
- Parolee for less than one year
- Covered by an approved immediate relative petition
- Property filed or granted application for adjustment of status
- Has continually lived in the United States since before January 1, 1972
- Living in the U.S. with the knowledge and permission or acquiescence of the USCIS and whose departure USCIS does not contemplate enforcing.

Non-immigrants are eligible only for the treatment of an emergency medical condition.

Undocumented immigrants are unable to provide documentation of immigration status; therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition.

- Undocumented children may be eligible for CHPlus B.
- Undocumented pregnant women continue to be eligible for Medicaid.