

Medicaid for Foster Children Questions and Answers

Questions as of March 2005

Question 1: Trainer stated that for a priority Interstate Compact for the Placement of Children (ICPC) approval of an out-of-state placement one of the documents needed is a court order. What court order is acceptable? Is it the order that initiated the placement or is it a separate court order that specifically indicates that priority placement is required?

Answer 1: The court order could be, but need not be the initial placement order. Per Regulation No. 7 of the ICPC. The court order must determine that a priority placement from one State to another is necessary. The court order must also reflect that the government agency has custody of the child. A court order finding entitlement to a priority placement is not valid unless it contains an express finding that one or more of the following circumstances apply to the particular case and sets forth the facts on which the court is basing its findings:

- a. the proposed placement recipient is a relative belonging to a class of persons who, under Article VIII(A) of the ICPC could receive a child from another person belonging to that same class, without complying with the ICPC (see section 374-a of the SSL) and (1) the child is under two years of age; or (2) the child is in an emergency shelter; or (3) the court finds that the child has spent a substantial amount of time in the home of the proposed placement recipient.
- b. The receiving State's Compact Administrator has a properly completed ICPC 100A and supporting documentation for over 30 business days, but the sending agency has not received a notice pursuant to Article III(d) of the ICPC determining whether the child may or may not be placed.

Question 2: What happens to the Medicaid of a NYS Non-Title IV-E eligible child who is placed in an out-of-state residential facility and the receiving state does not have MA providers enrolled in NYS Medicaid?

Answer 2: *From the Eligibility Manual page 4-16*

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.

Question 3: When a child is discharged from foster care and is in receipt of MA through continuous coverage provisions, and subsequently moves to another county, what county is responsible for MA – the old or the new county?

Answer 3: The county of origin (or the old county) would be responsible for the remainder of the continuous coverage period. The new county should do a new MA determination based on the new circumstances.

From the Eligibility Manual on page 4-27

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.

Question 4: If a non-Title IV-E child is placed out-of-state, could the sending county purchase a health insurance policy for the child while the child is in that placement (foster care or pre-adoptive placement)? The child would have health coverage and the county (state) could save money in the long run.

Answer 4: If medical costs are reduced by the purchase of private health insurance and the foster child is Medicaid eligible then the county can legitimately purchase the health insurance and receive Medicaid reimbursement.

Question 5: How does the Medicaid unit know where the foster child resides to make an appropriate Medicaid determination?

Answer 5:

From the Eligibility Manual 4-5

The 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
- Third party health insurance.

Question 6: How do we provide Medicaid for a child with a support order that indicates the child is covered under the mother's Third Party Health Insurance (TPHI), but the mother is no where to be found and none of the TPHI information is available to the county?

Answer 6: If you cannot verify the TPHI, you cannot enter it into WMS. WMS should reflect the current status.

From the Eligibility Manual page 4-25

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.
(emphasis added)

Question 7: Once parental rights are terminated; does the child lose the Third Party Health Insurance (TPHI) coverage that previously had under the parent's plan?

Answer 7: Yes. Remember to update WMS by completing the Third Party Data Sheet (DSS-4198).

Questions as of September 2004

Eligibility

Question 1: Is a child in foster care automatically eligible for Medicaid? Do we have to do a MBL budget?

Answer 1: The fact that a child is in foster care does not make that child automatically eligible for Medicaid. Only children in receipt of Title IV-E or SSI are considered automatically eligible for Medicaid. If a child in foster care is determined ineligible for Title IV-E and is not in receipt of SSI, eligibility for Medicaid must be determined using the specific eligibility methodology as issued by the NYS DOH. This includes completing a MBL budget. (See Eligibility Manual, page 4-9)

Question 2: Is it possible to be on Medicaid and not be Title IV-E eligible?

Answer 2: Yes, eligibility requirements for Medicaid and Title IV-E are different. Children in foster care who meet the eligibility requirements of Title IV-E are automatically eligible for Medicaid coverage. If a child is ineligible for Title IV-E, eligibility would then be determined using the specific eligibility methodology for non Title IV-E children in foster care as issued by the NYS DOH. (See Eligibility Manual, page 4-4, 4-5)

Question 3: Is it possible for a child to receive Medicaid in a MA/SSI case (case type 22) when he/she is not actually receiving SSI benefits?

Answer 3: Yes. In some cases, the Social Security Administration may determine that a child is not eligible for SSI benefits but still eligible to receive Medicaid through the MA/SSI case. The Auto/SDX updates client information, including the loss of SSI eligibility, via daily tape processes

from SSA through the SDX . In these instances no change would be made and the MA/SSI case would remain open.

Question 4: Our district uses one application for both Services and Medicaid. Is this correct?

Answer 4: Yes. It is not necessary that separate applications be completed for Services and Medicaid. As long as all necessary information is obtained, the same Common Application (LDSS-2921) may be used for both.

Question 5: Do we need a separate Medicaid application for each child?

Answer 5: No. If more than one child from the same home is placed in foster care, it is not necessary to complete a separate Common Application (LDSS-2921) for Medicaid for each child.

Question 6: When conducting a re-determination upon discharge for Medicaid, do we need to use a specific form? If so, what form?

Answer 6: When the child in foster care is discharged, his/her Medicaid eligibility must be re-determined based on his/her new living arrangements. The LDSS 3174, "Recertification Form For: Temporary Assistance (TA) – Medical Assistance (MA) – Medicare Savings Program (MSP) – Food Stamp Benefits (FS)" must be sent to the caretaker of the child. If discharged independently, then the LDSS 3174 is sent directly to the young adult.

Question 7: What happens to the Medicaid when a youngster in foster care is incarcerated for a period of time and then released?

Answer 7: When a foster child receiving Medicaid is incarcerated, the Medicaid is not available during the period of incarceration. Once the child is released, Medicaid eligibility would be reviewed.

Question 8: Why wouldn't a child who is certified blind or disabled be in receipt of SSI?

Answer 8: The Social Security Administration may have determined that a child is certified blind or disabled but ineligible for SSI payments for other reason, i.e. excess income/resources, etc. In some cases the local district may have conducted a Disability Review and determined that the child is certified blind or disabled but SSA has denied SSI benefits. In either case, the child would be certified blind or disabled but not in receipt of SSI benefits.

Question 9: How does a district determine whether the district or OMRDD is responsible for providing Medicaid covered to a child in foster care who is placed in an OMRDD living arrangement?

Answer 9: The responsibility for providing Medicaid coverage depends on the type of living arrangement and the '621' status of the child. (See Eligibility Manual page 4-21). The Eligibility Manual should be reviewed for more information regarding the types of living arrangements in which OMRDD is responsible for providing Medicaid coverage. A phone call to the residence should confirm whether OMRDD or the local district is responsible.

Discharge / Continuous Coverage

Question 10: Who is responsible for Medical coverage when a Title IV-E eligible child in a residential facility is placed out-of-state?

Answer 10: If a Title IV-E eligible child is placed out of state in a Title IV-E eligible setting, then the facility state is responsible for providing Medical Assistance. If it is a non Title IV-E child, or a Title IV-E child being placed in a non Title IV-E setting, then the NYS LDSS is responsible for the payment of medical expenses.

Question 11: Who signs the Medicaid application for a child released from the court? Do we sign on behalf of the child or does the child's parent have to sign?

Answer 11: The caretaker or child (if discharged independently) would be responsible for completing, signing and returning the recertification and any required documentation to the local district.

Question 12: Do we have to make a Medicaid re-determination for children under age 19 who are discharged from foster care? Don't the continuous coverage provisions apply?

Answer 12: When both Title IV-E and non Title IV-E eligible children are discharged from foster care, Medicaid eligibility must be re-determined based on the circumstances of the child's new living arrangements. When a child is not being discharged to a family on Temporary Assistance or Medicaid, a recertification packet should be sent to the caretaker (or child if discharged independently). If the child is under age 19 and has been determined Medicaid ineligible, or if eligibility cannot be determined, continuous coverage provisions would apply. Prior to the conclusion of the

continuous coverage period, a certification packet is sent to re-determine eligibility since circumstances may have changed.

Question 13: What if we don't have all the income information to make a Medicaid eligibility determination when a child under the age of 19 is discharged from foster care?

Answer 13: Upon discharge, a recertification packet should be sent to the caretaker (or child if discharged independently). If you are unable to determine eligibility because the caretaker or child has not responded or did not submit income information as requested, continuous coverage provisions would apply.

Question 14: Does continuous coverage apply to both Title IV-E (case type 13) and non Title IV-E (case type 20) cases?

Answer 14: Yes. Continuous coverage is supported by WMS for both Title IV-E (ADC/FC case type 13) and non Title IV-E (case type 20) cases.

Question 15: When discussing continuous coverage, what Medicaid case type goes with each one of the individual Medicaid categorical codes listed in the GIS message 03 MA/010?

Answer 15: The individual categorical codes listed in the GIS MA/010 (01-09, 13, 15, 26, or 43-48) are those codes for which the change from case type 13 to case type 20 is allowed by the system. Except individual categorical code 43 – Expanded MA levels Pregnant Women, all can be used with either case type 13 or 20. Categorical code 43 may be used with case type 20 only. The individual categorical code used should reflect the child's circumstances.

System Instructions

Question 16: Regarding the minor parent with legal custody of child, does principal provider code on parent affect the child's MA claim processing?

Answer 16: The Principle Provider Subsystem in CIN specific. It regulates per-diem payments and other medical payments for the recipient with a Principle Provider entry on file under their specific CIN. It does not affect payment for per diems or for claims sent to Computer Science Corporation (CSC) for payment to any other recipient CIN number.

Question 17: Foster care board rates are daily. Do we have to convert them to monthly? If so, how?

Answer 17: Yes, the local district would need to convert the foster care board rate to a monthly amount in order to enter it on MBL. To do this, the local district would multiply the daily rate by 30 days.

Question 18: We are unable to change the case number when changing a case type 13 to a case type 20 or vice versa. What do we do?

Answer 18: When changing a case type from 13 to 20 or vice versa, the case number must remain unchanged. If the local district wishes to change the case number, the active case would have to be closed and a new case opened with the new case number. Be advised that stacking problems can result if the active case is closed after the new case is opened. (see GIS-02-#016 or GIS 03 MA/010 – Continuous Coverage for Case Type 13, Case Type 13 to 20 and Vice Versa)

Question 19: Is there a plan to update the Electronic Eligibility Worksheet to include the MBL budgeting methodology for non-Title IV-E children?

Answer 19: No, at this point there is no plan to update the Electronic Eligibility Worksheet to include MBL budgeting methodology.

Third Party Health Insurance

Question 20: When a child with Third Party Health Insurance is placed in a voluntary child care agency that gets paid on a Medicaid per diem, who pays the childcare agency, Medicaid or TPHI?

Answer 20: TPHI benefits should always be applied to the fullest extent to ensure that Medicaid is the payer of last resort. Each TPHI policy includes different benefits. Therefore, when the local district verifies that a foster child is in receipt of TPHI, it is important to enter this information on WMS. This will prevent payment of medical bills by Medicaid until the TPHI has made and/or rejected payment. This includes the Medicaid per diems billed by voluntary childcare agencies.