

Office of Health Insurance Programs
Policy and Proposed Changes to Transition Children in Direct Placement
Foster Care into Medicaid Managed Care
April 2013

Children enter foster care often as a result of abuse and neglect and have a range of physical, mental, and/or developmental disabilities that may be greater than other children. Due to this, access to comprehensive, high quality health care is essential. As demonstrated in the Northwest Foster Care Alumni Study (published by Casey Family Programs, Harvard Medical School, and others), more than half (54%) of children in foster care have one or more mental health disorders, including an incidence of post-traumatic stress disorder that is five times that of the general population. In addition, other studies indicate that 60 percent of children in foster care exhibit developmental delays and at least one chronic medical condition. Care management and the integration of health and behavioral health service are essential to promoting the wellness of these children.

The NYS Department of Health has received CMS approval to begin mandatory enrollment of children in direct placement Foster Care in April 2013. The transition will occur in counties outside of New York City, and enrollment will be handled by the individual local departments of social services (LDSS). Children in foster care who are cared for through a voluntary foster care agency (both per-diem and non per-diem) as well as children in the B2H and OMH SED Waiver programs will not be transitioned until additional program features are developed to address the provision of services to this population.

The Department has conducted several stakeholder workgroup meetings with State agencies, local departments of social services, and Medicaid managed care organizations (MCOs) to identify obstacles and opportunities that affect the enrollment of this population. This document reflects the policy decisions that were developed to provide guidance to Medicaid managed care plans and local departments of social services. These requirements are intended to ensure a consistent statewide policy of enrolling children in Foster Care into Medicaid managed care organizations.

I. Enrollment and Disenrollment

1. Enrollment

- a. Enrollment will be phased in on a case by case basis at the county. Individual enrollees will not be given a specified amount of time in which to select a MCO, nor will this population be auto assigned. Due to the unique characteristics of this population, it has been determined that manual

enrollment should occur at the local district level to ensure that an informed and appropriate choice occurs.

- b. At intake into foster care, the county, in consultation with the child’s medical consentor (birth parents or as determined by placement authority) will determine if the child is currently enrolled in a MCO and if not, will select the best MCO for the child. Children who are enrolled in managed care at the time of initial intake may remain enrolled in the same plan or may change plans at this time, if appropriate.
- c. Children in foster care will be enrolled in MCOs based upon matching MCO networks with current service providers and service locations. Selection of a MCO will be conducted by the LDSS. MCO selection activities will include: evaluation of the provider networks and service locations; identification of the child’s current primary care provider (PCP); and placement arrangements for the child. Children currently in direct placement foster care will be enrolled in managed care at the next case evaluation or assessment (i.e. Service Plan Review), or before the deadline set by the Department as indicated below.

Number to Enroll	Enroll by Date	Number of Districts
< 20	6/1/2013	29
20-50	7/1/2013	14
50-150	8/1/2013	7
200-300	9/1/2013	2
over 300	10/1/2013	1

- d. MCOs must send all notices, Welcome Letter, and MCO identification cards to LDSS foster care coordinators in accordance within 14 days of enrollment, following timeframes in the MMC/FHP Model Contract. However, MCOs must provide a form of temporary identification for new enrollees in foster care and transmit it to the LDSS foster care coordinator by the next business day following the request or as needed to allow immediate access to services. For current enrollees entering foster care, the MCO will issue replacement identification cards or alternative documentation upon request of the LDSS foster care coordinator by the next business day following the request. Per regular business rules, children in foster care who are new to managed care are enrolled prospectively. Any care required prior to the effective date of enrollment will be covered under fee for service Medicaid.
- e. Exemptions or exclusions from mandatory managed care enrollment for this population must follow guidance provided by the Department and must be

adequately documented by the LDSS in the foster care and managed care case records. Exemptions may be considered when the foster parent lives out of state or outside the network service area of any plan serving the district of responsibility, when a child is expected to return to a birth parent within a short time frame, or Medicaid eligibility will be less than 6 months.

2. Disenrollment

- a. All enrollments and disenrollments will be effective the first day of the following month if the request is made prior to pull down. The foster care coordinator or LDSS case manager will effectuate this change through the district or Maximus as appropriate.
- b. At discharge from foster care, or disenrollment from an MCO, plan liaison and LDSS foster care coordinator must work closely together to ensure that the LDSS and the new MCO (if this is a plan transfer) are aware of the transition and the current care plan can be coordinated. If the enrollee is considered unstable by either the health care provider or the LDSS, or has a chronic condition, the MCO liaison and LDSS foster care coordinator will collaborate to ensure continuity of care plans are in place upon disenrollment or discharge from foster care.

3. Lock In Rules

- a. Good cause disenrollment rules will be modified to include a provision that children in foster care may change MCOs during intake, foster care placement or a change in placement, regardless of Lock In period. Children in foster care may be disenrolled or transferred to another plan at these times if appropriate. Enrollees in foster care may also change primary care providers within their plan as needed with good cause.

4. General Activities

The following is a list of activities to assist with the transition and enrollment of children in direct placement foster care.

- a. DOH has sent to the counties a list of children currently in direct placement foster care. A date by which to complete enrollment of current cases and guidance for coding exemptions into WMS was provided at that time.
- b. MCOs will identify a liaison to be readily available to the county during regular business hours to address any issues for managed care enrollees in foster care.

- c. MCOs were sent a list of children in foster care who are currently enrolled in the plan.
- d. LDSSs will identify a foster care coordinator to be a contact for the MCO for foster care issues in general as well as specific to cases in foster care.
- e. MCOs, counties, and providers will have a system of communication to ensure mandated and appropriate physical and behavioral health services are delivered in a timely manner.
- f. MCO liaisons and LDSS foster care coordinators will work closely to monitor appropriate care and treatment for children in foster care.
- g. Periodic conference calls will be scheduled by the Department with the local districts and MCOs to assess progress in enrollment of this population and identify any issues, including access to care.
- h. The Department will periodically run enrollment reports to assess the progress with managed care enrollment, identify any outlier counties and to provide technical assistance if needed.
- i. All communication containing Protected Health Information will be transmitted in such a manner as to assure compliance with HIPAA and HITECH requirements and maintain confidentiality of patient information.

II. Access to Care

1. Coordination between MCO and LDSS

Concern has been raised as to whether children in foster care will receive the specialty care and additional services required to meet the needs of this high risk population. Specific areas of concern include close coordination between the MCO and the LDSS, periodic diagnostic assessments, and continuity of care.

To address coordination between the LDSS and the MCO, a system has been established for effective communication and to address urgent issues that may arise. Each local district has identified a foster care coordinator who will act as the main contact person for communication with the managed care plans, and MCOs have identified a liaison to coordinate with the LDSS foster care coordinator (see attached). This system is needed specifically to address issues identified by the county in a timely manner, and to alert MCOs of new or current enrollees entering foster care.

The following processes will be in place to promote access to care:

- a. LDSS foster care coordinator will notify the MCO liaison within 5 working days, either electronically or in writing, using the transmittal form provided by the Department, when a child in foster care is enrolled in the managed care plan, or when a current managed care enrollee is entering foster care. A system for this notification must be agreed upon between the MCO plan liaison and the LDSS foster care coordinator to meet the needs of both parties. This activity is in addition to established processes currently in place for routine enrollments.
- b. MCOs will issue replacement identification cards or other temporary identification, upon request by the LDSS, to the LDSS foster care coordinator for current enrollees who are in foster care. The MCO liaison will produce a new card or other temporary identification by the following business day and send directly to the LDSS foster care coordinator or case manager.
- c. MCOs will not issue the temporary or replacement identification card to foster parents since the child is in the legal custody of the county. MCOs will not require a court order or other documentation as a condition of issuing temporary or replacement identification card to the county. A request submitted by the LDSS foster care coordinator or case manager as specified above is sufficient documentation.

2. Provider Network

- a. To promote continuity of care and ensure that health care services are delivered in a trauma informed manner, MCOs may be required to augment their provider network where necessary to include fee for service health care providers who have traditionally treated this population. If a child in foster care is placed in another county, and the plan in which he or she is enrolled operates in the new county, the MCO must be flexible in allowing the child to transition to a new Primary Care Provider without disrupting the care plan in place.
- b. For current enrollees, all foster care intake assessments necessary at the time of entry into foster care must be covered by the MCO either through a contracted health care provider or through an out of network health care provider if determined by the county. Any use of an out of network provider must be reviewed and authorized by the plan. To the extent available in the service area, MCOs must ensure that health care providers knowledgeable in conducting trauma informed health care services are available.
- c. Some counties utilize specific specialty health care providers for intake and ongoing comprehensive assessments for children in foster care. To the extent possible, MCOs are strongly encouraged to contract with those health care

providers and must be flexible in working with these providers, as identified by the counties, to perform initial assessments, annual diagnostic evaluations, mandated assessments, and provide recommended treatment for these children. LDSSs will utilize plan contracted providers who are identified as having expertise in treating this population. If the managed care network does not include providers with such expertise, MCOs will be required to authorize services out of network until such time when they have a participating provider with such expertise.

- d. MCOs are required to provide case management activities that will ensure that mechanisms are in place to meet the health care needs of these individuals. Children in foster care will utilize MCO case management services as determined and requested by the foster care case worker, following an assessment or upon recommendation by a provider.
- e. Some providers have practices that are exclusive to providing health care services to children in foster care. We encourage plans to be flexible in allowing these providers to participate in this limited capacity to avoid delays or availability issues for this population.

3. Required Assessments

- a. At intake into foster care, an immediate assessment is required by the LDSS to identify and document signs of neglect and abuse or unmet need. An intensive diagnostic assessment, including a complete physical, mental and developmental health, substance abuse and dental assessment is performed within 30 days of intake, in addition to periodic mental health and diagnostic health assessments.

Note: See American Academy of Pediatrics “Fostering Health: Health Care for Children and Adolescents in Foster Care”, 2nd Edition (<http://www2.aap.org/fostercare/FosteringHealth.html>), and NYS OCFS “Working Together Health Services for Children in Foster Care” (http://www.ocfs.state.ny.us/main/sppd/health_services/manual.asp).

- b. MCOs are required to cover assessments as identified by the LDSS for these enrollees, including the intake assessment, complete diagnostic assessments and any additional state mandated assessments within the time frames specified by state law, regulation and the county. The LDSS foster care coordinator and the MCO liaison must work together to ensure these assessments are completed on time. Overall, MCOs are expected to ensure that the health and mental health care treatment recommendations identified through the assessment process of children in foster care are adequately met.

- c. MCOs must reimburse these providers at the contracted rate or if non participating, at the fee for service rate. If mandated assessments and/or treatment are court ordered, these services must be reimbursed. The LDSS should use a network provider for children currently enrolled in an MCO. MCOs may use network “LDSS approved assessment providers”, however, if none participate with the plan, MCOs must authorize out of network care.

4. Additional activities to ensure access to services and continuity of care

- a. The Medicaid managed care plans have been given a list of providers who provide services to children in foster care. MCOs must be flexible in augmenting their provider network to include those specialty providers located in the service areas, or reimburse for assessments and services, or subcomponents thereof, on a non participating basis.
- b. Through the liaison, MCOs must report to the LDSS foster care coordinator any change in an enrollee’s status, including address change or change in health status. Upon notification, the LDSS must act on the information provided by the MCO, including follow-up with the child or foster parent as appropriate, and update case information in the system.
- c. The LDSS will report to the MCO liaison any changes in status that affect care and services for the enrollee, including, but not limited to the need for additional assessment; change in status resulting from diagnostic assessments; new foster care placement address.

III. Complaints and Appeals

- 1. MCOs, counties, and providers will coordinate and streamline access to care for this high need population. In the event that requested services are not authorized or continued by the plan due to medical necessity, the county may file an appeal on behalf of a child in foster care. Additionally, the county may request a Fair Hearing with Aid to Continue on behalf of the child, and a provider may request an external appeal.
- 2. Health care providers and the local district may also call the Managed Care complaint line (1-800-206-8125) if a MCO denies, decreases, or otherwise limits care by authorizing incremental treatment rather than a recommended length of stay, or makes a treatment decision the health care provider does not consider appropriate.

IV. Summary of Critical Policy Changes

To summarize, the following are changes in policy to address specific needs of the foster care population:

1. Phase in of enrollment begins on 4/1/2013 and will be completed in a time frame determined by the Department based on case volume at each local district.
2. Enrollment activities will be conducted on case by case basis at the local level. Auto-assignment will not apply for this population.
3. MCOs and LDSS will each designate an individual to be in direct contact for coordinating care and services and to monitor enrollee activities.
4. MCOs will issue welcome letter or temporary plan identification and replacement ID cards to the LDSS.
5. Mandated assessments are covered prospectively by MCO.
6. Good cause for disenrollment is expanded to include changes in a foster care child's situation.
7. MCOs will augment provider networks to include specific providers identified by LDSS and health care providers as having the needed expertise to conduct required and mandated assessments, enhanced periodicity schedule and health care services. If providers with this expertise are not available within the network, the MCO will cover these services with a non participating provider at the fee for service rate.
8. When prescribed by a physician, plans must authorize medications within 2 business days. If a child is prescribed medication prior to entering foster care, it is imperative that the medication continue without interruption. The plan must allow for at least one refill of a previously prescribed medication.
9. In the event of a hospitalization or inpatient stay, the LDSS, hospital, and MCO must coordinate needed services. In addition to working with the hospital, when possible, the LDSS must be provided at least 2 business days advance notice of a discharge in order to identify an appropriate living situation for the child upon discharge from the facility.

Health Services Time Frames

The chart below outlines the time frames for initial health activities, to be completed within 60 days of placement. The column labeled Mandated indicates whether an activity is required. The “M” in the time frame column indicates that the activity is required within a mandated time frame. Initial health activities include:

- Immediate screening of the child’s medical condition, including assessment for child abuse/neglect.
- Immediate efforts to obtain medical consent.
- Immediate attention to HIV risk assessment.
- Comprehensive health evaluation: A series of five assessments provides a complete picture of the child’s health needs and is the basis for developing a comprehensive problem list and plan of care.
- Follow-up health evaluation that incorporates information from the five initial assessments.
- Ongoing efforts to obtain child’s medical records and document medical activities.

INITIAL HEALTH SERVICES TIME FRAMES			
Time Frame	Activity	Mandated	Who Performs
24 Hours	Initial screening/screening for abuse/neglect		Health practitioner (preferred) or caseworker/health staff
5 Days M	Initial determination of capacity to consent for HIV risk assessment & testing	X	Caseworker or designated staff
5 Days M	Initial HIV risk assessment for child without capacity to consent	X	Caseworker or designated staff
10 Days M	Request consent for release of medical records & treatment	X	Caseworker or health staff
30 Days M	Initial medical assessment	X	Health practitioner
30 Days M	Initial dental assessment	X	Health practitioner
30 Days	Initial mental health assessment	X	Mental health practitioner
30 Days M	HIV risk assessment for child with possible capacity to consent	X	Caseworker or designated staff
30 Days M	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	Caseworker or health staff
45 Days	Initial developmental assessment	X	Health practitioner
45 Days	Initial substance abuse assessment		Health practitioner
60 Days	Follow-up health evaluation		Health practitioner
60 Days M	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	Caseworker or health staff
60 Days M	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	Caseworker or health staff

Source: http://www.ocfs.state.ny.us/main/sppd/health_services/

Draft Transmittal Form

Date: XXXXXX

**(XXX) County Local Department of Social Services
or (Plan Name)**

Child's Name:

DOB:

CIN:

Worker:

Foster Parent/s Name:

Address:

Telephone:

This child is currently enrolled in (Name of Plan) and is entering into Foster Care.

Plan ID number: _____ Primary Care Physician:

This child is entering into/is currently in Foster Care and is being enrolled in (Name of Plan).

Effective Date of Enrollment: _____

This child is being disenrolled from (Name of Plan).

Plan ID number: _____ Primary Care Physician:

This child has moved to the following address:

Street:

City, State, Zip:

Telephone:

Other Action:

Name of Foster Care Coordinator Telephone Email

Name of MCO Liaison Telephone Email