TO: Local District Commissioners, Medicaid Directors, Child Support Coordinators

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Medicaid Medical Support Transmittal

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison
Upstate (518)474-8887 NYC (212)417-4500

The purpose of this General Information System (GIS) message is to advise local departments of social services of certain provisions of Chapter 215 of the Laws of 2009, which became effective October 9, 2009, and to introduce a new form for use in providing Medicaid information for the child support program. Chapter 215 amended various sections of the Family Court Act, Domestic Relations Law, and Civil Practice Law and Rules to establish definitions for "cash medical support," "reasonable cost," "reasonably accessible" and the priority for deductions by income execution. The amendments established rules for courts to follow in determining the noncustodial parent's cash medical support obligation. A joint administrative directive (ADM) with the Office of Temporary and Disability Assistance will be released shortly detailing local district responsibilities under the new provisions. This GIS introduces the attached Medicaid Medical Support Transmittal (OHIP-0030). This transmittal needs to be completed in order for the court to establish the cash medical support obligation from the noncustodial parent (NCP) when the child is in receipt of Medicaid managed care or Medicaid fee-for-service.

OHIP-0030 - Medicaid Medical Support Transmittal

The Medicaid Medical Support Transmittal is completed for cases that are not exempt from a referral to the IV-D unit. It is to be completed, as necessary, at opening, undercare or renewal. It is also to be completed at the request of the local Child Support Enforcement Unit (CSEU). For purposes of a hearing with the support magistrate, this form is a certified document and may be offered as evidence during a court proceeding. If required by the court, printouts of Medicaid expenditures and proof of Medicaid coverage authorization dates for the child **may** need to be attached to this transmittal.

At the top of the transmittal form, in addition to county name, WMS case number, date and other required information, the name of the worker completing this form must be entered. There is room for two (2) children of the same noncustodial parent on this form. Additional forms are to be completed if required.

Part 1: Personal Information

Custodial parent (CP) information must be provided, including the CP's gross monthly income. The NCP's information must be pursued with the CP and completed in this section with as much information as possible. This information is obtained during the eligibility interview or from the DOH-4220, Access NY Application.

Part 2: Purpose for Transmittal

Most of the selections in this area are self-explanatory. As cases become newly eligible for an IV-D referral, temporarily exempt, or in the event good cause is determined for a case already active or pending in the CSEU, this information must be relayed to the CSEU. This section is also used to indicate Medicaid data is being provided to the CSEU to be used for cash medical support and/or recoveries.

Part 3: Child Information for the NCP Named in Part 1

If multiple children are being referred and one child is exempt from IV-D action, this is indicated by checking the box labeled "EXEMPT" after the child's identifying information. This box is also used to indicate a child who is now exempt and was previously referred to the CSEU.

When a child resides in an intact household or already has health insurance other than Medicaid, but paternity has not been established, the "Paternity Establishment Only" box is checked.

When the establishment of a cash medical support obligation is sought and the child is in managed care or there is a pending managed care enrollment, managed care should be checked as the coverage type. The monthly premium for the health plan in which the child is enrolled or will be enrolled is entered with the start date of the managed care enrollment ("Coverage Dates: Start ___"). For children with a future managed care enrollment date, it should be noted next to"Coverage Dates: Start ___," on the form, that the managed care enrollment is pending. Monthly premium information is available from the managed care coordinator in each local district. Fee-for-service payments made during any period of Medicaid managed care enrollment are NOT considered here or in any recovery of fee-for-service payments.

If the Medicaid child is fee-for-service, this is indicated along with the "Current coverage" box. If the case is closing, the "Medicaid Closing Date" is to be entered. When the current coverage box is checked, the court will use the information to establish the maximum annual cash medical support obligation.

The section labeled, "Expenses in Prior Periods/Years," is completed if the local district is seeking recovery for past periods of Medicaid eligibility. This may include fee-for-service expenditures for the period prior to the enrollment in managed care, or fee-for-service expenditures or managed care premiums from previous years.

When the court has set the maximum annual cash medical support obligation, the NCP is billed based on this obligation. In situations where the NCP does not follow through with payments to the local district, the “Recovery of Fee-For-Service Costs” is to be completed to notify the CSEU. Copies of any billing notices sent to the NCP must be attached. Non-payment may result in court action by the CSEU.

Subsequent to the Medicaid eligibility post partum period, confinement costs may be recovered in accordance with State statute. If the local district is seeking recovery of these costs as part of the NCP’s obligation, the amount for confinement expenses is to be entered on the transmittal form for women who were enrolled in fee-for-service while pregnant. For women enrolled in managed care during their pregnancy, the total amount of managed care premiums paid for the period of enrollment in managed care should be entered. The maternal delivery payment (usually referred to as the "kick payment"), the newborn delivery payment(newborn "kick payment") or any fee-for service payments made while the woman/baby are enrolled in managed care are NOT included when seeking recovery of confinement costs.

Part 4: Certification

The “Certification” section must be completed and signed in order for the form to be admissible in court.

The Medicaid Medical Support Transmittal (OHIP-0030) is attached and may also be found on the intranet or through CentraPort.

Medicaid Medical Support Transmittal

County Name _____ **WMS Case Number**_____ **Date** _____
To _____ **Unit/Agency** _____ **Telephone #**_____
From _____ **Unit/Agency**_____ **Telephone #**_____

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PART 1: PERSONAL INFORMATION

Custodial Parent (CP) Name _____ **CP SSN** _____ **CP Date of Birth** _____
CP Address_____ **CP Telephone No**_____
_____ **CP Monthly Gross Income $**_____
Medicaid Case Name_____ **Medicaid Case Number**_____

Noncustodial Parent (NCP) Name _____ **NCP SSN** _____ **NCP Date of Birth** _____
NCP Address _____ **NCP Telephone No**_____
_____

PART 2: PURPOSE FOR TRANSMITTAL

☐ **New Case** ☐ **New/Updated MA Information** ☐ **Recovery of Fee-for-Service Medicaid Costs**
☐ **Addition to Existing Case** (see child listed in Part 3)
☐ **Good Cause Claim Request:** Child #____ ☐ **Referred to Domestic Violence Liaison:** Child #____ Date_____
☐ **Good Cause Reviewed by Medicaid:** Child #____ ☐ Approved by Medicaid - Date _____ ☐ Not Approved
☐ **Child # ___ already in case is now exempted**
☐ **Temporary Suspension of Medical Support Action due to**:
☐ Pregnancy - EDC _____
☐ NCP in receipt of Medicaid
☐ Other _____
☐**Resume Medical Support Action due to**:
☐ Pregnancy /Post Partum-End Date _____
☐ Other _____
☐ **Change in Status/Case (Identify Change):** _____

PART 3: CHILD INFORMATION FOR THE NCP NAMED IN PART 1 ☐ **Check if additional children are on separate transmittal**

Note: Check box after child's name/line #/CIN only if EXEMPT from Medical Support Requirements

CHILD 1

Child Name _____ **WMS Line #**_____ **CIN** _____ ☐ **EXEMPT**

☐ **Establish Cash Medical Support Obligation** ☐ **Paternity Establishment Only**

Coverage type: ☐ Fee-for-Service ☐ Managed care – Monthly Premium: $_____

Coverage Dates: Start_____ ☐Current coverage **OR** ☐ Medicaid Closing Date _____

☐ **Expenses for Prior Periods/Years** Period/Year _____ ☐ Managed care premium **OR** ☐ Fee-for-Services expenditures for child: $_____

Period/Year _____ ☐ Managed care premium **OR** ☐ Fee-for-Services expenditures for child: $_____

☐ Check if additional years attached

☐ **Recovery of Fee-For-Services Costs**: For the period from _____ to _____ Total paid on behalf of child: $_____

Billing notice(s) of medical support sent to NCP on: _____ Total payment(s) received from NCP $ _____ Net due: _____

☐ Copy of billing notice(s) to NCP attached

☐ **Confinement Costs:** ☐ Pregnancy Fee-For-Service costs $_____ **OR** ☐ Pregnancy capitation payments total $_____

CHILD 2

Child Name _____ **WMS Line #**_____ **CIN** _____ ☐ **EXEMPT**

☐ **Establish Cash Medical Support Obligation** ☐ **Paternity Establishment Only**

Coverage type: ☐ Fee-for-Service ☐ Managed care – Monthly Premium: $_____

Coverage Dates: Start_____ ☐Current coverage **OR** ☐ Medicaid Closing Date _____

☐ **Expenses for Prior Periods/Years** Period/Year _____ ☐ Managed care premium **OR** ☐Fee-for-Services expenditures for child: $_____

Period/Year _____ ☐ Managed care premium **OR** ☐Fee-for-Services expenditures for child: $_____

☐Check if additional years attached

☐ **Recovery of Fee-For-Services Costs**: For the period from _____ to _____ Total paid on behalf of child: $_____

Billing notice(s) of medical support sent to NCP on: _____ Total payment(s) received from NCP $ _____ Net due: _____

☐ Copy of billing notice(s) to NCP attached

☐ **Confinement Costs:** ☐ Pregnancy Fee-For-Service costs $_____ **OR** ☐ Pregnancy capitation payments total $_____

Attach additional pages if more than two children are associated with the NCP

PART 4: CERTIFICATION

I hereby certify that: 1) I am an employee of the _____ County Department of Social Services, which is required by the NYS Social Services Law to provide correct and complete information from its records in response to requests by the Support Collection Unit; 2) the information in this transmittal was taken from records of the _____ County Department of Social Services; 3) such information is maintained in the regular course of business; 4) it is the regular course of such business to maintain such information; and 5) a memorandum or record of the information was made at the time of the act, transaction, occurrence or event, or within a reasonable time thereafter. I certify that I have been designated by the Commissioner of Social Services for the purpose of making this certification.

Dated: _____ **Signature: _____** **Title: _____**

Print Name: _____ **Telephone #:_____**