29-I VFCA HEALTH FACILITY FREQUENTLY ASKED QUESTIONS TABLE OF CONTENTS

#	Category	Question	Answer	Additional Guidance
1.	29-I Health Facility Documentation	Are contacts with MMCP or basic MMCP information expected to be documented in Connections (CONNX) or can they be kept in individual EHRs?	No. MMCP information is not required to be documented in CONNX. This information can be kept in the EHR.	
2.	29-I Health Facility Documentation	How is medical necessity documented?	Providers must establish medical necessity prior to billing for Core Health-Related Services. There is no specific form or report that 29-Is must use to capture or report medical necessity; however, this determination must be supported by documentation in the child/youth's record. It is the responsibility of the 29-Is to maintain this documentation. The 29-I License Guidelines outlines the practitioners that can determine medical necessity.	Article 29-I VFCA Health Facilities License Guidelines Final Draft, page 6 - 7
3.	29-I Health Facility Guidelines	Are the staffing ratios outlined in the 29-I Health Facility Guidelines mandatory?	No. The staffing ratios are suggested ratios; the 29-I Health Facility must determine the best ratios based on the children/youth in their care at any given time.	
4.	29-I Populations	Can a PCP within the VFCA that obtains MMCP credentialing serve patients beyond children/youth in the direct care of the 29-I Health Facility at the 29-I Health Facility?	29-I Health Facilities can only provide care for populations outlined in the 29-I Billing Manual.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 5
5.	29-I Populations	Is there an age cut-off for 8D Baby designation?	Children who are in the care of a 29-I Health Facility whose parent is also in the care of the 29-I Health Facility are considered 8D status. These children will be considered 8D designation until they are discharged from the facility, or if their status changes.	
6.	29-I Populations	Do MMCPs need to indicate 8D status for the child/youth in MMCP internal IT systems or on their ID cards?	No. 8D status does not need to be indicated in the system or on ID cards, as these members will be enrolled and eligible for the same benefits as a child/youth in the care and custody of a 29-I VFCA Health Facility.	
7.	Absences	Will change of status be needed when a child is hospitalized? Will days of hospitalization need to be removed from care days?	Permissible absences for the Core Limited Health-Related Services are still reimbursable can be found in section *Absences and Impact on Claiming* in the New York Medicaid Program 29-I Health Facility BILLING GUIDANCE.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.12
8.	Adults 21 and over	Where can I find more information on services that adults 21 years or older can receive upon safe discharge from 29-I Health Facility?	The 29-I Health Facility treatment team will coordinate with the MMCP to develop a timely discharge plan to adult services that is appropriate to meet the individuals' needs. Further information regarding the types of programs available to individuals 21 and older are listed in the links in the 'Additional Information' column.	• Adult BH HCBS BHO@omh.ny.gov (email with specific questions) • Adult Health Homes • HARP • Front Door, OPWDD • OASAS

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9.	Adults 21 and over	Under what circumstances can 29-I Health Facilities bill for services received by individuals over the age of 21?	Situations may arise where an individual currently in the care of a 29-I Health Facility turns age 21 while awaiting transition to another placement or living arrangement. 29-I Health Facilities will be reimbursed by MMCPs or Medicaid FFS for Other Limited Health-Related Services that are part of the Medicaid benefit package for adults as outlined in the 29-I Billing Manual. Adults age 21 and older are not eligible for Children's HCBS, CFTSS, or 29-I Core Health-Related Services.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, *Appendix G*
10.	Adults 21 and over	Is there a limit to how long Other Limited Health-Related Services can be provided to individuals over 21?	The 29-I Health Facility treatment team should be working in collaboration with the MMCP and community providers to arrange for the transition as soon as safely possible. OLHRS services may continue as long as the conditions in Section 3.4 of the 29-I Billing Manual are met.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 3.4
11.	Billing/Rates/ Claiming	How do I know if I should bill Fee-For-Service (FFS) via eMedNY or a Medicaid Managed Care Plan (MMCP) for 29-I Health Facility services?	Information about the child/youth's Medicaid coverage and plan enrollment is found through ePACES. If the child/youth is enrolled in a MMCP, that MMCP must be billed. For children/youth not yet enrolled in a plan, bill FFS via eMedNY.	https://www.emedny.org/HIPAA/QuickRefDocs/ePACES-Eligibility_Response.pdf
12.	Billing/Rates/ Claiming	How will providers bill for HCBS and/or CFTSS for children in foster care?	Although some children/youth will now be enrolled in an MMCP and claims will therefore be directed to the MMCP for enrolled children/youth, billing for Children's HCBS and CFTSS will not otherwise change as a result of the foster care transition to Medicaid Managed Care. Providers should refer to the HCBS Settings Rule to ensure that billing for HCBS is appropriate based on the 29-I Health Facility Type.	NYS Children's Health and Behavioral Health Services Billing and Coding Manual – Version 2021-1
13.	Billing/Rates/ Claiming	Do the soft limits listed in the 29-I Billing Manual apply to HCBS/CFTSS?	No. Children's HCBS and CFTSS billing rules remain the same and are outlined separately in the *NYS Children's Health and Behavioral Health Services Billing and Coding Manual*. The foster care transition does not impact the guidance previously issued on the delivery of CFTSS and Children's HCBS.	NYS Children's Health and Behavioral Health Services Billing and Coding Manual – Version 2021-1
14.	Billing/Rates/ Claiming	How will a 29-I Health Facility bill for children/youth that are Title IV-E eligible, placed out of state, and excluded from MMCP enrollment?	Children/youth who are placed out-of-state are not eligible for Medicaid Managed Care enrollment. The 29-I Health Facility should check ePACES, or otherwise confirm the child/youth's Medicaid coverage on the date of service to determine the appropriate payor, which may be the receiving state. Please refer to *New York Medicaid Program 29-I Health Facility BILLING GUIDANCE* for further details.	

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15.	Billing/Rates/ Claiming	Should there be only one rate code/procedure code per claim?	Each claim can only reflect one rate code and one **BILLABLE** procedure code. Additionally, all non-billable procedure codes should be added to billable claims as appropriate to describe the all the services that occurred during the encounter.	
16.	Billing/Rates/ Claiming	Will some plans pay a higher reimbursement rate than other plans? How can providers obtain information regarding MMCPs' rates?	MMCPs are required to pay at the Medicaid residual per diem rate for each level of care for Core Limited Health-Related Services for the four-year transition period. MMCPs are required to pay according to the Other Limited Health-Related Services fee schedule for the four-year transition period, unless an alternative payment arrangement is approved by the State. 29-I Health Facilities may engage in conversations with MMCPs regarding alternative reimbursement structures. The MMCP and 29-I Health Facility may agree to change the arrangement for OLHRS at any time, and such arrangements are sent by the MMCP through the DOH provider contracting process, for State approval.	Please refer to the Core Limited Health-Related and Other Limited Health-Related fee schedules
17.	Billing/Rates/ Claiming	Can 29-I Health Facilities bill Medicaid FFS or an MMCP for supervision of a child/youth who is admitted to a hospital?	No. This type of supervision would be provided by childcare staff and covered under the Maximum State Aide Rate (MSAR) payments that 29-I Health Facilities receive. This supervision does not fall under per diem reimbursement for Core Limited Health-Related Services.	
18.	Billing/Rates/ Claiming	If a child/youth receives a mandatory assessment prior to entering foster care, can the child/youth still receive the same mandatory assessment upon placement at the 29-I facility in the same month it was provided in the community?	Yes. If child/youth received a mandatory assessment prior to entering foster care, an assessment would still need to be conducted as part of the required and mandated assessments for a child/youth entering foster care.	
19.	Billing/Rates/ Claiming	How are the non-billable procedure codes used? Is there a list of specific services that are allowable for Office Visits?	The list of the non-billable procedure codes in the Billing Manual contains the most commonly used codes. Providers should add to the claim any non-billable procedure codes that are not included on this list, provided those procedure codes are accurate and applicable to the service delivered. Procedure codes will be used to identify the types of services provided by the 29-I Health Facility and will not impact payment amounts.	

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20.	Billing/Rates/ Claiming	How will vaccines be billed?	For non-COVID-19 vaccinations, the provider will bill for the administration of the vaccine (billable rate code 4599). The provider will then add a non-billable procedure code indicating which immunization was administered. There is separate guidance for billing for the administration of COVID vaccines.	Standard Vaccine Billing Guidance: • Medicaid Fee-for Service Coverage Policy and Billing Guidance for Vaccinations COVID Vaccine Billing Guidance: • https://health.ny.gov/health_care/medicaid/covid19/guidance/billing_guidance.htm
21.	Billing/Rates/ Claiming	Will MMCPs accept paper and electronic claims?	Yes. MMCPs are required to accept paper and electronic claims submissions.	
22.	Billing/Rates/ Claiming	Are rates for Essential Community Providers the same as those for 29-I Health Facilities?	No. Rates for Essential Community Providers are negotiated with the MMCP, unless subject to State mandated rate requirements, such as those for behavioral health clinic services licensed by the Office of Mental Health.	
23.	Billing/Rates/ Claiming	How will claims submitted to the Plan by out-of-network providers be handled? Are there standards/requirements for all MMCPs or does each MMCP operate a little differently?	Out-of-network services almost always require prior authorization from the MMCP. There are exceptions, such as Emergency services and some out of area urgently needed services. The MMCP provider manual will describe procedures for authorization of out-of-network services, and the MMCP liaison will assist in obtaining timely access to such services when necessary.	
24.	Billing/Rates/ Claiming	If the State will pay the MMCP the residual per diem rate for CLHRS, what is the process as to how the 29-I is reimbursed?	The 29-I Health Facility will submit claims as appropriate for the CLHRS per diem residual rate to the MMCP that the child/youth is enrolled in. The MMCP then adjudicates the claim and provides appropriate payment directly to the 29-I Health Facility. During the four-year transition period, the MMCP will then send claims to eMedNY for any CLHRS payments made to 29-I Health Facilities.	
25.	Billing/Rates/ Claiming	Are 29-I Health Facilities permitted to provide services through Article 31/28 licenses (based on higher reimbursement rates) and still bill the residual per diem through Article 29-I?	Providers with multiple operating certificates should submit claims for services based on the setting in which the services were delivered. Article 31/28 services and 29-I services must not be duplicative. Refer to *Concurrent Billing* guidance in the Billing Manual.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 3.5
26.	Billing/Rates/ Claiming	What happens if OLHRS units billed by a provider exceed the units outlined in the 29-I billing guidelines?	All OLHRS units are soft limits and can be exceeded with documented medical necessity and coordination with the MMCP.	

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27.	Billing/Rates/ Claiming	Can a provider submit CLHRS claims under OLHRS claims category when CLHRS units are exceeded?	No. OLHRS must be provided and billed for separately from those services included in the CLHRS. 29-I Health Facilities may not separately bill for activities performed by a professional when the Full Time Equivalent (FTE) for that position is funded within the CLHRS per diem rate. CLHRS are per diem payments and can only be claimed for the day(s) the child/youth was in care of the 29-I Health Facility. CLRHS will only be authorized for one unit per day and cannot be exceeded.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.15
28.	Billing/Rates/ Claiming	Can a provider bill both CLHRS and OLHRS in the same claim?	No. CLHRS and OLHRS must be billed separately.	
29.	Billing/Rates/ Claiming	Will out-of-state providers still be able to bill the currently carved-out FFS services (e.g., School-based Health Centers and Family Preservation and Family Support Services Program)?	The foster care transition will not impact current out-of-state billing practices.	
30.	Billing/Rates/ Claiming	How do I bill for interpretation services?	If a child/youth receiving OLHRS is in need of interpretation services during that encounter, including either language interpretation or sign language, the interpretation service should be billed under rate code 4673.	
31.	Billing/Rates/ Claiming	For Rate code 4597 (Screening – developmental/emotional/behavioral) can we bill for more than one procedure code in a day?	Providers may exceed the soft limit of more than one unit per day for rate code 4597 only with documentation of medical necessity. Include the respective procedure codes with each claim.	
32.	Billing/Rates/ Claiming	What are appropriate codes for children/youth that agencies should be using as a default diagnosis for Core Limited Health-Related Services?	Providers should select the appropriate ICD-10 Diagnosis code that applies. Diagnosis code Z62.21 – Child in welfare custody may be used for children/youth ages 0 – 17 until a more appropriate diagnosis is made. For youth ages 18 and older, providers should report an appropriate alternative code.	
33.	Billing/Rates/ Claiming	How do providers determine how many units to claim?	Providers must document the time spent during the encounter and then refer to the Billing Manual Table 2: *Timed Units per Encounter of Service* to determine the number of units to submit on the claim.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, *Table 2*
34.	Billing/Rates/ Claiming	When submitting a claim, do the modifiers need to be indicated in the same order as they are outlined in the Billing Manual?	If there is more than one modifier indicated in the Billing Manual, the provider must include all modifiers. However, the modifiers do not need to be in a particular order on the claim.	
35.	Billing/Rates/ Claiming	Can a provider include multiple non-billable procedure codes under any rate code or only under Office Visit 4594?	If a provider includes multiple procedure codes on a claim, only the first procedure code combination will pay.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4

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36.	Billing/Rates/ Claiming	Can a provider include multiple billable procedure codes on a single claim?	No. If a provider includes multiple procedure codes on a claim, only the first procedure code will pay. Two claims must be submitted to allow for multiple billable procedure codes to be reimbursed.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4
37.	Billing/Rates/ Claiming	How should a 29-I VFCA Health Facility bill for psychiatric medication management?	Medication management is covered during the course of an office visit; the office visit is billable while the medication management procedure code is non-billable. The provider would submit a claim for the office visit and add the medication management procedure code to the claim to indicate medication management was included in the encounter.	
38.	Billing/Rates/ Claiming	Is there a copay for pharmacy benefits for foster care children/youth?	Children/youth under age 21 are exempt from copays.	
39.	Billing/Rates/ Claiming	How should plans bill in instances where certain services were recently approved but are retroactive to an earlier date, such as Physician Administered Drugs and interpretation services?	Plans should use Delay Reason Code DR3 when billing for services outside of the 90-day timely filing window due to State configuration errors. For delays related to enrollment (i.e., plan was not initially enrolled in COS 0163 needed for Physician Administered Drugs), plans should use DR4. Physician Administered Drugs and interpretation services are not billed outside the capitation payment, so plans will not bill eMedNY for these services.	
40.	Billing/Rates/ Claiming	How should providers submit claims outside of the timely filing window?	Providers must adhere to timely filing guidelines as outlined in their contract with the MMCP and per eMedNY guidelines. In instances where providers were unable to submit fee-for-service claims during this window, the applicable delay reason code should be used. In instances where providers were unable to submit managed care claims during this window, providers should refer to the MMCPs' billing manual and/or their individual contracts with MMCPs with whom they are contracted.	Timely filing information: https://www.emedny.org/info/TimelyBillingInformation_index.aspx Delay Reason Code list: ALPHA CONVERSION CHART (emedny.org)
41.	Billing/Rates/ Claiming	What is the effective date of the addition of the rate codes for TB (4684) and interpretation services (4673)?	Tuberculosis (TB) testing and interpretation services were approved through the State Plan Amendment effective 9/1/21. However, these services were included in the managed care benefit package prior to 9/1/21 and required to be covered by plans. Therefore, plans should cover TB testing and interpretation services beginning 7/1/21. For children/youth in FFS, these services are billable from 9/1/21 forward.	

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42.	Billing/Rates/ Claiming	What rates do 29-Is bill for children/youth who are remaining in FFS and not enrolled in managed care? What is the process to bill FFS rate?	For children/youth not enrolled in a MMCP and remaining in FFS, 29-I Health Facilities will bill the residual per diem for Core Limited Health-Related Services and OLHRS via eMedNY. Further details regarding claims submission can be located in Sections 4.5 and 4.6 in the 29-I Billing Manual.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE Also see eMedNY for training on use of the eMedNY system.
43.	Billing/Rates/ Claiming	Where can 29-Is check to ensure that the correct codes have been loaded to their provider profile?	The "Rate Summary" attachment in eMedNY show what rate codes were loaded to each 29-I's profile.	
44.	Billing/Rates/ Claiming	What is meant by a 'step-down' agency? Are these the same as 'non-per diem agencies'?	These are not the same as non-per diem agencies; 'step-down' agencies are targeted facility types that are stepping down to the CLHRS rate from a higher per diem rate.	
45.	Billing/Rates/ Claiming	If interns are performing psychotherapy under the supervision of a licensed provider, which NPI should be used: the OCFS unlicensed practitioner ID (05448682), or the NPI of the supervising provider?	Providers have the option to bill under either the unlicensed provider code or the supervising practitioner's NPI until further notice.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 3.12
46.	Billing/Rates/ Claiming	Is the use of nitrous oxide used by dental providers a reimbursable service?	Nitrous oxide is a covered service when medically necessary. Under Medicaid FFS, reimbursement for nitrous oxide is included in the reimbursement for the procedure; it is not separately reimbursable. MMCPs are required to cover nitrous oxide and to have an adequate network of dental providers to serve their members. How plans reimburse providers for covered benefits and whether this is a separately reimbursable service by plans should be based on the contract between the plan and their providers.	Dental policy manual: https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf
47.	Billing/Rates/ Claiming	What Bill Type should 29-I providers use? How should claims submitted with an alternative Bill Type be handled?	29-I claims are to be submitted using Bill Type 079*x,* with the last digit representing the sequence of the claim in the episode of care to account for corrected and resubmitted claims. If a provider submits a claim with an alternative Bill Type, the plan should not be denying these claims and is instead expected to pend the claim and reach out to the provider to offer education regarding this requirement.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.5 and 4.8

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48.	Billing/Rates/ Claiming	How long do providers have to submit claims? How should providers handle claims that have not been submitted during that window?	For services provided to members enrolled in an MMCP, providers should submit claims according to the Plan's timely filing rules. Plans must waive filing timeframes if there was a plan error in accepting or processing the claim, or if there are valid reasons for late submission. Providers should contact the Plan regarding denied claims for timely filing. If the issue is not resolved, the provider may file a complaint with DOH via email to managedcarecomplaints@health.ny.gov. For services provided to members in Medicaid FFS, providers must submit claims within 90 days, unless the claim is delayed due to circumstances outside the provider's control, in accordance with eMedNY timely filing guidelines. When appropriate, Delay Reason codes should be utilized when submitting FFS claims outside the timely filing window. MMCPs should submit passthrough payments for CLHRS to the State within 30 days of claim payment, and no later than 180 days from date of service. For pass through claims that are submitted more than 90 days after the date of service, plans should use Delay Reason Code "03" to avoid claims rejecting due to untimely filing.	eMedNY timely filing guidelines 29-I Billing Manual
	Billing/Rates/ Claiming	When can 29-Is begin billing for services provided to children with Child Health Plus (CHP)?	The target implementation date for the new benefits in CHP is January 2023, per ELFA language. However, to the extent that 29-Is provide benefits that are already covered under CHP, such as immunizations and lab services, providers and plans can enter into contracts to provide these services to the CHP population.	

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	Billing/Rates/ Claiming	Must claims for Core and/or OLHRS be submitted to third party commercial payers (TPHI) if the member's primary insurance is Medicaid? Is the Medicaid residual per diem for Core services reimbursable by any payer other than Medicaid?	It is the provider's responsibility to determine the member's type of coverage (Medicare, Medicaid, or private insurance). Medicaid is the payor of last resort and all Medicare and third-party coverage must be exhausted before payment for 29-I health services by Medicaid. However, for FFS claims submitted on or after August 15, 2022 and managed care claims submitted on or after November 15, 2022, the requirement to maintain acceptable documentation of attempts to secure third party reimbursement as required under 18 NYCRR §540.6 is waived for Core and OLHRS, including HCBS and CFTSS, provided by 29-I health facilities to children/youth in foster care; providers do not need to bill and receive a denial from third party insurance prior to billing for these services for children in foster care. This requirement to exhaust third party coverage before billing Medicaid remains in effect for individuals served by the 29-I that are not in foster care, including children/youth who have been discharged from foster care and children/youth who are placed with the agency by the Committee on Special Education (CSE).	Notification to 29-I VFCA Health Facilities Regarding the Waived Requirement to Receive a Third-Party Health Insurance Denial Prior to Billing for Services Provided to Children/Youth in Foster Care
49.	Care Coordination	How will the MMCP be notified if a child/youth is referred to a specialist?	29-I Health Facilities are responsible for coordinating the care of children/youth in their care. If the MMCP typically requires a PCP referral for specialist care, or the specialist care requires prior authorization, the liaisons should coordinate to ensure access to the specialist without PCP referral or arrange for authorizations as necessary.	
50.	Communications	Who will inform the MMCP of a change of a child/youth's address and how?	If a child/youth's status changes (between 29-I Health Facility and LDSS), the 29-I Health Facility or LDSS is required to submit a Transmittal Form and follow up with any additional communication between foster care liaisons if needed. If the child is transitioning from one 29-I Facility to another, the receiving 29-I Facility is responsible for completing the form. Use of a transmittal form is not necessary when there is a change in address due to a change in foster homes.	Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 2.0 Attachment D
51.	Communications	If I can't resolve claiming and coverage issues for children/youth enrolled in an MMCP by working with the MMCP, where can I submit a formal complaint?	Complaints can be submitted to the Bureau of Consumer Services (BCS) Complaint Unit at managedcarecomplaint@health.ny.gov.	

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52.	Communications	Who should MMCPs contact when a child/youth is absent without consent (AWOC)?	MMCPs should only notify other parties if it is believed that no notifications have been made to date. MMCPs should first connect with the MMCP Liaison at the 29-I, as it is the primary responsibility of the 29-I to make these initial contacts.	
53.	Communications	Are MMCPs permitted to speak directly with foster care members who are 18 years of age and older?	Yes. MMCPs can speak directly with members 18 years of age and older, provided it is the member's desire to have direct contact with their Plan (i.e., as opposed to through the MMCP Liaison). MMCPs must also use authentication mechanisms to verify the identity of the person with whom they are speaking.	
54.	Contracting/ Credentialing	How will a VFCA know which Essential Community Providers have completed contracting with individual MMCPs (In-Network and Out-of-Network providers)?	Each MMCP will update the provider directories available on their websites. Providers are also required to post what health insurances they accept on their websites.	
55.	Contracting/ Credentialing	If a 29-I is not contracted with a Managed Care Plan, how will they get paid?	Except for emergency department services and some out of area urgently needed services, 29-I Health Facilities must notify and/or obtain pre-authorization from MMCPs for out-of-network services, and ideally arrange for a Single Case Agreement. MMCPs are responsible for providing needed out-of-network services for children/youth in foster care, but require notification prior to receipt of claims for these services. If notification does not occur and/or pre-authorization is not received, these claims may be denied and the 29-I Health Facility may have to contact the plan to resolve and/or may have to go through the appeals process to receive payment. Providers may contact the MMCP liaison to confirm the MMCP's prior authorization requirements. Executing a Single Case Agreement may be a straightforward process, such as the MMCP issuing a letter of agreement.	Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract Section 10.13 and Section 10.26
56.	Contracting/ Credentialing	For behavioral health contracting, will there need to be contracts signed for 29-I with both the managed care and the behavioral health care organization?	Depending on the delegation arrangement, it will typically be required that providers contract with the MMCP's benefit managers directly, which may include behavioral health, vision, dental, or other services. MMCPs should clarify where such contracting is required.	

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57.	Contracting/ Credentialing	Are plans permitted to add language to their contracts with 29-I facilities to ensure the facilities are making an effort to discharge the member?	The decision for a child/youth to be placed in foster care is a matter determined by the court. 29-I Health Facilities may provide services in accordance with their license. However, MMCPs and 29-I Health Facilities may negotiate terms in their provider contract agreements regarding the responsibility of the MMCP and 29-I to work collaboratively toward a developing and implementing a safe discharge plan or transition from the 29-I Health Facility toward other MMCP covered services as appropriate to the child/youth's placement status.	
58.	Contracting/ Credentialing	Where should plans submit their 29-I networks on an ongoing basis?	Beginning July 1, 2022, MMCPs must submit their 29-I networks via the Provider Network Data System (PNDS) portal on a quarterly basis.	
59.	CSE Children/ Youth	Can CSE children/youth continue to receive OLHRS one-year post-discharge?	Yes. Children/youth who are discharged from a 29-I Health Facility may continue to receive Other Limited Health-Related Services from any 29-I Health Facility up to one-year post discharge.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 3.4
60.	CSE Children/ Youth	Does the MMCP complaints and appeals process apply to CSE children/youth and youth 18+ who are still in the care of a 29-I Health Facility?	The MMCP complaint and appeals process is available to any MMCP member. 29-I Health Facilities can file a complaint or appeal on a member's behalf with written consent from the member.	Further information regarding the MMCP appeal process can be located here and in the MMCP member handbooks
61.	CSE Children/ Youth	Do Transmittal Forms need to be submitted for CSE-placed children/youth?	Yes. For CSE-placed children/youth who are enrolled in plan, please complete the Transmittal Form for notification of placement and any change in status as outlined in Section VI of the Transmittal Form. There is a checkbox in this section specific to CSE-placed children/youth.	Transmittal Form and Instructions
62.	Definitions	What is the difference between a child "in the care of a 29-I Health Facility" versus "a child in foster care"?	Children/youth are placed in foster care by court order. Children/youth in the care of a 29-I Health Facility may include children/youth in foster care and additional populations such as CSE-placed, 8D babies, etc. Please see *Populations Served by 29-I Health Facilities* for a complete list of the children/youth that may be in the care of 29-I Health Facilities.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 5
63.	Discharge	What documentation must 29-Is submit to continue billing for services for longer than one-year post-discharge?	MMCPs and 29-Is should communicate regarding the specific documentation/information needed to document the need and justify billing for OLHRS longer than one-year post-discharge. Examples of such information may include, but is not limited to, progress notes, team meeting minutes, treatment plan goals, and discharge plans. MMCPs and 29-Is should also work together to discuss and determine options for safely transitioning the child/youth to an appropriate provider for continued necessary services.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 3.4

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64.	Discharge	What services are permissible to be provided/billed for during trial discharge?	Core and Other Limited Health-Related Services can be delivered and billed during trial discharge; see detailed billing rules regarding absences in the *New York Medicaid Program 29-I Health Facility BILLING GUIDANCE*.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.12
65.	Discharge	What is the difference between a trial discharge and final discharge? Is a Transmittal Form required in both instances?	For a trial discharge, there is no primary contact change, whereas the primary contact *does* change upon final discharge, which will be the parent/guardian or discharge resource. Children/youth remain in foster care upon trial discharge. The Transmittal Form is not required for trial discharge; however, MMCPs must be informed of enrolled children/youth's permanency plan and need to be involved in the discharge plan. Providers/LDSS must complete the contact information section of the Transmittal Form to reflect any changes.	
66.	Discharge	Where should MMCPs send materials upon a child/youth's discharge from a 29-I, particularly in instances where the address listed on the Transmittal Form differs from the address where the child/youth will be residing?	MMCPs should send all materials to the address listed in Section V of the Transmittal Form. If no address is provided by the discharging 29-I, all materials should be sent to the discharging 29-I's administrative address; it will then be the 29-I's responsibility to coordinate sending any materials to the child/youth. The address of foster parents should not be listed on the Transmittal Form and/or known by MMCPs, except for one-off instances where this has been discussed and determined between all parties (i.e., 29-I/MMCP/LDSS/ foster parent(s)) to be in the child/youth's best interest.	29-I Transmittal Form and Instructions
67.	Enhanced Federal Funding	How long will the enhanced Federal Matching Percentage (eFMAP) as part of the American Rescue Plan Act (ARPA) be in effect? Will providers be automatically reimbursed for these enhanced rates or will they have to submit claims for retroactive reimbursement?	Once approved, the proposed 25% rate increases for 29-I Core Limited Health-Related Services will be in effect until 9/30/22. Payments will be retroactive to 7/1/21 (when 29-I services were carved-in to managed care). Providers will not be required to resubmit previously adjudicated claims. Additional details will be provided when the rate increases are approved.	
68.	Enrollment	Must all children/youth in 29-I Health Facilities be enrolled in Medicaid Managed Care Plans?	No. Some children/youth that may be served by 29-I Health Facilities may be excluded from Medicaid Managed Care (i.e., cannot enroll in Medicaid Managed Care). Some children/youth may be exempt from Medicaid Managed Care (i.e., may enroll but are not required to). Effective July 1, 2021, children/youth placed in foster care in NYC and children/youth placed in the care of a VFCA statewide are no longer excluded from Medicaid Managed Care.	

#	Category	Question	Answer	Additional Guidance
69.	Enrollment	Will initial enrollments be retrospective to the first day of the month a child/youth enters foster care? For example, if entry to foster care is 8/10, would the effective month of enrollment be 8/1? How would payment for services rendered by FFS providers between 8/1 and 8/10 be affected?	If a child/youth enters foster care on 8/10, and the case is opened on eMedNY on or before 8/31, and the child/youth is not excluded from enrollment, the effective date of the MMCP enrollment is 8/1. The State engages in a reconciliation process with the MMCPs to account for any payments made by FFS prior to enrollment and during the month in which the child/youth is retrospectively enrolled.	
70.	Enrollment	Will any changes in plan enrollment be prospective to the first of the next month of coverage?	If an enrolled child/youth changes MMCPs, the change will be effective prospectively on the first of the following month.	
71.	Enrollment	Who will provide the authorization code to use when requesting NYMC change a child/youth's enrollment?	NYMC provided the 3-digit alpha-numeric code to each 29-I Health Facility in the Spring of 2021. It should be noted that CSE-placed children/youth are not part of this enrollment process.	
72.	Enrollment	Are MMCPs allowed to work with the 29-I to reconsider member's plan enrollment if after an analysis of the member's service providers, it is determined they could be better suited by another MMCP?	Yes. The 29-I VFCA Health Facility/LDSS will have the opportunity to redetermine the child's needs and change MMCP at any time. These changes will be prospective to the 1st of the month after the change is made.	
73.	Enrollment	What is the monthly reconciliation report and who receives it?	The report, called the Monthly Placement Snapshot Report, is a data report that OCFS/DOH will generate and share with the MMCPs through New York Medicaid Choice. This report shows data valid only on the day it is produced and may be used only to confirm there are no members who have been placed in foster care for whom the MMCP has not received a Transmittal Form. The information in the report does not supplant placement information provided on the most recent Transmittal Form received for the child.	
74.	Enrollment	If the child/youth is placed in a 29-I VFCA Health Facility is their MMCP enrollment locked in or can there be changes to enrollment at any time?	Medicaid Managed Care plan changes can occur at any time in the best interest of the child/youth, but is prospective to the first of the following month after the change is made.	

#	Category	Question	Answer	Additional Guidance
75.	Enrollment	What address will be provided for children/youth in foster care on the 834 NYSOH, 834 eMedNY, and Maximus?	The address on the 834 may be the child's last home address or other community location. Therefore, MMCPs must identify and track the correct address for notices based on the 1) Transmittal Form; 2) if placed with a 29-I health Facility, the MMIS ID number associated with Principal Provider Code 10, and the address provided for that MMIS on the 29-I Health Facility file posted on the DOH HCS roster page; or 3) if enrolled through New York Medicaid Choice and placed with a 29-I Health Facility, the VF supplemental file from New York Medicaid Choice (which includes the same MMIS addresses as the HCS file).	
76.	Enrollment	If a member is showing as enrolled in plan on eMedNY but the 834 has not been received yet, what enrollment status should be considered the 'source of truth'?	eMedNY would be considered the source of truth in this instance. Please reach out to the State with any questions regarding information contained on eMedNY.	
77.	Enrollment	How can plans verify enrollment if the 834 form is not received? If a member shows as enrolled via eMedNY, the member may not necessarily show up in the plan's system.	MMCPs will receive official enrollment notifications via the 834 enrollment form. In instances where MMCPs receive the Transmittal Form prior to the official enrollment notification, MMCPs should perform an internal check prior to definitively stating that the child/youth is not enrolled in plan, as it may be possible that the plan has not yet processed the 834. eMedNY would be considered the source of truth in instances where the 834 has yet to be received. Please reach out to the State with any questions regarding information contained on eMedNY.	
78.	Enrollment	How can enrollment be verified in instances where a child/youth has two CINs?	If a child/youth has two active CINs on the same date, ePACES will return zero results; therefore, providers should reach out to LDSS to confirm enrollment and resolve instances of duplicate CINs. The State continues to work toward mitigating duplicate CINs.	
79.	Enrollment	If a child/youth is placed in foster care with a 29-I Health Facility and is still covered under their parent/guardians' commercial insurance policy, with Medicaid FFS as secondary, is a Transmittal Form required to notify the plan of initial placement and/or placement changes? Is the plan required to have oversight and collaboration with the 29-I in these instances?	Since all foster care policy guidance is limited to the mainstream managed care population, plans are under no obligation to use the Transmittal Form, nor are required to have oversight and collaboration with the 29-I Health Facility where the child/youth is placed in these instances.	

#	Category	Question	Answer	Additional Guidance
80.	Essential Community Providers	How are essential community providers defined?	Essential Community Providers are, as identified by the State, providers with expertise in serving children/youth placed in foster care. Essential Community Providers do not include practitioners working at a 29-I. MMCPs will reimburse community providers for covered Benefit Package services in accordance with the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 2.0
81.	ID Cards	Where should MMCPs send ID cards and other associated materials? Should this be to the 29-I's administrative address or to the address where the child/youth is actually residing?	Cards should be sent to the administrative address of the 29-I or the address listed on the most recent version of the Transmittal Form.	
82.	Laboratory Services	Can providers bill for multiple labs conducted on the same day, provided these are for different laboratory tests? (e.g., COVID test and urinalysis)	29-I VFCA Health Facilities may only bill for one instance of each laboratory procedure per day. The performance of multiple laboratory procedures of the same type for the same child/youth on the same day is not reimbursable. However, the performance of multiple laboratory procedures of different types for the same child/youth on the same day remains reimbursable. For example, billing for both a Hemoglobin test and a COVID-19 polymerase chain reaction (PCR) test given to the same child/youth on the same day is permissible. If two PCR tests are given to the same child/youth on the same day; only one is reimbursable.	Daily unit limits for 29-I VFCA Health Facilities laboratory services are found in the 29-I VFCA Health Facilities Billing Manual.
83.	Mandatory Assessments	Are the mandatory assessments required for all children/youth in foster care?	Yes. These assessments are outlined in the *Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Managed Care* policy paper and the *29-I Health Facilities License Guidelines*.	Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 2.0 Article 29-I VFCA Health Facilities License Guidelines Final Draft

#	Category	Question	Answer	Additional Guidance
84.	Mandatory Assessments	How should the assessments in the "Foster Care Initial Health Services" outlined in the Article 29-I VFCA Health Facilities Licensure Guidelines and indicated in the Billing Manual be conducted? Can providers use codes for initial evaluations more than once?	Mandatory assessments must be performed within the timeframes outlined. These assessments may take multiple days to perform. Plans are not permitted to require prior authorization for these assessments; however, 29-I Health Facilities and LDSSs are expected to keep MMCPs informed of a child's/youth's assessment and treatment needs. There may be instances that the assessment needs to be repeated when associated with subsequent admission to a 29-I Health Facility due to medical necessity and/or regulation, LDSS or OCFS mandate, or court order.	
85.	Mandatory Assessments	Do MMCPs have any oversight responsibilities for the 29-I Health Facility's Initial Health Services Assessments?	MMCPs must cover all required foster care intake assessments necessary. MMCPs share the responsibility with the 29-I Health Facility to ensure that children/youth enrolled in their plans receive all medically necessary and mandatory assessments and care.	
86.	Monitoring/ Licensure	What entity will monitor the Managed Care Plans' compliance with quality care initiatives for foster care children/youth?	MMCPs are contracted with the State and are monitored for quality and performance standards by the State.	
87.	Monitoring/ Licensure	Are MMCPs responsible for monitoring 29-I Health Facility services?	No. The State will be responsible for monitoring and oversight of 29-I Health Facilities.	
88.	Out-of-Network Access	How many days from the enrollment date does the out-of-network access apply?	There is no time limit for out-of-network access. A child/youth must be enrolled in a MMCP operating in the district of fiscal responsibility; however, in instances where it has been decided to place the child/youth in a 29-I Health Facility or foster home that is outside of the district of fiscal responsibility, the MMCP is responsible for ensuring access to geographically accessible providers, even if these providers are out-of-network or out of the MMCP's service area. In the case of a long-term foster care placement outside of the MMCP's service area, and solely at the direction of the LDSS or 29-I Health Facility, the MMCP will coordinate with the LDSS or 29-I Health Facility for a smooth transition of enrollment to an alternate MMCP serving both the district of fiscal responsibility and the county of placement.	

#	Category	Question	Answer	Additional Guidance
89.	Pharmacy	What carve-out pharmacy list should be used for foster care?	The Foster Care Drug Carve-Out list that was in place through June 30, 2021 can be located here. This list identifies medications and supplies that will be paid for under Medicaid Fee-For-Service for children/youth who are placed in the care of a Voluntary Foster Care Agency or 29-I Health Facility receiving a Medicaid per diem payment. Voluntary Foster Care Agencies and 29-I Health Facilities receiving a Medicaid per diem were responsible to cover the cost of medications and supplies that were not on the Foster Care Drug Carve-Out List in effect until July 1, 2021. Effective July 1, 2021, the Foster Care Drug Carve-Out List no longer applies and members will access the pharmacy benefit via the managed care plan, or Medicaid FFS, depending on enrollment status. Certain physician administered drugs and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies as listed in the Durable Medical Equipment, Prosthetics and Supplies Manual and categorized within Appendix A of that manual will continue to be covered by the member's MMCP when billed as a medical or institutional claim.	Medicaid Foster Care Carve-out List Preferred Drug Program List
90.	Pharmacy	Are vitamins covered in MMC and FFS?	Yes. Vitamins are covered by MMC and FFS.	
91.	Pharmacy	Will any 29-I Health Facilities be licensed as pharmacies?	No. 29-I VFCA Health Facilities will not be licensed as pharmacies.	
92.	Pharmacy	Are foster care prescriptions typically a 30-day refill?	Yes. 30-day refills are typical; however, pharmacies can expect to see other refill cycles as well (60 days, 90 days).	

#	Category	Question	Answer	Additional Guidance
93.	Pharmacy	Are the drugs referenced in the 'Physician Administered Drugs' section of the *Billing Manual* the only drugs that are applicable to this guidance, or are other prescription drugs and OTC drugs not covered by the plan formularies applicable here as well?	Please follow the guidance referenced in the 29-I Billing Manual. The links included provide accurate information regarding which drugs are eligible for reimbursement as a Physician Administered Drug. OTC drugs and additional drugs not found on the linked list would not be eligible for reimbursement as a physician administered drug. All therapeutic categories/classes of prescription drugs and OTC drugs that are on the Medicaid FFS formulary must be on the MC formulary. Plans are required to provide a similar pharmacy benefit; however, they may not cover every drug that is on the FFS formulary. Drugs that are not on the FFS formulary *may* be covered by plans, if medically necessary, on a case-by- case basis for each child/youth. 29-I Health Facilities would receive payment for the administration of a physician administered drug by billing for an office visit. The claim should include both the appropriate billable office visit code along with any appropriate non-billable codes (e.g., 96372 for injectables).	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.14
94.	Phase One Opt-In	Will agencies that obtain 29-I licensure in February 2021 have the ability to be reimbursed by FFS for the CLHRS (per diem) and the OLHRS?	Yes, 29-I Health Facilities that opt into early licensure February 2021 will submit claims for CLHRS and OLHRS via eMedNY FFS.	
95.	Phase One Opt-In	Will agencies that obtain 29-I licensure in February receive the residual and reimbursement for medical services from NY State (as opposed to the managed care plans)?	Phase One 29-I Health Facilities billed Medicaid Fee-For-Service for Core Limited Health-Related Services and Other Limited Health-Related Services claims for children/youth in their care that are covered by Medicaid Fee-For-Service. Children in the care of a 29-I Health Facility were not enrolled into an MMCP until Phase 2 on July 1, 2021. Some children will continue to be exempt or excluded from MMCP enrollment and 29-I Health Facilities will continue to bill Medicaid FFS for those children/youth that are not enrolled in an MMCP.	
96.	Phase One Opt-In	If a VFCAs opts out of Phase 1, will this impact Phase 2?	No. The intent is that all approved 29-I Health Facilities will be licensed by 7/1/21; agencies opting in for Phase 1 have elected to obtain the 29-I license sooner and begin providing services in accordance with the 29-I model and billing structure starting 2/1/21.	

#	Category	Question	Answer	Additional Guidance
97.	Primary Care Physician (PCP)	Can 29-I Health Facilities provide primary care if they are not credentialed as a PCP?	Yes. Providers working at 29-I Health Facilities are not required to become credentialed with plans as a PCPs as part of this transition; however, if a provider working at a 29-I Health Facility elects to become a PCP, they must undergo the plan credentialing process for PCPs. Please refer to the MMC model contract for further information regarding PCP requirements.	Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract
98.	Primary Care Physician (PCP)	Is there a waiver process for PCPs that do not work the required 16 hours per week?	Yes. The MMCP can request a waiver of this requirement from DOH.	
99.	Primary Care Physician (PCP)	Will MMCPs use auto-assignment for PCPs where the LDSS or 29-I Health Facility has not indicated a PCP?	Yes. PCPs will be auto-assigned by the MMCP if a PCP has not been selected and communicated to the MMCP.	
100.	Primary Care Physician (PCP)	How do we notify plans of changes/updates to PCPs, particularly if a PCP was auto-populated during the enrollment process?	Updates/changes to the PCP should be documented on Section IV of the Transmittal Form and submitted to the MMCP the child/youth is enrolled in.	
101.	Primary Care Physician (PCP)	What course of action should 29-Is take if a child/youth's PCP is not a participating provider with the child/youth's MMCP?	The VFCA should consider an enrollment change to a participating plan if access to this particular PCP is critical for the child/youth.	
102.	Primary Care Physician (PCP)	How should plans complete the PCP field on the member ID card if a PCP is not known at the time of enrollment?	The Plan shall issue an identification card within fourteen (14) days of an Enrollee's Effective Date of Enrollment. If unforeseen circumstances, such as the lack of identification of a PCP, prevent the Plan from forwarding the official identification card to new Enrollees within the fourteen (14) day period, alternative measures by which Enrollees may identify themselves such as use of a Welcome Letter or a temporary identification card shall be deemed acceptable until such time as a PCP is either chosen by the Enrollee or auto assigned by the Plan. The Plan agrees to implement an alternative method by which individuals may identify himself/herself as Enrollees prior to receiving the card (e.g., using a "welcome letter" from the Plan) and to update PCP information on the identification card.	
103.	Services/ Practitioners/ Providers	What Medicaid services can be provided by VFCAs that do not have 29-I licensure?	Only agencies with a 29-I license are permitted to provide and bill for Core Limited Health-Related Services and/or Other Limited Health-Related Services requiring the 29-I licensure. MMCPs are not required to have a contractual relationship with non-29-I VFCAs.	

#	Category	Question	Answer	Additional Guidance
104.	Services/ Practitioners/ Providers	Do transportation services require pre-authorization?	Transportation related to accessing routine health care services is covered within the Medicaid residual per diem rate for Core Limited Health-Related Services and would not require pre-authorization. Non-routine transportation does require pre-authorization. Please refer to the 'Routine Transportation' and 'Medical Transportation' sections in the *New York Medicaid Program 29-I Health Facility BILLING GUIDANCE* document. Transportation services are **not** part of the managed care benefit package; they are covered under Medicaid FFS, even for children enrolled in MMCPs.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.18 and Section 4.19
105.	Services/ Practitioners/ Providers	Are emergency transports covered under Core or Other Limited Health-Related Services?	No. Emergency transports should be billed by the transportation provider (e.g., ambulance) to eMedNY (Medicaid FFS).	
106.	Services/ Practitioners/ Providers	Can the same practitioner provide both Core and Other Limited Health-Related Services?	Yes. Each practitioner may only be allocated as one (1) FTE in total across all the services they are providing. The 29-I Health Facility can make cost allocation decisions and organizational decisions that meet the needs of the children/youth they serve.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.15
107.	Services/ Practitioners/ Providers	Can I use other providers outside of my agency to provide Core Limited Health-Related Services?	29-I Health Facilities may enter into employment contracts with outside providers for Core Limited Health-Related Services. MMCPs will reimburse the 29-I Health Facility for the provision of Core Health-Related Services.	
108.	Services/ Practitioners/ Providers	What Utilization Management requirements apply to services provided by essential community providers that are outside of Other Limited Health-Related Services (e.g., surgical services; dental services)?	MMCPs should continue to follow existing State guidelines related to Utilization Management for services outside of Core and Other Limited Health-Related Services.	
109.	Services/ Practitioners/ Providers	Do Core nursing services include Private Duty Nursing, Personal Care Aides, Home Health Aides, and/or other LTSS or LTSS-like services? If not, are children/youth in foster care eligible for these services when enrolled in plan?	Long-term Services and Supports (LTSS) are not included in the Core nursing services. The MMCP Benefit Package includes LTSS. 29-I Health Facilities may contact the MMCP foster care liaison for help arranging LTSS for enrolled members.	Other information regarding long term care can be located here.
110.	Services/ Practitioners/ Providers	What is the maximum age a former foster care youth can receive services in a 29-I Health Facility?	The treatment team should be working with youth toward a safe discharge plan prior to and upon turning age 21; it is not expected that individuals over age 21 will remain in a 29-I Health Facility for an extended period of time and should only occur in extenuating circumstances. Adults over the age of 21 are not eligible for CFTSS or Children's Waiver HCBS and the Core Residual Per Diem cannot be billed for individuals over the age of 21.	

#	Category	Question	Answer	Additional Guidance
111.	Services/ Practitioners/ Providers	Will OLHRS cover TB testing?	Yes. The State is added a rate code to allow for reimbursement of TB testing. This update was made in version 2021-3 of the Billing Manual.	
112.	Services/ Practitioners/ Providers	Is there a minimum and maximum number of participants that can be in a group for Psychotherapy?	Determine the appropriate group size based on the needs of the children/youth in attendance and using clinical judgement. Each participant's encounter would be claimed separately for the time they received the services (e.g., a group of three children for a 30-minute session would require three separate claims of two units).	
113.	Services/ Practitioners/ Providers	Are there separate benefits or MMCPs for a youth in foster care who is pregnant?	No. The MMCP benefit package provides medically necessary comprehensive coverage to all members, including prenatal and labor and delivery services.	
114.	Services/ Practitioners/ Providers	Since Applied Behavior Analysis (ABA) Therapy has been carved out of the managed care benefit package, does a child in need of these services need to be disenrolled from their plan to FFS?	No. The child can remain enrolled in managed care. The ABA provider would bill Medicaid FFS.	
115.	Services/ Practitioners/ Providers	Can children/youth receive nutritional services from 29-I providers?	29-I Health Facilities are not current authorized to provide nutrition counseling by a registered dietician and/or nutritionist under OLHRS. However, the State plans to pursue a State Plan Amendment to add these services/practitioners for 29-I OLHRS. In the interim, children/youth in need of nutritional services should be referred to a community practitioner.	
116.	Services/ Practitioners/ Providers	What is the approval process for children/youth in foster care to receive environmental and/or vehicle modifications?	Being placed in foster care does not preclude children/youth from receiving medically necessary modifications. MMCPs are responsible for ensuring that children/youth in foster care and enrolled in the Children's Waiver receive access to needed modifications. MMPCs that have questions about how to fulfill requests for modifications for youth in care should contact the State via the secure email EModVModAT@health.ny.gov and provide the following details: • Child/youth's name and CIN • Condition and/or diagnosis of the child/youth, if known • Name of the VFCA/29-I the child/youth is working with • Name of the foster family and address, if known • Type(s) of modifications requested	

#	Category	Question	Answer	Additional Guidance
117.	Services/ Practitioners/ Providers	Who is responsible for completing the initial dental assessment? What is the timeframe in which this assessment should be completed?	A dental screening must be conducted as part of the initial health assessment for all children/youth entering foster care and children/youth must be referred for dental care, as appropriate. Best practice is for all children/youth over the age of three to have a diagnostic examination by a dentist within 30 days of foster care placement. However, all children three years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed.	
118.	Services/ Practitioners/ Providers	How should agencies resolve payment for court-ordered services that are not included in the benefit package?	It is the responsibility of the MMCP to ensure access to necessary services, including those mandated per court-order. Providers can submit a complaint to DOH via email to managedcarecomplaints@health.ny.gov, if there are disagreements whether a service is covered and/or a needed service is not being delivered.	Court Ordered and Mandated Service Attestation for Provision of Court Ordered or Mandated Medical Care
119.	Services/ Practitioners/ Providers	Are 29-Is permitted to set up a 'chair' at the 29-I and provide dental services to children/youth who are placed at the agency?	Yes. Privately practicing dentists may set up a chair to provide dental services at a 29-I and bill for the services provided directly to the child/youth's plan. There may not be any remuneration between the dentist and the 29-I, as 29-Is are not permitted to provide dental services. However, there are limitations for Article 28s providing these services.	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-09-14_shared_space_guide.pdf
120.	Training	Are MMCPs required to provide trainings to the VFCA on their protocols for communication, system for notifications, authorizations, reconciliation processes, standards of documentation that may be specific to their operations (separate from training on claims testing)?	MMCPs are required to provide trainings for their contracted providers. Providers can reach out to their contracted MMCPs for additional information on trainings available.	
121.	Transmittal Form	Will a Transmittal Form be required for both enrollment of children currently in care (June enrollment cycle) as well as new enrollments?	The Transmittal Form notifies the MMCP regarding placement; the form does not notify MMCPs of enrollment. MMCPs will receive enrollment lists directly from the State's enrollment broker, New York Medicaid CHOICE, and will receive enrollment notification via an 834 transaction. Between May 15, 2021 and June 30, 2021, 29-I Health Facilities may elect to use the service needs spreadsheet to send transmittal information to MMCPs, or send a completed Transmittal Form for each child to be enrolled July 1, 2021. Effective July 1, 2021, LDSS and 29-I Health Facilities must only use the State standard Transmittal Form to notify MMCPs of placements as per the form's instructions.	Foster Care Transmittals Template May 15 Through June 30

#	Category	Question	Answer	Additional Guidance
122.	Transmittal Form	How will MMCPs be informed regarding a child/youth's discharge?	MMCPs will be officially notified of a child/youth's discharge from a 29-I Health Facility via the Transmittal Form. MMCPs/29-I Health Facilities/LDSS should be communicating regarding treatment and discharge planning throughout the child/youth's placement; all parties should be aware of treatment goals/discharge plan and progress toward those goals.	Additional information on the Transmittal Form can be found here: Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 2.0
123.	Transmittal form	Is the Transmittal Form used if the child is placed with non-29-I VFCA provider?	Yes. Transmittal Forms are required to be provided to the MMCP by the LDSS for both children/youth in direct care and those placed in non-29-I VFCAs.	
124.	Transmittal Form	Does the Transmittal Form still need to be submitted within 5 days of admission/ transfer/discharge even if the case is not officially open on eMedNY or ePACES?	Yes. The Transmittal Form will serve as the official means of notification of placement in instances when other sources of enrollment information are not yet available and will be the starting point of a conversation between the 29-I and MMCPs.	
125.	Transmittal Form	Does a Transmittal Form need to be submitted if a member's diagnosis changes?	No. The Transmittal Form needs to be sent during the circumstances outlined in the Transmittal Form Instructions. Changes in clinical/medical information should be discussed between 29-Is and MMCPs following communication processes established by both parties.	Transmittal Form and Instructions
126.	Treatment Plan	Is there a template 29-I Health Facilities can use to develop a treatment plan?	29-I Health Facilities are required to have a treatment plan that reflects the needs and goals of the child/youth they are serving; however, there is not a standard template for a treatment plan as providers do not have a standard EHR system.	
127.	Treatment Plan	Are 29-I Health Facilities required to provide MMCPs with a treatment plan for each child/youth enrolled in a plan?	While 29-I Health Facilities are required to develop an individualized treatment plan within 30 days of admission and update on an annual basis for all members, they are not required to routinely share the treatment plan with MMCPs. 29-I Health Facilities may share the treatment plan with MMCPs in instances when it would be beneficial to support communication and service authorization.	
128.	Treatment Plan	For children/youth that are transitioning from today's requirements to the implementation of the 29-I Health Facility standards when does their treatment plan need to be updated to comply with any new standards?	Treatment plans are expected to be completed by July 31, 2021.	

#	Category	Question	Answer	Additional Guidance
129.	Treatment Plan	Can standard be changed to 60 days for initial assessment? Foster families are experiencing challenges getting kids into the PCP within that timeline.	No. The 30-day assessment timeframe is required under State regulations.	
130.	Utilization Review	Can you provide some examples of when UR would occur based on a child/youth's enrollment date?	The following UR timeframes apply to medications, LTSS, Children's Waiver HCBS, and OLHRS: 1. Plan enrollment effective dates 7/1/2021-10/1/2021: no UR until April 1, 2022 2. Plan enrollment effective date 11/1/2021: no UR until May 1, 2022 3. Plan enrollment effective date 12/1/2021 and ongoing: no UR until 180 days from enrollment effective date	
131.	Vaccine Billing	What procedure code do we use for youth 19 and older when administering vaccines?	For non-COVID-19 vaccinations, use procedure code 90471: Administration of vaccine for youth 19 years of age and older.	Further vaccination administration claiming instructions located in: New York Medicaid Program 29-I Health Facility BILLING GUIDANCE
132.	Vaccine Billing	Can a provider bill for an office visit and COVID vaccine administration on the same day?	Yes, if services other than a COVID vaccine are provided. NYS Medicaid enrolled providers, if within their scope of practice, can bill an Evaluation and Management (E&M) visit on the same day as the COVID-19 vaccine administration, when additional services are provided that are beyond the components represented in the COVID-19 vaccine administration code, and when all of the key components of the E&M code have been provided and documented.	https://www.health.ny.gov/health_care/medicaid/covid19/guidance/billing_guidance.htm

#	Category	Question	Answer	Additional Guidance
133.	Vaccine Billing	Can a provider bill for an office visit and COVID vaccine testing on the same day?	If the 29-I has a limited lab license and is billing for the lab test, and the only service being provided is the COVID test, then the 29-I can bill for the lab test, but not separately for specimen collection. If the COVID test is part of an office visit that includes other services, the provider can bill for an office visit and the lab test on the same date. The 29-I should report the procedure codes for specimen collection on the claim. If the 29-I does not have a limited lab license and is not billing for the COVID test, if the only service provided is COVID test specimen collection the 29-I can bill for specimen collection as a stand-alone service under the office visit rate code, unless the specimen collection is completed by nursing staff compensated under the Core Per Diem. However, if specimen collection is part of an office visit that includes other services and is billed under OLHRS, it cannot be billed separately. In summary, if the 29-I is billing for an office visit and/or COVID test, specimen collection cannot be billed separately. If specimen collection is completed by Core per diem staff, it cannot be billed separately.	
134.	Vaccine Billing	Would the cost of vaccines purchased by 29-I facilities to be administered to children/youth not eligible for VFC program be covered under this provision?	Vaccines for individuals being served at a 29-I, who are ineligible for the VFC program due to age, would be billed using Procedure code 90471.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.19
135.	Vaccine Billing	Can 29-I facilities administer COVID vaccines to non-foster care population (both Medicaid enrolled adults and children)?	The 29-I License currently only allows the Health Facility to provide OLHRS (including COVID vaccine administration) to children/youth in their care, or in the care of another VFCA. The State continues to explore the possibility of expanding Emergency Orders to allow for 29-Is to administer the vaccine to any eligible individuals.	
136.	Vaccine Billing	What practitioner(s) can bill for Vaccine Counseling? What practitioner(s) can bill for Vaccine Administration?	For both Vaccine Counseling and Vaccine Administration, any 29-I practitioner qualified to provide that service under their scope of practice, such as a Registered Nurse, can provide that service. Vaccine counseling is billable as a stand-alone service. When provided by an RN under the supervision of a physician, vaccine counseling can be billed under the physician's NPI.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE, Section 4.19