Question	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 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.	
3.	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 , Populations Served by 29-I Health Facilities
4.	29-I Populations	Is there an age cut-off for 8D Baby designation?	Children that 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.	

Question	Category	Question	Answer	Additional Guidance
5.	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.	
6.	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 that are reimbursable can be found in section *Absences and Impact on Claiming* in the New York Medicaid Program 29-I Health Facility BILLING GUIDANCE	
7.	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 (email BHO@omh.ny.gov with specific questions) • Adult Health Homes • HARP • Front Door, OPWDD • OASAS

Question	Category	Question	Answer	Additional Guidance
8.	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 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 for a period of time. 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 *-Former FC Adults Older than 21 who are Still in the Care of the 29-I Health Facility*
9.	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 billing manual are met.	Section 3.4 New York Medicaid Program 29-I Health Facility BILLING GUIDANCE
10.	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's Medicaid coverage and plan enrollment is found through ePACES. Once 29-I Health Facility services are included in the Benefit Package, 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

Question	Category	Question	Answer	Additional Guidance
11.	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 2019.2 October 22, 2019
12.	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 2019.2 October 22, 2019
13.	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.	

Question	Category	Question	Answer	Additional Guidance
14.	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.	
15.	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

Question	Category	Question	Answer	Additional Guidance
16.	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.	
17.	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, this assessment would still need to be conducted as part of the required and mandated assessments for a child/youth entering foster care.	
18.	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 facility but will not impact payment amounts.	

Question	Category	Question	Answer	Additional Guidance
19.	Billing/Rates/ Claiming	How will vaccines be billed?	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 what immunization was administered. There is separate guidance for billing for the administration of COVID vaccines.	*New York Medicaid Program 29-I Health Facility BILLING GUIDANCE* – *Appendix C* *New York State Medicaid Coverage Policy and Billing Guidance for the Administration of COVID-19 Vaccines Authorized for Emergency Use*
20.	Billing/Rates/ Claiming	Will MMCPs accept paper and electronic claims?	Yes. MMCPs are required to accept paper and electronic claims submissions.	
21.	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.	
22.	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.	

Question	Category	Question	Answer	Additional Guidance
23.	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.	
24.	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 -Concurrent Billing section
25.	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.	

Question	Category	Question	Answer	Additional Guidance
26.	Billing/Rates/ Claiming	Can a provider submit CLHRS claims under OLHRS claims category when CLHRS units are exceeded?	No. Other Limited Health-Related Services must be provided and billed for separately from those services included in the Core Limited Health-Related Services. 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 Medicaid residual per diem rate for the provision of Core Limited Health-Related Services. 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.	Refer to Cost Allocation of Services on page 19 of the New York Medicaid Program 29-I Health Facility BILLING GUIDANCE
27.	Billing/Rates/ Claiming	Can a provider bill both CLHRS and OLHRS in the same claim?	No, CLHRS and OLHRS must be billed separately.	
28.	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.	
29.	Billing/Rates/ Claiming	What services can we apply the U4 modifier to for the 10% increase for services performed in a language other than English?	The U4 modifier for services provided in a language other than English can be applied to OLHRS only.	

Question	Category	Question	Answer	Additional Guidance
30.	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.	
31.	Billing/Rates/ Claiming	Voluntary Foster Care Agencies will be billing the daily per diem as a "Core Limited Health Related Service" beginning in February and will need to include a diagnosis on the claim. Are there more appropriate codes for children that agencies should be using as a default diagnosis?	Providers should select the appropriate ICD10 Diagnosis code that applies. Diagnosis code Z62.21 -Upbringing away from parents may be used until a more appropriate diagnosis is made.	
32.	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
33.	Billing/Rates/ Claiming	What procedure code do we use for youth 19 and older when administering vaccines?	Procedure code 90471: Administration of vaccine for youth 19 years of age and older. Refer to the Billing Manual for COVID-19 vaccination administration claiming instructions, which were added in version 2021-3 of the Billing Manual.	New York Medicaid Program 29-I Health Facility BILLING GUIDANCE

Question	Category	Question	Answer	Additional Guidance
34.	Billing/Rates/ Claiming	When submitting a claim do the modifiers need to be indicated in the same order they are outlined in the billing guidance?	If there is more than one modifier indicated in the billing manual, the provider must include all modifiers, however they 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
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
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? If so, can we eliminate that? What would it take?	Children under 21 are exempt from copays today and will continue to be exempt after July 1, 2021.	

Question	Category	Question	Answer	Additional Guidance
39.	Billing/Rates/ Claiming	Must core limited services claims be submitted to third party commercial payers if primary to Medicaid? Is the residual per diem service reimbursable by any payer other than Medicaid?	It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the member is eligible to receive. 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. For Core Services, acceptable documentation of attempts to secure third party reimbursement as required under 18 NYCRR §540.6, includes documentation of a rejection by third party insurance for a date of service within the previous 12 months of the date of service being billed, or since a change in third party coverage, whichever is later. Providers must exhaust third-party coverage for each claim for Other Limited Health Related Services, in accordance with 18 NYCRR §540.6. Please see the regulation referenced in Additional Guidance for more information.	https://regs.health.ny.gov/content/section-5406-billing-medical-assistance.

Question	Category	Question	Answer	Additional Guidance
40.	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.	
41.	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 1.0 Attachment D
42.	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.	

Question	Category	Question	Answer	Additional Guidance
43.	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 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.	See the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract* Definitions, Section 10.13 Emergency Services, and Section 10.26 Urgently Needed Services.

Question	Category	Question	Answer	Additional Guidance
44.	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.	
45.	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 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.	
46.	CSE Children/ Youth	Can CSE children/youth continue to receive OLHRS 1 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.	*Other Limited Health-Related Services (Optional services a 29-I Health Facility may provide)* section - New York Medicaid Program 29-I Health Facility BILLING GUIDANCE

Question	Category	Question	Answer	Additional Guidance
47.	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
48.	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.	*Populations Served by 29-I Health Facilities*- New York Medicaid Program 29-I Health Facility BILLING GUIDANCE
49.	Enrollment	Must all children 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). On the effective date of the transition, children/youth placed in foster care in NYC and children/youth placed in the care of a VFCA statewide will no longer be excluded from Medicaid Managed Care.	

Question	Category	Question	Answer	Additional Guidance
50.	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.	
51.	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.	
52.	Enrollment	Who will provide the authorization code to use when requesting NYMC change a child/youth's enrollment?	NYMC will provide this code to 29-I Health Facilities prior to the first enrollment cycle. It should be noted that CSE-placed children/youth are not part of this enrollment process.	
53.	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. These changes will be prospective to the 1st of the month after the change is made.	

Question	Category	Question	Answer	Additional Guidance
54.	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.	
55.	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.	

Question	Category	Question	Answer	Additional Guidance
56.	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).	
57.	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.	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 1.0

Question	Category	Question	Answer	Additional Guidance
58.	Mandatory Assessments	Are the mandatory assessments required for all children in Foster Care?	Yes. These 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 1.0 Article 29-I VFCA Health Facilities License Guidelines Final Draft
59.	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.	

Question	Category	Question	Answer	Additional Guidance
60.	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.	
61.	Monitoring/ Licensure	What entity will monitor the Managed Care Plans' compliance with quality care initiatives for foster care youth?	MMCPs are contracted with the State and are monitored for quality and performance standards by the State.	Anyone can file a complaint regarding the quality of or access to care provided through a NYS Medicaid managed care plan by calling 1-800-206-8125 or writing to managedcarecomplaint@health.ny.gov
62.	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.	

Question	Category	Question	Answer	Additional Guidance
63.	Out of Network Access	How many days from enrollment date does the out-of-network access apply?	There is no time limit for out of network access; it depends on where the child/youth is placed. A child/youth must be enrolled in a MMCP operating in the district of fiscal responsibility. It may be 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 they 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.	

Question	Category	Question	Answer	Additional Guidance
64.	Pharmacy	What carve-out pharmacy list should be used for foster care?	The Foster Care Drug Carve Out list that will be 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 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 will continue to be responsible to cover the cost of medications and supplies that are not on the Foster Care Drug Carve-Out List until July 1, 2021. Effective July 1, 2021, the Foster Care Drug Carve-Out List will no longer apply 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*

Question	Category	Question	Answer	Additional Guidance
65.	Pharmacy	Are vitamins covered in MMC and FFS?	Yes, vitamins are covered by MMC and FFS.	
66.	Pharmacy	Will any 29-I Health Facilities be licensed as pharmacies?	No, 29-I VFCA Health Facilities will not be licensed as pharmacies.	
67.	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).	
68.	Phase one	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.	
69.	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 will bill 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 will not be enrolled into an MMCP until Phase 2 on July 1, 2021. Even after Phase 2 begins, 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.	

Question	Category	Question	Answer	Additional Guidance
70.	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.	
71.	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
72.	Primary Care Physician (PCP)	Is there a waiver process for PCPs that do not work the required 16 hour per week?	Yes, the MMCP can request a waiver of this requirement from DOH.	
73.	Primary Care Physician (PCP)	Will MMCPs use auto-assignment for PCPs where the LDSS or 29I 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.	

Question	Category	Question	Answer	Additional Guidance
74.	Services/ Practitioners/ Providers	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*.	
75.	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.	
76.	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

Question	Category	Question	Answer	Additional Guidance
77.	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).	
78.	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.	Refer to Cost Allocation of Services on page 19 of the New York Medicaid Program 29-I Health Facility BILLING GUIDANCE
79.	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 an 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.	
80.	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.	

Question	Category	Question	Answer	Additional Guidance
81.	Services/ Practitioners/ Providers	Do Core nursing services include Private Duty Nursing, Personal Care Aides, Home Health Aides and 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.
82.	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 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.	
83.	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.	

Question	Category	Question	Answer	Additional Guidance
84.	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, group of three children for a 30-minute session would require three separate claims of two units	
85.	Services/ Practitioners/ Providers	Are there separate benefits or MMCPs for a child/youth in foster care that is pregnant?	No. The MMCP benefit package provides medically necessary comprehensive coverage to all members, including prenatal and labor and delivery services.	
86.	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.	

Question	Category	Question	Answer	Additional Guidance
87.	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 an 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
88.	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 1.0

Question	Category	Question	Answer	Additional Guidance
89.	Transmittal Form	Where can I find the Transmittal Form and submission process?	Information on the Transmittal Form can be found in the Policy Paper.	Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care Version 1.0
90.	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 in direct care and those placed in non-29-I VFCAs.	
91.	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.	
92.	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.	

Question	Category	Question	Answer	Additional Guidance
93.	Treatment Plan	For children/youth that are transitioning from today's requirements to the implementation of the 29-1 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.	