2026 NY Medicaid Article 29-I Health Facilities Reimbursement Rules Overview

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Overview

Article 29-I of the New York State Public Health Law establishes a framework that allows **Voluntary Foster Care Agencies (VFCAs)** to become licensed health facilities for the purpose of delivering **limited health-related services** to children and youth in foster care.

- Its primary goal is to ensure that children in the care of VFCAs receive coordinated, medically necessary services through Medicaid, either via Managed Care Plans or Fee-for-Service.
- The licensure enables VFCAs to bill Medicaid for both **Core Limited Health-Related Services (CLHRS)** and **Other Limited Health-Related Services (OLHRS)**. These services are integrated into Medicaid Managed Care and Fee-for-Service Medicaid billing systems.
- The population served under Article 29-I includes children and youth for whom the VFCA has direct care responsibility. Includes those in direct placement, residential care, boarded out arrangements, ensuring access to trauma-informed and comprehensive care within the foster care system.

Children and Youth in Foster Care

Includes children/youth placed in Voluntary Foster Care Agencies (VFACs) licensed under Article 29-I

Typically placed by Local Departments of Social Services (LDSS) or the Office of Children and Family Services (OCFS)

Medicaid Enrolled Children/Youth

Medicaid Managed Care (MMC)

Fee-for-Service (FFS) Medicaid

Children with Complex Needs

May include children/youth with:

- Behavioral health needs
- Developmental disabilities
- Trauma-related conditions
- Chronic medical conditions

These facilities are equipped to deliver **trauma-informed**, **coordinated**, and **comprehensive care** tailored to the unique needs of foster care populations.

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Health Plan Responsibilities Under Article 29-I Billing Guidelines

1. **Network and Contracting Requirements**
    - Molina maintains and monitors a network of providers that is sufficient and adequate for delivery of all covered services to children and youth served by Voluntary Foster Care Agencies (VFCAs). Key standards include:
        - Contracts all licensed 29-I Health Facilities within its service area.
        - Collect program integrity information, as required in the MMC Model Contract, and ensure providers are not excluded from Medicaid or Medicare.
        - Accept DOH licensure, designation, or operating certificates for credentialing 29-I Health Facilities, without requiring additional credentialing for individual staff.
        - Maintain billing and identifier information for all licensed 29-I Health Facilities in the claims system, regardless of their network participation status.
        - If a child/youth is placed in an out-of-network 29-I Health Facility, ensure claims are reimbursed at in-network rates without requiring a single case agreement.
2. **Access to Care Requirements**
    - Ensure the child or youth in foster care receives timely and coordinated care. This coordination is in accordance with the continuity of care requirements outlined in the MMC Model Contract.
    - Ensure the child or youth in foster care has a Primary Care Provider (PCP) assigned.
    - Ensure children discharged from 29-I Health Facilities continue to receive services for up to one year, with possible extensions based on age and care needs.
    - Allow access to non-participating providers within 30 minutes/30 miles (or the next closest provider) for medically necessary services when Molina's network lacks appropriate providers.
    - Acknowledge and investigate access to care inquiries and/or complaints within three (3) business days of receipt, or sooner if the urgency of the request warrants expedited handling.
3. **Payment for Core Limited Health-Related Services**
    - Cover CLHRS for the full period the child/youth is both enrolled and placed with the facility, even if placement notification is delayed.
    - Molina Healthcare is responsible for paying the Medicaid residual per diem rate to 29-I Health Facilities for Core Limited Health-Related Services.
    - These payments are made on a per child/per day basis and are standardized based on the facility type and level of care.
    - During the four-year transition period, Molina Healthcare acts as a pass-through entity, billing the State for the per diem rate.
4. **Payment for Other Limited Health-Related Services**
    - Cover OLHRS as defined in the 29-I Billing Guidance.
    - Molina Healthcare must reimburse 29-I Health Facilities for optional services (e.g., CFTSS, HCBS) if the facility is designated to provide them.
    - These services are billed separately from the per diem and require appropriate coding and documentation.
5. **Claims Processing**
    - Providers must ensure claims are submitted with the correct rate codes, procedure codes, and billing units as outlined in the Article 29-I Billing Guidelines manual.
    - Molina reimburses 29-I Health Facilities as outlined in the 29-I Billing Guidance.
    - Cover medically necessary services provided by 29-I Health Facilities, regardless of the facility's network status.
    - Accept paper or electronic claims from 29-I Health Facilities and offers an electronic payment option (i.e., electronic funds transfer-EFT) or paper check.
    - Ensure claims meet medical necessity and documentation standards.
    - Support concurrent billing for Core and Other services when appropriate.
    - Reimburse 29-I Health Facilities at in-network rates regardless of their network participation status.
    - Molina is not responsible for reimbursing services for children/youth placed in 29-I Health Facilities but residing in certain settings or during specific absences, as outlined in the 29-I Billing Guidance.
    - Acknowledge and investigate claims and billing issues within two (2) business days of receipt.
6. **Compliance and Oversight**
    - Molina Healthcare must ensure that 29-I Health Facilities meet licensure requirements, maintain Medicaid enrollment, and adhere to medical necessity guidelines.
    - They are also responsible for monitoring utilization and ensuring services are delivered in accordance with Medicaid standards.
7. **Coordination with State Agencies**
    - Molina Healthcare must coordinate with the New York State Department of Health (DOH) and the Office of Children and Family Services (OCFS) regarding implementation, rate transitions, and compliance issues.

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Reimbursement Guidelines for Health Plans Under Article 29-I

Medicaid Residual Per Diem Rate

- Pay the **standardized per diem rate** for Core Limited Health-Related Services.
- Rates vary by **facility type and level of care** (e.g., foster boarding home, group home, diagnostic center).
- Act as a **pass-through entity** during the transition period (until July 2024), billing the State for reimbursement.

Fee-for-Service vs. Managed Care

- **Fee-for-Service (FFS)**: Used when the child/youth is **not enrolled** in a managed care plan.
- **Managed Care**: Pay for services and submit claims to the State for reimbursement.

Single Case Agreements (SCAs)

- If a 29-I Health Facility is **not contracted** with Molina Healthcare, ensure claims are reimbursed at in-network rates without requiring a single case agreement.

Claims Submission Requirements

- Molina Healthcare must :
- Accept paper or electronic claims from 29-I Health Facilities and offers an electronic payment option (i.e., electronic funds transfer-EFT) or paper check.
- Ensure claims are submitted with proper **documentation of medical necessity**.
- **Daily billing** is used for Core services.
- **Unit-based billing** is used for Other services (e.g., 15-minute increments, per visit).
- Acknowledge and investigate claims and billing issues within two (2) business days of receipt.

Coding and Rate Tables

- Molina Healthcare must use Article 29-I Billing Guidelines for:
  - Core service rate codes
  - Other service rate codes
  - Revenue codes
  - Optional services under Phase 1 licensure

List of codes and services referenced in Appendix B - H

Additional Requirements:

- Monitor utilization, ensure provider licensure, and maintain network adequacy.
- Services must be medically necessary, documented, and aligned with treatment planning standards.
- Coordinate with DOH and OCFS for compliance and updates.

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Covered Services Under Article 29-I

Core Limited Health-Related Services (CLHRS) - Mandatory

These services must be provided by all 29-I Licensed Health Facilities and are reimbursed via a **Medicaid residual per diem rate**:

- Skill Building (by Licensed Behavioral Health Practitioners)
- Nursing Services
- Medicaid Treatment Planning and Discharge Planning
- Clinical Consultation/Supervision Services
- VFCA Medicaid Managed Care Liaison/Administrator

These services are standardized and must be available to all children residing in the facility**. Only one per diem rate per child per day can be billed**, corresponding to the facility type and care level.

Other Limited Health-Related Services (OLHRS) - Optional

These services may be provided based on the child/youth's individualized treatment plan and require State designation.

- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community-Based Services (HCBS)
- Screening, preventive, diagnostic and treatment services related to physical health
- Screening, preventive, diagnostic, and treatment services related to developmental and behavioral health

These are billed per unit (i.e., per 15 minutes, per visit) and **require appropriate coding** and **documentation**. Claims should reflect the provider's credentials, and the accurate number of service units delivered for compliance.

MMC Plans and FFS cover both Core and Other Limited Health-Related Services depending on the youth's enrollment status

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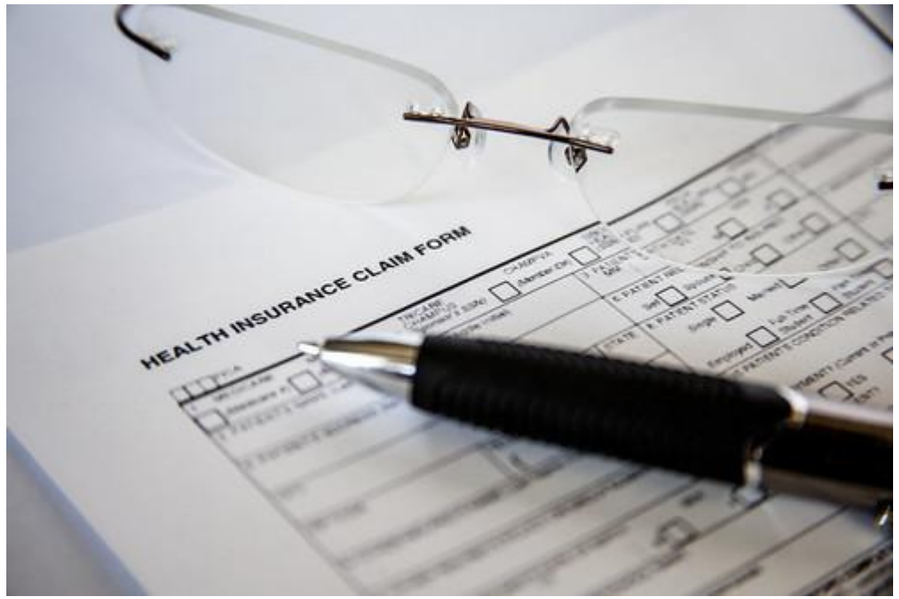
CLHRS Reimbursement Rules and Rate Codes

Reimbursement Rule: CLHRS are reimbursed at Medicaid Fee-for-Service (FFS) residual per diem rates through June 30, 2027.

CLHRS are billed daily and can be submitted with a range of multiple dates of service on one claim.



Billing Details:

- **Claim Format**: Institutional claim using UB-04 or 837I format
- **Bill Type**: service code 0121
- **Rate Codes**: service code billed must be paired with one of the Core service rate codes 4553–4557
- **Value Code**: 24 (used to indicate rate code on claim)
- **Concurrent Billing:** Core and Other services can be billed together if medically necessary and properly documented. Claims must include the correct codes and modifiers.

Additional Billing Guidelines:

- **Approved Absence Categories**
  - Facilities **may claim the Medicaid residual per diem rate** for up to 7 consecutive days per episode for situations like weekend visits, holidays, parental visits, respite care, college/vocational training attendance, vacations, school trips, or trial discharges.

Example of CLHRS and Rate Codes

Service	Rate Code
Skill Building (by Licensed Behavioral Health Practitioners)	4553
Nursing Services	4554
Medicaid Treatment Planning & Discharge Planning	4555
Clinical Consultation/Supervision	4556
VFCA Medicaid Managed Care Liaison/Administrator	4557

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OLHRS Reimbursement Rules and Rate Codes

Reimbursement Rule: OLHRS are reimbursed at Medicaid FFS fee schedule rates unless alternate arrangements are approved.

Billing Details:

- **Claim Format**: Professional claim using 837P or institutional if applicable
- **Bill Type**: service code 0268
- **Rate Codes**: service code billed must be paired with appropriate rate codes for CFTSS or HCBS services
- **Value Code**: 24 (used to indicate rate code on claim)
- **Procedure Codes:** CPT/HCPCS codes must match the service provided
- **Modifiers:** May be required depending on service type and provider

Additional Billing Guidelines:

- **Concurrent Billing:** Core and Other services can be billed together if medically necessary and properly documented. Claims must include the correct codes and modifiers.
- **Interpreter Services:** May be billed with appropriate modifiers and documentation.
- **Interns and Limited Permit Holders:** Services must be supervised and billed under a licensed provider.

Examples of OLHRS & Rate Codes

Service	Rate Code
CFTSS – Other Licensed Practitioner (OLP)	1521
CFTSS – Community Psychiatric Support and Treatment (CPST)	1522
CFTSS – Psychosocial Rehabilitation (PSR)	1523
HCBS – Caregiver/Family Supports and Services	1511
HCBS – Prevocational Services	1512
HCBS – Supported Employment	1513
HCBS – Respite (Planned and Crisis)	1514
HCBS – Community Self-Advocacy Training and Support	1515
HCBS – Non-Medical Transportation	1516

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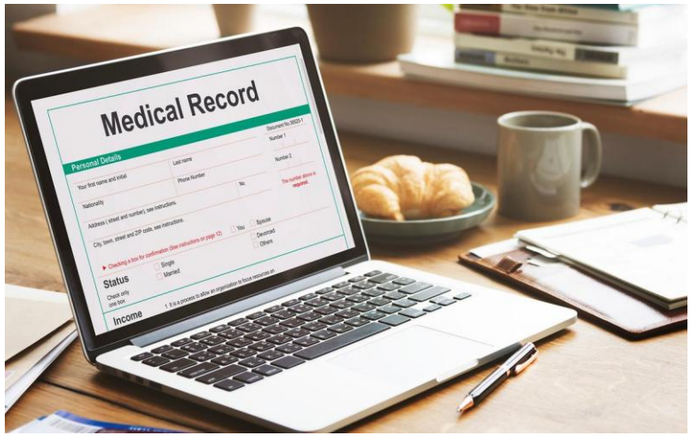
Medical Necessity and Documentation Requirements

Medical Necessity Determination

- Practitioners authorized under Article 29-I License Guidelines are responsible for making medical necessity determinations, which must be completed prior to billing for any Core or Other Limited Health-Related Services.

    - These typically include:
        - Licensed behavioral health professionals
        - Nurses
        - Physicians or other credentialed providers



Documentation Standards

- Medical necessity determination must be supported by clinical documentation in the child/youth's record.

- Documentation must include:
    - Clinical rationale for the service
    - Treatment goals aligned with the child's care plan
    - Service delivery details (i.e., time spent, modality, provider credentials)

Claims Impact

- If medical necessity is not documented in the child/youth's record, the claim may be denied by MMC Plans or Fee-for-Service (FFS) Medicaid. This applies to both Core and Other Limited Health-Related Services.

- Claims submitted without proper documentation are subject to post-payment audits. If documentation is found to be insufficient or missing, the provider may be required to repay funds received for those services.

- For services that exceed limits (e.g., multiple units per day), medical necessity must be documented to justify the additional billing. Without justification, excess units may be denied or pended for review.

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Additional Population requirements

1. Age Eligibility for Covered Services

- **Post-Discharge Services**: Children/youth discharged from a 29-I Health Facility can continue receiving *Other Limited Health-Related Services* for up to **one year** after discharge.

- **Extension Beyond One Year** is allowed if:
  - The youth is **under 21**, receiving services for an *Episode of Care*, and hasn't safely transitioned to another provider.
  - The youth is **under 21**, receiving **CFTSS or Children's HCBS**, and hasn't safely transitioned to another designated provider per their care plan.
  - The individual is **21 or older**, and:
    - Was receiving services before turning 21.
    - Has not safely transferred to another placement or living arrangement.
    - Is compliant with a safe discharge plan.
    - The 29-I facility is actively working with the Health Plan to ensure safe discharge, including court-ordered services if applicable.

2. 8D Designation

- A child is assigned an 8D status when:
  - The child is **in the care of a 29-I Health Facility** and
  - Their **parent is also concurrently in care** at the same facility

- The designation helps identify and track children who are part of a parent-child placement within the foster care system. The child retains the 8D designation until they are discharged from the facility or until there is a change in their placement status (i.e., the parent is no longer in care).

- The 8D designation is a clinical and administrative identifier, not a billing modifier. It ensures appropriate care coordination but **does not change the billing codes or reimbursement structure** under Article 29-I.

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Article 29-I Exclusions – Non-covered Services

1. General Exclusion Rules

- Services must be medically necessary and properly documented.
- Facilities without 29-I licensure are not authorized to bill Medicaid for health-related services.

2. Non-Covered Services and Situations

- **Absence-Related Exclusions** - Medicaid residual per diem cannot be claimed when a youth is:
    - In inpatient hospital care
    - In secure legal detention
    - In another residential facility reimbursed by Medicaid (e.g., psychiatric centers, skilled nursing facilities)
    - Transferred or discharged (except for the day of admission or discharge)
    - On trial discharge or non-secure detention beyond 7 consecutive days
    - In out-of-state congregate care settings
    - Refused re-entry by the 29-I facility (must be discharged for payment purposes)
- **Age-Based Exclusions** - Adults over 21 are not eligible for:
    - Core Limited Health-Related Services (per diem)
    - Children and Family Treatment and Support Services (CFTSS)
    - Children's Home and Community-Based Services (HCBS)
- **Provider and Licensing Exclusions** - Services provided by:
    - Unlicensed agencies
    - Uncredentialed providers
    - Non-designated providers for CFTSS or HCBS
    - Interns or limited permittees without supervision or outside scope
- **Service-Type Exclusions**
    - Maximum State Aid Rate (MSAR) payments are not covered under Article 29-I billing guidance.
    - Article 29-I is not applicable to general hospitals, clinics, or non-foster care providers.
    - Routine transportation and non-medical HCBS transportation are not billable under Core Limited Health-Related Services.
    - Durable Medical Equipment (DME) and pharmacy items may require separate billing and are not always covered under 29-I services.
    - Other Limited Health-Related Services do not include the following services, which should be provided by Medicaid participating providers (i.e. essential community providers) and billed directly by these providers to MMC Plans and Medicaid FFS:
        - surgical services
        - dental services
        - orthodontic care
        - general hospital services including emergency care
        - birth center services
        - emergency intervention for major trauma
        - treatment of life-threatening or potentially disabling conditions

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Billing Example – Office Visit

When billing for an office visit, the claim would include rate code 4594, one of the billable Evaluation and Management (E&M) or prevention procedure codes (99202-99205, 99212-99215, 99381-99385, 99391-99395, 99401-99404), and any additional non-billable procedure codes relevant to the services that was provided.

- A child/youth was a new patient with moderate presenting problems (based on medical decisions of the practitioner seeing the child/youth for the visit) and the child/youth was seen for 45 minutes.

- The claim must reflect the following information:

Rate code	Procedure Code description	Modifier	Procedure Code	Billable Units	Units Billed
Unit Limit 12 units/day					
4594	New Patient Office or outpatient visit (typically 30 minutes) usually presenting problem(s) are moderate severity	U9, SC	99204 (billable code)	15 minutes	3 units
	Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g. holidays, Saturday, or Sunday) in addition to basic service	N/A	99051 (non-billable code)	N/A	N/A
	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	N/A	90863 (non-billable code)	N/A	N/A

Billing Example – Other Limited Health Related Service Claim

If a 29-I Health Facility provides Developmental Test Administration using rate code 4589 for one hour and thirty minutes.

The claim must reflect the following information:

- Rate code – 4589
- Procedure codes 96112 and 96113 with a total of 6 units on the claim

If more than one procedure code is billable on the claim the units must reflect what was delivered in the encounter. Any claim submitted with a non-billable procedure code will not reimburse for any units.

Table 4: Managed Care Claims Example

Example: (Same date of service) 9/2/2021	Same Child: "Youth receiving care"	Procedure code	Units
Rate Code 4589 (same rate code)		96112	4
		96113	2

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