VFCA – Voluntary Foster Care Agency

Effective July 1, 2021, children/youth placed in foster care, including those in direct placement foster care and placement in the care of VFCAs statewide, will be mandatorily enrolled in MMC unless the child/youth is otherwise exempt or excluded from enrollment.

29-I Health Facilities may provide Children and Family Treatment and Support Services (CFTSS) and Children's Home and Community Based Services (HCBS) as part of their Other Limited Health-Related Services. 29-I Health Facilities who wish to provide CFTSS and HCBS are required to receive the appropriate designation(s) from the State.

All eligible health care providers are required to enroll in Medicaid in order to receive reimbursement for delivering a Medicaid service. Those that have obtained a 29-I licensure must maintain one. If a VFCA is not currently credentialed with Molina Healthcare, please review the credentialing policy at the end of the presentation.

*Please reference the below for the most up to date guidance

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/

CLHRS versus OLHRS

Core Limited Health-Related Services

- Nursing Services
- Skill Building
- Medicaid Treatment & Discharge Planning
- Clinical Consultation and Supervision Services
- Managed Care Liaison/Administration

Other Limited Health-Related Services

- Alcohol and/or Drug Screening, testing and treatment
- Developmental Testing
- Psychotherapy (Individual, Family, Group)
- Neuropsychological testing/evaluation services
- Psychiatric Diagnostic Examination
- Office Visit
- Smoking Cessation Treatment
- ECG
- Screening Developmental/emotional/behavioral
- Hearing and Evaluation of Speech
- Immunization Administration
- Laboratory Services
- Children and Family Treatment and Support Service (CFTSS)
- Home and Community Based Services (HCBS)

- Core Limited Health-Related Services are mandated to be provided by 29-I Health facilities while OLHRS are provided dependent on symptom presentation and clinical needs.
- Upon discharge from foster care, all Core Limited Health-Related Service authorizations must be approved for 1 year after discharge to allow for a proper transition to community-based programs and to prevent gaps in care.

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VFCA – Voluntary Foster Care Agency

Continued

- 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 MMCPs/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

Category of Services

There are two main category of services that can be provided by a 29i Facility

1. CORE limited health related services (Mandatory)
2. OLHRS (Optional)

29-I Health Facilities must be enrolled with category of service code 0121 to bill for Core Limited Health-Related Services, and category of service code 0268 to bill for Other Limited Health-Related Services.

For services to qualify for Medicaid reimbursement, the child's/youth's health/behavioral health record, treatment plan, service plan and/or plan of care must reflect that the services provided:

- were medically necessary and appropriate and
- were rendered by qualified practitioners within their scope of practice (including supervision requirements), as defined in applicable State Law

Medical Necessity

- Must be determined by a Licensed Practitioner of the Healing Arts
- Must include how the Core Limited Health-Related Services are intended to address any of the following:

1. Deliver preventive supports through an array of clinical and related activities including psychiatric supports, information exchange with Medicaid community and skill-building.
2. Reduce the severity of the health issue that was identified as the reason for admission.
3. Provide targeted treatment related directly to the child's ability to function successfully in the home and school environment (e.g. compliance with reasonable behavioral expectations; safe behavior and appropriate responses to social cues and conflicts; or medically appropriate care).

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BILLING

Core Limited Health-Related Services are reimbursed with a Medicaid residual per diem rate paid to 29-I Health Facilities on a per child/per day basis to cover the costs of these services. For children/youth not enrolled in a plan, providers must bill Medicaid Fee-for service (FFS) via eMedNY.

- Core Limited Health-Related Services (Medicaid residual per diem) rates differ based on both the level of care and the facility type the 29-I Health Facility is operating. Since a 29-I Health Facility may operate more than one facility type in one or more levels of care, it may be necessary for a 29-I Health Facility to bill several different Core Limited Health-Related Services (Medicaid per diem) rates, depending on how many facility types that 29-I Health Facility operates.
- The Core Limited Health-Related Services (Medicaid per diem) rate billed must correspond to the rate for the facility type the individual child/youth is residing in.

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29i_billing_manual_final.pdf

Core LIMITED RATE SERVICES CAN BE FOUND AT THE BELOW LINK

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm

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BILLING CONTINUED

Core Limited Health-Related Services must be provided and billed for ***separately*** from Other Limited Health-Related Services.

29-I Health Facilities may not separately bill for activities performed by a professional ***when the Full Time Equivalent (FTE) at 100% for that position is funded within the Medicaid per diem rate*** for the provision of Core Limited Health-Related Services.

- 29-I Health Facilities must appropriately allocate the costs associated with each type of service in the annual cost report filings submitted to the State.
- Time spent by practitioners providing Core Limited Health-Related Services must be allocated to and billed under the Medicaid per diem.
- 29-I Health Facilities can allocate percentages of individual practitioners' FTEs to Core and Other Limited Health-Related Services

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CONCURRENT BILLING

In circumstances in which the child is receiving services from an Article 29-I Health Facility **and a** community provider such as an Article 31 or Article 28, there should be no duplication of services. **When a clinical need is identified that is distinctly different and not duplicative to those needs being addressed through the 29-I Health Facility,** it may be determined medically necessary for both services to be provided concurrently.

Transitional Rates for Core Limited Health-Related Services Rates

Transitional rates will be updated yearly beginning July 1, 2021 through July 1, 2024.

On July 1, 2024, all 29-I Health Facilities will be reimbursed the standard rate schedule based on facility type

For 29-I Health Facilities that are receiving a transitional rate for Core Limited Health-Related Services, rates will be specific to the facility type that is transitioning with a unique agency-based rate

Billing limits

- Only one Core Limited Health-Related Services (Medicaid per diem) rate per day for each individual child/youth can be billed.
- Core Limited Health-Related Services are billed daily and can be submitted **with a range of multiple dates** of service on one claim.
- The Medicaid per diem rate is paid for the duration of the child's stay in the 29-I Health Facility.
- The Medicaid per diem is not reimbursable after the individual's 21st birthday.

Table 1: 29-I Health Facility Types Level

- **Level 1 General Treatment**
  - Foster Boarding Home

- **Level 2 Specialized Treatment**
  - Therapeutic Boarding Home (TBH)/AIDS
  - Medically Fragile (former Border Babies)
  - Special Needs

- **Level 3 Congregate Care**
  - Maternity
  - Group Home (GH)
  - Agency Operated Boarding Home (ABH)
  - Supervised Independent Living Program (SILP)

- **Level 4 Specialized Congregate Care**
  - Group Residence (GR)
  - Diagnostic
  - Institutional
  - Hard to Place / Other Congregate
  - Raise the Age

Rate Codes and Other Billing Information

Level	Description	Facility	Rate Code	Procedure Code	Modifier	Unit	Unit Limit
Level 1	General Treatment	Foster Boarding Home	4288	H004		Per Diem	1 day
Level 2		TBH	4289	55145		Per Diem	1 day
		Medically Fragile	4290	55145	TF	Per Diem	1 day
		Special Needs	4291	55145	U1	Per Diem	1 day

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Rate Codes and Other Billing Information

Level	Description	Facility	Rate Code	Procedure Code	Modifier	Unit	Unit Limit
3	Congregate Care	Maternity	4292	H004	HD	Per Diem	1 day
		Group Home	4293	55145	HA	PD	1 day
		ABH	4294	55145	U2	PD	1 day
		SILP	4295	55145	U3	PD	1 day

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Rate Codes and Other Billing Information

Level	Description	Facility	Rate Code	Procedure Code	Modifier	Unit	Unit Limit
Level 4	Specialized Congregate Care	Group Residence	4296	55145	HA US	Per Diem	1 day
		Diagnostic	4297	55145	TG	Per Diem	1 day
		Institutional	4298	55145	U5	Per Diem	1 day
		Hard to Place/Other	4299	55145	U6	Per Diem	1 day
		Raise the Age	4300	55145	U7	Per Diem	1 day

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Absent Categories

- **Rate for all days of episode of absence of the following:**
- Weekend visits
- School and religious holidays
- Vacation days (including stay at camp)
- Up to 21 days per calendar year
- Visits to potential foster or adoptive parents
- Up to seven consecutive days per visit
- Organized school trips
- Foster care youth attends and is a resident at an in-state or out-of-state college, university, or technical/vocational training setting but the foster care placement setting is within New York State
- Respite care and services (non-institutional and institutional)

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Non Permissible Absent Categories

Non Permissible Categories Include:

- Inpatient hospital days
- Other residential facility/setting days when that entity is reimbursed via Medicaid

If the 29-I Health Facility has advised the fiscally responsible Local Department of Social Services (LDSS) that they will not accept the return of the absent youth in foster care to their agency, then:

- None of the absent days (even if they would otherwise fall into a permissible absence category) are reimbursable for the purposes of the Core Limited Health-Related Services (Medicaid Per Diem) rate, and;
- The 29-I Health Facility must discharge the youth

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Foster Care Liaison

- A Foster Care Liaison is a subject-matter-expert who is readily available to the LDSS, VFCA, and 29-I Health Facilities during regular business hours to address any issues for members enrolled in foster care. They provide high-touch and timely coordination to members in foster care. The Foster Care Liaison has experience, expertise, and knowledge of:

  - The Child Welfare System
  - Healthcare requirements for the foster care population
  - The unique and complex needs of the foster care population
  - Medicaid Managed Care policies and operations

- The Foster Care Liaison is in frequent contact with:

  - Local Department of Social Service (LDSS)
  - VFCA and 29-I Health Facilities
  - NYS Office of Children and Family Services (OCFS)
  - Health Homes
  - Community agencies

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Liaison Roles & Responsibilities

- The FC Liaison's roles and responsibilities include:
- Assisting with referrals for needed services, provider selection, and ensuring continuity of care
- Assisting with foster care disenrollment and transitions
- Assisting with foster care placement changes, including accessing health care
- Interacting with clinical and billing staff
- Coordinating with health care providers, including school and community-based services
- Assisting with maintaining eligibility for health insurance
- Coordinating benefits
- Providing consultation regarding consent and/or confidentiality issues
- Assisting with court ordered services and fair hearings
- Communicating with the LDSS, VFCA, and 29-I Foster Care Liaisons at a minimum of once per month
- Working with the Medically Fragile Liaison to meet PH needs, as necessary for foster care members
- Generating referrals to case management as found appropriate

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Appointment Availability

All Providers in the Molina network will comply with the following appointment availability guidelines.

- **Emergency Care:** Immediately upon presentation at a service delivery site.
- **For CPEP:** inpatient mental health and Inpatient Detoxification Substance Use Disorder services and Crisis Intervention services; immediately upon presentation at a service delivery site.
- **Urgent Care:** Within twenty-four (24) hours of request.
- **Non-Urgent "Sick" Visit:** Within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- **Routine , non urgent, preventative appointments except as otherwise provided in this Section:** Within four (4) weeks of request.
- **Specialist Referrals (not urgent), preventative appointments, except as otherwise provided in this Section:** Within four (4) to six (6) weeks of request.
- **Initial Prenatal Visit:** Within three (3) weeks during first trimester, two weeks during the second trimester, and one week during the third trimester.
- **Adult Baseline and Routine Physicals:** Within twelve (12) weeks from enrollment. (Adults > 21 years) [Applicable to HIV SNP Program only]: Adult baseline and routine physicals: within four (4) weeks from enrollment (Adults > 21 years)

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Availability Timeframes

- **Well Child Care:** Within four (4) weeks of request.
- **Initial Family Planning Visits:** Within two weeks of request.
- **In-Plan Mental Health or Substance Use Follow-Up:** Pursuant to an emergency hospital discharge or release from incarceration, where the Plan is informed of such release, mental health or Substance Abuse Disorder follow up visits with a participating provider: within five (5) days of request, or a clinically indicated.
- **In-Plan, Non-Urgent Mental Health or Substance Use and/or Substance Use Disorder Outpatient Clinic, including a PROS clinic Visits** with a Participating Provider: Within one (1) week of request.
- **Initial PCP Office Visit for Newborns:** Within two (2) weeks of hospital discharge. [Applicable to HIV SNP Program} Initial PCP office visit for newborns within forty-eight (48) hours of hospital discharge or the following Monday if the discharge occurs on a Friday. `
- **Provider Visits to Perform Health, Mental Health and Substance Use Assessments:** for the purpose of making recommendations regarding a recipient's ability to perform work when requested by a Local Department of Social Services (LDSS) Provider: within ten (10) days of request by a Member, in accordance with Benefit Agreement.

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Availability Timeframes

- Behavioral Health Specialist referrals (non-urgent):

  For Continuing Day Treatment, Intensive Psychiatric Rehabilitation Treatment programs and Rehabilitation services for residential Substance Abuse Disorder treatment services: within two (2) to four (4) weeks; and

  For PROS programs other than clinic services: within two (2) weeks of request.

- Urgent care – within 24 hours.
- Emergency Services/CPEP – immediately; 24 hours a day/7 days per week
- For urgent needed Substance Use Disorder inpatient rehabilitation services, stabilization treatment services in OASAS certified residential settings and mental health or Substance Use Disorder outpatient clinics, Assertive Community Treatment(ACT) , Personalized Recovery Oriented Services (PROS) and Opioid Treatment Programs: within twenty-four hours of request
- OASAS Residential Treatment – immediately for inpatient substance use detoxification and within twenty-four (24) hours for inpatient rehabilitation services, stabilization treatment services, substance use disorder outpatient and opioid treatment programs.
- Non-24-hour Diversionary Psychopharmacology Services – within two (2) calendar days.

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Availability Timeframes

- Medication Management – within 14 calendar days
- Outpatient mental health office and clinic services – within two (2) to four (4) weeks of request.
- Psychological or neuropsychological testing – non-urgent within two (2) to (4) weeks
- Personalized Recovery Oriented Services (PROS) pre-admission status – begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted. Pre-Admission is open-ended with no time limits. Appointment should be given within 24-hours of request.
- Personalized Recovery Oriented Services (PROS) Admission – begins IRP is approved by the plan. Appointment should be given within weeks of request.
- Mental Health Continuing Day Treatment (CDT) – Appointment should be offered within two (2) to four (4) weeks of request.
- Mental Health Intensive Outpatient – Appointment should be offered within one (1) week of request.
- Assertive Community Treatment (ACT) – new referrals made within 24 hours and should be made through local Single Point of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determination of eligibility and appropriateness of ACT
- Outpatient office and clinic treatment provided by OASAS certified agencies – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request.
- Medically Supervised Outpatient Substance withdrawal – LOCADTR tool to inform level of care determination. Appointments should be offered within 24 hours of request.

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Availability Timeframes

- Opioid Treatment Program (OTP) services – LOCADTR tool to inform level of care determinations. Appointments within 24 hours of request.

- Substance Use Disorder Intensive Outpatient – LOCADTR tool to inform level of care determinations. Appointments should be offered within one week of request.

- Substance Use Disorder Day Rehabilitation – LOCADTR tool to inform level of care determinations. Appointments should be offered within two (2) to four (4) weeks of request.

- Stabilization and Rehabilitation services for residential SUD treatment – LOCADTR tool to inform level of care determinations. Appointments should be offered within 24 hours of request.

- For Foster Care, a comprehensive initial assessment needs to be done. These series of assessments will provide a complete understanding of the foster care child's health needs and should be used to develop a comprehensive treatment plan for the enrollees.

Initial Health Services Time Frames				
Time Frame	**Activity**	**Mandated Activity**	**Mandated Time Frame**	**Who Performs**
24 Hours	Initial screening/ screening for abuse/ neglect	x	x	Health Pactitioner (preferred) or Child Welfare caseworker/health staff
5 Days	Initial determination of capacity to consent for HIV rist assessment & testing	x	x	Child Welfare Caseworker or designated staff
5 Days	Initial HIV rist assessment for child without capacity to consent	x	x	Child Welfare Caseworker or designated staff
10 Days	Request consent for release of medical records & treatment	x	x	Child Welfare Caseworker or health staff
30 Days	Initial Medical assessment	x	x	Health Practitioner
30 Days	Initial dental assessment	x	x	Health Practitioner
30 Days	Initial Mental health assessment	x	x	Mental health Practitioner
30 Days	Family Planning Education and Counseling and follow	x	x	Health Practitioner
30 Days	HIV risk assessment for child with possible capacity to consent	x	x	Child Welfare Caseworker or designated staff
30 Days	Arrange HIV testing for child with no possibility of capacity to consent &	x	x	Child Welfare Caseworker or health staff
45 Days	Initial developmental assessment	x		Health Practitioner
45 Days	Initial substance abuse assessment			Health Practitioner
60 Days	Follow-up health eveluation	x	x	Health Practitioner
60 Days	Arrange HIV testing for child determined in follow-up assessment to be	x	x	Child Welfare Caseworker or health staff
60 Days	Arranve HIV testing for child with capacity to consent who has agreed in	x	x	Child Welfare Caseworker or health staff

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Member Portal

- FC and VFCA members can log into their member portal to:
  - Print off a paper ID card and request a new card. New card will be received within 24 hours
  - Change or find a doctor
  - Make a payment (Marketplace exchange members only)
  - Get health reminders for services
  - Check prescription drug coverage
  - View their claims history
  - View their medical profile (assessments, conditions, care plan)
  - Share their records with their care team, if applicable

Note: LDSS may create an account on behalf of the foster care child as the guardian in order to access the member portal capabilities.

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Participation in Credentialing

Providers are required to patriciate in Molina's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Molina and applicable accreditation. State and Federal requirements. This includes providing prompt responses to Molina's requests for information related to the credentialing or re-credentialing process. The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law

Providers must notify Molina no less than thirty (30) days in advance when they relocate or open an additional office. When this notification is received, a site review of the new office may be conducted before the Provider's recredentialing date.

Please reference section 12 of the Molina Healthcare Provider Manual for full policy.

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References

- https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29i_billing_manual_final.pdf
- https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm
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- https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/final_draft_vfca_health_facilities_license_guidelines_5_01_18.pdf

- Core Limited Health-Related Services (Medicaid per diem) Rates
- https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/29-i_draft_rates_final_11.23.20.pdf

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