



**Department
of Health**

**Transition of School Based Health Center Benefit and Population
Into Medicaid Managed Care**

Frequently Asked Questions

Enrollment:

1. How does a child enroll in an SBHC?

A child is enrolled in the SBHC by the SBHC with the completion of an appropriate consent form. Students who are 18 years old and over, and those meeting Public Health Law (PHL) requirements, can consent on their own behalf.

2. What is the State's expectation of MMCPs' role in the SBHC enrollment process?

MMCPs do not have any particular role in enrolling children in the SBHC.

3. Can a child enroll in a SBHC if they do not attend that school?

A child can be enrolled in a SBHC if he/she is a student who lives in the school district. For example, a child who is home schooled or who attends another school in the same district could use the SBHC if the SBHC has the capacity to serve the child and the principal/school administrators have made arrangements for building access. This process is addressed in the MOU between the Article 28 sponsor and the school/school district. This is a rare occurrence.

4. If a child is enrolled in one SBHC can they receive services from another SBHC?

This would be a rare occasion but may happen, such as if a child moved to another school/school district. The child may still be enrolled in his/her previous SBHC at the time of his/her initial visit, but would be required to enroll into the new SBHC where he/she currently resides.

5. If a school has both a SBHC and SBHC-D does a child have to be enrolled and sign a consent form for each separately?

If the SBHC-D is collocated with the SBHC, one consent form may be used, but services must be delineated and separate signatures are required for the SBHC and SBHC-D.

6. Does a child need to be enrolled in the SBHC to receive SBHC services?

Children who are not officially enrolled in a SBHC may use the SBHC on a limited basis for such incidents as "first aid visits" or medical emergencies that would otherwise be handled by a school nurse.

Contract/Credentialing

1. Can you please advise what the credentialing criteria is for SBHC's? Do they have a license or operating certificate? Do they need general and professional liability insurance? Are there other criteria we should request from them?

Yes, providers must be licensed and insured. As plans attain accreditation from national bodies such as the National Committee for Quality Assurance (NCQA) and The Joint Commission, standards and some credentialing criteria may differ by plan. Plans will be outreaching to SBHCs directly on their credentialing criteria.

2. Is it correct to state that all SBHCs must be sponsored by an Article 28 facility and some of those Article 28s could also be Federally Qualified Health Centers (FQHC); however, being a FQHC is not a requirement of a sponsoring Article 28 facility?

Yes, it is a requirement that all SBHCs be sponsored by an Article 28 or diagnostic and treatment center approved by the Office of Primary Care and Health Systems Management. Some of the sponsoring agencies are also approved Federally Qualified Health Centers (FQHCs), but this is not a requirement for being a sponsor of a SBHC.

3. Can the State provide the most current list of all the SBHC Article 28 sponsoring facilities, including SBHC-D?

Yes, the Department sent out the most current list of SBHCs sites and Article 28 sponsors to insurance plans as of March 24, 2016.

The link below is the NYS SBHC Sponsor Directory:

http://www.health.ny.gov/facilities/school_based_health_centers

The Link Below is the SBHCs in NYC:

<http://schools.nyc.gov/Offices/Health/SBHC/SBHC.htm>

4. If a SBHC facility is already credentialed by the health plan and provides dental services, is there a need to separately credential the dentists?

Dental providers will need credentialing by the plan, or the plan may delegate this to the provider. If the dentist is currently credentialed for dental they do not need to be re-credentialed.

5. Can the State clarify whether plans must re-credential providers who they have already credentialed or is it permissible to consider the provider credentialed?

Once a provider is credentialed by a plan they do not need to re-credential, but the service profile will need to be updated.

6. Is it the State's expectation that Plans contract with School Based Health Centers that may be administered by non-par hospitals? If a hospital does not contract with the Plan (is not in our provider/hospital network) but does operate a school based health center, would we be required to contract with them only for the school based services?

Yes, plans are required to offer a contract to all Article 28 facility sponsored SBHCs in their service area (and all five boroughs if servicing any part of NYC). Due to federally mandated reimbursement requirements, Federally Qualified Health Centers (FQHCs) may opt out of contracting with plans and would be reimbursed by the State pursuant to DOH's "NYS Managed Care Supplemental Payment Program for FQHCs Policy Document" Plans would not be required to contract with out of network providers for non SBHC services.

7. Some health plans in New York City currently do not contract with hospitals for primary care services. These contracts are limited to subspecialty services. Under these arrangements/systems, the SBHC is not recognized as a specific service. Can the SBHC be recognized under the contract as a specialty service for payment purposes?

SBHCs are considered primary and preventive care and can be a child's primary care provider (PCP). Health plans need to develop a mechanism to reimburse SBHCs even if the SBHC is not the child's PCP and ensure that the contract links appropriately to the plan's billing system.

8. Can the State provide further guidance regarding the requirement that SBHC sponsors contract with MCO subcontractors (for dental and behavioral health) and the SBHC sponsors' acceptance of credentialed BH and dental providers of those entities?

Yes, SBHCs and MCOs will need to ensure that appropriate contracting vehicles are in place if the MCO uses subcontracted benefit managers to ensure continued payment.

9. What is required from a Credentialing perspective, credentialing of the Sponsoring Organization, the site and the individual? Can the highest level in that hierarchy (Organizational Credentialing) be credentialed in lieu of credentialing all individuals within a site?

All practitioners must be credentialed. To the extent that Model Contract obligations are met, delegation (Organizational Credentialing) is acceptable. Nothing additional would be required for the carve-in.

10. Will model language to include the SBHC sites in the Article 28 facility contract modifications be provided?

DOH does not provide model agreements/templates for MCO-Provider contracts, but all agreements must follow the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs, which include Standard Clauses for Managed Care Provider/IPA/ACO Contracts. MCOs may submit template agreements to DOH for approval and use with multiple providers.

11. What is required if current arrangements for payment under the current contract does not include the use of APG or PPS rates?

Plans must pay FFS rate according to policy. This is typically either through APG's or PPS. A contract amendment or new contract would need to spell out the payment methodology.

12. If a FQHC decides to contract with some of the MCOs can they get a higher rate via negotiation that would be larger than the PPS or wrap around rate?

FQHCs are free to negotiate a rate that is higher than the applicable FFS rate. (Note: Plans may choose to, but are not required to accept a higher rate.) The wrap rate will reimburse the FQHC for the amount, if any, that the FQHCs blended Medicaid rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC.

13. Do you know the rules for, “organizational credentialing”? I.e., do Article 28s have to have 100 or more practitioners in order to qualify to do organizational credentialing? Neither SDOH regulations for Article 44 certified Managed Care Organizations (MCOs) nor the Medicaid Managed Care/HIV SNP/Family Health Plan Model Contract (Model Contract) establish “rules for organizational credentialing”. Under regulation (10 NYCRR 98-1.12(k)) and the Model Contract (section 21.4) MCOs serving the Medicaid population must have a formal credentialing/re-credentialing process in place consistent with generally accepted standards and SDOH Recommended Guidelines for Credentialing Criteria. There is nothing to prevent Plans from establishing “rules for organizational credentialing” within their credentialing/re-credentialing processes with respect to what types or size entities they can delegate credentialing/re-credentialing activities. For any delegation of the plan’s obligation to credential its par providers the plan must ensure that the delegate’s credentialing/re-credentialing process is consistent with generally accepted standards and SDOH Guidelines.

14. We have a question regarding whether the health plans could allow SBHCs to contract under their Facility Tax ID, instead of each individual Provider NPI; one of the main concerns we have is that with provider turnover SBHCs could be at risk of losing potential revenue while new providers get credentialed.

Providers need to be individually credentialed. The SBHC transition policy includes provisions for retroactive payment once credentialing is completed.

15. All the sponsoring entities are either hospitals or FQHCs that we already contracted with. We were planning to load the sites and docs, etc. However, we don't list all the SBHC sites in our contracts. They are on the credentialing documents and loaded individually. For hospital contracts, we have language in the contract that states that entities can be added or deleted without amendments. If we proceed in this matter – we won't have each of the SBHC sites listed in contracts, but they will be loaded/credentialed individually for correct payment. Would this be acceptable to the state?

Section VIII(3) of the Policy Paper notes that all SBHC sites will be reflected in the agreements between Plans and Sponsors. Directly listing each site may not be required if language in the contract clearly identifies SBHCs as entities covered by the terms of the contract. Review of specific language used in contracts would be necessary to definitively determine this would be acceptable. The list of individual sites subject to the contract should still be provided to the State for tracking purposes.

16. Do Plans need to contract with all SBHCs?

Plans need to contract with all willing Article 28 Sponsor Facilities and their SBHC sites in the Plan's service area. This includes all of New York City for Plans serving any of the 5 boroughs. For the Sponsor to be considered "willing" both parties must agree to the rates outlined in Section VI of the Policy Paper or mutually accepted alternate rates (see NYS Mainstream Medicaid Managed Care and School Based health Center Billing Guidance). It is acceptable for FQHCs only to refuse to contract with the MCO. If a FQHC identifies they are only willing to contract at a rate higher than what is outlined in Section VI of the Policy Paper and the Plan is willing to contract at the specified rates, but not the rate stated by the FQHC; this would be considered unwillingness on the part of the FQHC. Non-FQHC Sponsors must contract with all Plans that have service areas covering any of their SBHC sites.

17. May plans request the DOH rate letter from the sponsor when contracting?

Yes, health plans may request the DOH rate letter the sponsor has received from DOH.

18. Please clarify the contract amendment language regarding the 90 day notice to providers when there is a change to their contract?

PHL 4406-c(5-c)(a) requires plans to notify a provider 90 days in advance of making a change to a contract that will have an adverse effect on the provider.

19. What is the legal authority that provides FQHCs do not need to contract with plans and governs how they get paid?

See 42 U.S.C. §1396a (bb) and similar language in Section 2807 of the Public Health Law.

Claims and Billing

1. Is the State able to share any data, such as the number of children seen in a SBHC in a given year or the number of SBHC-related encounters?

Yes, the Department can share some billing data that addresses certain encounter data such as well child visits, dental visits, immunizations, and other services that managed care plans collect.

2. Some vendors do not currently have an APG payment system or methodology in place. IT projects are under development and currently will not be able to pay the APG rate. Do plans have a 2-year transition period to complete the IT project? If so, will health plans be required to provide retrospective payment to the providers during the time the APG system is not in place?

The plan must pay the Fee for Service (FFS) rate. This can be achieved either by the APG rate or billing the equivalent of the APG rate. The plan must pay the FFS rate in a timely manner.

3. If an FQHC wants to be paid under an existing dental provider contracted rate, would this be allowed?

Yes. For FQHCs a currently existing contract rate may be used for the SBHC or SBHC-D site.

4. Should we anticipate billing by both individual and facility providers on both UB and 1500 claim forms? Are there any reporting requirements? Are SBHC and SBHC-D claims submitted on professional (HCFA) or facility(UB04) claims forms?

Both professional and facility claims may only be submitted when services are provided by a licensed physician at a hospital-sponsored SBHC site. When services are provided at these sites by other individuals or the sponsor is a D&TC; only the facility claim form is to be submitted.

All claims should be submitted electronically whenever possible.

See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for more information.

5. Will the providers use specific codes (POS, Revenue Codes, etc.) to identify SBHC claims?

See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional coding guidance.

6. Plans would appreciate a process be developed for reimbursement that does not include the plan conducting a reconciliation of claims to prevent duplicate payment for the same service. Is the State's expectation that Plans should deny services as a duplicative claim when services such as a dental cleaning are performed within the same timeframe at another location? (To be cross-referenced with response provided by QI/UM/CC workgroup).

During the transition of SBHC to managed care, it is expected that the provision of SBHC and SBHC-D services to children will be maintained. If the SBHC is billing twice for the same patient on the same day, the claim would be considered duplicative and should be denied. If the claim is for the same service for one patient by a different provider or on a different day, it is not considered duplicative, and must be paid. The MMCP and SBHC will develop a process to share information relating to the provision of services to children.

7. Will FQHC PPS rates be updated prior to 7/1/2018 (the implementation date)?

The most recent version of the rates can be found on the DOH website. The Medicaid FQHC rates, the PPS and the wrap around/shortfall, are posted on the DOH webpage at https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_rates.htm.

8. Will contracted FQHCs who do not participate in APGs bill plans using rate codes or will a crosswalk to CPT codes be published?

No new crosswalk to CPT codes is currently being created.

9. Based on the way 5(c)(ii) is worded, it appears plans are being instructed to deny claim lines related to family planning services when the primary diagnosis for an SBHC office visit is something other than family planning.

The policy paper has been revised since the submission of this question. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

10. Does the PPS wrap mean Plans will pay for all the services and be reimbursed from the State in the wrap-around payment? If so what is the methodology? Is this as a stop-loss reimbursement from the State? Or something additional such as a kick payment?

FQHCs may obtain supplemental payment from DOH beyond the plan's contracted rate to ensure they receive the full PPS rate. This is not stop loss or a kick payment. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

11. Since FQHCs are not submitting separate claims, is the State paying for the shortfall wraparound using encounter data? Or are plans going to have to report this in another way? In addition, in situations where there is a non-APG FQHC-contracted with a plan, plans would need a crosswalk from rate codes to CPT codes if non-APG FQHCs will continue to bill using PPS rate codes for the 2-year transition period.

FQHCs can obtain supplemental payments using existing state processes for contracts under which the plan's payment is less than the FFS rate.

12. What if the MMCP and a SBHC sponsor currently have a negotiated rate for other lines of business and the rate paid is higher than the current applicable Medicaid fee-for-service rate?

The SBHC transition policy does not require an MMCP to reimburse a SBHC sponsor at higher than the FFS rate. However, subject to Departmental approval, MMCPs and Article 28 sponsors may mutually agree to an alternative arrangement that results in reimbursement equivalent to or greater than the FFS rate for SBHC and SBHC-D services.

13. How many plans and their vendors are not set up to bill APGs?

Nearly all plans and vendors are set up to make these payments presently. Currently, only one plan states that its systems are not currently configured to pay utilizing APG rate methodology. A conclusive number of vendors has not been identified at this time.

14. Is it correct to assume that the overview outlined in the attached PowerPoint (Attachment 1. SBHC Billing Overview) allows plans to issue relevant denials when claims are not segregated by these service types?

MMCPs (or vendors where appropriate) should be receiving and adjudicating all submitted claims in accordance with contracted rates, except for visits that include Family Planning Only services. These Family Planning Only claims should be submitted to eMedny. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

15. If a FQHC refused to contract with a MCO how would they get paid?

For medically necessary and Medicaid reimbursable services provided to managed care enrollees that are either unpaid or occur outside a contract between the FQHC and MCO/IPA, the State will reimburse FQHCs at the full FQHC rate under rate codes 4026, 4027 and 4028. Additional information:

http://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_policy_document.htm

16. As per Section VI.5.c.ii of the SBHC transition policy is the State's intent for plans to pay or deny the family planning services in these situations?

See *NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance* for additional claims guidance.

17. In Section VI.3.a of the SBHC transition policy the State refers to the Prospective Payment System (PPS) as a rate, our understanding is that PPS is a payment methodology, the State clarify or provide their intended PPS rate?

The Prospective Payment System (PPS) is a payment methodology. This section of guidance refers to payments being made on claims in an amount equivalent to the payment calculated using PPS methodology.

18. Is Sections VI.3.a-b of the SBHC transition policy mandating plans utilize the PPS rate or are plans permitted to reimburse at a contracted or Medicaid FFS rate after the transition period?

The section referred to does not mandate rate setting following the two year transition period. The inclusion of the term "and thereafter" is in reference to federal requirements that FQHC's be made whole through supplemental payments. This requirement must continue to be met and is pervasive beyond the scope of this transition.

19. Can the State confirm if the MMCP is correct in its below analysis (also attached in PPT) of Sections VI.3.a-b of the SBHC transition policy? See Attachment 5.

See *NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance* for additional claims guidance.

20. Are you saying that the requirements in Section VI.3 of the SBHC transition policy constitute mandates after the transition period? The implication being if currently the MMCP is contracted to pay a FQHC sponsor at the FFS rate are we mandated to now amend our agreement to pay APG or PPS post 6/30/20?

The provided guidance is specific to the two year transition period. Amendments to current agreements for this purpose are not required at this time. Please refer to the above response for question 17.

21. Can the State advise if during the transition period the MMCP is permitted to offer the SBHC the same fee schedule (i.e. FFS) used currently with a FQHC sponsor's agreement?

A currently existing contract rate may be used for the SBHC or SBHC-D site.

An FQHC is entitled to the full FFS rate whether paid in full by the plan or not. When a plan's contracted rate with an FQHC is less than the FFS rate, the FQHC may obtain supplemental payment from DOH to ensure payment of the FFS rate in full.

22. These requirements are only for the transition period and do not constitute any billing requirements after June 30, 2020?

Yes, this is correct.

23. Can mock claims be created and distributed to SBHC providers?

Claims testing is specific to each managed care plan. We encourage each SBHC to work with MMCPs to submit test claims.

24. Where should claims for dental and behavioral health be submitted (to the vendor or plan)?

Claims should be submitted to the payor identified in the contract.

25. If a claim is billed to the managed care plan, with a family plan service code, diagnosis, and the family planning indicator, will the APG software bundle the service or is there an edit that will display on these service codes informing the provider to bill Medicaid FFS?

The claims submission process has been revised since the submission of this question. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

26. What occurs if the claim is billed with the family planning diagnosis and family service code but without the family planning indicator?

The claims submission process has been revised since the submission of this question. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

27. What if the family planning indicator is billed, but the diagnosis code is not a family planning diagnosis code?

The claims submission process has been revised since the submission of this question. See NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for additional claims guidance.

28. What is the UCR rate for service codes not bundled and are billed above the APG?

SBHCs and plans are to follow the APG manual for calculation of claims payment.

29. Further clarification is required as to what constitutes the FFS rate. Can NYSDOH confirm whether this is correct or whether there are other FFS rate schedules for SBHCs?

Please see NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance for a definition of Fee-For-Service.

30. Since 89X does not have an inpatient or outpatient designation, our EDI 837 validation tool may trigger rejects for inbound claims from providers when situational elements which require an inpatient or outpatient designation are needed. I would assume other plans would have similar issues with their EDI validation tools. Has an outpatient or inpatient designation been considered with NUBC?

EDI guidance indicates that since April 1, 2013, 089X is considered outpatient only.

31. Does the State intend plans to configure denials for services rendered at SBHCs/SBHC-Ds that may have service limits?

Plans are required to provide the same scope of services under managed care as is available to FFS recipients, and may issue denials for services that exceed Medicaid program service limits, where such benefit limits exist. Plans and SBHCs/SBHC-Ds must work prospectively to communicate and coordinate necessary care.

32. During a two-year transition period from July 1, 2018 through June 30, 2020 what are the requirements for contracted reimbursement rates for SBHC and SBHC-D providers?

During the two-year transition, the reimbursement responsibility of MMCPs in dependent on contract terms as follows:

For SBHCs, and FQHCs that use APGs, the plan must contract at the APG rate, its equivalent or a mutually agreed to negotiated rate that is not less than the FFS rate.

For FQHCs that opt out of APGs, the plan and FQHC may agree to continue with payments at the current contracted rate or contract at a rate that is not lower than the Medicaid Fee-for-Service (FFS) rate. FQHCs may obtain supplemental reimbursement from DOH using existing processes to ensure receipt of the full FFS rate in any instances where plan payment is less than the FFS rate due to a negotiated or current contract rate.

For additional information, see “New York State Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance” Section III(B).

33. Is the state reimbursing plans based upon encounter data?

Encounter data will not be directly used to reimburse plans. It may be used in the development of rate methodology.

34. Can the State clarify if SBHCs will be billing on a HCFA claim and if so in what circumstances? As per DOH’s reply to question 205.3 in the last Claims & Billing FAQ

it appears that all SBHC claims should be on an institutional or paper UB claim form and not a HCFA form?

For electronic submission of facility claims, use form 837i; for professional claims, use 837p. See “NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance” Section IV for additional details.

35. Has NUBC been approached advising of usage for SBHCs, so designation would not be changed?

See Section IV of “New York State Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance” regarding the use of bill type 089.

36. A plan received a professional claim with multiple lines being billed and multiple primary diagnoses being billed for each line. Only one item contains the z30 diagnosis code as the primary diagnosis. Do we deny the entire claim or only deny the line item that contains the z30 diagnosis so the provider bills the state? If plans are to pay only line items that do not contain z30 diagnosis codes, how will this affect APG billing methodology?

When filling out a professional claim with multiple diagnosis codes, SBHCs must follow procedures identified by the Plan. The procedure recommended by the Claims and Billing Sub-Workgroup is:

- *Use Line 1 of Box 21 on the HCFA 1500 Form or Box L-2300 on the 837p Form to identify the primary diagnosis code for claims submission.*
- *For consistency, this should also be identified as the diagnosis pointer in Line 1 of Box 24 on the HCFA 1500 Form or Box L-2400 on the 837p Form.*

If a Z30 Family Planning Code is listed as the primary diagnosis, the Plan must deny the claim in full and the SBHC should resubmit the claim to the State for Fee-For-Service reimbursement. If the primary diagnosis is not one of these codes, the Plan must pay the entire claim.

37. Can SBHCs bill for the following services:
90882: complex care management
90887: family consultation
96101-96103: psychological testing: various
96110-96111-developmental testing
96116-psychological testing: neuro-behavioral
96118-96119 psychological testing; various

SBHCs can bill for services rendered as listed in the 3M Enhanced Ambulatory Patient Groups Crosswalk (EAPG). A link to this information is included on the Department’s website and can be found at the following address:

<https://dashboard.emedny.org/CrossWalk/html/cwAgreement1.html>.

38. If a SBHC is a FQHC that has not contracted with a plan and services are provided to a plan enrollee, how are claims handled?

The claim must initially be sent to the plan. Upon receipt of a denial of payment, the claim should be sent to eMedNY to receive payment at the PPS rate.

39. Can a SBHC that is not a FQHC submit claims for a plan enrollee when there is no contract between the plan and the SBHC?

No, the SBHC must participate in a contract with the plan to receive payment. The SBHC would not be able to submit bills for Fee-For-Service payment other than permanently carved-out services, such as Family Planning Services.

40. Are there any qualifying provider types, or limits, to providers that can bill for SBHC services? For instance, would a nurse practitioner or physician assistant be reimbursable as well as a physician? Are these services rendered by psychiatrists, psychologists or also by medical physicians or non-clinical professionals such as social workers or counselors?

Qualifying primary care provider (PCP) types are: NP, PA and MD. However, most SBHC visits are performed by a NP or PA. The physician's role in SBHC is usually of the that of a collaborating/supervising nature and not direct provision of care, with the exception of behavioral health, where a psychiatrist may provide direct care. There are currently no limitations on primary care provider PCP visits. For behavioral health (BH) providers, the qualifying provider types include: LCSW, LMSW (if supervised by LCSW, psychologist, or psychiatrist), psychiatric nurse practitioner, licensed psychologist, and psychiatrist. Dentists are the qualifying provider types for dental services.

If the SBHCs are is not the child's individual's primary care provider PCP, the SBHCs currently works to ensure the well-child visits are not duplicative by requesting those records from the child's PCP. primary care providers. It is anticipated that the integration of SBHC and SBHC-D services within the existing managed care framework, and coordination of services with the child's primary care provider, will improve quality and promote an efficient, effective delivery system.

41. What is the State's expectation for how MMCPs should process claims for carved-out services? Should Plans deny these claims as "Bill to Fee-for-Service" or deny as "Non-Covered Service"?

If the service is covered by Medicaid, health plans should deny such claims and bill to Medicaid FFS.

42. Plans request that the State provide a list of family planning codes that would qualify for EOB suppression when the primary diagnosis is not family planning, but where MMC plans will receive claims with these services listed from SBHCs (which will not be paid but must be suppressed on EOB).

To assist in targeting these services, the Department shared a list of family planning procedure and diagnosis codes used in FFS in November 2015.

43. What is the state's look-back plan regarding recouping payment for children who are not-enrolled in the SBHC, if applicable?

Currently, the Department does not recoup SBHC payment for non-enrolled students.

44. Does the SBHC carve-in apply to Child Health Plus (CHP)? If so, will the SBHC bill Medicaid directly for individuals with CHP?

No. Child Health Plus is not a Medicaid program so the carve-in doesn't apply.

45. Can you advise if plans are expected to conduct claims testing with all SBHC providers or is a sampling sufficient?

Claims testing is required for all SBHC sites. If a sponsor submits claims on behalf of their sites, it is acceptable for plans to complete claims testing with the sponsor if the sponsor includes all their sites in the testing.

46. Is it possible to pay for a LCSW counseling claim and a medical claim on the same day? If so, what needs to be done if they are both to be paid for?

FQHCs that are not APG billers would only bill once using the FQHC rate code to the plan or eMedNY as appropriate. The one code would incorporate all of the covered services including the LCSW and medical services. A separate fee would not be paid for the LCSW counseling. If the SBHC is a FQHC non-APG biller and the primary reason for the visit is family planning, bill one claim to NYS via eMedNY. If the SBHC is a FQHC non-APG biller and the primary reason for the visit is not family planning, bill one claim to the plan.

All sites billing using APG methodology would submit a separate claim for the LCSW/LMSW counseling service because this counseling claim extends beyond the threshold for the APG clinical visit grouper. The medical services would be billed using appropriate codes while the counseling service would be claimed using rate code 3257, 3258, or 3259. The use of modifiers 25 and 59 would be included as appropriate. The medical claim would still be directed either to the plan or eMedNY depending on whether the primary diagnosis is family planning. The counseling claim is always sent to the plan.

47. If a multi-line HCFA claim contains Z30 as a primary diagnosis on any line, but other claim lines contain a valid primary diagnosis, the entire claim should be denied? Is it denied as 'Non-Covered Service' or 'Diagnosis Not Covered'?

When filling out a professional claim with multiple diagnosis codes, SBHCs must follow procedures identified by the Plan. The procedure recommended by the Claims and Billing

Sub-Workgroup is: 1) Use Line 1 of Box 21 on the HCFA 1500 Form or Box L-2300 on the 837p Form to identify the primary diagnosis code for claims submission. 2) For consistency, this should also be identified as the diagnosis pointer in Line 1 of Box 24 on the HCFA 1500 Form or Box L-2400 on the 837p Form. If a Z30 Family Planning Code is listed as the primary diagnosis, the Plan must deny the claim in full and the SBHC should resubmit the claim to the State for Fee-For-Service reimbursement via eMedNY. If the primary diagnosis is not one of these codes, the Plan must pay the entire claim.

48. If MMCPs do not credential Physician Assistants (PAs), how are services provided by PAs at SBHC's billed?

Currently, PAs bill under a licensed physician.

49. Is the expectation the Article 28 facility will be submitting claims to the plans (rather than the SBHC sites/providers)? And subsequently plans will reimburse the Article 28 facility?

The contracted entity will submit claims to the plans. The contracted entity is usually the Article 28 facility rather than the SBHC site. The claims testing process will identify whom will submit the claims to the plans.

OI/UM/Care Coordination:

1. SBHCs that do not offer behavioral health and/or reproductive health services on-site in the SBHC are required to provide referrals. What does the State mean by referral? Referral to another SBHC site or to a BH provider?

It is a requirement that SBHCs provide access to behavioral health services and reproductive health services. If the SBHC site does not offer these services on-site, the student must be referred for such services. This referral can be made to another provider in the community or another SBHC site that offers such services.

2. Does the State have any age range for the eligible population for (enrollment in) SBHC services?

School-aged children up to 21 years of age are eligible for SBHC enrollment.

3. Under MMC if a MD or an NP is listed as a PCP in their system then the MMC assigns a panel of patients to that provider. How would these panels be handled since we can only see students who are enrolled in the SBHC?

Plans will need to ensure that they prevent PCP assignment to their members who are NOT enrolled in the SBHC. Students enrolled at a SBHC may choose any plan-credentialed PCP.

4. If a SBHC provider is not the PCP for a child and they need to make a referral can the SBHC provider make the referral or should they send the patient back to the plan for the referral?

Most health plans will accept an in-network referral made by a SBHC. But in some cases, a plan may require referrals be made by the child's PCP. Health plans will need to work with and educate SBHC providers on the required referral process for their plan.

5. Could you provide clarification for references in the Transition Policy document in Section VII Confidentiality regarding the suppressing EOBs / denial notices but yet sending notice of adverse action (Fair Hearing). This statement seems contradictory, as we generally include the Fair Hearing notice with the EOBs/ denials. Who should these notices be addressed to since the member will be a minor?

The Policy Paper does not state that a notice must be sent for every adverse action. The Policy Paper states the plan should adhere to OHIP's "Policy for the Protection of Confidential Health Information for Minors Enrolled in NYS Medicaid Managed Care Plans" (Suppression Policy). Notices not subject to the Suppression Policy would be sent in accordance with the Medicaid/Family Health Plus/HIV SNP Model Contract and standard procedures the plan utilizes to comply with prevailing confidentiality requirements.

6. For SBHCs that do not offer behavioral health and/or reproductive health services on-site in the SBHC that are required to provide referrals: what if the member is referred out-of-network?

Any reproductive health services deemed family planning services are carved out of SBHC services with open access available. For other reproductive health services and behavioral health services, managed care plans are expected to provide information to SBHCs about in-network service options that are covered in order to prevent out-of-network service referrals. Out-of-network referrals should only be made when there are no identified in-network providers able and available to provide the medically necessary service. Prior authorization from the managed care plan is required for any out-of-network service provision. Out-of-network referrals must be coordinated with the plan and must be addressed in the contract between the plan and provider.

7. What Member and Provider communication/notification should health plans send to the members/providers regarding the SBHC implementation?

The Department develops templates for plan member handbooks and benefit notification letters. Plans obtain DOH approval for member educational materials and will distribute approved documents to their members with the necessary information. Plan websites will also be updated to provide information regarding the SBHC implementation.

8. Will the state provide Plans with a list of all the services that will require prior authorization, besides dental and behavioral health services?

The SBHC transition policy describes services for which plan may not require prior authorization. Plans are responsible for notifying participating providers which services will require prior authorization as per the plan's policies (and in accordance with applicable law, regulation and Medicaid managed care program requirements).

9. Can a Plan host dental day at SBHC facilities? If so, is there an approval process for vendor of choice, such as Hello Smile, that can be used?

If the SBHC has a dental provider in place already, this could be an issue. As the Department of Education would require these services to be open to all children in a given population, limits based on coverage for the children cannot be applied. A provider could limit participants based on other reasonable parameters like age or grade level. The SBHC would need to meet requirements for an SBHC-D as a separate consent is required for dental services from that for other SBHC services.

10. If my child is enrolled in the SBHC can they still keep their primary care provider (PCP), or are they required to use the SBHC as their PCP?

Children who are enrolled in the SBHC can continue to keep their PCP and are eligible to seek health care services from the SBHC, as well. In some instances, the SBHC may become the child's PCP at the child's parent or guardian's request.

11. The policy paper mentions that "SBHCs will be listed as approved sites for care in MMCP provider directory and promotional materials." Can the State confirm the final decision regarding how SBHCs will be listed in the plans' provider directories given that these centers are only open to students attending the school? Plans have requested the ability to just list the SBHC sites (rather than the individual providers offering services in those sites) in their directories. It has been our understanding that there is flexibility here (depending on whether credentialing will occur at the provider or facility level and whether any of the SBHC providers are already contracted with the plan to serve outside the SBHC). Will the State provide guidance on the language requirements?

Yes, the state will be issuing guidance on provider directory language.

12. Will there be a change to the member handbook? Will the State provide a template/verbiage to incorporate in the Member Handbook for these new carve-in benefits?

Yes, the state will be providing guidance on the Member Handbook updates.

13. Can the state confirm if nutritional services are covered under the SBHC benefit?

Under the Medicaid Managed Care Carve In, nutritional services included in the state plan benefit package are covered. These are considered expanded services and may not be available at all SBHC sites. See “Principles and Guidelines for School Based Health Centers in New York State” Section II(A)(4)(c) for more information.

14. Is group dietary counseling covered by Medicaid?

This is not included in the state plan benefit package.

15. If nutritional services are considered an enhanced service, would they potentially be subjected to prior authorization?

No. Students will have direct access to all services provided by the SBHCs and SBHC-D without the need for referral or prior authorization, except certain dental and behavioral health services as specified in the policy paper under Sections II(2)(a) and II(2)(b).

16. Are “restorative procedures, limited periodontics, prosthodontics, oral and maxillofacial surgery and orthodontics” as quoted in the policy paper considered enhanced services possibly requiring prior authorization?

The SBHC-D benefit includes Medicaid covered dental services. MMCPs may not require prior authorization for routine preventive services, such as: sealants, fillings, fluoride treatments, simple extractions (which includes the elevation and/or forceps removal of an erupted tooth or an exposed root) and cleanings provided in SBHC-D sites. More extensive care such as endodontics and oral and maxillofacial surgery are not considered enhanced services as they are included in the Medicaid dental benefit, however, MMCPs may require that SBHCs obtain prior authorizations for this more extensive care.

17. Will providers need to supply additional data reporting, beyond claims data, starting on 7/1/18 and will this be required as part of a provider contract?

The standard clauses for MCO–Provider contracts include provisions that requires the provider to "...comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or DFS guidelines or policies...", including "quality improvement/management" and "reporting of clinical encounter data." To the extent that plans need additional data beyond clinical encounter data from provider claims to meet quality improvement and management reporting requirements, providers will need to provide the data or provide access to the plans to such data, depending on specific terms of the contract.

18. A) School Districts generally pay for developmental testing. Will Plans be required to cover developmental testing? If so, please provide the service descriptions/definitions and the behavioral health procedures codes and rates for Development Testing and for “Intensive Psychiatric Treatment”.

B) Will the State provide a letter template to notice members of this new carve in benefit? If so, when?

Section II(2)(b)(ii) of “Transition of School Based Health Center Benefit and Population into Medicaid Managed Care” states: “MMCPs may require prior authorization for more extensive evaluation and treatment services such as psychological testing, neuropsychological testing, developmental testing, and intensive psychiatric treatment. SBHC programs that provide these additional services under their sponsor’s Article 28 license should consult with MMCPs and/or the MMCPs’ behavioral health benefit vendors for plan-specific requirements.”

19. With the upcoming BH carve-in for children scheduled for 7/1/2017 how will the BH services for kids who are SSI, be part of the services for SBHC implementation?

Information on the Children’s Medicaid System Transformation is available on the Department’s website at:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/child_mrt.htm. This carve in is now effective 7/1/18. The carve in is not related to a child’s SSI status, but seeks to expand services available to children who currently receive Home and Community Based Services (HCBS) under six 1915(c) waiver programs by moving the waiver services to State Plan or the 1115 MRT Waiver. This transition will also carve in certain BH services for enrollees under 21 years old. Providers must be designated by the State to provide the new children’s HCBS or new children’s State Plan services. See https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/provider_design.htm for more information.

Once the SBHC carve in is effective, Medicaid Managed Care Plans are responsible for reimbursing SBHCs for covered services that are provided under the SBHC’s certification and Article 28 license AND are included in the Medicaid Managed Care Benefit Package, as per the SBHC transition policy.