School-Based Health Center (SBHC) Transition to Medicaid Managed Care FAQs

History and Process

1. What enrollee communications should Medicaid managed care plans (MMCPs) send regarding the SBHC implementation?
    a. The Department of Health (DOH, the Department) develops templates for MMCP member handbooks and benefit notification letters. MMCPs must distribute these notices to every plan enrollee 30-days prior to implementation. MMCP websites will also be updated to provide information regarding the SBHC implementation.
2. In the past there was to be a pilot program prior to implementation- why is that not being considered at this time?
    a. The limited timing of the implementation, April 1, 2025, did not allow for a pilot program to be considered.
3. Why is the benefit being implemented in the middle of the school year?
    a. April 1 is the start of the New York State Fiscal Year.
4. How will the MMCP know which enrollees are part of an SBHC and in need of member notices?
    a. Member notices will be sent by the MMCP to every enrollee in the plan, regardless of whether they are currently enrolled in an SBHC.

SBHC Enrollment

1. How does a child/adolescent enroll in an SBHC?
    a. A child/adolescent is enrolled in an 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 Department's expectation of the MMCP's role in the SBHC enrollment process?
    a. MMCPs do not have a role in enrolling children/adolescents in the SBHC.
3. Can a child/adolescent enroll in an SBHC if they do not attend that school?
    a. A child/adolescent can be enrolled in an SBHC if the student lives in the school district. For example, a child/adolescent 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 them, and the principal/school

administrators have made arrangements for building access. This process is addressed in the Memorandum of Understanding (MOU) between the Article 28 operator and the school/school district.

4. If a child/adolescent is enrolled in one SBHC, can they receive services from another SBHC?
    a. This is possible but is a rare occurrence. The operator should contact the DOH program manager for allowability and reporting requirements.
5. If a school has both an SBHC and SBHC-D, does a child/adolescent have to be enrolled and sign a consent form for each separately?
    a. 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/adolescent need to be enrolled in the SBHC to receive SBHC services?
    a. Children/adolescents who are not officially enrolled in an 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.
7. Does the Department have any age range for the eligible population for (enrollment in) SBHC services?
    a. School-aged children/adolescents up to 21 years of age are eligible for SBHC enrollment. If the school district offers a preschool program, enrollees as young as preschool age can get care at the SBHC.

Coordination of Care

1. The SBHC transition paper states that SBHCs that do not offer behavioral health and/or family planning and reproductive health services on-site in the SBHC are required to provide referrals for those services. What does the Department mean by referral? Referral to another SBHC site or to a provider?
    a. It is a requirement that SBHCs provide access to behavioral health services and family planning and reproductive health services. If the SBHC 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. Under Medicaid managed care (MMC), if a provider is listed as a Primary Care Provider (PCP) in their system, then the MMCP 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?
    a. MMCPs will need to ensure that they prevent SBHC providers from being assigned to their enrollees who are NOT enrolled in the SBHC. Students enrolled at an SBHC may choose any MMCP-credentialed PCP.

3. If an SBHC provider is not the PCP for a child/adolescent 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?
    a. Most health plans will accept an in-network referral made by an SBHC. In some cases, a plan may require referrals to be made by the child/adolescent's PCP. MMCPs need to work with SBHC providers to educate them on the required referral process for their plan.
4. Can SBHCs refer enrollees out-of-network when they do not provide a service on-site?
    a. MMCPs 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 MMCP is required for any out-of-network service provision. Out-of-network referrals must be coordinated with the MMCP and must be addressed in the contract between the MMCP and provider. Family planning and reproductive health services may be accessed in-network or from any qualified Medicaid provider of the enrollee's choice. No referral from a PCP or approval by the plan is required to access family planning and reproductive health services.
5. Can a child/adolescent that is enrolled in an SBHC still keep their PCP or are they required to use the SBHC as their PCP?
    a. Children/adolescents who are enrolled in the SBHC may keep their PCP and are also eligible to seek health care services from the SBHC. In some instances, the SBHC may become the child/adolescent's PCP at the request of the parent or guardian.
6. Can the Department confirm if nutritional services are covered under the SBHC benefit?
    a. Under the MMC 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 Section II(A)(4)(c) of the *Principles and Guidelines for School Based Health Centers in New York State* document for more information.
7. If nutritional services are considered an enhanced service, would they potentially be subject to prior authorization?
    a. No. Students will have direct access to all services provided by the SBHC and SBHC-D without the need for referral or prior authorization, except certain dental services as specified in the *Transition of School-Based Health Center Benefit and Population into Medicaid Managed Care* policy paper under section II(2)(a).

8. School districts generally pay for developmental testing. Will MMCPs be required to cover developmental testing? If so, please provide the service descriptions/definitions and the behavioral health procedure codes and rates for development testing and for 'Intensive Psychiatric Treatment'.
    a. SBHC programs that provide these additional services under their Article 28 operator's license should consult with MMCPs and/or the MMCP's behavioral health benefit vendors for plan-specific requirements.
9. If an MMCP denies the school-based service, is there a statute our practice can use for appeal?
    a. Appeal rights apply and instructions are provided in an Initial Adverse Determination.

Confidential Services

1. How will billing for family planning and reproductive health care be managed?
    a. Family planning and reproductive health services are included in the MMC benefit package and must be billed to the MMCP accordingly.
2. Will billing information be sent to enrollees at home?
    a. No. MMC enrollees do not receive a bill or Explanation of Benefits (EOB).
3. The child/adolescent may not want their PCP to know that they are sexually active- can that information be protected?
    a. MMCPs are required to comply with the *Policy for the Protection of Confidential Health Information for Minors Enrolled in NYS Medicaid Managed Care Plans*.
4. Without a carve-out of family planning, if our operator does not have a contract with an MMCP, we will still not be able to apply for the Family Planning Benefit Program, so how will we get paid?
    a. MMC enrollees have "free access" to family planning and reproductive health services. Free Access means MMC enrollees may obtain family planning and reproductive health services, as well as HIV testing and pre- and post-test counseling when performed as part of a family planning and reproductive health encounter, from either the MMCPs in-network provider or qualified Medicaid health care provider of the enrollee's choice. No referral from the PCP or approval from the plan is required to access such services. SBHCs would bill Medicaid fee-for-service in this scenario.
5. What will the reimbursement be for mental health services? How do we ensure confidentiality?
    a. MMCPs 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 MMC benefit package. MMCPs should adhere to the Department's *Policy for the Protection of Confidential Health Information for Minors Enrolled in NYS Medicaid Managed Care Plans.*

Claims and Billing

1. If a Federally Qualified Health Center (FQHC) wants to be paid under an existing dental provider contracted rate, would this be allowed?
    a. Yes. For FQHCs, a currently existing contract rate may be used for the SBHC or SBHC-D site.
2. 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?
    a. Both professional and facility claims may only be submitted when services are provided by a licensed physician at a hospital operated SBHC site. When services are provided at these sites by other individuals or the operator is a diagnostic and treatment center, 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.
3. Will the providers use specific codes (POS, Revenue Codes, etc.) to identify SBHC claims?
    a. See *NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance* for additional coding guidance.
4. Is it the Department's expectation that MMCPs should deny services as a duplicative claim when services such as a dental cleaning are performed within the same timeframe at another location?
    a. During the transition of SBHC to managed care, it is expected that the provision of SBHC and SBHC-D services to students will be maintained. If the SBHC is billing twice for the same enrollee on the same day, the claim would be considered duplicative and will be denied. If the claim is for the same service for one enrollee 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/adolescents.
5. Will FQHC Prospective Payment System (PPS) rates be updated prior to implementation?
    a. Rate updates can be found on the DOH website, which is updated quarterly to reflect any rate changes. The Medicaid FQHC rates, including the PPS and the wrap around/shortfall, are posted on the DOH website here.
6. What is a PPS wrap payment?
    a. FQHCs may obtain supplemental payment from the Department 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.

7. Will contracted FQHCs who do not participate in APGs bill MMCPs using rate codes or will a crosswalk to CPT codes be published?
    a. FQHCs should follow contractual billing guidance.
8. Since FQHCs are not submitting separate claims, is the State paying for the shortfall wrap-around using encounter data? Or are plans going to have to report this in another way?
    a. FQHCs can obtain supplemental (wrap) payments using the existing state processes for rate code 1609.
9. If an FQHC refused to contract with an MMCP, how would they get paid?
    a. Please refer to the *Transition of School-Based Health Center Benefit and Population into Medicaid Managed Care* policy paper.
10. Can the Department clarify what the Prospective Payment System (PPS) is?
    a. The Prospective Payment System (PPS) is a payment methodology for FQHCs paid under a specific rate code in Medicaid FFS. The PPS rates are provider specific and are published on the DOH website at: https://www.health.ny.gov/health_care/medicaid/rates/fqhc/fqhc_rates.htm.
11. Does the SBHC transition policy mandate that plans utilize the PPS rate or are MMCPs permitted to reimburse at a contracted or Medicaid FFS rate after the transition period?
    a. Please see the updated *Transition of School-Based Health Center Benefit and Population into Medicaid Managed Care* policy paper. For SBHCs/SBHC-Ds operated by Article 28 FQHCs, MMCPs must reimburse pursuant to the contract in place.
12. Can the Department advise if during the transition period the MMCP is permitted to offer the SBHC the same fee schedule (i.e. FFS) used currently with an FQHC operator's agreement?
    a. 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 the State to ensure payment of the FFS rate in full.
13. Can mock claims be created and distributed to SBHC providers?
    a. Claims testing is specific to each MMCP. The SBHC should work with MMCPs to submit test claims.
14. Where should claims for dental and behavioral health be submitted (to the vendor or plan)?
    a. Claims should be submitted to the payor identified in the contract between the MMCP and the SBHC.
15. Can the Department clarify what is meant by the Medicaid FFS rate?
    a. Please see the *NYS Mainstream Medicaid Managed Care and School Based Health Center Billing Guidance* for a definition of Fee-For-Service.

16. Does the Department intend MMCPs to configure denials for services rendered at SBHCs/SBHC-Ds that may have service limits?
    a. Plans are required to provide the same scope of services under managed care as is available to Medicaid FFS recipients and may issue denials for services that exceed Medicaid program service limits, where such benefit limits exist. MMCPs and SBHCs/SBHC-Ds must work prospectively to communicate and coordinate necessary care.
17. During a two-year transition period what are the requirements for contracted reimbursement rates for SBHC and SBHC-D providers?
    a. Please see section III(B) of the *NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance*.
18. 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?
    a. SBHCs can bill for primary health, mental health, social, health education, and dental services rendered in accordance with the *Principles and Guidelines for School-Based Health Centers in New York State* using the appropriate Medicaid-assigned FFS APG rate codes, and procedure codes listed in the Solventum Health Information Systems [formerly known as 3M Health Information Systems (3M) Ambulatory Patient Groups Crosswalk (EAPG)]. A link to this information is included on the Department's website here: https://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm
19. Can an SBHC that is not an FQHC submit claims for an MMCP enrollee when there is no contract between the plan and the SBHC?
    a. No, the SBHC must participate in a contract with the MMCP to receive payment. The SBHC would not be able to submit bills for Medicaid FFS payment other than family planning and reproductive health services obtained through the free access policy.
20. Are there any qualifying provider types, or limits to providers that can bill for SBHC services?
    a. SBHC Article 28 clinics may bill MMCPs for services that are rendered by a NYS Medicaid recognized/enrolled provider type and included in the Medicaid managed care benefit package. For more information, visit the following site: Provider Enrollment.
21. Does the SBHC carve-in apply to Child Health Plus (CHP)? If so, will the SBHC bill Medicaid directly for individuals with CHP?
    a. No. Child Health Plus is not a Medicaid program so the carve-in does not apply.

22. Can you advise if MMCPs are expected to conduct claims testing with all SBHC providers or is a sampling sufficient?
    a. Claims testing is required for all SBHC sites. If an operator submits claims on behalf of their sites, it is acceptable for MMCPs to complete claims testing with the operator if the operator includes all of their sites in the testing.
23. Is it possible to pay for a licensed clinical social worker (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?
    a. Please see section VI of the *NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance*.
24. If MMCPs do not credential Physician Assistants (PAs), how are services provided by PAs at SBHCs billed?
    a. Currently, PAs bill under a licensed physician.
25. Is the expectation that the Article 28 facility will be submitting claims to the MMCPs (rather than the SBHC sites/providers)? And subsequently MMCPs will reimburse the Article 28 facility?
    a. 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 MMCP.
26. Will students/families have to pay co-pays?
    a. There are no co-pays or deductibles in Medicaid managed care.
27. If a patient has a non-participating MMCP and is seen for school-based treatment, can the services be billed to Medicaid?
    a. See section III of the *Transition of School Based Health Center Benefit and Population into Medicaid Managed Care* policy paper.
28. Are we able to wrap an SBHC encounter if it meets the FQHC criteria?
    a. Article 28 FQHCs participating in the Supplemental Payment Program should submit eligible SBHC claims to rate code 1609.

Contracts/Credentialing

1. Can you please advise what the credentialing criteria is for SBHCs? Do they have a license or operating certificate? Do they need general and professional liability insurance? Are there other criteria MMCPs should request from them?
    a. 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. MMCPs 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 FQHCs, however, being an FQHC is not a requirement of a sponsoring Article 28 facility?
    a. 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 operating agencies are also approved FQHCs, but this is not a requirement for being an SBHC operator.
3. Can the Department provide the most current list of all the SBHC Article 28 operating facilities, including SBHC-D?
    a. The Department shared an updated list of SBHC sites and the Article 28 operators via email with MMCPs on October 30, 2024. The most current list of SBHC Operator sites can be found here: sponsor directory.pdf. The most current SBHC-D Operator Directory can be found here: SBHC Dental Provider Directory 2023.
4. If an SBHC facility is already credentialed by the MMCP and provides dental services, is there a need to separately credential the dentists?
    a. Dental providers will need credentialing by the MMCP, or the MMCP 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 MMCPs must re-credential providers who they have already credentialed or is it permissible to consider the provider credentialed?
    a. Per Section 21.4 of the *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Model Contract),* MMCPs must re-credential participating providers a minimum of once every 3 years. The Department is not requiring that providers be re-credentialed more frequently than as outlined in the Model Contract. However, the service profile will need to be updated.
6. Is it the Department's expectation that MMCPs contract with SBHCs that may be administered by non-par hospitals? If a hospital does not contract with the MMCP (is not in our provider/hospital network) but does operate an SBHC, would we be required to contract with them only for the school-based services?
    a. Yes, MMCPs are required to offer a contract to all SBHCs operated by Article 28 facilities in their service area (and all five boroughs if servicing any part of New York City). Due to federally mandated reimbursement requirements, FQHCs may opt out of contracting with plans and would be reimbursed by the State pursuant to the *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 MMCPs 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?

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

8. Can the Department provide further guidance regarding the requirement that SBHC operators contract with MMCP subcontractors (for dental and behavioral health) and the SBHC operators' acceptance of credentialed behavioral health and dental providers of those entities?
   a. Yes, SBHCs and MMCPs will need to ensure that appropriate contracting vehicles are in place if the plan 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?
   a. 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?
   a. The Department 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 the Department 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?
   a. MMCPs must pay the Medicaid FFS rate according to policy. Please refer to the *NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance* for additional information.
12. If an FQHC decides to contract with some of the MMCPs, can they get a rate via negotiation that would be larger than the PPS or wrap around rate?
   a. Please refer to the *NYS Mainstream Medicaid Managed Care and School-Based Health Center Billing Guidance*.
13. What are 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?
   a. Neither DOH regulations for Article 44 certified Managed Care Organizations (MCOs) nor the 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 DOH 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 DOH guidelines.

14. Can MMCPs allow SBHCs to contract under their Facility Tax ID, instead of each individual Provider NPI?
    a. Providers need to be individually credentialed. The *Transition of School-Based Health Center Benefit and Population into Medicaid Managed Care* policy paper includes provisions for retroactive payment once credentialing is completed.
15. May MMCPs request the DOH rate letter from the operator when contracting?
    a. Yes, MMCPs may request the rate letter the operator has received from the Department.
16. Please clarify the contract amendment language regarding the 90-day notice to providers when there is a change to their contract.
    a. 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.

Technical Assistance and Support

1. Will SBHCs be receiving support when they receive denied claims? Who can SBHCs contact for this support/help?
    a. The SBHC should contact the MMCP's provider relations representative. If no resolution is received, the SBHC may submit a complaint to the Bureau of Consumer Services at managedcarecomplaint@health.ny.gov.
2. Will there be a specific point of contact delegated at each MMCP to address SBHC questions?
    a. The Department provided SBHCs with a list of designated points of contact at each MMCP for billing, benefit, and contracting questions.

Dental

1. Frequency-based denials are a huge concern for dental- how can we ensure patients will not be sent EOBs with patient responsibility and how will that affect us receiving at least the PPS rate?
    a. MMCPs do not issue EOBs. In addition, Medicaid beneficiaries cannot be billed for Medicaid covered services. If the MMCP denies the claim, the SBHC will not be paid; however, this decision can be appealed.
2. Will contracting be required for SBHC-Ds that are operated by Academic Dental Center clinics?
    a. MMC enrollees may self-refer to an academic dental center. Consistent with Chapter 697 of Laws of 2003 amending Section 364-j of the Social Services Law, dental services provided by Article 28 clinics operated by academic dental centers may be accessed directly by MMC enrollees without prior approval and without regard to network participation. The MMCP may require prior approval for orthodontic treatment by academic dental centers.
3. Could you explain 4028 for the SBHC-D providers and if we are eligible for this funding?
    a. FQHCs bill eMedNY directly for supplemental payment for services provided to MMCP enrollees that would otherwise qualify under Medicaid FFS rules for payment at one of the FQHCs three Medicaid FFS rate codes – 4011, 4012 or 4013. For managed care visits that are either unpaid or occur outside of a contract between the FQHC and MCO/IPA, the State will reimburse FQHCs at the full FQHC rate under rate codes 4026, 4027 or 4028. Please see the *NYS Managed Care Supplemental Payment Program for FQHCs Policy Document* for further information.
4. Can you please define SBHC-D? We provide services in a Dental van; how will we be impacted by this update?
    a. The transition incorporates SBHC-D services including those provided within a school building or campus (i.e. Mobile Vans).

Private Insurance

1. Will private insurance be able to be billed? If yes, will their co-pay be waived?
    a. No, if a child/adolescent has comprehensive third-party health insurance, they are not eligible to enroll in Medicaid managed care.