Frequently Asked Questions Regarding Billing Updates for Children's HCBS, CFTSS, and 29-I OLHRS

Effective December 1, 2023, NYS is implementing a billing change that will allow claims for Children's Home and Community Based Services (HCBS), Article 29-I Health Facility Other Limited Health-Related Services (OLHRS), and Children and Family Treatment Support Services (CFTSS) to be paid based on the county in which services were provided, rather than a provider's corporate headquarters or central office address. This update is necessary to align with the Centers for Medicare and Medicaid Services (CMS) billing requirements, which dictate that services must be reimbursed based on the location of service delivery.

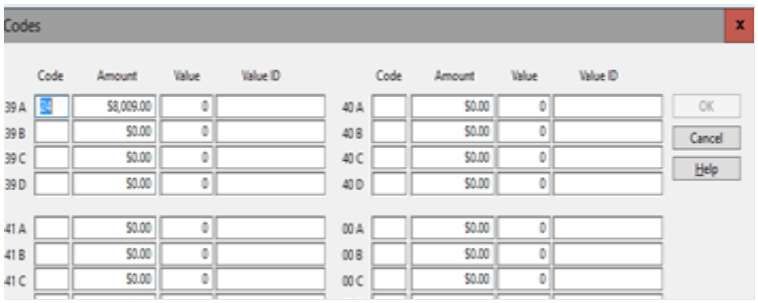
1. Is the FIPS table within the guidance final?
    - **Answer:** Yes, guidance and billing codes linked below
    - 2023-09-05_bill_req_update_member.pdf (ny.gov) and
    - cftss-hcbs_kids_fips.pdf (ny.gov)

2. If the provider does not bill the FIPS Code/County Locator Code, is it appropriate to deny claims?
    - **Answer:** Yes, for claims with date of service on or after 12/1/2023.

3. Is the requirement stating that providers must submit claims with the appropriate Value Code + applicable FIPS Code/County Locator Code and MMCPs are to accept claims? OR is the requirement stating that providers must submit claims with the appropriate Value Code + applicable FIPS code/County locator code and MMCPs are to 1) accept the claims and 2) price the claims according to the location as defined by the applicable FIPS code/county locator code.
    - **Answer:** MMCPs will have to accept electronic claims with Value Code 85 + appropriate FIPS code AND paper claims with Value code 61 + appropriate County Locator Code and pay the provider the correct amount for the county in which services were rendered to the child. The state has different regional amounts (upstate/downstate) for each CFTSS, HCBS, and some 29-I OLHRS. Plans will have to ensure the appropriate amount is paid to the provider based on the new FIPS/County Locator Code used on the claim.

4. How is onsite/offsite billing for CFTSS impacted by this billing update?
    - Answer: Services provided will now be reimbursed at the correct amount based upon where they are rendered vs. the previous reimbursement method which was based upon the county of the provider's administrative office.

5. Value code boxes- which boxes are acceptable for codes?
    - **Answer**: **When billing electronically** - Value code 24 and the rate code are to be entered in field 39A; the rate code is input into the amount field. Value code 85 and the FIPS code are to be entered in field 40A; the 5-digit FIPS code is input into the amount field. **When billing paper claims** - Value code 24 and the rate code are to be entered in field 39A; the rate code is input into the amount field. Value code 61 and the county locator code are to be entered in field 40A.



6. Please identify what changes will be necessary for the MMCPs to bill the State for services that are carved out. Please clarify if the changes differ from how MMCPs will receive claims and need to reimburse providers.
    - **Answer:** MMCPs will have to send electronically or on paper the same Value Codes and FIPS or county locator codes that the billers have claimed to your Plan in order to be reimbursed by NYS.

7. Why is there a need to have a separate process for paper vs electronic claims?
    - **Answer:** The coding varies based on paper or electronic billing due to eMedNY system limitations.

8. If a claim for these services is received without a FIPS code, what is the expectation for payment? Pay based on the provider's corporate address, like is currently occurring? Or deny the claim and request a rebill with the FIPS code?
    - **Answer**: MMCP Claims: that do not include the required FIPS/County Locator Code should be denied by MMCPs for dates of service on or after 12/1/2023.
      Fee-for-Service (FFS) Claims: eMedNY is configured to deny FFS claims that lack this information for dates of service on or after 12/1/2023.

9. MMCPs expressed they will require 90 days to implement configuration changes. We recommend the State revisit the implementation date.
    - **Answer:** This change was discussed at various meetings with MMCPs and Providers in August of 2023 and MMCPs were formally notified on September 5, 2023. The implementation date will not be changed.

10. How are claims that are being readjusted for dates of service before 12/1/23 that may not include the 85/61/FIPS coding to be handled?
    - **Answer:** If a claim is submitted for dates of services prior to 12/1/23 current coding should be utilized. For dates of services on or after 12/1/2023, claims require the FIPS/County locator code information, otherwise the MMCPs should deny the claim.

11. What LOBs does this apply to? CHP? MMC?
    - **Answer:** This billing update is for Medicaid Managed Care Plans including Mainstream Managed Care and HIV Special Needs Plans as well as Fee-for-Service Medicaid.

12. What is the impact of this billing update on pass through payments for HCBS?
    - **Answer:** MMCPs will need to include applicable FIPS/County Locator Codes on their pass-through claims in order to receive payment.

13. What impact will this have on MMCOR reporting and what changes if any can we expect?
    - **Response:** The MMCOR collects data at the service category level and does not differentiate billing locations. Therefore, this billing update will not impact MMCOR reporting.

14. Currently we are reimbursing payments on Value and Rate codes. Once this goes into effect, we also have to reimburse to include the 85/61/FIPS coding. This creates some challenges in the amount needing to be configured in the timeframe before go live 12/1/23. *For example: Providers that serve multiple areas will have to be configured in our system with multiple codes and reimbursement rates. We would request 90 days to go live once we have received the full requirements to allow for system configuration, testing, and provider education to decrease the amount of abrasion.*
    - **Answer:** MMCPs continue to be required to pay claims based on Value and Rate Codes. This change simply changes the Value Code used for electronic claims to ensure the rate is paid based on where the service was rendered versus where the billing providers corporate headquarters is located. MMCPs have been given 90 days to configure their systems for this change. There is no additional coding required, and the process is the same.

15. Why is the FIPS code being required?
    - **Answer**: This update is necessary to align with the Centers for Medicare and Medicaid Services (CMS) Medicaid billing requirements, which dictate that services must be reimbursed based on the location of service delivery, instead of a provider's corporate headquarters or central office. The FIPS/County Locator Code allow providers to indicate the location of service delivery, which will trigger systems to pay providers accordingly.

16. Within Children's HCBS services, for Palliative Care – Counseling and Support Services:
    - Our understanding of the additions to this benefit, based on the guidance, are that the HCBS provider bills Rate Code 7952 (Bereavement – Assessment/Counseling) and rate Code 8017 (Palliative Care – Counseling and Support Services) and that the Health Home bills Rate Codes 7946-7951 (Bereavement Services). Is this correct?
        - **Answer:** Yes. Health Home claims for this service on or after 12/1/23 must include the appropriate FIPS/County Locator code.
    - If this is correct, are we also correct in assuming that Rate Code 7952 would be subject to the use of the FIPS code? And that Rate Codes 7946 – 7951 would not? Rate Codes 7946 – 7951 already have separate Upstate and Downstate codes outlined in the Billing Manual, and because these are billed by Health Homes, we were assuming that these <u>would not</u> be subject to usage of the FIPS code, even though they are included within the HCBS service array.

- **Answer**: The Bereavement – Assessment/Counseling 7952, Palliative Care – Counseling and Support Services 8017, and all the Health Home Bereavement 7946-7951 will need to be billed the same FIPS/County locator code as all other HCBS. These rates are authorized in the Children's HCBS Waiver.

17. Is there a list of Rate Codes that will no longer be in use?
    - **Answer:** None of the CFTSS, HCBS, or 29-I rate codes have changed.

Answers regarding rural rates will be forthcoming, as NYS is awaiting approval from CMS.

Any additional questions should be submitted to BH.Transition@health.ny.gov