



**Department
of Health**

Office of
Health Insurance
Programs

Community First Choice Option (CFCO) MCO Q&A

January 29, 2019

CFCO: Upcoming Readiness Activities and Trainings

The following readiness activities and training sessions are upcoming:

CFCO Readiness Activity/Training	Date
Open Q&A Webinar	January 29, 2019
Development and Implementation Council Meetings	Quarterly, ongoing dialogue
Additional Guidance on Congregate and Home-Delivered Meals	February 2019

MCO Q&A Network Questions

Q: Can DOH please share all CFCO contracting requirements expected of MCOs, considering contracting with new providers typically takes 120 days?

A: The contracting requirements have not changed as a result of the CFCO services carved into the Managed Care benefit. Please note that while the requirements are unchanged, MCOs now need to contract with providers for the seven remaining CFCO services. MCOs should know the scope of the new benefits and establish relationships with their providers.

Q: Understanding that providers will need specialized skills to deliver V-Mods, E-Mods, and AT. Will CFCO network adequacy requirements be adjusted to allow plans to contract with a provider to service multiple counties, instead of plans being required to contract with at least 2 providers per county for each service/benefit?

A: Plans will be expected to contract with as many providers in their service area as necessary to meet demand for these specialized services. However, because of the specific nature of some of these new CFCO services, the Department will provide an initial period before enforcing network adequacy requirements. MCOs will be required to demonstrate good faith effort to complete contracting requirements during this period and ensure their enrollees' access to services. For those services that don't have specific locations (such as vehicle modifications), MCOs may need to have single contract agreements or may need to go beyond the current 30 mile/30 minute requirement to engage service providers.

MCO Q&A Network Questions

Q: Will plans be expected to credential providers? If so, plans will need credentialing requirements at least 120 days in advance to secure network adequacy for its members, assuming the only credentialing requirements will be ensuring CFCO providers are licensed and bonded by the State.

A: Plans are permitted to set their own credentialing standards for contracting with providers that meet or exceed the requirements stated in the SPA and guidance.

Q: Will CFCO providers be required to enroll in Medicaid FFS?

A: Individuals offering services to members related to their ADL, IADL, or health related task needs must be Medicaid enrolled providers. Please note that certain service providers are exempt for the Century 21st Cures Act that requires all MCO providers be enrolled as Medicaid providers. For example, service providers for Home Delivered/Congregate Meals, Environmental, and Vehicle Modifications are not required to have an MMIS provider identification number.

MCO Q&A Network Questions

Q: We have reached out to the providers listed on the CFCO site to ensure they have the ability to provide the service listed. However, most of the providers we have made contact with advised us they can not provide the service listed by the DOH.

A: Plans and districts have several months to develop capacity to meet these member needs. The list on the website are providers who are currently or who have in the past been providers of that service to individuals enrolled in one of the State's 1915(c) waivers. The list of services is not exhaustive. The Department will continue working with Plans and Districts to develop contacts for service delivery. We will continue to share any additional contact information that we feel will be of assistance in securing appropriate service providers for CFCO services.

MCO Q&A Billing and Claims

Q: How can plans report out on encounters if CFCO providers submit invoices for payment?

A: We will be contacting plans shortly to determine if Plans and third party services will be able to convert invoices from non-traditional Medicaid providers into a correct format for claims payment. In addition, please note that a training for encounter reporting for the managed care plans is in development and will be shared with the plans as soon as it is complete.

Q: Does DOH plan to implement a mechanism for tracking CFCO utilization and expenses (i.e., annual or life-time CFCO expenses) across plans? We recommend utilizing ePACES as the means of tracking and communicating expenses. Without a centralized tracking system/mechanism, individuals could transfer between plans and potentially receive duplicative CFCO benefits/services.

A: Yes, DOH has plans to develop a mechanism for tracking CFCO utilization and expenses. This would be done as phase II of CFCO Evolution Project in eMedNY. Initially, CFCO services provided to an individual enrolled in a managed care plan should be memorialized in the person centered plan of care. This document should follow the client from plan to plan and from plan to fee for service. A more robust tracking system for capitated clients is part of a phase II project in eMedNY.

MCO Q&A Billing and Claims

Q: For one-time or annual CFCO expenses that exceed threshold maximums outlined in guidance. What is the procedure plans should follow regarding remaining balances above set expense thresholds? For example, a plan receives a CTS cost projection form with an anticipated total costs of \$5,500. Assuming all criteria is met, the member's \$5,000 would be covered. What process is the plan to follow regarding the remaining \$500?

A: Plans are expected to use their utilization review procedures, including Medical Director review as needed, to determine whether devices/supports/services that exceed the cap are medically necessary and cover services accordingly.

Q: Will the guidance include appropriate codes that providers would use for billing?

A: Yes, please note that training for encounter reporting for the managed care plans is in development and will be shared with the plans as soon as it is complete.

Q: What safeguards will be put in place to avoid duplication of services? How should plans track this? E.g., if a member receives a V-Mod from a previous plan. What is to stop the same member from requesting an additional V-Mod from a new plan?

A: The Person-Centered planning process will assist with safeguarding as all services received from all entities will be discussed and documented. When a plan to plan transfer occurs, it is up the receiving plan to ensure that accurate service records/plans of care are obtained to mitigate any duplications of services

MCO Q&A Billing and Claims

Q: Are you expecting the CFCO providers, mechanics, and construction providers to bill using claim forms, rate codes, etc.?

A: The service providers for environmental and vehicle modifications, moving and community transition service are not traditional medical service providers and as such will more than likely bill using invoices. DOH will work with MCOs in developing options for appropriate claims payment and reporting of these expenses.

Q: Will there be billing codes for moving assistance?

A: Yes, there are several rate codes noted in the rate chart posted on the CFCO website.

Note: HCPCS codes for Community Transition services and Moving Services are the same codes in the MMCOR guide. DOH is working to resolve this issue.

Q: During a previous call the State guidance described a bid process that would require 3 bids. However, on the same call it was stated that network adequacy would likely be 2 per county. Has there been any review or changes that would address this disconnect?

A: Plans are not required to obtain three bids; that is a requirement for FFS service authorization.

MCO Q&A Rates and Finance

Q: What is the methodology being used to determine and establish plan rates for CFCO utilization?

A: The methodology is consistent with the normal process for incorporating benefits. The Department will utilize all available data sources and consult with its actuary to ensure rates for services are actuarially sound and meet federal requirements.

Q: When will draft rates be released for plan comment?

A: Draft capitation rates will be released on the normal schedule for rate release. The department will take into consideration any special updates on an as needed basis.

Q: How do MCOs record and report out on payments for CFCO utilization?

A: DOH will work with MCOs in developing options for appropriate claims payment and reporting of these expenses.

MCO Q&A Rates and Finance

Q: How will CFCO costs be reconciled to ensure plans are appropriately funded for CFCO utilization?

A: Adjustments will be incorporated into the capitation rates at-risk just like other benefits.

Q: How does DOH plan to fund CFCO (e.g., risk score adjustment)?

A: The methodology is consistent with the normal process for incorporating benefits. The Department will utilize all available data sources and consult with its actuary to ensure rates for services are actuarially sound and meet federal requirements.

Q: How will the premium be adjusted to accommodate these new benefits?

A: The department's actuaries will use available data sources to incorporate the additional services into the rate.

MCO Q&A Care Management

Q: How will fair hearing judges be educated on new CFCO benefits, including all benefit guidelines, procedures, expense thresholds, and exclusions (e.g., page 1 of V-mod guidance outlines criteria a vehicle must meet in order to qualify for modification, such as it must be "less than five years old or register less than 50,000 miles on the vehicle odometer")?

A: The Department will ensure that the Administrative Law Judges receive all necessary information on the coverage provided by the CFCO SPA.

Q: Considering the obstacles encountered in FIDA with the requirement of obtaining "wet signatures" on PCSPs/POCs, can DOH please revisit wet signature requirements, or at least expand the definition of what is acceptable as a wet signature, based on past experience in FIDA?

A: Wet signatures is a federal requirement. We are open to suggestions from the plans on how to streamline this process.

MCO Q&A AT/E-Mods

Q: Is the \$15,000 for AT, V-Mods, or E-Mods based on a calendar year?

A: Yes, the limit is based on the calendar year.

Q: In the draft E-Mod guidelines it indicates, “leased homes are not eligible for E-Mods.” Most consumers in lower counties rent. What does this mean for them?

A: This is referring to provider-leased homes. The full sentence states: "Provider owned or leased homes are not eligible for E-Mods." Provider-owned or controlled settings are not compliant HCBS settings and as such, individuals who reside in such settings are not eligible for CFCO services. E-Mods in leased homes that are member controlled require landlord sign off prior to seeking bids or contracting for modifications.

MCO Q&A AT/E-Mods

Q: Under Assistive Technology: “Functional needs will be assessed using a state-approved assessment tool.” All assessments are conducted face to face. Is this a separate tool from the UAS?

A: The UAS may establish a functional need that AT could efficiently address. Once an AT has been requested the care/case manager on behalf of the individual seeks a clinical justification from the appropriate clinician (e.g., Occupational Therapist, Speech Language Pathologist, clinician from Article 16 or 28 clinic, Physical Therapist, or other licensed professional) and/or service specialist to assess the individuals need for the requested service or device. In addition, the clinical justification must include a home environment assessment to determine if there are any obstacles to the use of the AT in the home.

Q: Under Assistive Technology: “AT is for the specific use of the individual identified in the POC” Can this individual be someone other than the member if the use is to benefit the member? Or perhaps they cannot operate the AT independently?

A: Yes, AT is covered if the enrollee needs assistance with operation. This should be specified in the justification, but the AT is specifically for the use of the enrollee.

MCO Q&A V-Mods

Q: Is the plan responsible for ongoing verification of valid license, registration, and insurance on modified vehicles while member is enrolled with MLTC?

A: No, this is not an ongoing requirement unless another modification is planned for the future.

Q: If inspection of the vehicle reveals a need for structural or mechanical repairs in preparation for V-Mods, are these repairs covered under the V-Mod benefit? Or is the vehicle owner required to complete these repairs before modifications can be made?

A: The vehicle must be structurally sound prior to the modification. This is the responsibility of the enrollee and not the Plan.

MCO Q&A V-Mods

Q: Does the DOH have a list of State/Federal programs that offer V-Mods as a way to explore other potential payment sources for this service?

A: Additional resources are provided in the [Vehicle Modification Service Authorization Guidelines](#) located on the [NYSDOH CFCO website](#).

Q: The document CFCO Guideline for Authorizing V-Mods states, "The V-Mod provider is responsible for obtaining the necessary bids from entities approved by ACCES-VR to provide vehicle modifications" and it also states that "the MCO, LDSS, or DDRO is responsible for obtaining the number of required bids (depending on the needed V-Mod) and for selecting the vendor to provide the V-Mod based on the lowest bid that meets the assessed need." Who is responsible?

A: Please note that MCOs are NOT required to obtain bids. This requirement only extends to the LDSS and DDRO. Please see the final guidelines on the [NYSDOH CFCO website](#).

MCO Q&A V-Mods

Q: Are members required to report removal of V-Mods in the event of the return of a leased vehicle or sale of the modified vehicle? What are they going to be instructed to do with the equipment in these situations?

A: They are required to report the removal of the V-Mod, but are not required to return it to the plan.

Q: Will the plan be provided with usual and customary rates for vehicle parts and service charges so that determination can be made about the fairness of the bids being submitted?

A: Please note that MCOs are NOT required to obtain bids. This requirement only extends to the LDSS and DDRO. Please see the final guidelines on the [NYSDOH CFCO website](#).

Q: Will the DOH be delegating the task of verifying that members do not exceed the \$15,000 limit to the plans? Or will DOH be doing the verifying themselves?

A: Yes, the Plans will be responsible for monitoring the service limits. Please note that service limits can be exceeded due to medical necessity. The Plan's Medical Director will make that determination.

MCO Q&A V-Mods

Q: Can the CDPAP PA own the vehicle?

A: Yes, the vehicle of the CDPAP PA can be modified for the enrollee if the PA provides the primary, long-term support and transportation for the enrollee.

Q: Did you say the member can utilize the vehicle modification allotment every calendar year? If so, can they change their cars annually?

A: Yes, the service limit is based on the calendar year. If the enrollee has an assessed need for the V-Mod and meets the CFCO eligibility criteria, s/he can theoretically get a V-Mod every year.

Q: Who determines if a member is appropriate for requested V-Mod changes? E.g., is the member appropriate to drive, use hand controls, etc.? Who is responsible for training the member on the use of the newly added V-Mod?

A: The plan will determine through the person-centered planning process if the enrollee is appropriate for the service. The V-Mod Provider will train the enrollee on how to utilize the newly added modification.

MCO Q&A V-Mods

Q: Who is responsible for Vehicle Standards? Member's current driver license activity? E.g., Is a license in good standing and is it valid? Who is responsible for determining the validity of vehicle registration, insurance, and inspection?

A: The V-Mod Provider will determine if the vehicle is structurally sound for the modification. The Plan is responsible for determining if the driver's license is in good standing as well as the vehicle registration, inspection, and insurance information.

Q: On page one of V-Mod guidance, there is a list of criteria that vehicles must meet in order to qualify for modification(s). Who assesses the vehicle to ensure it is "structurally sound" as this seems to require expertise and/or specific licensure to make this determination? Is this performed, for example, by an ACCESS-VR approved Certified Driver Rehabilitation Specialist?

A: Yes, the provider of the V-Mod would make this determination.

MCO Q&A-Skill Acquisition, Maintenance, and Enhancement (SAME)

Q: The draft guidelines state: “SAME services are appropriate for individuals who can learn to live in the community with or without support.” How is this capacity assessed? Is there a standard tool that will be released for plans to assess this capacity?

A: The functional needs assessment and the person-centered planning process will assist with determining the client's ability to learn to live in the community with or without support.

Q: “Services may be time-limited and authorized for a timeframe that the individual can be expected to learn to perform the new task(s) independently.” Will more guidance be provided on authorization timeframes for acquisition, maintenance, and enhancement?

A: Yes, the final guidelines will be released shortly and will provide this additional clarity.

MCO Q&A-Skill Acquisition, Maintenance, and Enhancement (SAME)

Q: Assessment of Functional Needs for AT and SAME: Will this be completed utilizing the UAS assessment, or will there be a specific state-approved assessment customized to evaluate the need for these services?

A: Yes, the UAS tool can assess for functional needs.

Q: Is there a qualifying mini-mental score for the SAME program?

A: No

Q: Are SAME hours in addition to PCA hours? E.g., can a member be receiving 7-days x 3-hours of PCA services, and also receive 7-days x 2-hours of S.A.M.E services (5 hours per day total)?

A: If the enrollee has an assessed need for both personal care and SAME service, they can both be authorized as long as they don't occur at the same time. The activities provided with the SAME service cannot overlap in time nor function with Personal Care Services. The SAME authorization guidelines will be released shortly and will assist with the service authorization.

MCO Q&A-Skill Acquisition, Maintenance, an Enhancement (SAME)

Q: How will plans know who are approved providers for SAME? What will be provided to plans?

A: A listing of SAME providers for OPWDD and children in the consolidated waiver is on the NYSDOH CFCO website. Please note that OPWDD providers can only provide SAME services to OPWDD individuals and children in the consolidated waiver. Personal Care workers in the DOH system can provide SAME services across the spectrum in conjunction with personal care services.

MCO Q&A-Transportation

Q: Currently, MLTC covers medical transportation and under CFCO. The plans will begin to cover social transportation as well. Once a member receives an E-Mod will he no longer be eligible for transportation services as this would be considered duplication of services?

A: Social transportation is not a CFCO service. If the enrollee has an assessed need for non-emergency medical transportation (NEMT) the plan is responsible for providing that service. If the modified vehicle can fill that assessed need, then NEMT would not be authorized.

Q: Are you saying that there is no stand-alone social transportation benefit under CFCO and it may only be accessed as part of SAME?

A: Social transportation is not a CFCO service. Community transportation can be provided as a component of the SAME service if there is an assessed functional need for it.

Q: When will guidance on non-emergency and social transportation be available?

A: Social Transportation is not a CFCO service. Non-emergency medical transportation is within MLTC currently and, plans will continue to assess and authorize as they currently do.

MCO Q&A-Transportation

Q: Will social transportation be coordinated by MAS?

A: Social Transportation is not a CFCO service.

Q: We did not see transportation for social occasions mentioned, is this no longer being included in the CFCO benefits?

A: Social transportation is not a CFCO service. Community transportation can be provided as a component of the SAME service if there is an assessed functional need.

MCO Q&A General Questions

Q: Are members permitted to receive services outside of their service address? Slide-5 of 8/29/18 presentation states: "HCBS recipients must live in compliant settings, regardless of where the services are rendered."

A: Yes, as long as it is an HCBS-compliant setting.

Q: Are denials/approvals of documented via the Adverse Determination and Approval letters (IAD w/wo AC, OON, LTSS, NSAN, and SIAN) currently used for all other MLTC services that are being used?

A: Yes. The Department will provide additional guidance.

MCO Q&A General Questions

Q: Are the time frames for decisions and appeals the same as the current ones used for all other MLTC services?

A: Yes. The Department will provide additional guidance.

Q: Will CFEEC evaluators be responsible for determining the need for all CFCO services? Or is it just a determination for Personal Care Services?

A: The role of CFEEC remains unchanged. If an individual is seeking a CFCO service and is seeking enrollment into a MLTCP, the CFEEC evaluation will still be required to determine if the person has a need for a Community Based Long Term Care (CBLTC) service. Personal Care still remains a qualifying CBLTC for MLTC enrollment.

Q: What is the targeted Go-live date for this implementation?

A: July 1, 2019

MCO Q&A General Questions

Q: Will all of the training sessions be recorded as well?

A: Yes, all training will be recorded, and the training slides will be added to the NYSDOH CFCO website for reference.

Q: The one slide indicated that MCOs are to send a weekly file to Maximus. Is this a requirement for MLTCs then?

A: Yes, this requirement is for all MCOs, including MLTC Plans. The batch file to add or close an RRE code should be sent on a weekly basis to Maximus. If you have no new individuals to report or nothing to change, you don't need to submit a file. This is a requirement for both Mainstream and MLTC.

Q: Has the updated guidance addressed whether the services with limits are yearly and if so does the updated guidance advise how plans should or could track these limits when members switch plans within a calendar year?

A: The service limits are based on the calendar year. When a plan transfer occurs, it is up to the receiving plans to ensure that all information is received, including whether or not an enrollee has met service limits.

MCO Q&A General Questions

Q: If a request for a CFCO service is received outside or after the person center planning process, is a new person-centered service meeting required?

A: Yes. You may continue to use the most recent assessment if the needs of the enrollee have not changed. There must be an assessed need for the requested service to proceed with service authorization.

Q: What is the process that the state followed for vetting CFCO providers listed on the state website?

A: The CFCO providers listed on the website are currently providing services through various waivers or have done so in the past.

MCO Q&A General Questions

Q: The Cost Description and Projection Form has a member signature line, is this required to be completed with the member?

A: Yes, it should be a part of the person-centered planning process.

Q: Timeframes: There are multiple steps required by the plan prior to rendering a determination for a CFCO service. What are the timeframes requirements from the time of request until a determination is rendered? Standard MLTC service authorization timeframes may not allow sufficient time for the collection of clinical justification, scheduling, and completion of home assessment, identification of landlord, exploring of other payment sources, and submission of required forms. If a CFCO service is denied, will the process be the same as current denials under the updated 5-1-18 policies (internal appeal prior to fair hearing)?

A: Timeframes for authorization determinations and notices are not changing as a result of the CFCO transition. The Department will work with plans to develop technical guidance in applying these requirements to the authorization of CFCO services.

Contact Information

[Questions/Comments - CFCO@health.ny.gov](mailto:CFCO@health.ny.gov)

https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm