NEW YORK STATE DEPARTMENT OF HEALTH

OFFICE OF HEALTH INSURANCE PROGRAMS

Division of Long Term Care

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Guidelines for the Provision of Services Under the Community First Choice Option (CFCO) Benefit Within Managed Long Term Care

Overview

Effective July 1, 2017, Medicaid Managed Long Term Care (MLTC) Plans will be required to expand and/or enhance the current benefit package to include all services and supports within the Community First Choice Option (CFCO) for adults age 21 and over. The expansion applies to MLTC Partial Capitation Plans, Medicaid Advantage Plus (MAP), and Programs of All Inclusive Care for the Elderly (PACE). FIDA plans already include a majority of CFCO services in the benefit package; services that are not included will be clarified/identified in future guidance. Services and supports under CFCO are Medicaid State Plan services that are community based, delivered through a person-centered and consumer-directed approach, and designed to maximize an enrollee's independence in the community.

To be eligible to receive CFCO services, an enrollee must:

- Require a nursing home level of care (NH LOC) as determined using the State's designated assessment tool, currently the Uniform Assessment System (UAS) assessment, or an institutional level of care[1];
- Be able to live safely in the community if s/he receives CFCO services; and
- Live in his/her own residence or the residence of a family member.

Many CFCO services and supports are already included in the managed care benefit package; however, the following guidelines identify the new and/or enhanced services and supports, the scope of benefits, and the role and responsibilities of the MLTC Plans.

I. Scope of CFCO Services and Supports

a) The services and supports new to the managed long term care benefit package are:

- Assistive Technology (beyond the scope of Durable Medical Equipment)
- Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) skill acquisition, maintenance, and enhancement
- Community Transitional Services
- Moving Assistance
- Environmental Modifications (beyond the scope of social and environmental supports)
- Vehicle Modifications

[1] For the purpose of CFCO services, an institutional level of care includes the level of care provided in a nursing facility, an Institution for Mental Diseases (IMD) or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

b) Non-Emergency Transportation will be expanded under CFCO to include social transportation, as appropriately authorized in the consumer's person centered service plan (PCSP).

c) The need for CFCO services must be identified in a Person Centered Service Plan.

d) CFCO services and supports must be delivered by providers consistent with all applicable licensure requirements, and federal and State laws, rules and regulations. All services must be provided by qualified individuals employed by, or contracted with, a network provider.

II. Continuity of Care

For consumers who are receiving community-based, long-term services and supports and who are required to mandatorily enroll in an MLTC Plan, the MLTC Plan must continue to authorize such services pursuant to the consumer's pre-existing service plan for at least 90 days after enrollment. This applies only to consumers who are transferring from Fee-for-Service (FFS) into an MLTC Plan under mandatory enrollment.

III. Accessing Services and Supports Under CFCO

a) Request for Service:

Requests for CFCO services may originate from an MLTC enrollee or, for an enrollee who is not self-directing, a designee selected by the enrollee. The designee may be anyone the enrollee chooses.

b) Functional Needs Assessment:

All functional needs assessments will be completed face-to-face with the enrollee and will record the enrollee's needs, strengths, preferences, goals and objectives for maximizing independence and community integration. It will also include an assessment of risk that identifies potential risks and vulnerabilities. All outcomes of the functional needs assessment must be incorporated into the PCSP, including those needs that are met by family or other informal supports.

i. Initial Assessment:

Once the request for services and/or supports under CFCO is received by the MLTC Plan, the Plan is responsible for arranging an assessment of the enrollee by a registered nurse who must be employed by the Plan or by one of its contracted providers. The contracted provider may be a certified home health agency or a licensed home health care services agency.

ii. Authorization of Services:

The MLTC Plan will review the assessment and the request for services to determine whether the enrollee meets the eligibility requirements for CFCO services and whether the enrollee needs the requested services. If the assessment indicates that the enrollee is eligible and the requested services are needed, the MLTC Plan is responsible for overseeing the development of the PCSP, which will include the amount, duration, and scope of the requested services that have been authorized;

identification of service providers; risk assessment; and risk management plan. The enrollee must sign the PCSP. Signing the PCSP does not waive, or in any way affect, the enrollee's right to a fair hearing or other appeals rights. The MLTC Plan must provide a copy of the PCSP to the enrollee.

If the enrollee is found ineligible for CFCO services due to not meeting requirements for NH LOC or not meeting requirements for residing in/moving to an allowable community setting, the MLTC Plan must consider if the enrollee's request for services and needs may be met through other MLTC Plan benefit package services, e.g., non-CFCO personal care services, adult day health care, physical therapy, etc.

iii. Reassessments:

The MLTC Plan will reassess the enrollee at least every six months, upon a significant change in the enrollee's condition/circumstances, or if requested by the enrollee. If the enrollee would like to be reassessed, s/he must notify his/her care manager or member services to request the reassessment.

IV. MLTC Plan Responsibilities

a) MLTC Plans are responsible for developing service authorization criteria and for determining eligibility for CFCO services for Plan enrollees using the UAS assessment. Provision of CFCO services must be in accordance with all applicable federal and State laws, rules and regulations, and Medicaid Managed Long Term Care program requirements.

b) MLTC Plans are responsible for the oversight of service planning and service delivery for enrollees, including the development of the PCSP.

c) MLTC Plans are responsible for monitoring the provision of CFCO services to ensure services provided in excess of State Plan utilization threshold limits are authorized on a case-by-case basis and in accordance with written medical necessity criteria.

d) MLTC Plans will contract with appropriately credentialed service providers and fiscal intermediaries to make CFCO services available to enrollees.

e) During the functional needs assessment and development of the PCSP, the MLTC Plan must provide written Notices of Determination (NODs) for the initial authorization, reauthorization, denial, reduction or suspension of requested services, as for all services, and in accordance with all applicable federal and State laws, rules and regulations, and Medicaid Managed Long Term Care program noticing requirements.

f) MLTC Plans will provide contracted providers with authorization for service provision, including, if applicable, the number of visits per week, level, and duration in accordance with the approved PCSP; applicable federal and State laws, rules, and regulations; and Medicaid Managed Long Term Care program noticing requirements.

V. Current Services and Supports Eligible for CFCO Claiming

a) Durable Medical Equipment (DME), Medical/Surgical Supplies
b) Non-Emergent Medical Transportation

c) Personal Care Level 1 and Level 2[2]
d) Home Health Care Aide
e) Home Delivered/Congregate Meals
f) Home Modifications under Social and Environmental Supports
g) Consumer Directed Personal Assistance Services
h) Personal Emergency Response Systems (PERS)

If an enrollee does not meet eligibility criteria for CFCO services, Plans must still provide identified needed services as covered in the Plan's benefit package.

VI. New Services and Supports Eligible for CFCO Claiming

a) Assistive Technology (AT) beyond the scope of Durable Medical Equipment: AT is defined as an item, piece of equipment, product system or instrument of technology, whether mechanical or electrical and whether acquired commercially, modified, or customized. The use of the AT must increase an enrollee's independence or substitute for human assistance that would otherwise be authorized (e.g., personal care services). AT **does not** include items that are covered within the scope of durable medical equipment. Examples of AT include but are not limited to:

- Motion/sound, toilet flush, incontinence and fall sensors
- Automatic faucet and soap dispensers
- Two-way communication systems
- Augmentative communication aids and devices
- Adaptive aids and devices

Providers of this service will assist the enrollee in the selection, acquisition and/or use of the authorized AT.

Electronic back-up systems are also included in the definition of AT. Electronic back-up systems are devices that enable an enrollee to secure help in an emergency, enhance safety in the community, or provide reminders that will assist the enrollee with activities such as medication management, eating or other activities for which monitoring is necessary.

The utilization threshold for Assistive Technology is $15,000 per 12-month period.

b) ADL and IADL skill acquisition, maintenance, and enhancement: These services and supports are intended to maximize the enrollee's independence and/or promote integration into the community by addressing the skills needed for the enrollee to perform ADLs and IADLs. This service may include assessment, training, supervision, cueing, or hands-on assistance to help an enrollee perform specific tasks, including:

- Self-care
- Life safety
- Medication management
- Communication
- Mobility

[2] Personal Care Services include assistance with ADLs, IADLs and health-related tasks through hands on assistance, supervision, and/or cueing.

- Community transportation
- Community integration
- Inappropriate social behaviors
- Money management
- Maintaining a household

This service may be time limited, especially when the enrollee can be reasonably expected to learn to perform the task(s) independently. However, the duration of assistance may be extended, or the scope may be changed from hands-on assistance to supervision and/or cueing, depending on the assessed need.

This service can be delivered in any community setting that does not already offer some form of paid human assistance to the enrollee. Such a setting might include the enrollee's home and work setting, but it would not include, for example, a social day care or adult day health care setting in which employees of the particular setting care for or oversee the enrollee. Additionally, this service cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973.

This service may be provided by direct care workers such as home health aides, personal care aides, personal attendants and, under the Agency with Choice Model (CDPAS), personal assistants. This service may also need to be provided by an individual with appropriate training, certification or licensure, depending on the activities being authorized.

c) Community Transitional Services: This service is intended to assist the enrollee who is transitioning from an institutional setting to a home in the community where s/he will reside. This service covers expenses related to setting up a household such as:

- Payment of the first and last month's rent
- Utility and rental deposits (security, broker leasing fees, set-up fees for heat, electricity, telephone)
- The purchase of basic essential household items such as furniture, linens, and kitchen supplies
- Health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy

This service is limited to an enrollee who is transitioning from a nursing facility, Institution for Mental Disease (IMD) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) to his/her home or the home of a family member where s/he will reside.

The utilization threshold for Community Transitional Services is a $5,000 one-time expense.

d) Moving Assistance: Moving Assistance is available to enrollees who are transitioning from an institutional setting to a community-based setting. This service covers the cost of physically moving the enrollee's furnishings and other belongings to the community-based setting where s/he will reside. To access this service, the Plan must use a moving company licensed/certified by the New York State Department of Transportation.

The utilization threshold for Moving Assistance is a $5,000 one-time expense.

e) Environmental Modifications (E-mods): This service encompasses internal and external adaptations to the enrollee's residence when the adaptations are beyond the scope of what is currently covered under the social and environmental supports benefit. The adaptations must be identified in the PCSP as being necessary to enable the enrollee to function with greater independence in his/her home or to substitute for human assistance that would otherwise be authorized (e.g., personal care services). Adaptations covered under this service include but are not limited to:

- Hydraulic, manual or electric lifts (or rented lifts if they are more cost effective)
- Widened doorways and hallways
- Roll-in showers
- Modifications of the bathrooms
- Cabinet and shelving adaptations
- Hand rails and grab bars
- Ramps
- Automatic or manual door openers and doorbells
- Water faucet controls
- Specialized electrical and plumbing system changes required to accommodate new equipment or supplies

This service does not include home improvements such as air conditioning, new carpet, roof repair, etc. that are unrelated to the PCSP. However, home improvement services and items previously included under social and environmental supports are now covered as a CFCO benefit under environmental modifications. All modifications must be made with construction-grade materials and must meet State and local building codes. Plans will continue to have the ability to authorize items such as air conditioning under social and environmental supports as long as medical necessity exists.

The utilization threshold for Environmental Modifications is $15,000 per 12-month period.

f) Vehicle Modification: This service covers the cost of modifications to a vehicle if it is the primary means of transportation for the enrollee. The vehicle may be owned by the enrollee or by a family member or non-relative who provides primary, consistent and ongoing transportation for the enrollee. Modifications are approved only when they are necessary to increase the enrollee's independence and inclusion in the community. Modifications that might enable an enrollee to operate a vehicle include but are not limited to:

- Hand controls
- Deep dish steering wheel
- Spinner knobs
- Wheelchair lock downs
- Parking brake extensions
- Foot controls
- Wheelchair lifts (including maintenance contracts)
- Left foot gas pedals

Additionally, modifications to the structure and internal design of a vehicle that are performed to meet the specific needs of an enrollee might include:

- Floor cut-outs
- Replacement of a roof with a fiberglass top

- Extension of steering column
- Raised door
- Repositioning of seats
- Wheelchair floor
- Dashboard adaptions

The utilization threshold for Vehicle Modifications is $15,000 per 12-month period.

g) Social Transportation: This service consists of transportation to and from non-medical activities such as social gatherings, religious services and other events in the community when the activity is related to the enrollee's functional needs and appropriately authorized in the enrollee's PCSP. Transportation modes include, but are not limited to, taxi, subway, livery, bus, and van.

Utilization thresholds for CFCO services and supports may be exceeded on a case-by-case basis where the MLTC Plan determines service(s) to be medically necessary. These thresholds do not reset when an enrollee changes plans. Therefore, when an MLTC enrollee transfers to another plan, plans are required to share plan of care information, including information about service utilization. Enrollees may not receive duplicative services within the Medicaid program.

VII. Network Requirements

DOH has provided MLTC Plans with a list of providers with whom Plans may contract for CFCO services. MLTC Plans must contract with a minimum of two providers per county for each service. An exception to this requirement may be allowed if an MLTC Plan can document diligent effort to identify service providers and that there is only one willing and qualified entity available to provide services in a geographic area, such as in a rural area. Plans will submit enhanced networks as part of the readiness review process. The network reviews will initially be manual reviews and will be included, when possible, in the Provider Network Directory System during 2017.

VIII. Claims Coding

The State will establish new rate codes to reflect the additional CFCO services. These rates codes will be utilized for fee-for-service claiming and can inform provider–plan billing. Appropriate coding will be identified for encounter reporting. For federal claiming and plan reporting purposes, enrollees determined by a Plan to be eligible for CFCO services will be identified by Restriction/Exemption (R/E) code CF. MLTC Plans will submit a file to New York Medicaid Choice (NYMC) that identifies enrollees who are receiving CFCO services, and this will result in posting of the CF code. Additional information on file transactions to NYMC will be forthcoming.

Plans are encouraged to monitor enrollment rosters to identify new enrollees and to ensure that all enrollees who are in receipt of CFCO services are identified with the CFCO R/E code. Further, for all enrollees utilizing CFCO services, plans must provide for continuity of care, as required for long term services and supports, as well as monitor the CFCO service utilization amounts to ensure that thresholds are not exceeded without a Plan determination of medical necessity.