



**Community First Choice Option (CFCO) Webinar
Frequently Asked Questions (FAQs)
October 19, 2016**

This document responds to and clarifies questions raised during the June 27, 2016 Community First Choice Option (CFCO) webinar hosted by the University at Albany School of Public Health. The CFCO materials are posted on the DOH/MRT website located here:

http://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm. In addition, please consult all previously posted materials in conjunction with the following FAQs. If you have any questions regarding this information, please email to the following address: CFCO@health.ny.gov.

Implementation

1. Q: Will CFCO services be implemented in Fee-For-Service (FFS) and Managed Care (MC) at the same time?

A: Yes. The State anticipates a statewide implementation date of April 1, 2017 for both FFS and MC.

2. Q: Under scenario 1, continued (slide 35) you left out: "Current Managed Long Term Care (MLTC) participants will be able to receive the new state plan services, but will have to go outside their managed care provider and access them through fee for service until 2017." Is this because this has been changed?

A: Yes. The information you are referring to was included in a previous presentation. CFCO will now be implemented in the MC environment at the same time as in the FFS environment.

3. Q: It was stated that CFCO will be in FFS and MC at the same time. What are the differences in what will be offered in FFS vs MC and are there eligibility differences?

A: There are no differences in the CFCO services that will be offered in FFS or MC. As State Plan services, they have to be offered in both the FFS and MC environments. Eligibility requirements are also the same for both environments.

4. Q: Can you set up a flow chart to show referrals/interaction/timelines?

A: Yes, the department is including flow charts in the guidance materials currently in development.

Person-Centered Service Plan

5. Q: Who determines who reviews the service plan? Is this the same as the Plan of Care (POC)?

A: The person-centered service plan (PCSP) will be reviewed by the coordinator (also referred to as the case manager), the consumer and any other individual the consumer would like to participate in the service planning process. Consumers will be reassessed every six months, when their support needs change, or at their request. Yes, the PCSP is the same as the POC.

6. Q: Will there be standardized tools or forms for the Service Plan?

A: The Department is drafting a form that will be used to develop the PCSP.

7. Q: Will current Service Coordinators have any input into the new service plan developed for this program?

A: We value the input of our stakeholders and will consider releasing our draft PCSP for public comment.

Settings

8. Q: Can you clarify what you mean by congregate setting? Are you referring to congregate care level I, II, III?

A: No, we are not referring to congregate care level I, II and III. A congregate setting is an environment where a number of people share the same space for a period of time. Examples include, but are not limited to: a nursing home, assisted living program, adult group home, mental institution, jail, and other long-term residential facilities.

9. Q: Are congregate care settings certified or non-certified?

A: Congregate care settings are certified settings.

10. Q: For CFCO, would a shared apartment be considered a home or a congregate setting?

A: A shared apartment that is not provider owned or provider controlled would be considered a home.

11. Q: For a setting to qualify as an individual's own home, must the consumer be the owner? Or can they rent?

A: A rented home/apartment qualifies as an eligible setting for CFCO services and supports. As long as the rented home/apartment is not provider owned or provider controlled, it would be considered a CFCO approved setting. The consumer does not have to own the home to be eligible.

12. Q: Can folks living in a Nursing Home with MCO coverage also access CFCO services in order to discharge to the community?

A: Yes, as long as the individual meets the eligibility criteria for CFCO, s/he can access the community transitional services offered under the CFCO umbrella.

13. Q: Adult day health care is not a CFCO service - could it be? It would be helpful in areas where there is a shortage of home care services.

A: Adult day health care is not a required or permissible CFCO service under Federal regulations.

Assessment and Authorization of CFCO services and supports

14. Q: Will the Community Assessment from the UAS be required for CFCO?

A: The community assessment suite of the UAS-NY is one of the assessments permitted for CFCO.

15. Q: Who will determine the Level of Care (LOC)?

A: The LOC will be determined using a State-approved assessment. The Department is still working on drafting guidance that details which entity will be responsible for determining the level of care.

16. Q: Regarding conflict free PCSP and assessment – does that mean care managers from managed care plans will not be allowed to complete the assessment and/or develop the care plan?

A: Plans are expected to establish appropriate firewalls to mitigate against assessment and care management conflicts.

17. Q: Who is responsible for authorization decisions and who will provide due process for authorization denials?

A: The Department is drafting guidance that will detail the authorization process across all eligible populations. Authorization denials and fair hearing rights will be included in this guidance.

18. Q: Are assessments completed face-to-face? If yes, who is responsible for the assessments?

A: Yes, all assessments must be completed face-to-face.

19. Q: Can a person leave MLTC if their needs can be met by CFCO?

A: All individuals enrolled in a MLTC plan that are in need of/ receipt of community based long term care (CBLTC) must stay enrolled in the plan to also receive CFCO services. Individuals always have the option to disenroll from the plan, but would not be able to access CBLTC in conjunction with CFCO without being enrolled in a MLTC plan.

20. Q: Are the Local Departments of Social Services (LDSS) responsible for modifications?

A: In certain instances, the LDSS will be responsible for assessing and authorizing environmental and/or vehicle modifications. The department is currently drafting

guidance outlining the roles and responsibilities of the LDSS in specific regard to these processes.

21. Q: If a person is in a MLTC plan, will the MLTC be responsible for the LOC assessment?

A: Yes. The MLTC plan will be responsible for ensuring the consumer meets the LOC requirement to receive CFCO services and supports.

22. Q: Do individuals have to go through the Conflict Free Evaluation and Enrollment Center (CFEEC) to access CFCO services?

A: Individuals that are enrolled in a Managed Care Organization (MCO) or are participating in a Home and Community Based Waiver do not need to obtain a CFEEC evaluation. All others would need a CFEEC evaluation to determine LOC eligibility.

23. Q: In FFS Medicaid, will prior approvals need to be generated?

A: Yes, prior approvals will need to be obtained for certain CFCO services. The department is currently drafting the guidance materials that will clearly state whether or not prior authorization is needed for a particular service, and how to obtain it.

24. Q: Does the individual have to go to CFEEC first, or can they go to the LDSS right away, regardless of immediate needs.

A: All FFS cases would originate with the LDSS and/or the Home and Community Based Services (HCBS) waiver they are enrolled in. All Immediate Need cases would continue to follow the assessment and authorization process currently in place.

25. Q: Role identification and expectations need to be spelled out from start to finish. Who determines LOC? Who conducts the assessment? We have 1 nurse that is available to conduct assessments. How are we expected to avoid conflict between the person conducting the functional assessment and the PCSP?

A: In cases such as these, federal regulations do provide an exception. When the LDSS can document diligent effort to identify that the only willing and qualified entity/entities to perform functional needs assessment and/or develop PCSPs in a geographic area, such as in rural areas, are also providers of HCBS. In the event that a conflict is unavoidable, the district must document the diligent efforts that were made to avoid the conflict in an effort to meet this requirement.

26. Q: Will the process for accessing CBLTC services be different than the authorization process to access CFCO services?

A: The policy that is in place for individuals in need of one or more of the CBLTC services for more than 120 days still stands. MLTC plan enrollment is still required to access these services and a potential authorization for CFCO would be completed during the course of the plan assessment process.

27. Q: Who helps individuals navigate through the authorization process for CFCO after Medicaid is approved?

A: Whichever entity is responsible for the assessment and authorization of services will assist the individual. The individual's starting point in the process will determine who they contact for assistance.

Service Delivery

28. Q: What is the biggest difference between the Traditional Agency model and the Agency with Choice model?

A: The traditional agency model is a delivery method in which the CFCO services and supports are provided by direct care workers employed by a traditional agency or provider. The agency with choice model, on the other hand, is a delivery method where the consumer receiving the CFCO services and supports is able to directly hire his or her own direct care workers. Under this model, the consumer will need to work with a fiscal intermediary (FI) who will keep track of the direct care worker's hours, pay the direct care worker and deduct required amounts for taxes and insurance from the direct care worker's paycheck.

29. Q: Can you speak more about a parent's ability to be a paid caregiver within the Agency with Choice model and the parameters around this?

A: Within the Agency with Choice model, parents of adult children (age 21 or older) can be hired to work as that adult child's direct care worker as long as they are not also the child's designee for decision making. The parent of a child younger than 21 cannot be that child's direct care worker.

30. Q: If a family member is hired, must they be over age 18 and living in the family home?

A: No, the hired family member does not need to be over the age of 18, nor does s/he need to live in the family home. Please follow this link for more information:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/cdpap_clarification.htm

31. Q: Can the Coordinator and direct care worker be employed by the same organization if the Coordinator is not also acting as a direct care worker?

A: No. Federal regulations state that a consumer cannot receive service coordination and another service provision (such as personal care) from the same agency.

32. Q: If a parent is a legal guardian, can they still be a paid caregiver under the Agency with Choice model?

A: An adult who is not legally responsible for the eligible individual's care and support may be a direct care worker for that eligible individual. In particular, this means that a parent of an adult child (21 years of age or older) may serve as that adult child's direct care worker. Parents of children who are younger than 21 cannot be hired as that minor child's direct care worker. Any other adult relative of the CFCO eligible individual may serve as the individual's direct care worker. Additional guidance on this can be found at the following link:
http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/16ma006.pdf

33. Q: Whose responsibility is it to monitor for potential duplication of services?

A: The coordinator (also known as the case manager) is responsible for monitoring the services the consumer receives to ensure there is no duplication of services. Responsibility also lies with the LDSS, MCOs and Waiver staff as appropriate. The Department of Health will also monitor the services as part of its role as the single State agency responsible for the administration of the New York Medicaid Program.

34. Q: Is this an enhancement to the individual's current services?

A: Many CFCO services were previously only available through certain waiver programs. CFCO eligibility criteria must be met to receive these new state plan services.

Eligibility

35. Q: Is CFCO only available for adults? If so, age 18 or age 21?

A: No, CFCO is available to all eligible individuals who meet the eligibility criteria, regardless of age.

36. Q: What if the client is not Medicaid eligible?

A: A consumer will not receive CFCO services and supports unless they are eligible for Medicaid without deeming.

37. Q: Will spousal budgeting guidelines apply for Medicaid eligibility?

A: Yes.

38. Q: One slide refers to a requirement that the consumer has natural supports available to assist the consumer if a direct care worker is not available. So, are consumers without natural supports not eligible for the in home service?

A: No, the presence of natural supports is not an eligibility requirement. We are just highlighting the fact that natural supports should be used whenever possible.

39. Q: Do children have to be Medicaid eligible in their own right, and not via the deeming process, in order to qualify for CFCO services?

A: Yes.

Coordination with the Office for People With Developmental Disabilities (OPWDD)

40. Q: Can a consumer be in a Home and Community Based Services (HCBS) waiver and receive CFCO services FFS through the LDSS?

A: Yes, there is nothing that prohibits a consumer from receiving CFCO services and waiver services at the same time as long as they are not duplicative. For example, a consumer can be receiving services through the OPWDD HCBS Waiver, and access CFCO state plan services to receive personal care services, which is not an OPWDD HCBS Waiver service. CFCO services and supports are state plan services. Therefore,

it is possible that some consumers will need to access these state plan services outside of their waiver program.

41. Q: If someone is eligible for an OPWDD waiver and CFCO, which agency is responsible for authorizing and, in turn, responsible for the fair hearing process?

A: Waiver programs will typically be responsible for intermediate oversight, assessment, reassessment, and service planning for enrolled consumers. Waiver programs will continue to be responsible for authorizing waiver services, including any that may also be available as CFCO services. The LDSS will continue to be responsible for non-waiver State Plan services, including CFCO services that are not available in the waiver. Depending on the waiver program, the LDSS may be required to conduct its own assessment and reassessment for CFCO services that are not available in the waiver, or it may rely on the assessment tool used by the waiver program as indicated by the Department. In either case, the LDSS shall coordinate the provision of these services with the waiver Coordinator and cooperate with the service planning process.

Coordination with the Traumatic Brain Injury (TBI) Waiver and the Nursing Home Transition and Diversion (NHTD) Waiver

42. Q: Does someone have to apply for CFCO services before accessing waiver services?

A: CFCO services are available in the Medicaid State Plan. Anyone in a HCBS waiver may seek out these services if a need exists. The rules around accessing State Plan Services remain unchanged in this regard.

43. Q: Will the current waiver recipient's transfer into this program?

A: CFCO is not a program, but rather a set of State Plan services. Those who meet the CFCO eligibility criteria will be able to access CFCO services. This includes those enrolled in waiver programs.

Collaboration with MCOs

44. Q: What makes Scenario 1 (slide 35) anything more than MLTC covered services?

A: Scenario 1 is highlighting the fact that nothing will change for Mary as the CFCO services and supports will be added to the benefit package.

45. Q: If you are seeking out the LDSS for CFCO services and have a need for more than 120 days of community based long term care, are you required to enroll in MLTC verses FFS?

A: The eligibility requirements for MLTC enrollment are not being changed. Needing services for more than 120 days is not the only determining factor for MLTC enrollment. However, if a consumer meets the eligibility criteria for MLTC, the LDSS would refer them to CFEEC to pursue enrollment. Please refer to the State's guidance materials for more information on the MLTC enrollment guidelines.

46. Q: Can a consumer be in mainstream managed care and receive CFCO services?

A: Yes, a consumer can be enrolled in a mainstream managed care plan and receive CFCO services and supports as long as they meet the CFCO eligibility requirements, and the services are not duplicative.

47. Q: According to scenario 1 (slide 35), are you saying that if a person does meet the eligibility criteria for CFCO services their Personal Care Services (PCS) would NOT be switched over to CFCO? Would CFCO only apply to new services she might need under CFCO like assistive technology?

A: Services currently available under the Medicaid state plan will continue to be available. From a FFS perspective, an individual authorized for PCS may have their services switched over to PCS under the CFCO state plan if they also meet all of the CFCO eligibility criteria. Individuals enrolled in a MCO would undergo a similar transfer from PCS to CFCO PCS if all eligibility criteria are met.

48. Q: Why not just fold this into MLTC?

A: CFCO services and supports are being added to the MLTC plan benefit. However, there will continue to be some consumers that are not yet enrolled in plans and some that will continue to need CFCO services in a FFS environment. Therefore, it is necessary for all agencies and programs to be aware of how CFCO services will be assessed and authorized under FFS.

49. Q: How does a current MLTC enrollee become aware of the additional CFCO services available within the plan benefit?

A: Current MCO enrollees will be made aware of the additional services in the benefit. Revised member handbooks will be created along with supplemental marketing materials. In addition, once the enrollee is re-assessed and determined to have an assessed need for a CFCO service and/or support, more education will be provided.

NY Connects Referral

50. Q: What role do you see local Offices for the Aging and/or NY Connects playing in CFCO? Can they refer individuals for CFCO?

A: The Department is currently drafting guidance materials that will detail the referral process for all referring entities.

Provider Enrollment/ Provider Capacity

51. Q: Can a Licensed Home Care Services Agency (LHCSA) participate as an Agency with Choice Model, considering the apparent conflict with personal care assistant (PCA) scope of practice and Health Related tasks?

A: The Agency with Choice Model requires a Fiscal Intermediary. A LHCSA can participate in this model only if it is acting in the capacity of a Fiscal Intermediary, as required by this model.

52. Q: How will the fee for service network of providers be determined and/or developed? What if the preferred provider is a non-participant?

A: All providers that will deliver CFCO services must be Medicaid providers and have a valid Medicaid number on record. These providers are expected to contract with both Managed Care Organizations and LDSSs for FFS. A list of providers is currently available here:
https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_options.htm

Additionally, the LDSSs will be provided a directory of providers when the CFCO Administrative Directive Memorandum (ADM) is released.

53. Q: Are all current providers expected to provide services to all eligible individuals across all "O" agencies?

A: No, providers may provide services through the entities they are currently contracting with, but they may also choose to seek additional opportunities to provide CFCO services through new contracts with additional entities.

54. Q: How do non-Medicaid providers become eligible to provide services under the CFCO State Plan umbrella?

A: A Medicaid application is required to initiate the process. Securing contracts with either the LDSS and/or MCOs would be the next step.

55. Q: How are the LDSSs going to provide services such as community habilitation, social transportation and vehicle modifications etc.? Are we going to have to contract for them?

A: For those individuals not enrolled in a MC plan, or on the path for mandatory enrollment, the LDSS will need to authorize the CFCO services, and will ultimately have to contract with CFCO service providers.

Service Limits / Definitions

56. Q: Since CFCO service will be available FFS, are there Fiscal Caps for services authorized? Does CFCO include individualized budgeting?

A: No. While some CFCO services have service limits, individuals authorized and utilizing CFCO are not subject to individualized budgeting. These are outlined in the State Plan Amendment, and will be highlighted in the administrative guidance that is forthcoming.

57. Q: So is the plan to have CFCO eventually replace the current LDSS Personal Care program?

A: No, the services offered under CFCO will not replace any of the current services offered by the LDSS. CFCO services and supports are state plan services with different eligibility requirements that must be met in order for a consumer to access them.

58. Q: How would somebody utilize the community transition service to transition from an institutional setting?

A: The department is currently developing guidance materials that will clearly outline the roles and responsibilities of the LDSS, MCOs, OPWDD and OMH in regards to assessing for and authorizing CFCO services and supports.

59. Q: Will CFCO consider developing a transportation service that is non-emergent, transportation to work?

A: No. Unfortunately, the federal regulations do not allow CFCO services and supports to include any kind of employment supports, including transportation.