NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Community First Choice Option

Billing, Claims, and Encounter Reporting
within the Managed Care Environment

March 2019

Purpose

- Provide Managed Care Organizations (MCOs) with the opportunity to discuss the operationalization of the remaining seven Community First Choice Option (CFCO) services.
- Ongoing discussions will continue with MCOs and the Department until the implementation date of July 1, 2019.
- Today we will specifically discuss Billing, Claims, and Encounter Reporting.

CFCO Eligibility Criteria

- An individual eligible to receive CFCO services must:
  - Be Medicaid eligible for community coverage with community-based long term care (with or without a spend down) or be Medicaid eligible for coverage of all care and services;
  - Have an assessed institutional level of care; and
  - Reside in his/her own home, or the home of a family member.
- Individual's Medicaid eligibility may not be dependent on:
  - Spousal impoverishment post-eligibility rules;
  - The Special Income Standard for Housing Expenses; or
  - Family of one budgeting for a child participating in a HCBS Waiver (State is seeking CMS approval to allow family of one children under the proposed consolidated Children's 1915(c) Waiver to be eligible for CFCO services)

CFCO Eligibility Criteria, *continued*

- All services must be offered to all eligible individuals across the disability spectrum
  - o Recipients may participate in Waiver Programs and receive other State plan services and supports as long as they are not duplicative
  - o The CFCO services will be available in FFS and in the Managed Care Benefit packages (Mainstream, MLTC, MAP, PACE) on July 1, 2019

NOTE: Individuals enrolled in current 1915(c) Waivers that may not meet CFCO eligibility criteria, but do meet the criteria of Waivers, will continue to access these services under the authority of the 1915(c) Waiver.

CFCO Services Effective July 1, 2019

Today's workgroup meeting will be focused solely on the CFCO services coming in to the Managed Care benefit package on July 1, 2019. These services are:

- o Assistive Technology (AT)
- o Environmental Modification (E-Mod)
- o Vehicle Modification (V-Mod)
- o Moving Assistance
- o Community Transitional Services (CTS)
- o Skill Acquisition Maintenance and Enhancement (SAME)
- o Home-Delivered/Congregate Meals

Billing, Claims, and Encounter Reporting Questions

- Can the State share some insights on the current experience of FFS providers within the waiver services related to billing and payment?

- Benefits such as V-Mods and E-Mods are limited to $15,000 per year. However, the guidance states that these limits may be exceeded based on medical necessity and with prior approval from the plan. This can further increase costs beyond the annual limit. Plans noted that the rate add-on from DOH should be updated to adequately reimburse plans for the added costs.

Billing, Claims, and Encounter Reporting Questions

- Will premiums (PMPM) increase for MLTC?
- A plan noted that some CFCO services are similar to the Environmental Support Services that are already included in the MLTC package, which rely on invoicing to facilitate reimbursement. Does the State intend for plans to use the same invoicing process for CFCO?
- How will the providers bill plans?

Billing, Claims, and Encounter Reporting Questions

- How will these providers be paid?
- Will the State issue a CFCO billing manual and if so, when?

Billing, Claims, and Encounter Reporting Questions

- Which CFCO services are billed on a CMS 1500 claim form?
- Which CFCO services are billed on a UB-04 claim form?
- Must the CFCO/HCBS providers submit their CFCO claims on a UB form?
- Currently, for HCBS services provided to members enrolled in MLTC, HARP and MCO, the providers use HCFA forms without a rate code. If providers are required to include a rate code on the CFCO claim, they would need to use the UB form. Providers would then be required to use both a HFCA form for HCBS services and a UB form for CFCO services. This would require the providers to use 2 different modalities for very similar services, for very similar populations.

Billing, Claims, and Encounter Reporting Questions

- Similar to the HARP implementation, will CFCO services need to be tracked and reported on their own Medicaid Managed Care Operating Reports (MMCORs)? If so, changes to the MMCOR reporting will necessitate a specific training on CFCO MMCOR reporting for plans.

- Is it possible to get info on the members we are slated to receive and the listing of the providers they are working with? That may give us a foothold on the transition while building the network accordingly. I have asked this question before.

- Will there be a supplemental file sent to MCOs to keep eligibility current?

Contact Information

Questions / Comments - CFCO@health.ny.gov

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