Community First Choice Option
Contracting and Credentialing
Frequently Asked Questions

General

Q1: Has Community First Choice Option (CFCO) been delayed by the budget?

A1: The enacted 2019-20 state budget includes a delay in the implementation of the following Community First Choice Option services from July 1, 2019 to January 1, 2020:

1. Assistive Technology
2. Community Transitional Services
3. Environmental Modification
4. Home Delivered Meals
5. Moving Assistance
6. Skill Acquisition Maintenance and Enhancement / Community Habilitation
7. Vehicle Modification

Prior to 1/1/20, waiver enrollees will continue to access the above services as available through the current waiver programs.

Q2: What Managed Care products will include the CFCO services?

A2: The remaining seven CFCO services will be carved in to the following Managed Long Term Care Products: Partial Capitation, PACE, FIDA-IDD, Medicaid Advantage and Medicaid Advantage Plus. The remaining seven CFCO services will also be carved into Mainstream Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Special Needs Plan (SNP).

Q3: Can DOH provide a list of links to these various guidance documents?

A3:
https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm
Scroll down to "CFCO Information and Resources" on this web page.

Q4: How will the bidding process work for Managed Care plans?

A4: The bidding process has been eliminated as a requirement on plans.

Contracting

Q5: Will rates and Healthcare Common Procedure Coding System (HCPCS) codes be provided to begin the contracting process?

A5: Draft rates, HCPCS codes and revenue codes have been provided and are available on the CFCO website:
https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm.

Q6: A Vehicle Modification (V-Mod) will cost a different amount, depending on factors such as the make, model, and age of the vehicle to be modified. Can the State clarify how plans should develop contracts given the significant variation in the costs of services?

A6: The contract should be specific to the service. Further, the contract needs to be flexible enough to accommodate case by case pricing.

Q7: In order to provide a V-Mod, we need to obtain a separate assessment to determine what mods are needed. Do we need to contract with the clinical assessors in addition to the V-Mod provider?

A7: Through the person–centered planning process, during a Plan of Care (POC) meeting, the care/case manager, individual, and anyone involved in the development of the POC will determine if a V–Mod is necessary. Once a V–Mod 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 individual's need for the requested V–Mod. The plans will need an appropriate agreement with V-mod providers and the clinician performing the assessment.

Q8: If we contract with an entity that provides modification evaluations on our behalf, does that require an administrative agreement with that entity? Will the contracts require DOH approval?

A8: Plans will need an administrative agreement for V-mods, Environmental Modifications (E-mods), Moving Assistance, and Community Transitional Services (CTS). Plans will need provider contracts for Assistive Technology, Skill Acquisition, Maintenance, and Enhancement (SAME), and Home Delivered Meals. Administrative agreements do not need to be submitted to the Department for approval, but provider contracts do.

Q9: We've heard that DOH is developing a template agreement for contracting with CFCO providers. What is the intended process for developing the template? We would like to be included in any process developing template language.

A9: No, the Department has not developed a template for plans to use. Plans that develop template agreements for CFCO services should follow the standards and processes set forth in the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs.

Q10: What kind of agreement should plans have with an E-mod or V-mod provider? If we already have a provider agreement in place, can we use that?

A10: Plans will need an administrative agreement for V-mods, E-mods, Moving Assistance, and CTS. Plans can amend existing contracts as needed to provide CFCO services.

Q11: Is a Business Associate Agreement (BAA) template appropriate for an administrative agreement?

A11: They are separate documents. A BAA establishes the permitted and required uses and disclosures of protected health information by the Business Associate. A BAA must be attached to any agreement between a HIPAA Covered Entity and its Business Associate where the Business Associate requires access to protected health information. A Technical and

Administrative Services Agreement sets the terms and conditions between two parties for the technical and administrative services contained within.

Q12: As an MLTC plan, do we need to contract with a Women and Minority Owned Business entity?

A12: While there is no required minimum for subcontracting with Minority and/or Women Owned Businesses (M/WBEs), MLTC plans are encouraged to make reasonable efforts to execute 5% of their subcontracts with certified M/WBEs.

Q13: Do MCOs have to submit to the Department, for review and approval, a contract amendment to include CFCO services?

A13: Yes, where a provider contract is used. The inclusion of new benefits and/or changes to reimbursement methodology are considered material amendments. Accordingly, the appropriate provider contract template would require review and approval by the Department prior to implementation.

Q14: What is the turnaround period for approval?

A14: For file and use of a provider contract, the review period would be 3 business days. All other provider contract reviews fall under 90-day review guidelines. Please see the attached link to the NYS Provider/IPA/ACO Contracting Guidelines for additional information. https://www.health.ny.gov/health_care/managed_care/hmoipa/guidelines.htm

Credentialing Providers

Q15: Can the State provide some general guidelines for credentialing providers with which plans have not had experience with in the past (i.e., V-Mod providers)?

A15: General credentialing criteria will apply (e.g.., can't be on an exclusion list) but plans should otherwise set their own criteria. Please note that there are service specific provisions that are detailed in the service authorization guidance documents located on the CFCO website.

Q16: What is the guidance on how providers will be selected?

A16: All service authorization guidelines include provider criteria.

Q17: Which CFCO providers are required to have a Medicaid ID?

A17: Enrollable provider types are required to enroll and obtain a Medicaid provider ID (See list at https://www.emedny.org/info/ProviderEnrollment/index.aspx).

Q18: Are E-mod and V-mod providers considered an NYS Medicaid enrollable provider?

A18: No. Provider types that are required to enroll can be found at: https://www.emedny.org/info/ProviderEnrollment/index.aspx.

Provider Listing

Q19: The State has identified CFCO providers on its website, but plans reported that some of these providers are no longer offering these services or there are no providers available in certain areas. Will the State be updating the list of CFCO providers on its website? If so, when should plans expect to see the updated list?

A19: The Department has provided a non-exhaustive list, as an aid to plans.

Q20: Is there a list of V-mod providers available by counties?

A20: V–mod vendors approved under the Quality Assurance Program of the National Mobility Dealers Association are listed here, which includes county information.

Network Adequacy

Q21: What are the network adequacy standards for the seven CFCO services coming into the Managed Care benefit on January 1, 2020?

A21: Plans must contract with a minimum of two providers per county, or region as applicable, for provision of CFCO services. An exception to this requirement may be allowed if a plan is able to document diligent efforts to identify service providers and there is only one willing and qualified entity available to provide services in a geographic area, such as in a rural area. Where contracts do not exist, plans must permit enrollees to access services through out-of-network arrangements.

For SAME/Community Habilitation services:

> *MCOs are required to offer contracts to any OPWDD Community Habilitation (CH) provider that serves at least 5 enrollees. For other OPWDD CH/SAME providers (less than 5 enrollees), the plan should, at a minimum, offer single case agreement to ensure continuity of care for individuals.*

Q22: Can the State provide network submission specifications? Will these be different from the current processes for each of the impacted Medicaid managed care products?

A22: Provider Network Data System (PNDS) requirements will be consistent with what is in the current model contracts and in accordance with the PNDS Data Dictionary, located here: https://www.health.ny.gov/health_care/managed_care/docs/dictionary.pdf Additionally, the PNDS is now able to capture the service area of ancillary provider types that operate from a single office location, but provide services in multiple counties.

Q23: When do we have to submit network adequacy PNDS submissions?

A23: CFCO service providers may be added at any time and the MCOs are to have a full, adequate network for these CFCO services no later than 2nd quarter 2020. However, it is the expectation of the Department that MLTCs authorize “out-of-network” arrangements for the provision of services in areas where an adequate number of providers does not exist. CFCO services will now show on each Plan’s required network services. The Department may take additional regulatory action should the plan have network deficiencies post 2nd quarter submissions in July 2020.

Q24: Our plan has had a contract in place with a home-delivered meal provider for the past few years. Can this count as one of the two providers needed for meal services?

A24: Yes.

Q25: When can Single Case Agreements be used for network adequacy?

A25: Single case agreements will not count towards network adequacy. However, they can be used to fill in the gaps when a provider is unwilling to contract.

For all services within a benefit package, plans must maintain a sufficient and adequate network for the delivery of covered services, meeting the standards required by 42 CFR Part 438 for availability of services and adequate capacity. If a plan is unable to provide necessary services through its contracted network for a particular enrollee, it must furnish those services outside of its network for as long as the plan is unable to provide them within the network.

Q26: Do VMod, EMod, and CTS service providers need to appear in the provider directory?

A26: Yes.