



# Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

**TRANSMITTAL:** 19 OHIP/ADM-01

**TO:** Commissioners of Social Services

**DIVISION:** Office of Health Insurance Programs

**DATE:** February 8, 2019

**SUBJECT:** Community First Choice Option

<b>SUGGESTED DISTRIBUTION:</b>	Director of Social Services Medicaid Staff Home Care Staff Fair Hearing Staff
<b>CONTACT PERSON:</b>	Local District Liaison: Upstate - (518) 474-8887 New York City - (212) 417-4500
<b>ATTACHMENTS:</b>	See Appendix I for Listing of Attachments

### FILING REFERENCES

Previous Ref. ADMs/INFs	Releases Cancelled	Dept. Regs. Law	Soc. Serv. & Other	Manual Ref	Misc.
None	None	18 NYCRR 505.14 18 NYCRR 505.28	365– a 365– f	None	None

## I. **PURPOSE**

The purpose of this Office of Health Insurance Programs Administrative Directive (OHIP ADM) is to provide Local Departments of Social Services (LDSS) with information and guidance regarding the Community First Choice Option (CFCO) and how the required CFCO services and supports are authorized, accessed, and delivered in New York State.

For the purposes of this ADM, Medicaid Managed Care (MMC) and Managed Long Term Care (MLTC) plans together will be referred to as the Managed Care Organization(s), or MCO(s). Additionally, “services and supports” will be referred to as “services.”

## II. **BACKGROUND**

CFCO became available to all states under the Affordable Care Act of 2010. This option provides a six percent (6%) increase in federal matching payments to states to expand and enhance Medicaid State Plan (State Plan) home and community-based attendant services to individuals in need of long-term care for Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related tasks that can be performed by an aide under State law. The LDSS will now be required to administer the CFCO through adherence to the State Plan, 42 CFR Part 441, and State-issued guidance, which will ensure statewide consistency when authorizing or reauthorizing CFCO services.

All services must be provided statewide in a manner that provides such services in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

## III. **PROGRAM IMPLICATIONS**

### A. **Key Program Contacts: Fee-For-Service and Managed Care**

CFCO will be available in New York as a service option through both Fee-for-Service (FFS) and Managed Care (Mainstream Medicaid Managed Care and Managed Long Term Care).

In the FFS environment, oversight, assessment, reassessment and service planning for individuals enrolled in straight FFS Medicaid (i.e., no waiver enrollment) seeking CFCO services will continue to be the responsibility of the LDSS. For individuals enrolled in the Traumatic Brain Injury (TBI) or Nursing Home Transition and Diversion (NHTD) 1915(c) waivers seeking CFCO services, oversight, assessment, reassessment and service planning will continue to be the responsibility of the Regional Resource Development Center (RRDC). For individuals enrolled in any of the Office for People with Developmental Disabilities (OPWDD) waivers, oversight, assessment, reassessment and service planning will continue to be the responsibility of the Developmental Disabilities Regional Office (DDRO) or its delegate. In all cases, when an individual presents at the LDSS seeking CFCO services, the LDSS will consult and collaborate with the other entities to ensure continuity of care and ease of access to CFCO services.

For all individuals enrolled in Mainstream Medicaid Managed Care and Managed Long Term Care seeking CFCO services, oversight, assessment, reassessment, service planning, and authorization will continue to be the responsibility of the MCO. The LDSS will not be responsible for any of these functions for Managed Care enrollees.

Please note that a consumer enrolled in a Medicaid Advantage (MA) plan can receive non-Community Based Long Term Care (CBLTC) CFCO services through FFS. The enrollee does not have to disenroll from the Medicaid Advantage plan to receive non-CBLTC CFCO services through FFS.

Individuals who receive Medicaid services through the New York State of Health (NYSOH), and are requesting CFCO services, must contact the Health Exchange Facility at [hxfacility@health.ny.gov](mailto:hxfacility@health.ny.gov) or 518-473-6397 for assistance.

## **B. Participant Eligibility**

An individual eligible to receive CFCO services must:

1. 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;
2. have an assessed institutional level of care (see below); and
3. reside in his/her own home, or the home of a family member.

CFCO services must be available to eligible individuals across the disability spectrum. Individuals in receipt of CFCO services will not be precluded from receiving other Home and Community Based (HCB) Long Term Care (LTC) services and supports through the Medicaid State Plan, a waiver, grant or demonstration, as appropriate. However, individuals will not be allowed to receive duplicative services in FFS and/or Managed Care.

## **C. CFCO Services**

Through CFCO, New York State is expanding consumer control over needed services, as well as expanding the access and availability of services that will allow individuals in need of long-term care to remain safely in, or return to, the community. Services under CFCO are Medicaid State Plan services that are community based, delivered through a person-centered approach, and designed to maximize an individual's independence in the community.

### **1. Current Services within CFCO**

- Consumer Directed Personal Assistance Program (CDPAP)
- Home Health Aide
- Homemaker/housekeeper (Personal Care – Level 1)
- Non-Emergency Medical Transportation (NEMT)
- Personal Care (Level 2)
- Personal Emergency Response System (PERS)

## **2. Personal Care**

The Personal Care service, as defined in the CFCO Final Rule and CFCO State Plan Amendment, includes supervision and/or cueing as a means to accomplish an ADL, IADL, or health-related task. This service is directly comparable to the personal care benefit defined as personal care services in 18 NYCRR Part 505.14 and in the State Plan. The federal rule, 42 CFR Subpart K, indicates that personal care services includes assistance provided to an individual to accomplish an ADL, IADL, or health-related task. Different levels of assistance may be provided to perform an ADL/IADL/task. The specific level of assistance provided must be based on the assessed needs of the recipient. Levels of assistance include supervision of the individual while performing the ADL/IADL/task; cueing/cognitive prompting/providing instructions while the individual is performing the ADL/IADL/task; or performing part or all of the ADL/IADL/task for the individual.

Personal Care services provided under State regulations/State Plan include the same levels of assistance as under CFCO. Please note that Personal Care services under CFCO or the State Plan do not include safety monitoring as an independent or “stand-alone” service in the absence of providing assistance with an ADL/IADL/tasks. The need for safety monitoring alone cannot constitute a service authorization for Personal Care. Supervision and/or cueing is a means of providing assistance with the needed ADL/IADL/health-related task in addition to providing partial or total hand-on assistance.

## **D. CFCO Service Delivery Models**

New York State offers two service delivery models under CFCO: the Traditional Agency model and the Agency with Choice model. In both models, to the extent desired by the individual, s/he maintains control over the delivery of services. Individuals who are not self-directing may select an adult who is willing and capable of directing the individual's services.

### **1. Traditional Agency Model**

The Traditional Agency model is a delivery method in which the services are provided by direct care workers who are employed by an agency or provider. Individuals will still exercise as much control over the selection, management and, if necessary, dismissal of their direct care worker as they desire. The LDSS, RRDC, or DDRO may contract with home care agencies or other approved providers to deliver CFCO services in the Traditional Agency model.

### **2. Agency with Choice Model**

The Agency with Choice model is a delivery method in which the services are provided by a direct care worker hired by the CFCO-eligible individual and not by an agency or provider. In this delivery model, which is similar to the manner in which services are provided within the Consumer Directed Personal Assistance Program (CDPAP), the individual will select, manage, train and, if necessary, dismiss his/her direct care worker. The direct care worker may be a relative who is not legally responsible for the individual, a neighbor, a friend or an independent direct care worker. However, the

direct care worker may not be a spouse, a person directing services on behalf of the individual or a parent when the individual is under age 21.

In the Agency with Choice model, a Fiscal Intermediary (FI) will be used to keep track of the worker's hours, pay the worker and deduct required amounts for taxes and insurance from the worker's paycheck. FIs can be licensed home care services agencies, independent living centers, or other entities that will pay the direct care workers employed by the individual, provided they have a Medicaid Management Information System (MMIS) provider number.

For individuals receiving CFCO services under the Agency with Choice model, the Department has developed a voluntary training packet explaining how to select, manage, and dismiss direct care workers. The nurse performing the assessment is responsible for making this packet available to the individual. Please see Attachment III, *Voluntary Training Program, How to Select, Manage and Dismiss Attendants*.

#### **E. Settings for the Provision of CFCO Services**

All CFCO services must be provided in the individual's home or community, as opposed to an institution or other isolated setting. Some settings in which CFCO services cannot be provided include, but are not limited to:

- a nursing facility;
- a hospital;
- an institution for mental disease;
- an intermediate care facility for individuals with an intellectual disability or related condition;
- a setting with the characteristics of an institution; or
- provider-owned or controlled residential settings.

#### **F. CFCO Service Providers**

All CFCO services must be provided within the scope of practice of the person providing the service and only by providers who have a valid Medicaid Management Information System (MMIS) number under the Medicaid program. Providers who currently have an MMIS number and currently have a contract with an LDSS to provide services under the Medicaid program are permitted to provide CFCO services as well. LDSSs may also enter into contracts with new providers to furnish CFCO services.

#### **G. Conflict of Interest Standards**

The LDSS will ensure that there is separation between the function of assessor or care manager/case coordinator and the other functions the same person performs at the LDSS or agency/provider.

An individual conducting a functional needs assessment (FNA) and/or developing a person centered service plan (PCSP) for CFCO eligible individuals shall not be:

- i. A parent who is legally responsible for the individual, the individual's spouse, or any paid caregiver of the individual;
- ii. Financially responsible for the individual;
- iii. Empowered to make financial or health-related decisions on behalf of the individual;
- iv. A person who would benefit financially from the provision of assessed needs and services; or
- v. A person who provides HCBS waived services for the individual or who has a business relationship with or is employed by a provider of HCBS waived services for the individual.

Federal regulations provide an exception to item (v) 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 this case, conflict of interest protections must exist within the provider entity/entities, including the separation of assessment/planning and HCBS provider functions. This exception extends to other unique situations, such as a single agency being available to serve individuals who only speak a particular language or to meet other specific cultural needs.

#### **IV. REQUIRED ACTION**

##### **A. Medicaid Eligibility Determination**

The operationalization of CFCO has no impact on the current Medicaid eligibility determination process. To be eligible for CFCO, an individual 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. However, an 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.

##### **B. Residential Determination**

After it is determined that the individual meets the CFCO Medicaid eligibility requirement, a residential status determination must be made. Only an individual living in his/her own home or the home of a family member is eligible for CFCO services. Until further notice, individuals who live in congregate settings, institutional settings, or provider owned and/or controlled properties are not eligible to receive CFCO services.

##### **C. Level of Care Determination**

The final step in determining CFCO eligibility is a Level of Care (LOC) determination. An initial determination must be made that the individual seeking CFCO services requires the LOC provided in a hospital, a nursing facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or

over. LOC for individuals between ages 21 and 65 needing psychiatric services is determined using hospital, ICF/IDD or nursing facility LOC criteria. Please note that once initial LOC eligibility is determined for these individuals, a LOC determination must be made at least annually thereafter utilizing the various state-approved assessment tools in use across disability populations in the State.

The LDSS must identify whether or not an individual seeking CFCO services is participating in any other State programs that could potentially provide duplicative services (e.g., MMC, MLTC, NHTD/TBI, OMH, OPWDD, etc.). LDSSs should utilize their resources for identification of participation in any such State program.

After an identification is made, the LDSS will direct the individual to the most appropriate service authorization pathway. Please see the chart included in Attachment IV, *Placement and Maintenance of CFCO RR/E Code - LDSS*, which details the steps necessary to determine the correct pathway for service authorization.

Once initial LOC eligibility is determined, an LOC determination must be made at least annually thereafter showing that the individual continues to meet the LOC criteria necessary for CFCO services. Ongoing LOC determinations will be made using various functional assessment tools in use across disability populations in the State. If a LOC outcome is not included as part of the assessment, it will be determined separately. Different tools are utilized to accurately assess an individual's specific needs based on the relevant institutional LOC being assessed (i.e., a skilled nursing facility, hospital, intermediate care facility, institute for mental disease, etc.).

#### **D. Physician's Order**

After the LDSS has determined that an individual seeking Personal Care Services meets all three CFCO eligibility criteria, the LDSS must provide the individual with the Department's *Physician's Order for Personal Care/Consumer Directed Personal Assistance Services*, DOH-4359. The Human Resources Administration (HRA) will continue to use the Medical Request for Home Care, form HCSP-M11Q to obtain the physician's order. After the individual has his/her physician complete this form, the individual must promptly return the form to the LDSS, after which the LDSS will authorize a functional needs assessment.

In order to assure information about the individual is current and to accurately determine service needs, all physician's orders for CFCO personal care services shall be based on a medical examination performed within 30 days of the date the orders are signed and must include a primary diagnosis. New physician's orders are required upon initial assessment or any subsequent reassessment. One copy of the physician's orders shall be maintained in the case record; another copy shall be forwarded to the assessor.

#### **E. Functional Needs Assessment**

The functional needs assessment (FNA) must be completed face-to-face and where the individual currently resides. A registered nurse, either employed by the LDSS or an approved provider agency, or directly contracted by the LDSS or the State, will conduct the FNA. The individual can request the participation of anyone that s/he wants involved in the FNA.

Various State-approved assessment tools are in use across the State to assess an individual across the critical domains of functional status, health condition and cognition. Currently, the Community Assessment within the Uniform Assessment System (UAS) is the most widely used of these tools. The UAS provides the nurse with a FNA tool that will record the individual's needs, strengths, preferences and goals for maximizing independence and community integration, as well as an assessment of risk that identifies potential risks and vulnerabilities. The results of the FNA will inform the development of the person-centered plan of care.

## **F. Person Centered Service Planning**

A Person Centered Plan of Care (POC) will be developed with the individual following completion of the FNA and will identify the individual's needs and goals related to living independently in the community. The individual can request the participation of anyone that s/he wants involved in the person centered planning process. Once assessed for functional need, the individual's service needs must be reviewed every six months, upon a significant change in condition, or if requested by the individual. A face-to-face review is also conducted annually to ensure that the individual continues to meet the CFCO LOC criteria.

The LDSS is responsible for conducting the person-centered planning process in compliance with 42 CFR § 441.540 and 42 CFR § 441.301. Please see Attachment I, *Person Centered Service Planning Guidelines for Medicaid Managed Care Plans and Local Departments of Social Services*. These guidelines are intended to provide information regarding the requirements for the Person Centered Service Planning (PCSP) process for enrollees in Medicaid Managed Care and for individuals receiving services through FFS from the LDSS. The Department has provided a Person Centered Service Plan template for LDSS to utilize. The use of this template is not mandatory, but strongly encouraged. The template is included as Attachment II of this ADM.

For individuals enrolled in a 1915(c) waiver or a managed care plan, their respective care manager will oversee the PCSP process and develop the POC. The LDSS will consult and collaborate where appropriate.

## **G. Authorization and Notice of Decision**

The LDSS is responsible for authorizing the CFCO services that are not available through an individual's MCO or waiver program, as applicable. The LDSS authorization/denial of CFCO services should be limited to only those CFCO services that are not in the individual's MCO or waiver benefit package. All CFCO services listed in Section III (C) (1) of this ADM are currently offered in both the Mainstream Managed Care benefit and the Managed Long Term Care benefit.

During the assessment and planning process, the LDSS must provide written notification of initial authorization, reauthorization or denial of the requested CFCO services. The notification must be completed in its entirety and provide the required information regarding fair hearings. The LDSS must use the existing service template notices for the mandatory CFCO services. Notice must be provided to the individual and, if applicable, the individual's designated representative. A copy of the notice must be maintained in the individual's case record.



## **H. Reassessment and Reauthorization**

Individuals will be reassessed when their support needs change, at their request, or at least every six months. The reassessment must be conducted using the same assessment tool that was most recently used. The POC must be reviewed and revised upon reassessment of functional need, at least every six months, when the individual's circumstances or needs change significantly, or at the request of the individual. Among the items that must be reviewed are the individual's ability to meet desired goals and outcomes based on the frequency, amount and duration of services authorized and provided.

The LDSS must provide written notification of the reauthorization or denial of the requested CFCO services to the individual and, if applicable, the individual's designated representative.

## **I. Reporting Requirements**

The LDSS is responsible for assisting the Department in fulfilling federal regulatory reporting requirements for CFCO service delivery (see 42 CFR § 438.580). The LDSS will maintain and furnish all information necessary for the Department to ensure adequate capacity and access for the participating population and to demonstrate administrative arrangements satisfactory to the Department. Reporting requirements will be provided to the LDSSs by April 2019. Please note that these CFCO-specific reporting requirements are additional; they do not negate existing reporting requirements.

Reports must be submitted to the Department's Division of Long Term Care on a quarterly basis.

## **J. Maximization of Medicare and Other Third-Party Insurance**

Before authorizing CFCO services, LDSSs shall make maximum use of home health and/or nursing services provided under Medicare or other third-party insurance whenever eligibility under those programs can be established.

## **K. Payment**

Payments made for CFCO services cannot be duplicative of other authorized services.

No payment to the provider will be made for authorized services unless the provider's claim is supported by documentation of the time spent in provision of services for each individual.

## **V. SYSTEMS IMPLICATIONS**

### **A. Recipient Restriction Exemption – System Edits and Limitations**

CFCO eligible individuals will need to be identified in the eMedNY system through a unique Recipient Restriction/Exemption (RR/E) code on the individual's file. For individuals deemed eligible for CFCO, RR/E placement started on April 1, 2018. Two (2)

new Restriction Codes have been created to identify CFCO eligible individuals. The new Client Restriction Codes are 'CF' and 'CO' and contain the following attributes:

- CF: Community First Choice Option (Non OPWDD)
  - Short Description: 'CFCO'
  - Long Description: Community First Choice Option (Non OPWDD)
- CO: Community First Choice Option (OPWDD)
  - Short Description: 'CFCO-OPWDD'
  - Long Description: Community First Choice Option (OPWDD)

The addition of the 'CF' or 'CO' RR/E code on the individual's eligibility file in eMedNY does not have an impact on the processing and payment of valid FFS Medicaid claims. The CFCO RR/E codes allows the State to identify and claim the additional six percent (6%) FMAP.

The placement and/or update of the CFCO RR/E code can be completed through eMedNY Thin Client or through a New York Medicaid Choice (NYMC) batch file process. eMedNY Security Profiles have been updated to allow add/update access via the Client Detail: Exception/Restriction Page. The following groups will have add/edit access:

- RR/E Code 'CF'
  - OPWDD
  - HRA/LDSS
  - DOH - Subject Matter Expert
  - MCO
- RR/E Code 'CO'
  - OPWDD
  - DOH - Subject Matter Expert
  - MCO

MCOs do not have access to EMedNY Thin Client and must utilize the NYMC batch file transmittal process to have the 'CF' or 'CO' RR/E code added to an individual's eligibility file in eMedNY. The MCOs transmit the individual client data via a file to NYMC which is then systematically transmitted to eMedNY. NYMC's role in the batch transmittal is only a data pass through. System edits are applied at the eMedNY level.

In addition to security profiles, eMedNY System edits were created based on CFCO criteria. These include:

- Specific RR/E codes cannot co-exist with a 'CF' or 'CO' (RR/E to RR/E Conflict).
  - More information on the RR/E to RR/E conflict is included in Attachment IV: *Placement and Maintenance of CFCO RR/E Code - LDSS*.
  - Additional trainings on RR/E codes and conflicts are scheduled for early 2019.
- Specific RR/E codes can only exist with a 'CF' or a 'CO' based on populations.
- Only specific Medicaid Eligibility Coverage Codes that meet the CFCO Medicaid eligibility criteria are allowed to co-exist with a CFCO RR/E code.
- Begin date for CFCO RR/E code cannot be prior to April 1, 2018. Please note that this date does not need to be the first day of the month; CF and CO RR/E

codes may be added to a file on any date that the CFCO eligibility criteria is determined.

## B. Recipient Restriction Exemption – Roles and Responsibilities

The placement of the CFCO RR/E code on an individual's eligibility file through Thin Client or batch file has been divided into the following two phases:

- The initial upload of CF and CO RR/E codes for current CFCO eligible individuals in both FFS and Managed Care ) who are in receipt of CFCO services on April 1, 2018; and
- CFCO eligible individuals in both FFS and Managed Care determined to be eligible after April 1, 2018.

During the initial upload phase, OPWDD and MCOs were required to identify CFCO eligible individuals within their current populations. The individuals identified as CFCO eligible had a 'CF' or 'CO' RR/E code uploaded to the individual's eligibility file to allow for the additional federal claiming.

OPWDD has identified their current population and completed the initial 'CO' RR/E code upload for all OPWDD individuals who meet the requirements for eligibility for CFCO services. Individuals with an RR/E code of 95 (OPWDD determined) who have met the requirements of Medicaid eligibility have an intermediate care facility (ICF) level of care and have met the residency requirement were coded as 'CO.'

The LDSSs will not be responsible for loading or removing a 'CO' RR/E code. OPWDD will continue to code CFCO FFS eligible individuals for their population. LDSS staff who encounter individuals with a OPWDD RR/E code and who meet the CFCO Medicaid and CFCO Residential eligibility criteria should be referred to the local Developmental Disability Regional Office (DDRO). For OPWDD eligibility, contact the Front Door: [https://opwdd.ny.gov/welcome-front-door/Front\\_Door\\_Contact\\_Numbers](https://opwdd.ny.gov/welcome-front-door/Front_Door_Contact_Numbers). For Medicaid coding issues for OPWDD eligible individuals, contact Revenue Support: [https://opwdd.ny.gov/opwdd\\_resources/benefits\\_information/revenue\\_support\\_field\\_office](https://opwdd.ny.gov/opwdd_resources/benefits_information/revenue_support_field_office).

For individuals enrolled in MCOs, CFCO eligibility will be determined by the MCOs. MCOs began the identification of their current enrollees for CFCO eligibility on April 1, 2018.

After the initial upload phase, it will continue to be the responsibility of OPWDD, MCOs and LDSSs to add and maintain the CFCO RR/E codes for their respective populations. LDSSs will use Attachment IV, *Placement and Maintenance of CFCO RR/E Code – LDSS*, for step-by-step procedures for determining CFCO eligibility, placement of the 'CF' RR/E code on designated population and referrals to authorized contact entities for CFCO eligibility determination and 'CO' RR/E code.

Due to system limitations listed above, MCOs, OPWDD, or other authorized contact entities may contact the LDSSs to review an existing Nursing Home RR/E Code (N1-N9) to allow placement of a 'CF' or 'CO' RR/E code. LDSSs should follow their existing process to review the RR/E N codes and, if applicable, update/inactivate the RR/E N code. LDSSs will be responsible for responding to the authorized contact entity with the

determination of the Nursing Home RR/E code.

**C. Claims Coding**

Billing codes for all April 1, 2018, mandatory CFCO services listed in this memorandum are the same as they have been for these services prior to the April 1, 2018, implementation date.

**VI. EFFECTIVE DATE**

The provisions in this Administrative Directive are effective February 8, 2019 and retroactive to April 1, 2018 where indicated.



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Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs

**LISTING OF ATTACHMENTS**

- Attachment I:** Person Centered Service Planning Guidelines For Managed Care Organizations and Local Departments of Social Services
- Attachment II:** Person Centered Service Plan Template
- Attachment III:** Voluntary Training Program, How to Select, Manage and Dismiss Attendants
- Attachment IV:** Placement and Maintenance of CFCO RR/E Code - LDSS