This Webinar was presented in Lacey Washington to Health Home Care Coordinators and allied staff as part of the monthly series of special topics. It was presented on August 13, 2015.

Today's Presenter

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Aging and Long Term Services Administration

Washington State Dept. of Social and Health Services

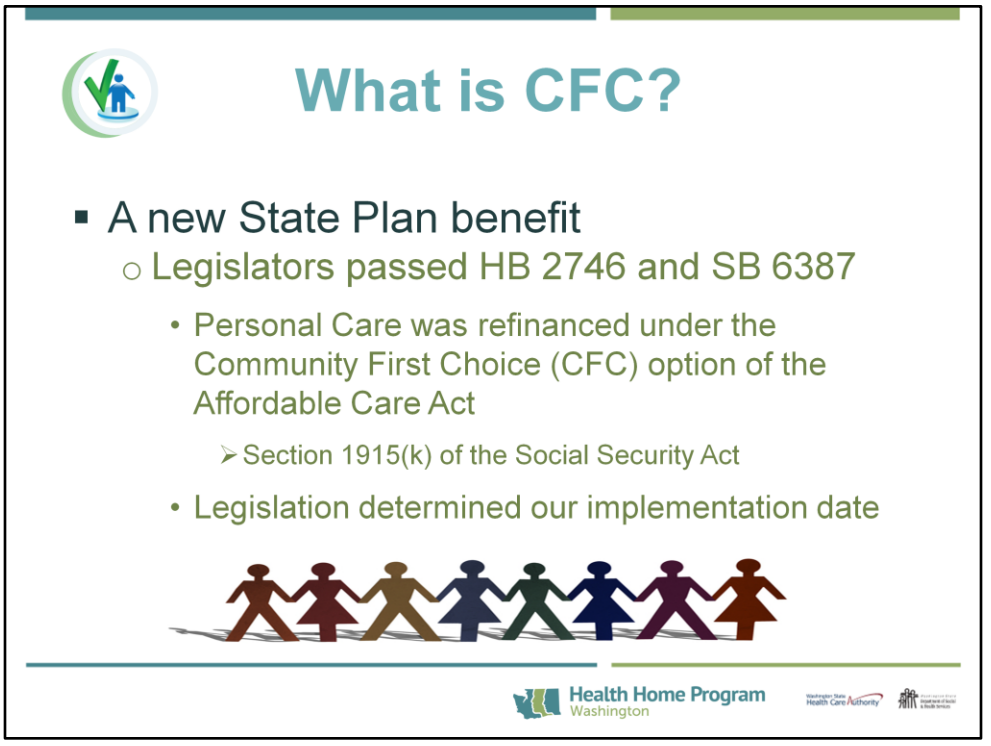
Community First Choice

Health Home Program Washington

Training Objectives

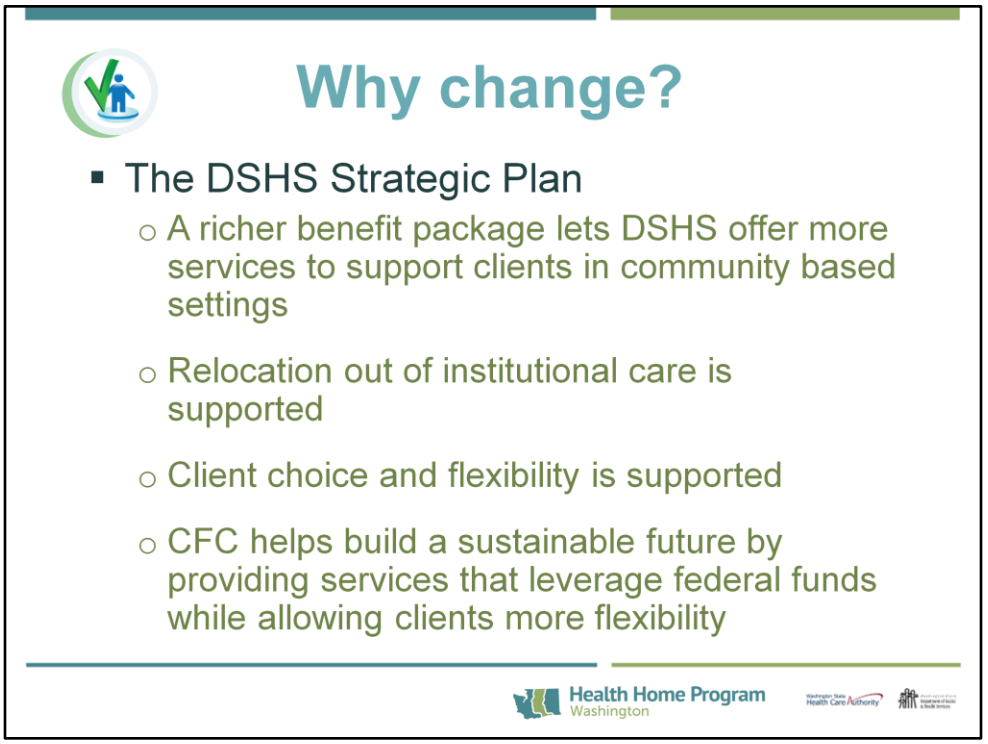
- What is CFC and why DSHS made this change
- Eligibility and Programs
- CFC Services and how they work
- Examine New Federal Rules:
  - Person Centered Planning
  - Home & Community Based Setting
- DSHS implementation of CFC

Health Home Program Washington



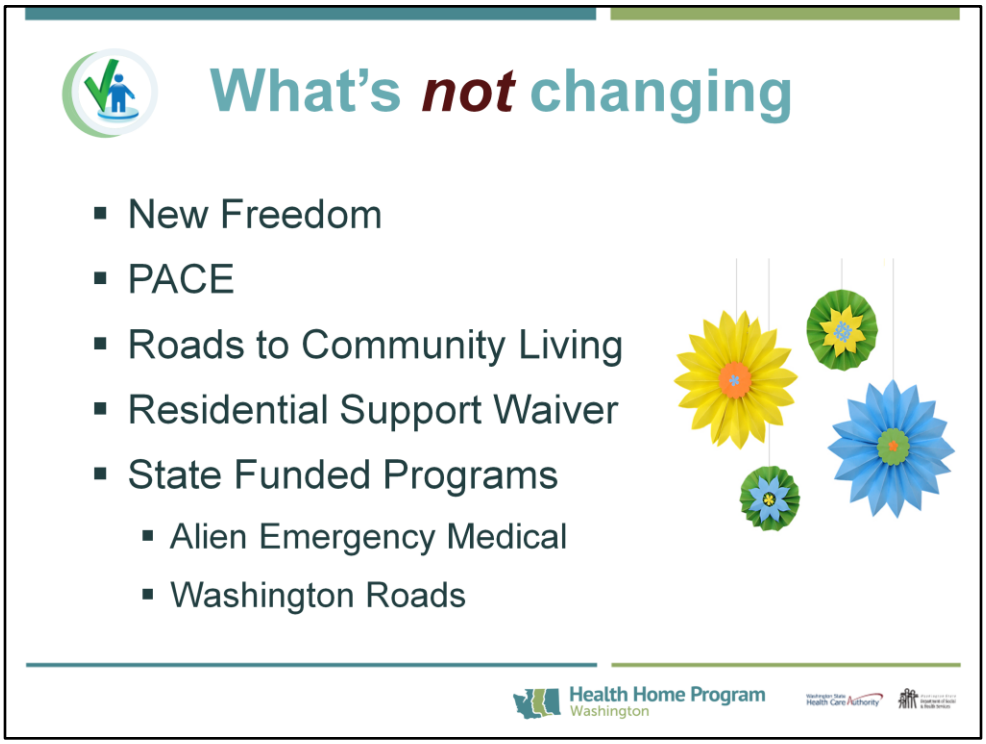
Key Points:

- This is not a replacement of MPC, it is an additional state plan program.
- Most of the State's personal care will be funded through CFC rather than MPC or COPES.
- A 7/1/15 implementation matches the State's fiscal year and budget year.



Key Points:

- These are some examples of how CFC aligns with our Agency's strategic plan.
    - We can do more with less state fund expenditure
    - Clients have more choice and flexibility than in past models
    - Community based care is the cornerstone of the program
    - Current COPES and MPC federal match is 50%, CFC has a 56% match which saves the state money



Key Points:

- Brief explanation of these programs.
- Health Homes is not in King County.
- These programs will remain as they are today.

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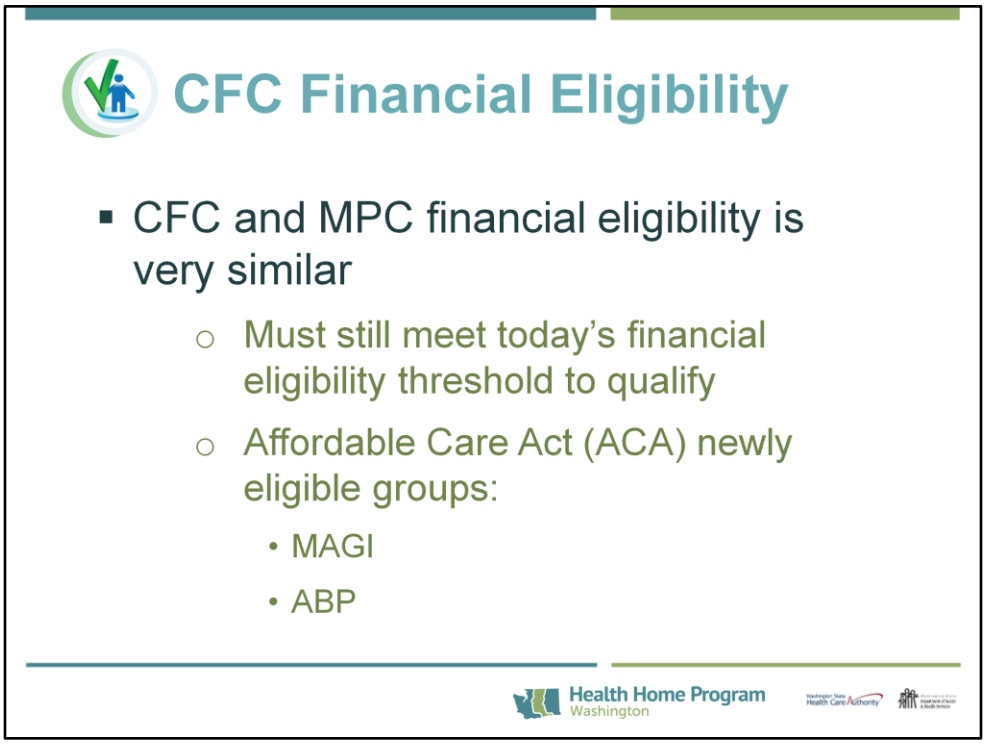
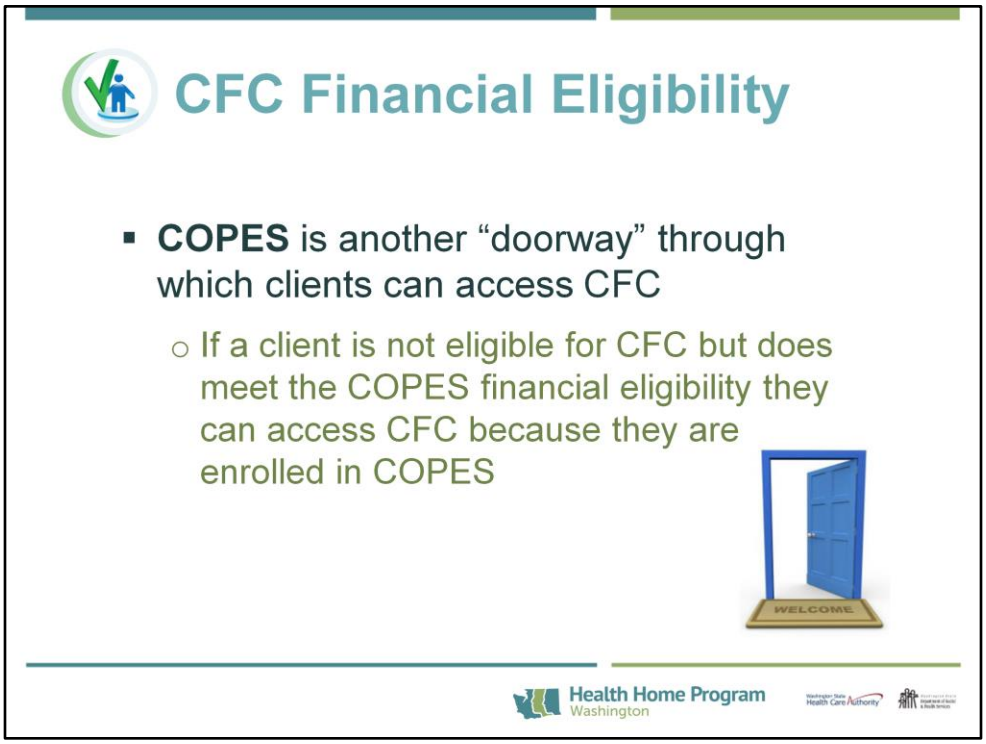
Financial Eligibility Basic Overview



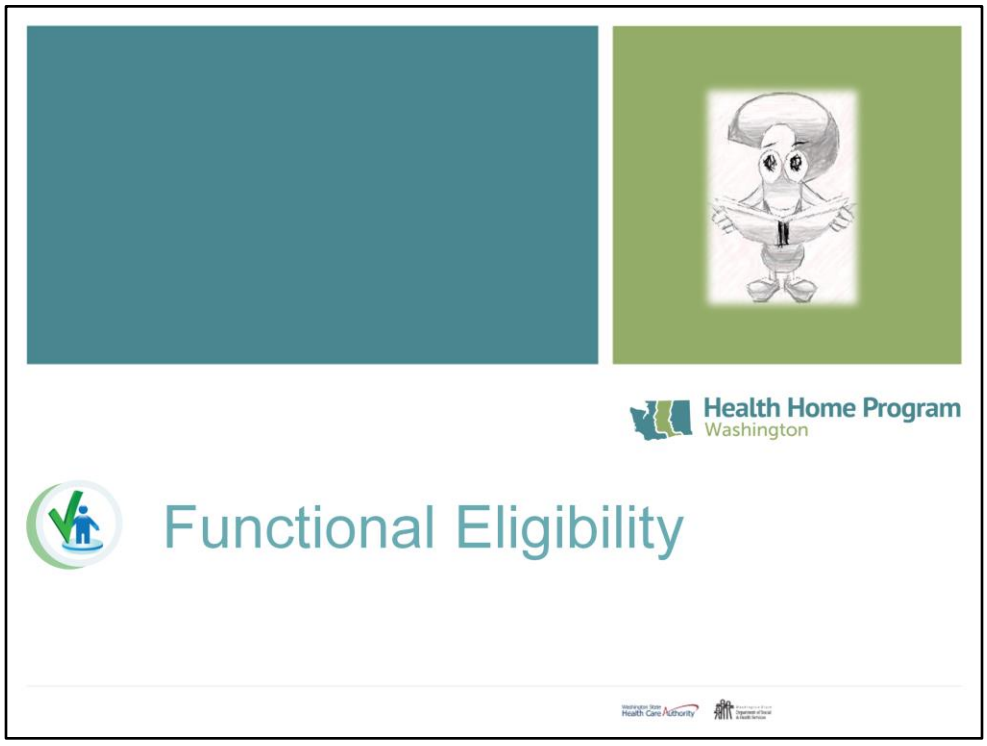
Key Points:

- CFC and MPC have similar basic eligibility.
    - The eligibility is based on the eligibility criteria for a Categorically Needy Apple health program.
- Generally, the people who were MPC or MAGI MPC before, will likely be financially eligible for CFC.
    - They still must meet functional eligibility
- ACA – Affordable Care Act added newly eligible groups on January 1, 2014.
- MAGI is Modified Adjusted Gross Income – more information can be found at http://www.lcdjfs.com/financial-support-services/medicaid/mag
- ABP is Alternative Benefit Plan



Key Points:

- Clients could become eligible for CFC through COPES, COPES is another doorway to eligibility.
    - If you are not financially CFC eligible (example: client has income that is too high) but you are eligible for COPES, you could enroll in COPES and that would then make you eligible for CFC as well; through a "back door".
    - If you do not qualify for COPES for some reason (example: client had a transfer of assets – which is not considered in CFC), the client does not qualify for CFC.
        - If there is a penalty period, just like now, the client may be eligible at the end of that penalty period.

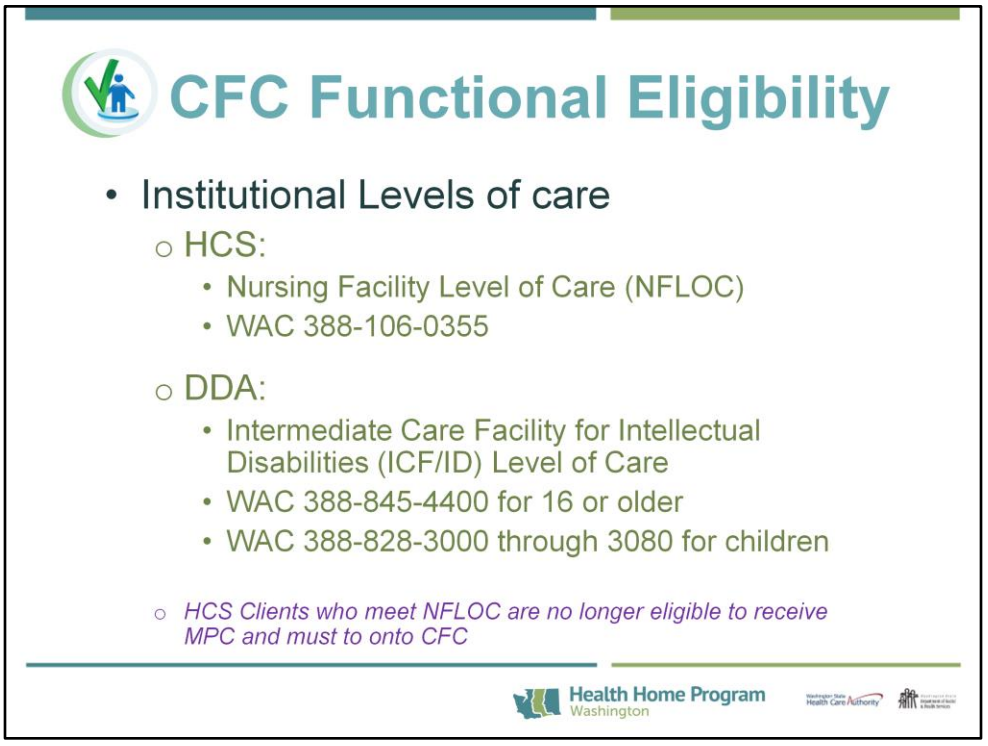


Key Points:

- Switching gears to functional eligibility
    - Considers Activities of Daily Living (ADLs)
        - Think of Katz ADL assessment or Minimum Data Set (MDS) used in nursing facilities (CARE somewhat mirrors MDS).
        - Client must need assistance with ADLs to be eligible.
        - ADLs include: (Per WAC 388-106-0355)
            - Eating, Toileting, Bathing, Transfer, Bed Mobility, Locomotion, and Medication Management.

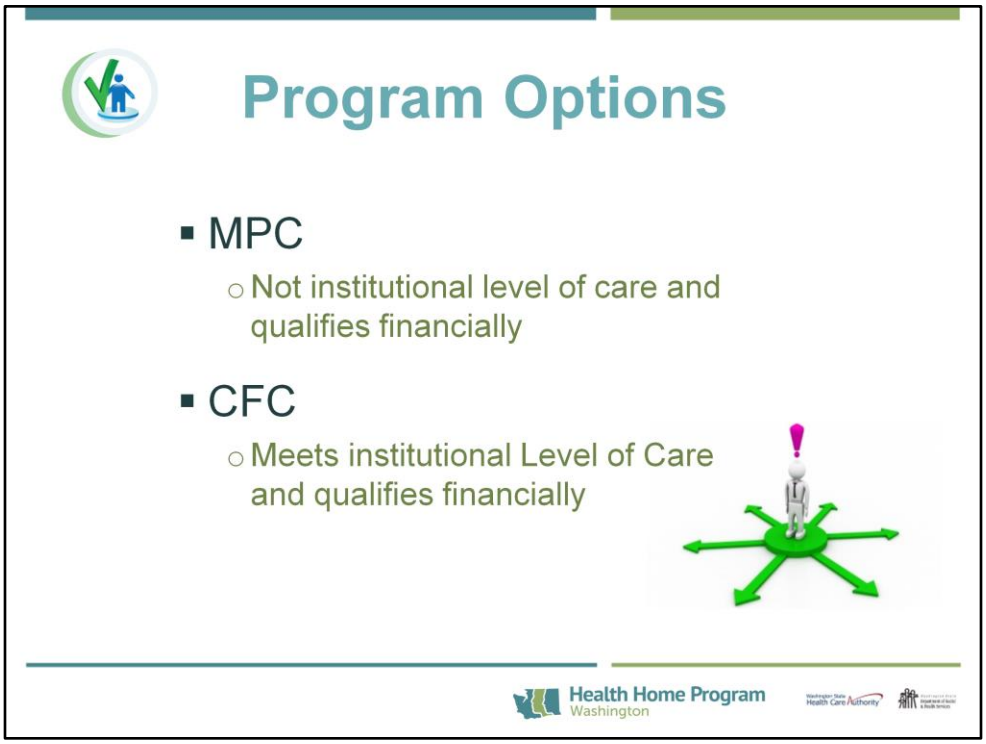
Key Points:

- MPC is not going away.
- Eligibility for MPC will change – only clients who **do not** meet institutional level of care will be eligible.



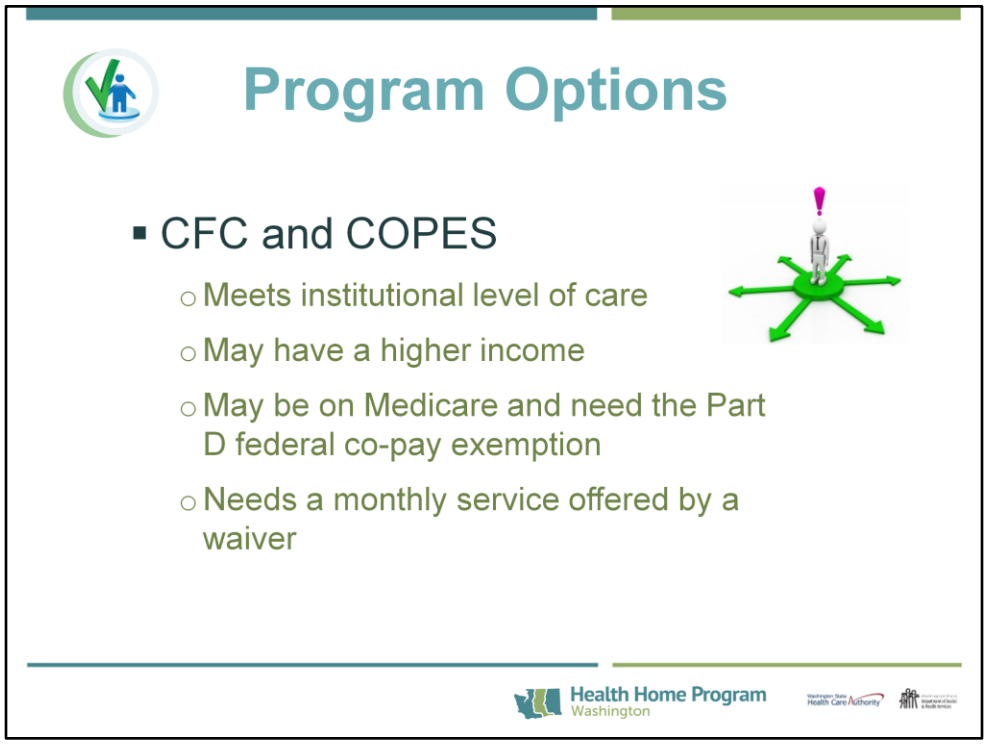
Key Points:

- Any client must require assistance with ADLs to be eligible:
    - For HCS, CFC functional eligibility mirrors COPES, the eligibility is based on NFLOC.
    - For DDA, CFC functional eligibility is based on ICF/ID and/or NFLOC.
    - And again, if a client meets NFLOC, they are not eligible to receive MPC, they must go onto CFC.



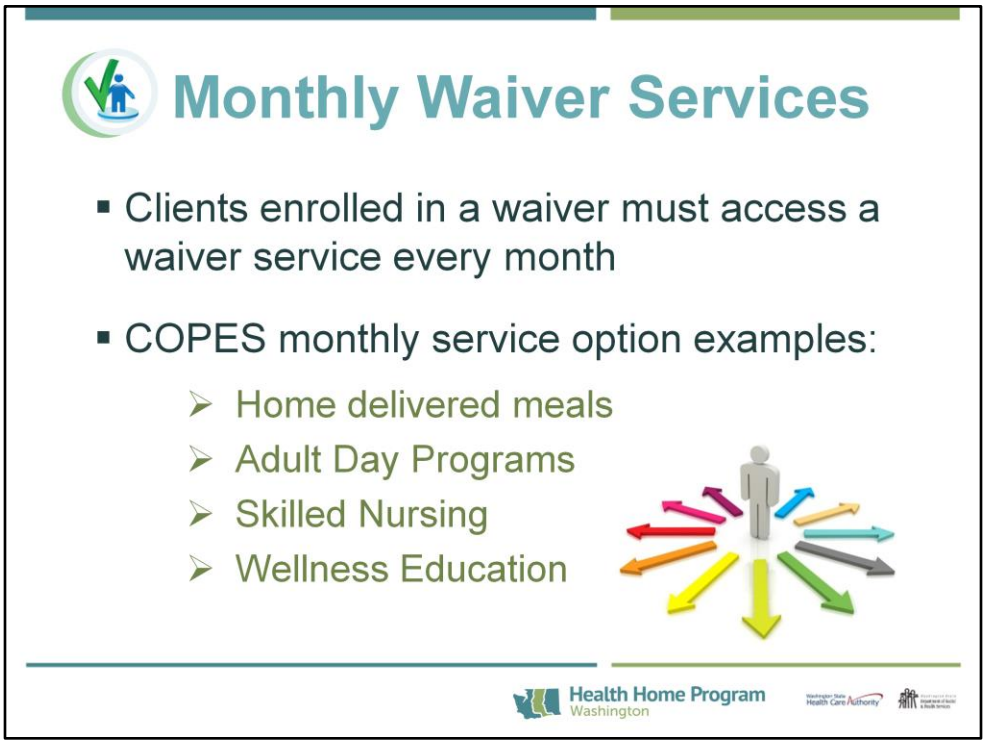
Key Points:

- This is a review of the program options combining functional and financial eligibility
    - MPC – Financially eligible but DO NOT meet NFLOC
    - CFC – Financial eligible and DO meet NFLOC



Key Points:

- COPES is more complex:
  - Financial eligibility criteria includes verifications of income, transfer of assets, and other considerations.
  - COPES may be considered for clients with Medicare who have Part D prescription co-pays.
  - Once someone goes onto COPES, personal care will not be a COPES service, so they must access one of the other services in COPES to maintain their eligibility for the COPES waiver.



Key Points:

- Having a monthly waiver service through COPES is an important detail
- These are some of the services available on a monthly basis to COPES participants
    - Any of these services are generally used on a monthly basis.
    - As long as they continue to get any COPES service they need and are qualified for monthly, they continue to be eligible for COPES.
    - Not receiving a monthly service would make them ineligible for the waiver.
- New Service: Wellness Education
    - A service designed to provide clients with individualized information on wellness, healthcare, disease management/prevention. Each client receives information created specifically for them once every month.
    - There is no reduction to hours or cost to clients for this service.

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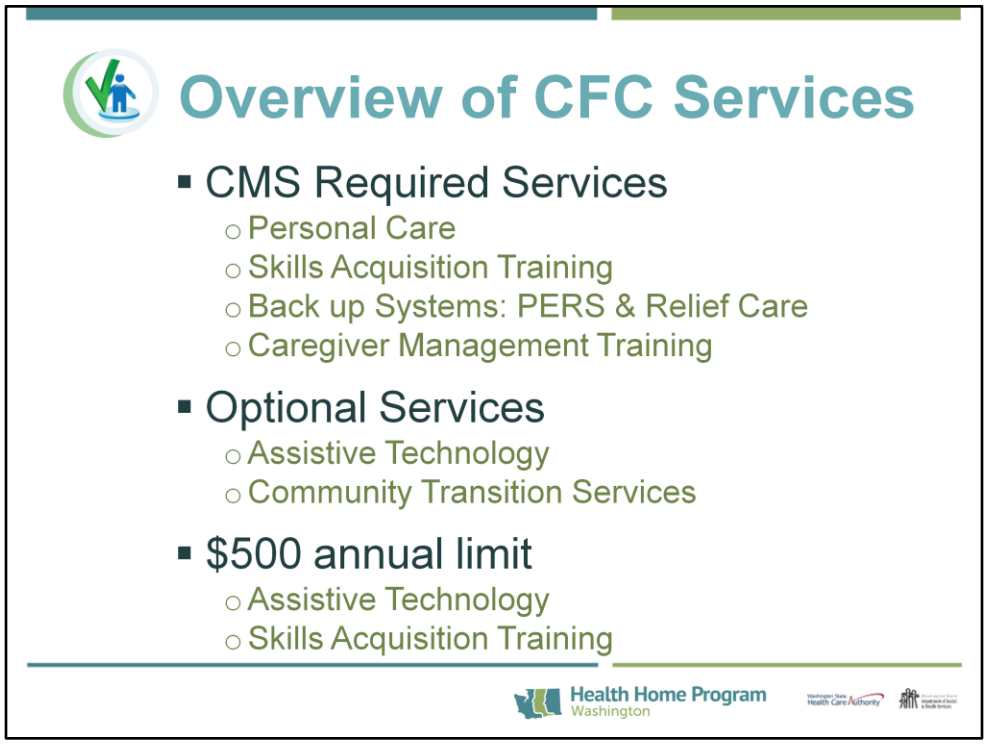
CFC Services



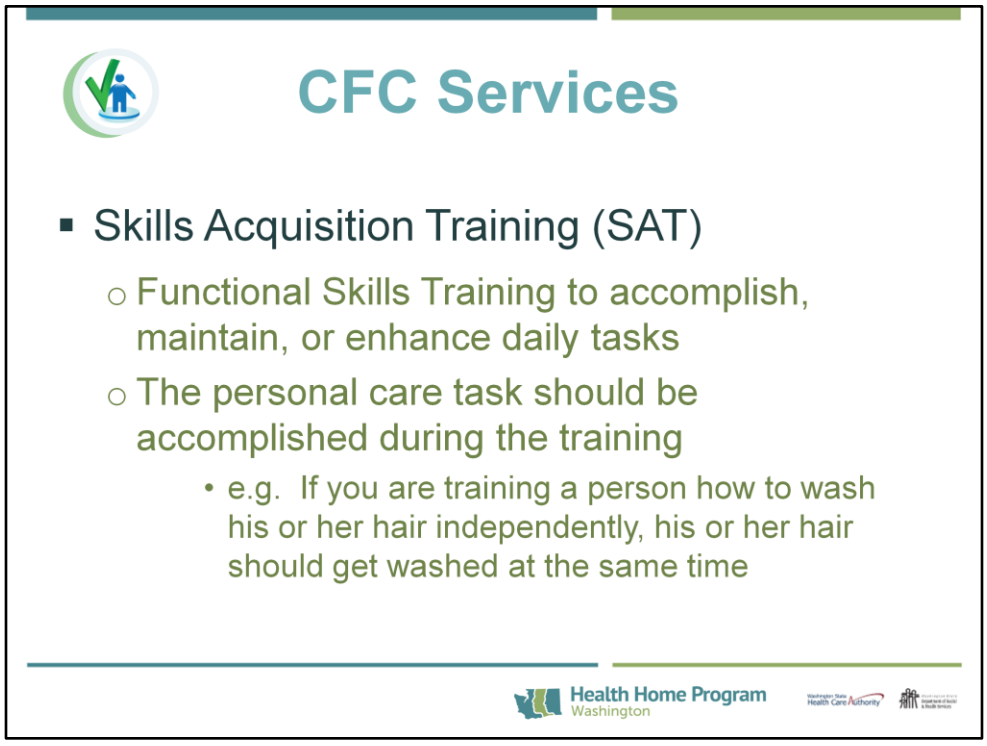
Key Points:

- This is an overview of all CFC services
    - Required services were those things that CMS required that we include in CFC
    - Optional services were services we had the option to include in CFC

These services will be discussed in the slides to follow.

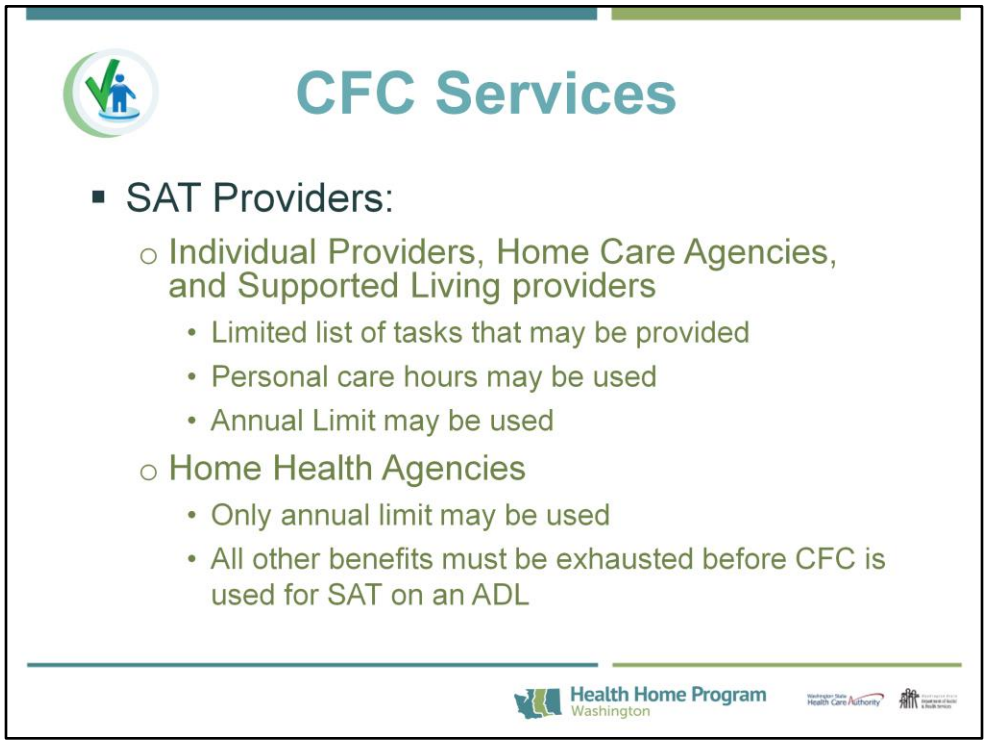
Key Points:

- Personal care is the same as in today's system and has the same providers.
- Clients could choose to have skills acquisition training in place of their personal care if they use an individual provider, an agency provider, or a supported living provider to provide SAT services.
    - If they use another provider, they would need to access their annual limit as the rate for these providers is higher.



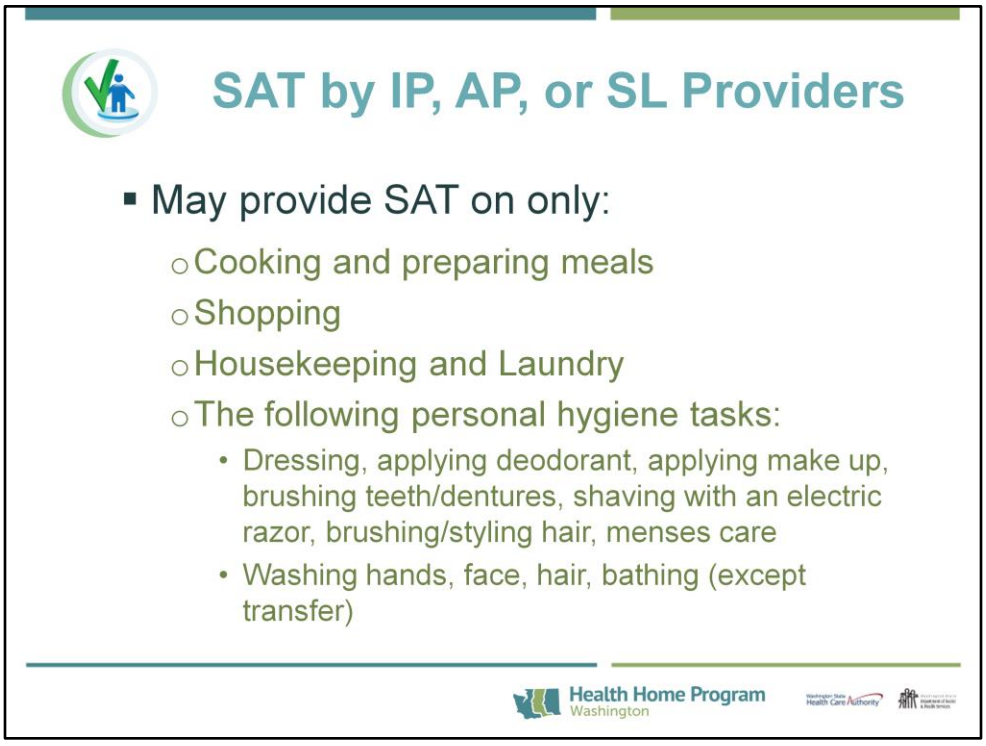
Key Points:

- Skills Acquisition Training is designed to allow a client to become more independent:
    - Clients may use their personal care hours to have training that is allowed to be provided by an IP an Agency provider, or a supported living provider.
    - Clients may use up to $500 per fiscal year to get additional skills training from an IP or Agency provider or if they choose to use a Home Health Agency provider.
        - This is part of an aggregate maximum benefit with Assistive Technology – so a total of $500 of any combination of AT and SAT.



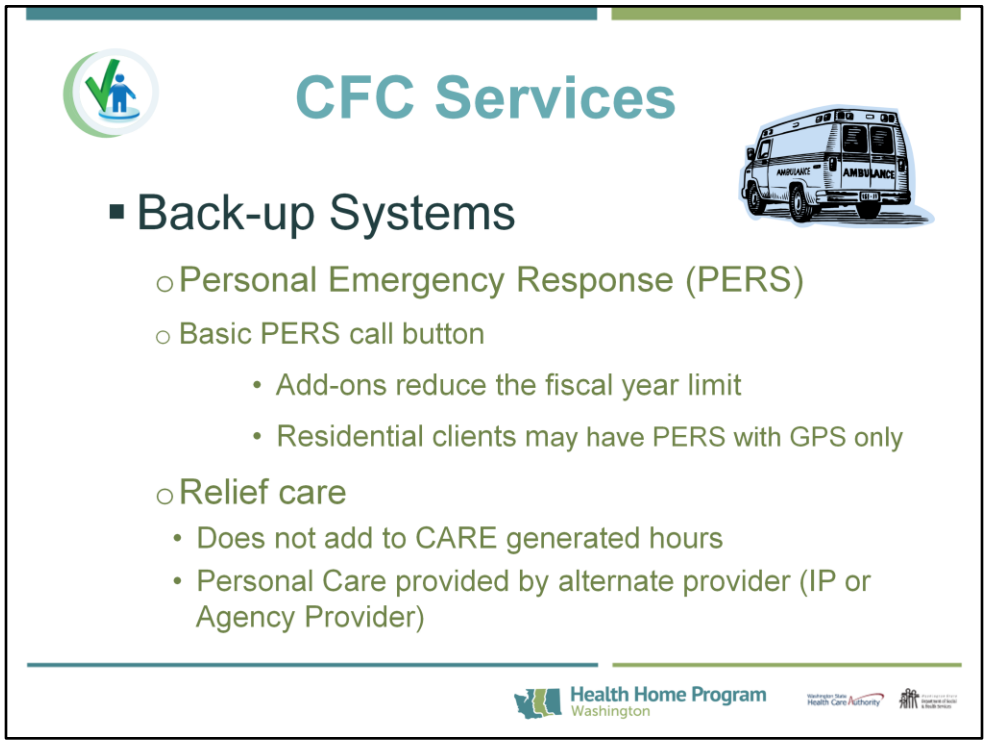
Key Points:

- Individual Providers, Agency Providers (Home Care Agencies), and Supported Living Providers:
    - May provide some limited tasks as SAT.
    - Client may use personal care hours if one of these providers is used or may use annual limit $500.
- Home Health Agencies:
    - Clients may **not** use their personal care hours for Home Health Agencies, but may access the annual limit.
    - All other medical benefits must be exhausted before using a Home Health Agency:
        - Both Medicare and Apple Health have a therapy benefit; which includes skills training for ADLs. These benefits MUST be used first before payment is authorized through CFC.
        - If a client wishes to access their benefits through any insurance carrier, including Medicare or Apple Health, they would visit their medical provider for a prescription and referral assistance.



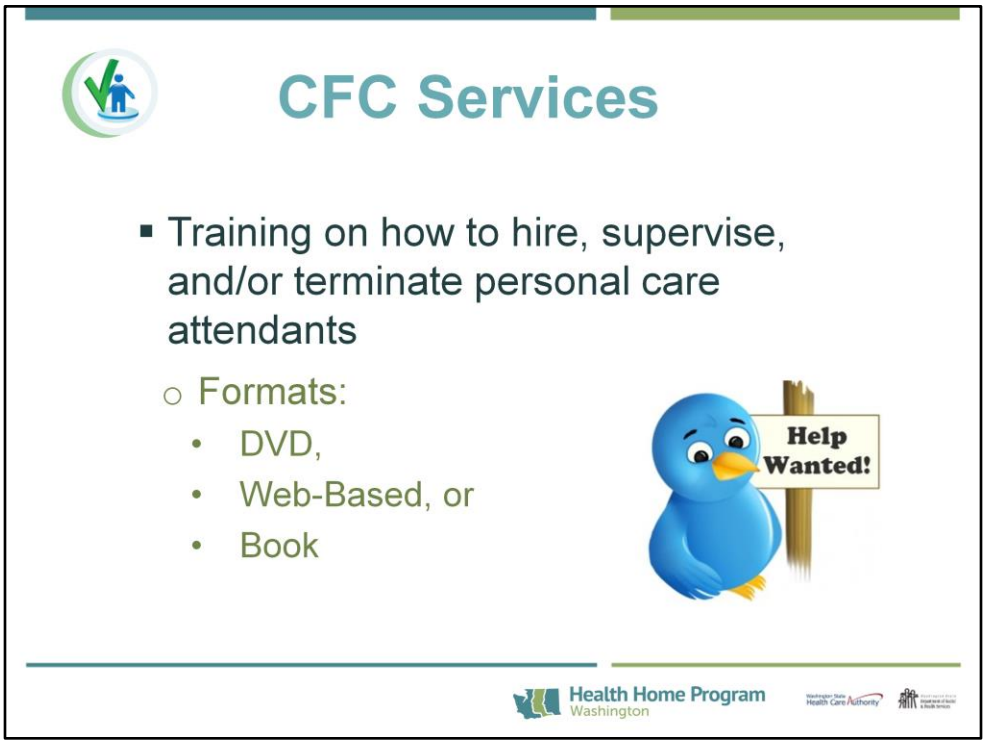
Key Points:

- SAT provided by an IP, AP, or S/L provider:
    - The tasks listed are the ONLY tasks these providers may provide SAT for. Anything else is outside of the scope of their practice.



Key Points:

- Back-up Systems include:
  - Basic PERS call button for those who qualify – any add-ons would be considered AT (any costs above the basic system cost)
    - Add-ons include: Falls detection, GPS, and Medication Systems only.
  - Residential clients may qualify for the basic PERS with GPS
    - Residential clients do not qualify for a PERS by itself or a PERS with any other add-on, the WAC only allows for a PERS plus GPS
- Relief care is personal care provided by provider that is not a regular provider:
  - Relief care does not add any hours to the CARE assessed hours.
  - It does highlight a discussion with the client that they can use their personal care hours to have more than one personal care provider contracted so that relief/back-up care is more easily facilitated.



Key Points:

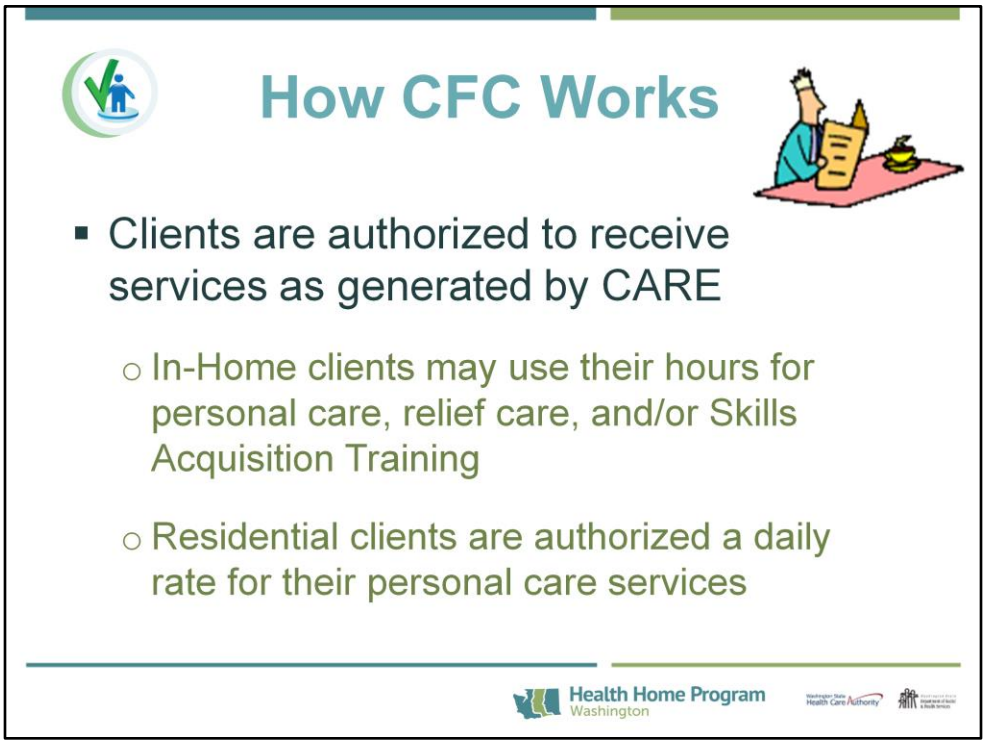
- Training on caregiver management:
  - No cost to the client.
  - Provided as a DVD, a link to a video on the web, or a book.

Key Points:

- CMS determined that there were some services that we had an option to provide.
- Transition services are much the same as they are today, in CFC there is an $850 per transition max.
    - RCL is the preferred program so if they are eligible, use that program first
    - Transitions may occur more than once per year, this is a per transition maximum.
    - This service is no longer available in the COPES waiver as of July 1, 2015.
    - There is still a state-only benefit that should only be used when the client is not eligible for RCL or CFC
    - The residential care discharge allowance of $815 still exists.

Key Points:

- Assistive Technology purchase requirements:
  - Must substitute for human assistance or enhance/increase independence.
  - Are items of technology, not necessarily any assistive device.
  - PERS add-ons like GPS, fall detection, or medication reminder/delivery systems cost more – the additional charge (above the cost of the basic system) counts toward this fiscal year maximum limit.
    - This will be effective at the next assessment.
  - Purchases of Assistive Technology and Skills Acquisition Training are aggregately maxed at $500 per state fiscal year.
  - Purchases must not be covered by any other payer source.



Key Points:

- This is similar to today's system:
  - Client gets either a daily rate or a number of monthly hours; which we now call "Monthly CFC Services".
  - Clients have a bit more choice in how they use their monthly service hours:
    - Personal Care, Relief Care, or Skills Acquisition Training.

- Residential clients have a daily rate as they do today:
  - Residential clients may access Skills Acquisition Training through the use of their $500 fiscal year limit.

Key Points:

- Purchases can be made for Skills Acquisition Training or Assistive Technology with this limit.
- This system uses the fiscal year rather than the calendar year and is not tied to the assessment year:
    - The charge to the annual limit is $20.17 per hour regardless of the provider's billed rate if IP or Agency provider is used. (When the client does not use monthly hours).
    - When using Home Health Agencies or professionally licensed providers, the provider's actual billed rate is used to reduce the available limit:
        - The client must exhaust all other payment sources for this before using this benefit.
        - Other payment source examples:
            - Medicare OT/PT benefits, Medicaid OT/PT benefits, Home Health or Hospice benefits, Private health insurance benefits.
            - Most of these payers have an Exception to Rule or Limitation Extension policy which must also be used before CFC.

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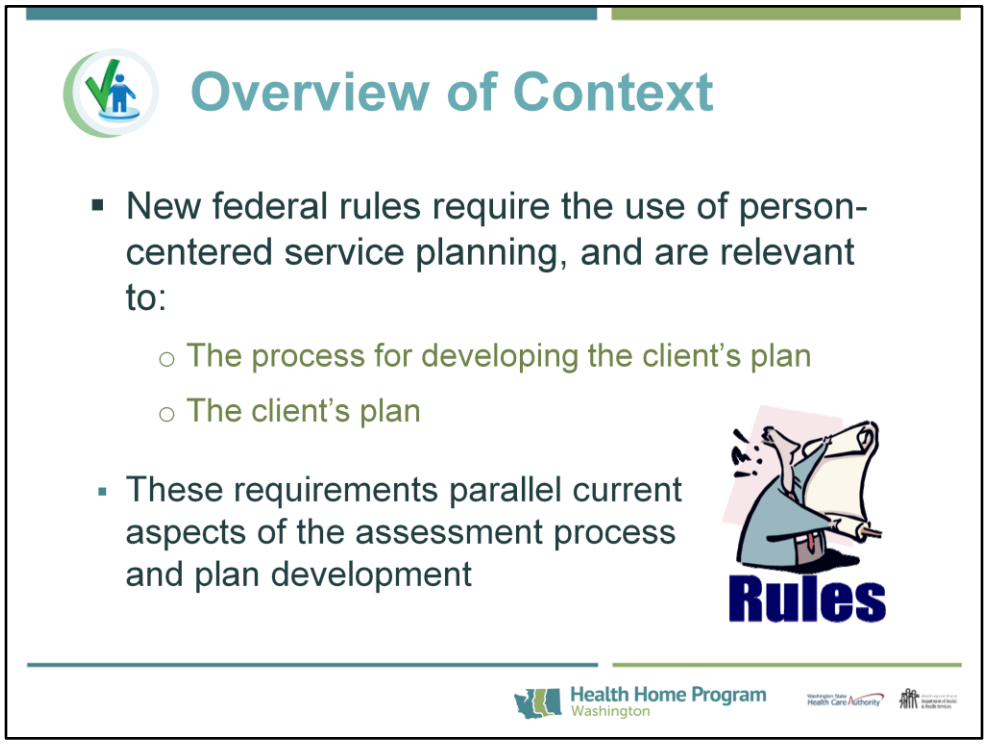
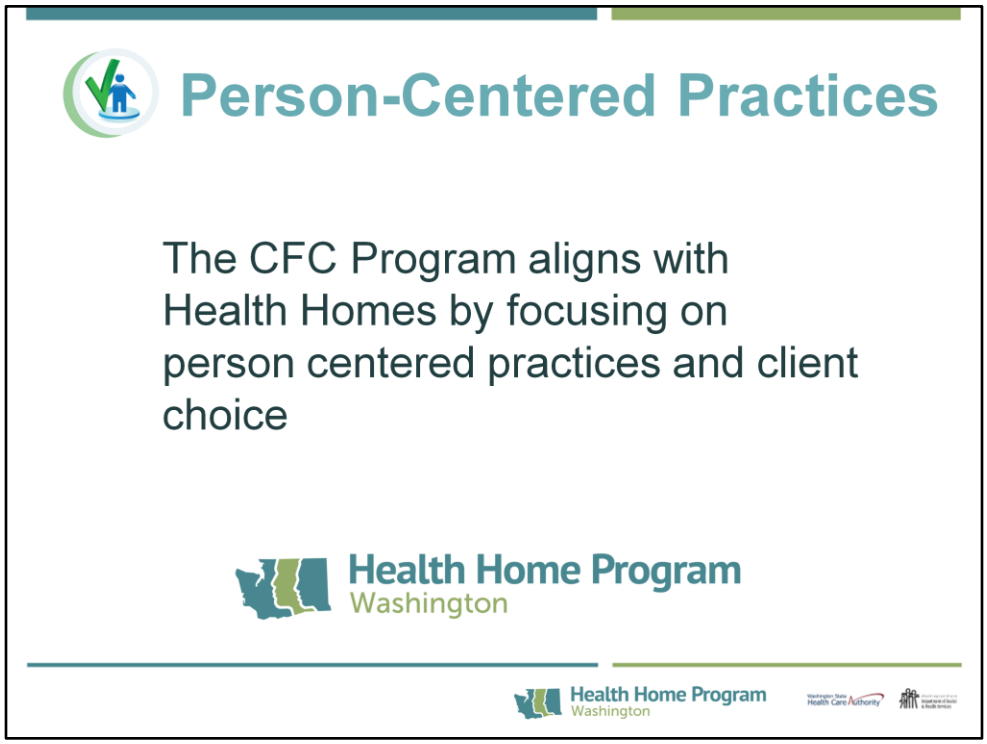
Person-Centered Service Planning



Setting background for training, in which HCBS federal rule requirements are being met.

- This should already be occurring in the assessment and plan development process,
- This curriculum is intended to make sure clear information is provided regarding these requirements, and
- Provides additional guidance for person-centered approach to services planning.

- This is an introduction to person centered planning and incorporates some of the theory and all of the federal rules for person centered service planning.



The client is the expert at being who they are and who they want to be.
Person centered practices recognize and value this, benefiting from the improved efficiency that comes from working with these strengths.

Key Points:

- The point of person centered service planning is to put the client into the driver's seat.
- It is to give the client the choice, the power, and the direction about what they want.
  - We do this to an extent now.
  - This is an enhancement to what we do today.

Person-Centered Practices:

- Are at the heart of health care reform and the Affordable Care Act (ACA)
- Influence positive quality of care
- Improve the effectiveness of long term services and supports (LTSS)

Person-Centered Practices

- Driven by the client
- May also include representatives the person has freely chosen or who are legally authorized
- Identify
  - strengths
  - preferences
  - health and safety needs and
  - desired outcomes and goals

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Person-Centered Practices

- Enable and assist the person in making informed choices and decisions
- Address service and support needs, and
- Consider client preferences for delivery of services and supports

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Key Points:

- CARE Considers Activities of Daily Living (ADLs):
    - Think of Katz ADL assessment or Minimum Data Set (MDS) used in nursing facilities (CARE somewhat mirrors MDS).
    - CARE tool was modeled after person centered planning practices.
    - Client must need assistance with ADLs to be eligible.
    - ADLs include: (Per WAC 388-106-0355)
        - Eating, Toileting, Bathing, Transfer, Bed Mobility, Locomotion, and Medication Management.

Key Points:

We have a start at being person centered, here are the ways we already are person centered in this context:

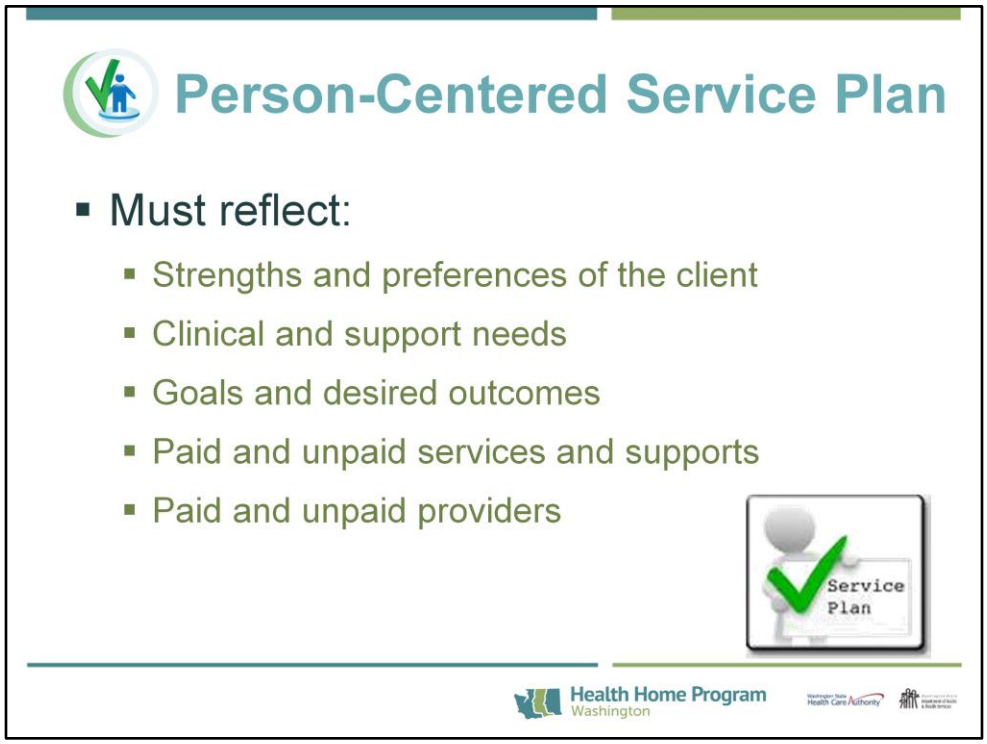
- Our assessment covers client needs and preferences.
- Our assessment asks about preferences for delivery of service and supports.
- Our assessment asks about informal supports.
- We ask about preferences in the delivery of services and supports.

Key Points:

- Reflect the setting the individual resides is chosen by client.
- Reflect that the client has been provided all long term care options:
  - In-home care,
  - Assisted living providers, and
    - Including ALs, ARCs, and EARCs
  - Adult Family Homes.

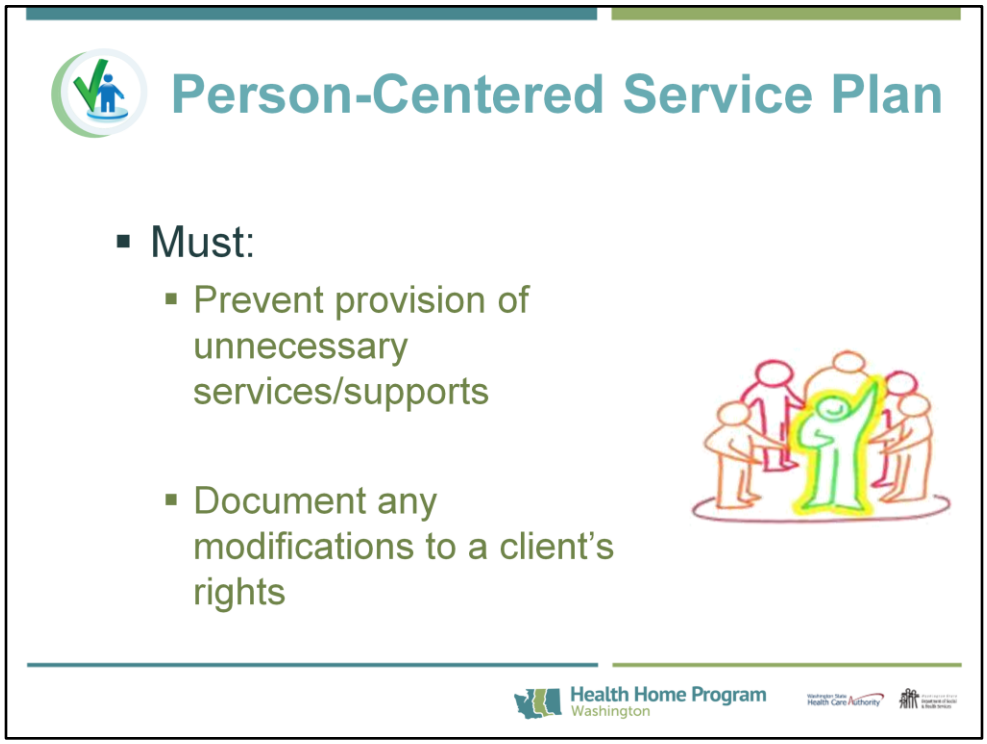
Key Points:

- Reflect the setting the individual resides is chosen by client.
  - State ensures that the setting includes:
    - Opportunities to seek employment,
    - Engaging in community life,
    - Control of own personal resources, and
    - Receive services in community comparable to those not receiving Medicaid HCBS.
  - If you find that a client's rights are being restricted in any way, evaluate the need for a referral to CRU or APS.
  - If there is no need for APS/CRU involvement, talk to the client about their rights and discuss alternative settings or providers.



Key Points:

- This is not a change from current policy. So if individuals are following current policy today, they will meet this new federal requirement.
- A person-centered service plan:
  - Reflects the client's strengths and preferences
  - Reflects the clinical and support needs
  - Includes the client's identified goals and desired outcomes, and
  - Reflects the paid and unpaid services and supports and providers to assist client to achieve their goals.



Key Points:

Documentation of any modification to client's rights must be in a note in the client file:

- Any sort of modification that takes away any basic client right.
- The note must be specific and must indicate what actions were taken, why they were taken, and what other actions that are less invasive have been tried prior to this action being taken.

Reviewing the Plan

- Must be reviewed and revised
  - At least every 12 months, or
  - When the client's circumstances or needs change, or
  - At the client's request

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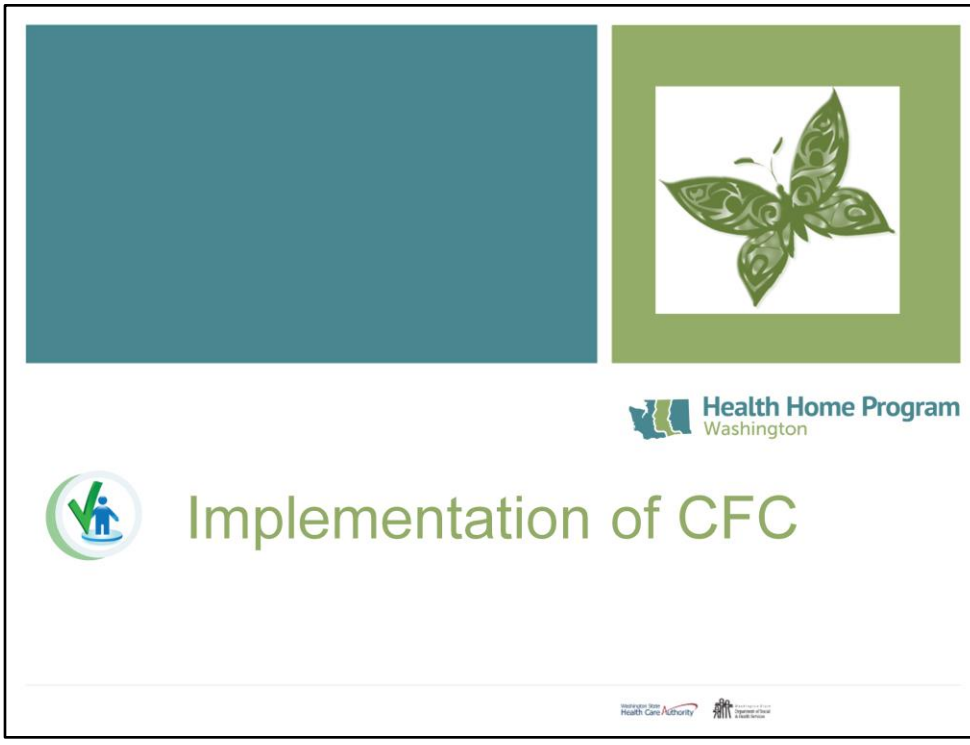
Key Points:

- Current procedures should be followed.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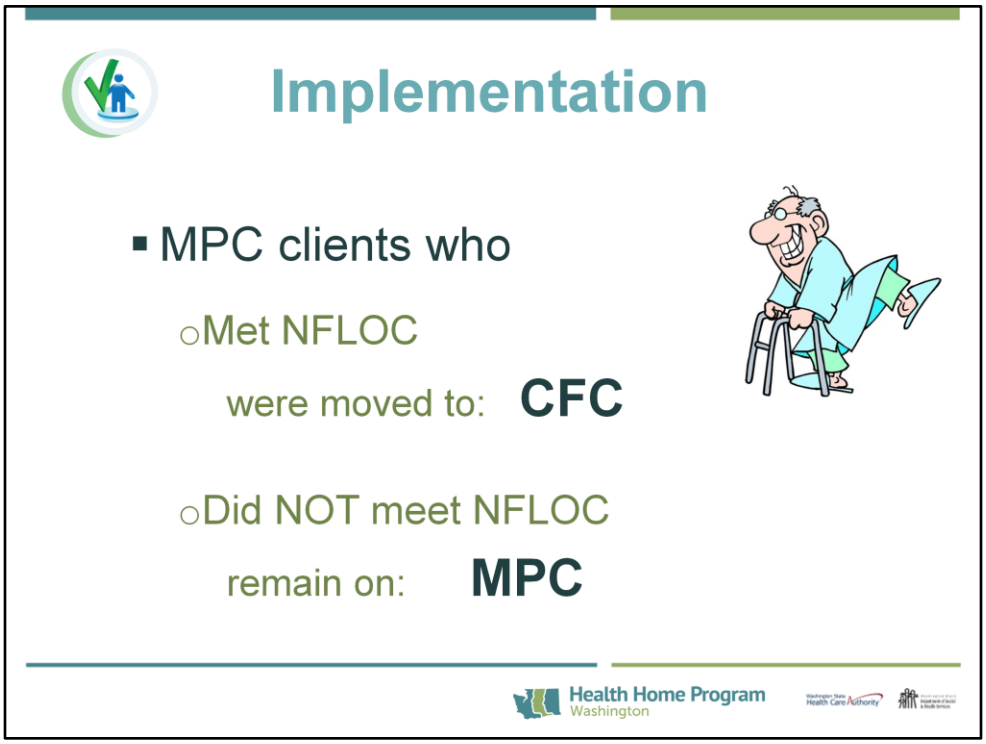
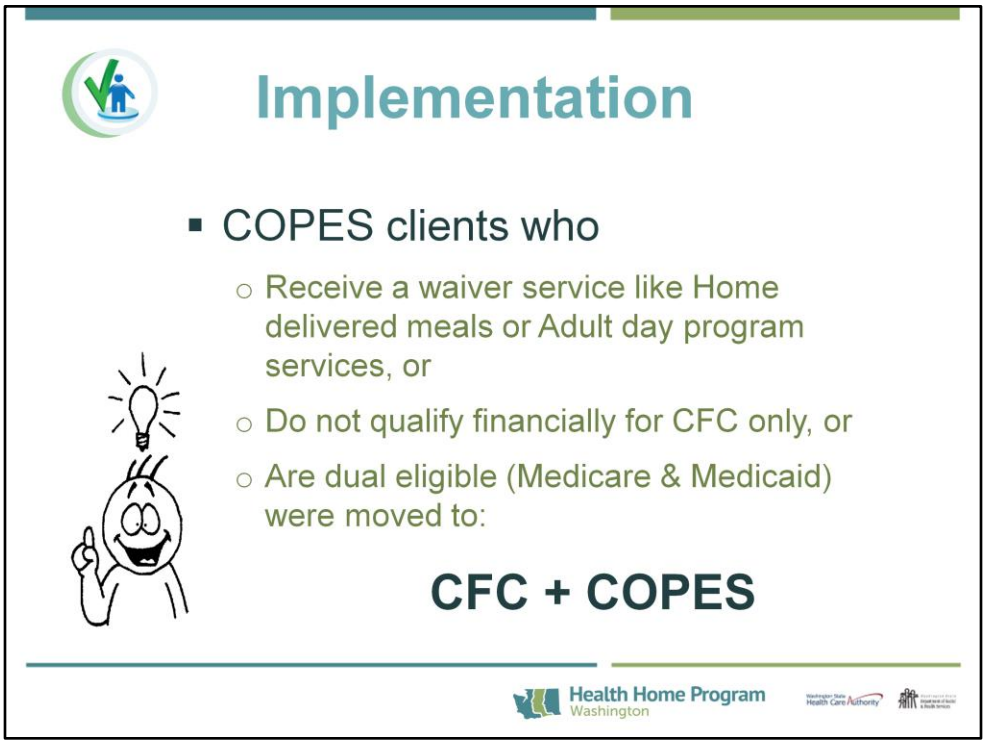
Implementation of CFC



Key Points:

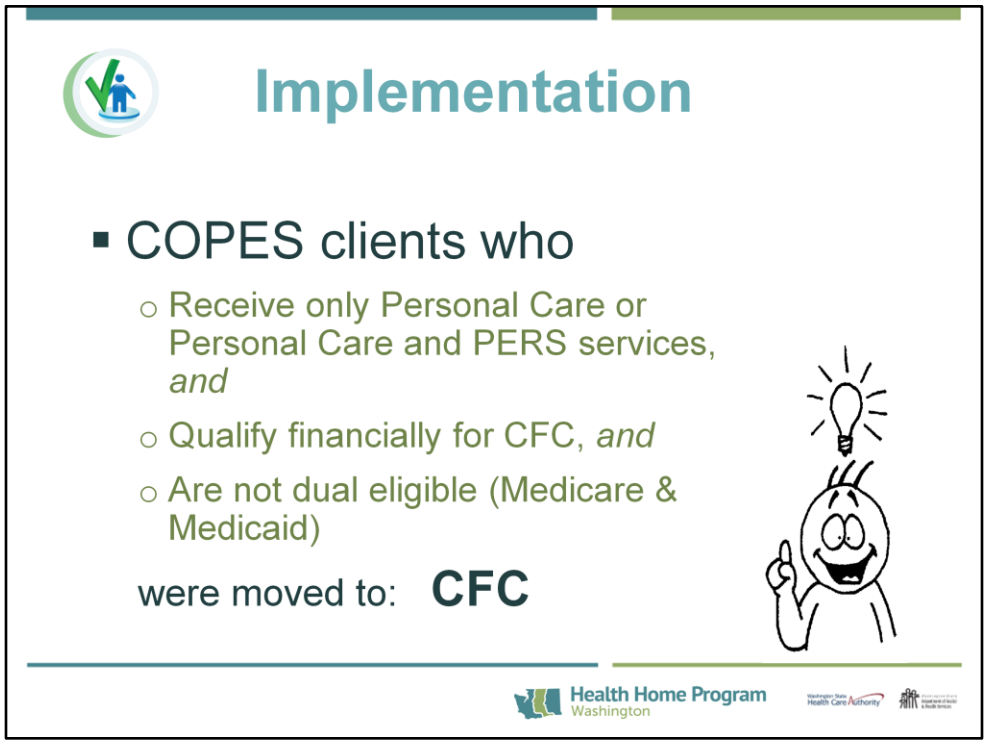
- MPC clients transitioning to CFC will have additional services available.
    - Any changes to services will not occur for most clients until the next assessment.
    - Any current services will continue uninterrupted by the same providers they are receiving services from today.

- The full explanation of CFC services will take place at their next annual assessment, significant change assessment, or if they request a change before their next planned assessment.



Key Points:

- COPES + CFC means the client is on both the CFC state plan and the COPES waiver.
- All COPES enrolled clients will have the wellness education program added as of 7/1/15.
- Anyone can cancel the service by calling and requesting cancellation.
- Any other changes to services will occur at the next assessment.



Key Points:

- Current COPES clients who are not on Medicare and were eligible for MPC services but may have been on COPES because they needed a PERS system or needed dental and did not get switched back to MPC will be switched to CFC and dis-enrolled from the COPES waiver.
- Any changes to services will occur at the next assessment.

Client Communication

- CFC Notification letters sent in May 2015
- HCBS rules notification sent July 2015
- Automatic conversion to CFC occurred
  - ProviderOne was not impacted by CFC
- Services will be reviewed with clients at the next assessment

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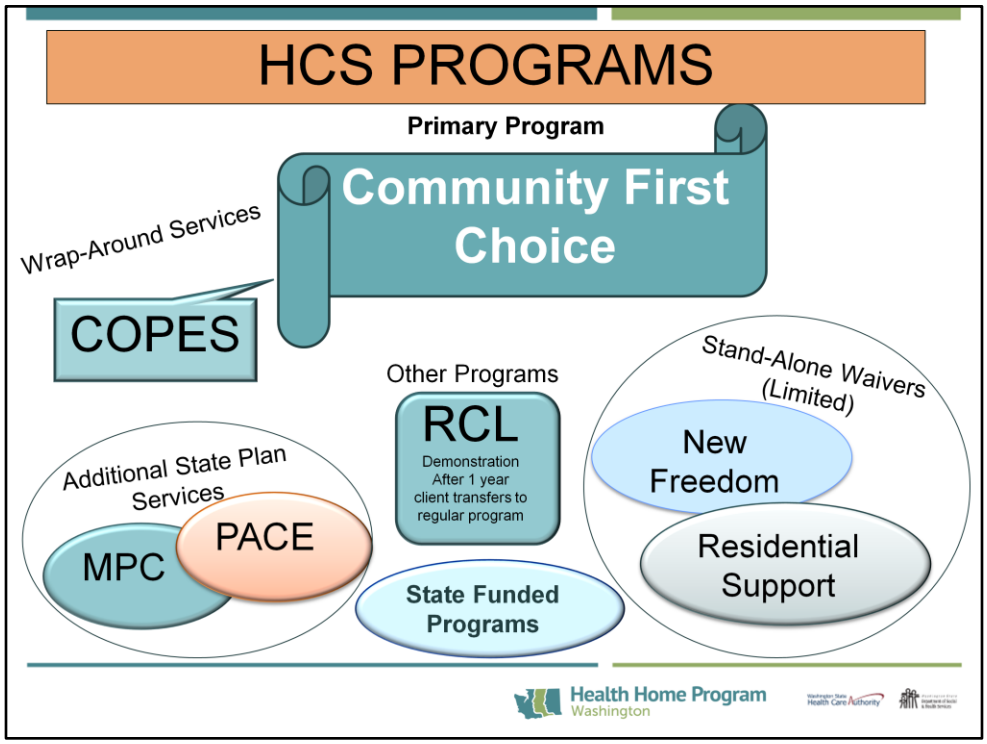
- As with any DSHS program **do not** screen clients out of services.
- Let the DSHS staff determine financial and functional eligibility because the rules are complex.
- Call your local DDA, HCS, or AAA office to get further information.
- Contact HCS or DDA directly to make a referral for a new client.



This is a visual of what HCS programs are offered.
As you can see, it is complex and our staff are trained on which program will best serve each individual client.

Where to Find More Information

- The DSHS CFC Website
  - https://www.dshs.wa.gov/altsa/stakeholders/community-first-choice-option
- Code of Federal Regulations (CFR)
  - HCBS: http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf
  - CFC: http://www.gpo.gov/fdsys/pkg/FR-2012-05-07/pdf/2012-10294.pdf

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