Transforming Lives

AFH Administrator Training

Module 9: Getting Ready

Adult Family Home Administrator Manual, Version 5.2

Washington State Department of Social & Health Services

Transforming lives

Agenda

- Medicaid Services and Supports
- Qualified Assessors
- Role of Case Managers
- Assessments/Preliminary Care Plans
- Medicaid Payment/Supplementation
- Exception to Rule (ETRs)
- Referral Agencies

Learning Objectives

At the end of this module, you will be able to…

- Describe Medicaid, and it's programs and supports
- Explain the role of the assessment/preliminary care plans
- Identify the qualifications of a qualified assessor
- Summarize the role of the CM
- Discuss Medicaid payment, supplementation, and ETRs

What do you know About Medicaid?

What is Medicaid?

- A government health insurance program
- Each state designs and administers its own Medicaid program
- To be eligible the resident must meet both functional and financial eligibility
- Payment for Medicaid services are sent directly to you

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Medicaid Contracts

- You must have a Medicaid contract to provide care to Medicaid recipients

- AFH contracts is a legal agreement between you (the AFH/ contractor) and DSHS/ALTSA

- The contract describes:
  - Your legal obligations and responsibilities
  - The conditions for receiving payment

Additional Contracted Medicaid Services

These services must be added to your Medicaid contract and have additional eligibility/requirements:

- Meaningful Day Activities (MDA)
- Expanded Community Services (ECS)
- Specialized Behavior support (SBS)

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Medicaid Funding Sources

- Community First Choice
- Community Options Program Entry System (COPES) Waiver
- DDA Waivers
- Medicaid Personal Care
- Residential Support Waivers
- Roads to Community Living
- State-funded Medical Care Services

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Medicaid Services and Supports - Introduction

- All Medicaid programs have different services and eligibility requirements
- Each client's services are unique based on their eligibility
- Only those eligible services that the resident has consented to are included in their service plan and authorized
- A provider cannot be paid for any Medicaid services that are not included in the resident's plan of care.

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Medicaid Services and Supports Part 1

- Adult Day Health
- Adult Protective Services
- Bed Hold for Medical Leave
- Behavior Health Support Team
- Client Training
- Community Choice Guide

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Medicaid Services and Supports Part 2

- Community Integration - $
- Meaningful Day $ - Contract
- Medical Escort - $
- Medical Mileage Reimbursement - $

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Medicaid Services and Supports Part 3

- Nursing Services
- Personal Care
- Private Duty Nursing – Specialized AFH
- Registered Nurse Delegation (RND)
- Residential Support Waiver - $ - Contracts (ECS, SBS)

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Medicaid Services and Supports Part 4

- Skilled Nursing
- Social leave
- Specialized Medical Equipment and Supplies
- Transportation - $
- Wellness Education

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Qualified Assessors

- **Medicaid**
  - Department Case Manager (HCS/DDA)
  - Area Agency on Aging (AAA)
- **Private Pay**
  - Masters Degree – 2 years experience
  - Bachelors Degree – 3 years experience
  - Nurse – 3 years experience
  - Physician

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Medicaid Case Manager

- Determines functional eligibility using a CARE assessment
- Works with resident to develop a plan of care
- Coordinates placement with AFH provider of client's choice
- Authorizes payment
- Provides case management

CHECK OUT A MESSAGE FROM YOUR CASE MANAGER

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Assessments

- In-Person interview by a qualified assessor
- Written assessment must contain all requirements of WAC 388-76-10335
- Used to develop a plan of care
- **Must receive and review prior to admission unless it is a TRUE emergency**
- Renewed/Revised

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CARE ASSESSMENT TOOL

A CM uses CARE to determine program eligibility and the level of services (daily/monthly rate) a resident is eligible to receive

CARE helps the CM:

- Identify resources and specialties the resident is eligible for
- Assist residents to achieve the highest level of functioning possible and
- Assist residents to maintain a sense of individuality

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Preparing for Your CARE Assessment

for people with developmental disabilities in Washington State

Play now!

Types of CARE Assessments

- Initial – In-Person
- Annual – In-Person
- Interim – Phone
- Significant Change – In-Person

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CARE Definitions

ADL/Bathing Self-Performance Levels

- Independent
- Supervision
- Limited
- Physical Help – Transfer Only-BATHING ONLY
- Extensive
- Physical Help – Hands on Assistance-BATHING ONLY
- Total
- Did Not Occur

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ACTIVITY: Match ADL level with the definition

Match ADL level with the definition

1. Independent _____
2. Supervision _____
3. Limited _____
4. Extensive _____
5. Total _____
6. Did Not Occur _____

A. You remind your resident to use the bathroom

B. You steadied your resident at least 3 times this week due to the uneven ground outside

C. You must feed your resident

D. Your resident was resistive to care and did not perform and get assistance with any personal hygiene tasks this week

E. Your resident is able to dress themself

F. You pulled your resident into a sitting position at least 3 times this week

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CARE Classification Groups - Criteria

The CARE tool uses the following criteria (WAC 388-106-0085) to place the resident in one of the following classification groups:

- Cognitive Performance - WAC 388-106-0090
- Clinical Complexity - WAC 388-106-0095
- Mood/Behaviors Symptoms - WAC 388-106-0100
- Activities of Daily Living (ADLs) - WAC 388-106-0105
- Exceptional Care - WAC 388-106-0110

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CARE 17 Classification Groups - WAC 388-106-0115					
Classification Group	Classification Criteria	Activities of Daily Living Score	Rate Sample		
			AFH	AFH + CI	ECS add-on for AFH
1) A Low	Not Clinically Complex or meet Mood & Behavior criteria, placed in "A" group	And ADL (0-4)	$85.24	$87.72	$49.76
2) A Med		And ADL (5-9)	$88.56	$91.04	$46.44
3) A High		And ADL (10-28)	$96.28	$98.76	$38.72
4) B Low	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (0-4)	$86.96	$89.44	$48.04
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 1			
5) B Med	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (5-14)	$94.56	$97.04	$40.44
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 4			
6) B Med-High	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score > 6	$102.62	$105.10	$32.38
7) B High	Mood & Behavior and DO NOT meet Classification for C, D, or E, classified as "B"	And ADL (15-28)	$105.60	$108.08	$29.40
	Behavior Points and a CPS score >2, and ADL score >1 and DO NOT meet Classification for C, D, or E, classified as "B"	And Behavior score of 12 or higher			
8) C Low	Clinical Complex and have a CPS score of < 4, placed in "C" group regardless of Mood & Behavior or Behavior points	And ADL (2-8)	$96.05	$98.53	$38.95
9) C Med		And ADL (9-17)	$110.68	$113.16	$24.32
10) C Med-High		And ADL (18-24)	$113.20	$115.68	$21.80
11) C High		And ADL (25-28)	$115.83	$118.31	$19.17
12) D Low	Clinically Complex and have a CPS score of 4-6 placed in "D" regardless of your mood and behavior qualification or behavior points.	And ADL (2-12)	$102.51	$104.99	$32.49
13) D Med		And ADL (13-17)	$112.97	$115.45	$22.03
14) D Med-High		And ADL (18-24)	$129.07	$131.55	$5.93
15) D High		And ADL (25-28)	$136.51	$138.99	$0.00
16) E Med		And ADL (22-25)	$165.12	$167.60	$0.00
17) E High		And ADL (26-28)	$192.59	$195.07	$0.00

*CI – Community Integration *ECS – Expanded Community Services *CPS – Cognitive Performance Scale
*> - Greater than *< - Less than *Current DDA and HCS Rates

Preliminary Care Plan – Private Assessor

Provides you with a preliminary service plan that includes:

- The resident's specific needs that were identified in the assessment
- The care options the resident chooses not to accept or refuse
- Ways to ensure the resident's health and safety related to any services/care refused
- The residents' goals and preferences
- How the AFH can meet the resident's needs

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HCS Service Summary/DDA Service Summary

HCS/DDA Preliminary Care Plans:

- Are person-centered
- Identifies items and services
- Makes providers aware of the resident's authorized services to determine if they can adequately perform the tasks assigned
- Makes appropriate referrals to community resources

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Financial Eligibility

- A Medicaid resident must be both functionally and financially eligible
- DDA/HCS Financial workers determine financial eligibility
- Client Responsibility is based on:
  - Third Party Resources
  - Room and Board
  - Participation

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Medicaid Payment

- Payer of last resort
- Medicaid Rates are published
- AFH payment corresponds to the payment rate assigned to the classification group in which CARE has placed the resident
- Certain Medicaid Waiver Payments may be excluded from income

"The contractor accepts the DSHS payment amount, together with any client participation amount, as sole and complete payment for the services provided under this contract. The contractor shall be responsible for collection of the client's participation amount (if any) from the client in the month in which services are provided."

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Supplementation for Medicaid Services or Items

The AFH **may not** request supplemental payment of a Medicaid recipient's daily rate for services, or items that are covered in the daily rate, or what the contractor is required to provide.

When you can request Supplementation

- To request supplementation for items NOT covered in the Medicaid rate, they must be included in your admission agreement **AND** in your Medicaid policy
- To avoid jeopardizing the resident's financial eligibility, family/friend must pay the AFH directly for additional items/services
- Must notify CM of additional charges (fraud)

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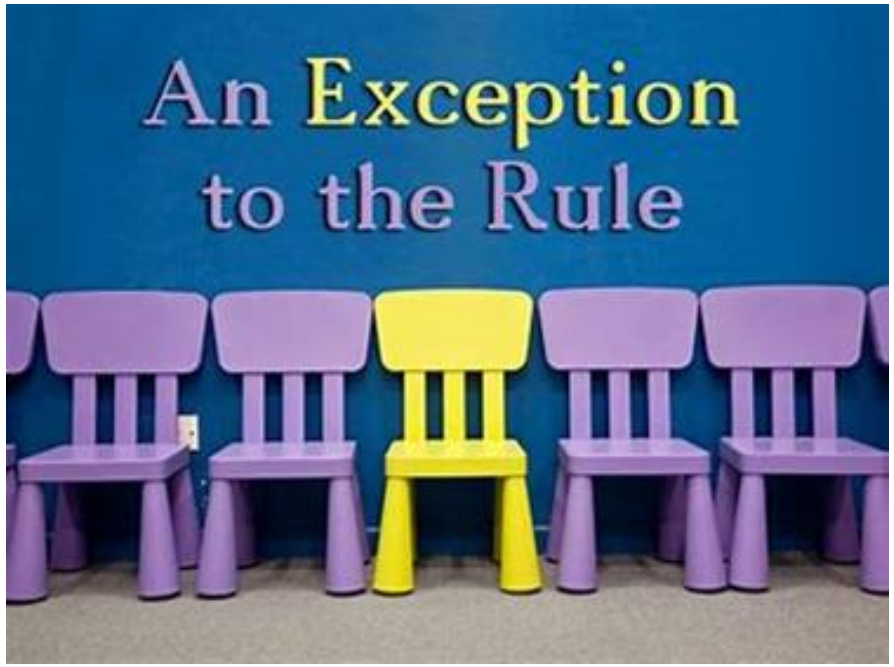
Exception to Rule (ETR)



- A resident may request an ETR, or a CM may request an ETR on the resident's behalf
- ETR decisions are based on:
  - Individualized needs for assistance with **personal care or skilled care**
  - <u>How those needs differ from the majority of clients in the same classification group</u>
  - Specific information provided by the CM and the provider

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Health Care Authority

- ProviderOne
- Participation Deductions
- Notifies the provider of a new authorization or if one has changed

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ProviderOne (P1)

- P1 is the program that pays you for providing care to your Medicaid residents
- CM authorize services through CARE that are sent to P1
- P1 receives the authorization from CARE and determines the amount your resident pays you each month
- You (as the Social Service Provider) and your resident/representative are sent an authorization notice
- Training Resources are available

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Referral Agencies

A "referral" is when a referral agency gives a client the names of specific care providers using a standardized form. A "referral" can also mean that a referral agency gives a provider a client's name, allowing the provider to contact the client directly about their care services.

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Referral Agencies – Fees and Refunds

- Referral agencies must clearly disclose their fees to providers and clients they work with.
- Clients and providers have the right to cancel their relationship with the agency at any time, with or without cause, and without penalties or cancellation fees.
- If a resident leaves the facility dies, is hospitalized, or transferred to another facility for more appropriate care within the first 30 days of admission, the agency must refund a prorated portion of the fees to the party who paid them. The refund is based on the number of days the resident stayed in the AFH.

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Referral Agencies – Medicaid Recipients

Medicaid or Medicare Clients

A Referral Agency cannot collect a referral fee for clients who are beneficiaries of Federal or State health care programs like Medicaid or Medicare. Should a client become a Federal or State funded consumer, then the referral fee will be prorated to cover only the private pay portion of the stay. Agencies can work on a private pay basis with family or friends of the senior.

Association of Senior Referral Professionals of Washington

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Referral Agencies – Contracts & Tips for Providers

- The state does not regulate, limit, or specify the fees charged by a referral agency.
- Carefully read and understand the referral agency's contract before signing it.
- Agencies may not require clients or providers to sign exclusive agreements for placement services.
- Agencies are not care providers and are not liable for the acts or omissions of a provider.
- Exercise due diligence before admitting a referral.
- Agency staff are considered Mandated Reporters.

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Residential Search Tool Locator

- Assists in matching Medicaid clients and their preferences with potential AFHs
- Services is free for all Medicaid contracted AFHs
- AIDA is no longer available

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Summary Review

During this Module, You Learned About…

- Medicaid; it's programs and supports
- The role of the assessment/preliminary care plans
- The qualifications of a qualified assessor
- The role of the CM and how they can assist you
- How to claim Medicaid payments
- The process for requesting supplementation and ETRs

Test Your Knowledge

True/ False?

1. ProviderOne requires an authorization before a Medicaid payment can be made

2. Some Medicaid services have an add on to the Medicaid rate

3. Anyone can complete an assessment that has an in-depth knowledge of the resident.

4. A client can receive any services they want

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Get Ready For Your Next Class

- Read the assigned modules prior to next class
- Download and become familiar with the Negotiated Care Plan template
- Study for Quiz #3 (Modules 6d, 7, 8, and 9)

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