Community First Choice (CFC)

Purpose

The purpose of this chapter is to define the Community First Choice (CFC) program; which provides assistance with personal care and other services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive and economical home & community-based services.

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**What is Community First Choice (CFC)?**

CFC is a Medicaid State Plan program. CFC eligibility includes clients who, in the absence of the home and community-based attendant services and supports provided under CFC, would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State Plan.

Medicaid Personal Care (MPC) is also a Medicaid State Plan program. MPC is available to those clients who do not meet institutional level of care. In Home and Community Services (HCS) institutional level of care is nursing facility level of care (NFLOC) and in DDA it is Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/ID) level of care.

CFC pays for personal care; which is assistance with the following Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health related tasks. Assistance for IADLs is available only when the client also needs assistance with ADLs.

|  |  |
| --- | --- |
| **ADLs** | **IADLs**IADLs must be incidental to the personal care need. |
| * Bathing
* Bed Mobility
* Body Care (application of dressings/lotions, foot care, etc.)
* Dressing
* Eating
* Locomotion
* Medication Management
* Toilet Use
* Transfer
* Personal Hygiene
 | * Meal prep
* Ordinary housework
* Essential shopping
* Wood supply
* Travel to medical
* Telephone use
 |

In addition to personal care services, clients may receive other services available through the CFC program when they meet all of the eligibility and sub-eligibility requirements.

Other services available through CFC include:

* Relief Care
* Nurse Delegation
* Skills Acquisition Training
* Personal Emergency Response Systems (PERS)
* Assistive Technology
* Community Transition Services
* Caregiver Management Training (how to select, manage, and dismiss personal care providers).

Clients may need other services which are available from the waiver (COPES) in addition to their CFC services. If they qualify for CFC, and are both functionally and financially eligible for waiver services, they can be on both programs simultaneously in order to access additional needed COPES services. The program option would be CFC + COPES in the CARE dropdown menu. Please note that the “+” means “and”. When a client is on CFC + COPES, they are enrolled in both the CFC program and in the COPES waiver.

DDA clients may also receive services through CFC and either the Basic Plus, Core, CIIBS, or IFS waivers. Clients must receive prior approval from DDA Headquarters to enroll on a waiver program.

**Who is eligible?**

To be functionally eligible for only the CFC program, and before services can be authorized, the client must meet **ALL** the following eligibility criteria:

1. **AGE**
	* If services are authorized by HCS/AAA, clients must be eighteen years of age or older
	* If services are authorized by DDA:
		+ Clients who meet DDA’s determination of a developmental disability may be any age
		+ Children with functional disabilities who do not meet DDA’s determination of a developmental disability may be served by DDA until age 18 (DDA will refer young adults age 18 and over to HCS)
2. **FUNCTIONAL ELIGIBILITY** – Meets Functional Eligibility as determined by CARE:
	* The individual meets nursing facility level of care as outlined in [WAC 388-106-0355(1)](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0355) or ICF/ID as outlined in WAC and WAC [388-828-3080](http://apps.leg.wa.gov/wac/default.aspx?cite=388-828-3080) and [388-828-4400](http://apps.leg.wa.gov/wac/default.aspx?cite=388-828-4400), or
	* Will likely need that level of care within 30 days unless services are provided; and
	* Chooses to live at home with community support services provided by a qualified provider, or live in one of the following department-contracted residential settings:
		+ Adult Family Home (AFH), or
		+ Assisted Living Facility (ALF), which includes contracted:
			- Assisted Living Facility (AL)
			- Adult Residential Care Facility (ARC)
			- Enhanced Adult Residential Care Facility (EARC),

Qualified Providers

**Qualified providers of personal care by setting**

**IN HOME:**

|  |  |  |  |
| --- | --- | --- | --- |
| PROGRAM | IP | Agency | Spouse |
| MPC  | **Yes** | **Yes** | No |
| CFC  | **Yes** | **Yes** | No |
| New Freedom | **Yes** | **Yes** | No |
| Chore  | **Yes** | **Yes** | **Yes** |
| State- Funded ABD Cash Only | No | No | No |

*Use the Home Care Referral Registry to help clients locate in-home providers.*

<http://www.hcrr.wa.gov/>

**RESIDENTIAL:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROGRAM | AFH\* | ARC | EARC | AL |
| MPC  | **Yes** | **Yes** | No | No |
| CFC  | **Yes** | Yes | **Yes** | **Yes** |
| New Freedom | No | No | No | No |
| Chore  | No | No | No | No |
| State- Funded ABD Cash Only | **Yes** | **Yes** | No | No |

*\* The AFH must have the specialty designation to meet the needs of the client.*

## Moving between CFC and CFC + COPES

## \*(NOTE: MPC and MAGI-based or ABP MPC clients are not eligible to move between MPC and CFC + COPES because they do not meet institutional level of care)

* 1. If CFC clients have needs beyond the amount, duration, and scope of the CFC program, consider enrolling the client into the COPES waiver and choosing the program option CFC + COPES.

To be eligible for waiver or institutional services a recipient must not have:

1. Transferred an asset for less than fair market value;
2. Ownership of a home that has equity greater than the current limit found on the [HCA standards chart](http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx)
3. Ownership of an annuity that does not meet the requirements in [Chapter 182-516](http://apps.leg.wa.gov/wac/default.aspx?cite=182-516)

Clients who are financially eligible for CFC can ONLY be authorized under CFC + COPES if:

* + 1. Documentation indicates why the client’s needs are beyond the amount, duration, or scope of CFC;
		2. Financial Services has verified eligibility for waiver services
* You must work with your financial services specialist even if the client is on SSI.
	1. When authorizing Home and Community Based Service (HCBS) waiver services (COPES) for SSI recipients, inform the SSI recipient of the requirement to submit an “*Eligibility for Review for Long-term Care Benefits”* form, [DSHS 14-416.](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-416.pdf)

The CFC + COPES option may be used when the client requires frequent COPES services. If the client is enrolled in CFC + COPES, they are enrolled in both the CFC state plan and the COPES waiver. As such, the client will not need to switch between programs to access the services for which they are eligible from either of these two programs. When a client is enrolled in CFC + COPES, they must access at least one COPES service every month in order to continue to be eligible for the COPES waiver.

If the client is only enrolled in CFC and wishes to access a waiver service on a short-term basis (for example: the client is eligible to receive a piece of durable medical equipment), he or she may enroll in CFC + COPES temporarily to access the waiver service. Once the service has been completed the client may then disenroll from the COPES waiver and return to only the CFC program.

If the LTC authorization is for short-term waiver services, ask the client to complete and sign the [14-416](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-416.pdf) form mentioned in number 2 above at the time of assessment. This will ensure that the Financial Services Specialist is notified of the change before the service ends.

1. Use the Financial/Social Services Communication form ([07-104](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/07-104.pdf)) to notify financial services of an SSI recipient applying for waiver services.
	* 1. The client must be financially approved and moved to CFC + COPES before a waiver service can be authorized and paid. Complete an Acknowledge of Services ([14-225](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-225.pdf)) form if this was not done at the time of the assessment to meet both CFC and waiver enrollment requirements.
		2. Authorize Services - To make payment for a short-term waiver service:
			1. Verify financial eligibility has been completed and there is a communication in DMS from financial (form 07-104) showing that the client is financially eligible for waiver program services.
			2. Open the service authorization for the month in which you will authorize payment for the short-term waiver service (e.g. a wheel chair ramp);
				1. The authorization Begin Date must be the 1st day of the month for the month that the needed short-term service will be paid.
				2. Notify financial services on a [07-104](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/07-104.pdf) of the COPES program addition.
				3. Enter the RAC for COPES into CARE.
			3. Once the service is paid, be sure all COPES services have been closed and terminate the RAC effective the last day of the month.
				1. Notify financial services on a [07-104](http://asd.dshs.https:/www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/07-104.pdfwa.gov/FormsMan/FormPicker.aspx) of the COPES termination.

Notes:

* If this will be an on-going service, (e.g. authorization of wellness education or home delivered meals), authorize CFC + COPES for the entire plan period.
* If the client is also on Medicare and has high prescription co-payments, you may authorize CFC + COPES for the entire plan period and ensure the client also receives a monthly waiver service.

Services Available through the CFC Program

In addition to personal care services, clients can receive other CFC services if they meet any secondary eligibility criterion that is applicable for these services. Federal rules requires that CFC services not replace other services that clients access under Medicaid, Medicare, health insurance, LTC insurance, and/or other community or informal resources available to them.

* If a client has other insurances or resources, you must document the denial of benefits before you can access other CFC services. Place this documentation in the client’s file.
* CFC Services may not be used when the vendor refuses the reimbursement or considers the payment inadequate from these other resources.
* CFC services may not supplement the reimbursement rate from other resources. ETRs are not allowed for the above circumstances.

Providers of these other CFC services must meet certain qualifications and be contracted through DSHS or the local AAA prior to services being authorized. Each local AAA maintains a list of contracted, eligible providers for HCS and AAA.

**Note: Prior to authorizing any service, verify that the client has an assessed need for that service and it is reflected in the client’s plan of care.**

**Personal Care Services**

[**WAC 388-106-0010**](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-106-0010) **– Definitions:**

**"Personal care services"** means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to functional limitations. Assistance is evaluated with the use of assistive devices.

***Personal Care Services***

Personal care assistance is provided to enable clients to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the client to perform a task. Personal care services may be provided on an episodic or on a continuing basis.

Personal care includes assistance with activities of daily living: bathing, bed mobility, body care, dressing, eating, locomotion outside room, walking or locomotion in room and immediate living environment, medication management, toileting, transfer, and personal hygiene.

Personal care may include assistance with the following instrumental activities of daily living (IADLs): meal preparation, ordinary housework, essential shopping, wood supply (when wood is the sole source of heat), travel to medical services, and telephone use. These IADLs may not comprise the entirety of the service for an individual; she or he must also have unmet need and accept assistance with ADLs.

Personal care may be provided for tasks completed outside of the client’s home as specified in the service plan. Personal care may be furnished to support clients in community activities or to access other services in the community. Personal care may be furnished in order to assist a person to function in the work place or as an adjunct to the provision of employment services.

Nursing tasks, such as administration of medication, blood glucose monitoring, insulin injections, ostomy care, simple wound care or straight catheterization may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistant certified and/or registered in the State of Washington.

* The following tasks CANNOT be delegated: Injections other than insulin, central lines, sterile procedures, and tasks that require nursing judgments. Providers are compensated for these services within their regular hourly rate.

Clients may choose an Individual Provider (IP), an agency provider, an adult family home, or a licensed assisted living facility which includes an AL, EARC or ARC. If an IP is chosen, the client has employer authority for the IP(s) including hiring, firing, scheduling and supervision. If a client is unable to provide supervision, an alternate supervisor must be identified in the service plan

Clients have the right to choose a representative for the provision of services and for service planning purposes when feasible. A representative must not also be a paid provider of care to that client.

If a client wishes to have training on how to hire, manage, or dismiss their caregiver, they may request training materials at any time. See Caregiver Management Training for more information on this service.

***Personal Care Service Providers***

* + Individual Providers (IPs) ([LTC Manual - In-Home Providers](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) Chapter 7A)
		- Must have a current contract with the Department;
		- Must be authorized to work in the United States;
		- Have passed the appropriate criminal background check;
		- Must be age 18 or older;
		- Have met all training and certification requirements;
		- Are regulated under WAC [388-71](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-71)-0500 through [388-71](http://apps.leg.wa.gov/WAC/default.aspx?cite=388-71)-1006.
	+ Home Care Agency (HCA) must have a current:
		- Department of Health (DOH) license located in Chapter [70.127](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.127) RCW and Chapter [246-335](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-335) WAC ; and
		- Contract with the Department or AAA.
	+ Assisted Living (AL), Adult Residential Care (ARC), and Enhanced Adult Residential Care (EARC) must have a current:
		- ALF License under Chapter [18.20](http://apps.leg.wa.gov/rcw/default.aspx?cite=18.20) RCW, and Chapter [388-110](http://apps.leg.wa.gov/wac/default.aspx?cite=388-110) WAC; and
		- Contract with the Department.
	+ Adult Family Homes must have a current:
		- AFH License under Chapter [70.128](http://apps.leg.wa.gov/rcw/default.aspx?cite=70.128) RCW and Chapter [388-76](http://apps.leg.wa.gov/wac/default.aspx?cite=388-76) WAC; and
		- Contract with the Department

**Relief Care Services**

Relief Care is a service that allows the client to use alternate service providers for personal care when a regular provider of personal care is not available or needs a break. This service does not add any hours to the monthly hours generated by CARE; it is simply an alternate use of the CARE generated hours.

Any pre-planned use of relief care must be noted in the service summary. Use due to un-planned absences, such as provider illness, does not need to be noted in the service summary, but must be authorized using the correct code for relief care.

Relief care is authorized separately from standard personal care. In ProviderOne, relief care is authorized using the code T1019 – U2. See the SSAM for more information on authorizing services in ProviderOne. Until January 1, 2016, see the SSPS manual for IP related service codes.

**Relief Care Providers**

* + Individual Providers (IPs) ([LTC Manual - In-Home Providers](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) Chapter 7A)
		- For qualifications, see Personal Care Service Providers
	+ Home Care Agency (HCA)
		- For qualifications, see Personal Care Service Providers

**Skills Acquisition Training Services (SAT)**

Skills Acquisition Training Services include functional skills training to accomplish, maintain, or enhance Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), or Health Related tasks. This service is provided concurrently with the performance of ADLs, IADLs, and/or health-related tasks. Services may complement therapy or nursing goals when coordinated through the support plan.

SAT may be provided by the following qualified providers:

1. Individual Providers, Home Care agencies, and Supported Living providers. SAT provided by these providers is limited to training on ONLY the following tasks:
	1. Cooking and meal preparation
	2. Shopping
	3. Housekeeping tasks
	4. Laundry
	5. Limited Personal Hygiene tasks including only:
		1. Bathing (excludes any transfer activities)
		2. Dressing
		3. Application of deodorant
		4. Washing hands and face
		5. Washing, combing, styling hair
		6. Application of make-up
		7. Shaving with an electric razor
		8. Brushing teeth or care of dentures
		9. Menses care
2. Home Health Agencies:
	1. When using a Home Health Agency for SAT all other payment sources such as Medicare or Apple Health must be used prior to CFC:
		1. Home Health, restorative care, and/or rehabilitative care are benefits usually covered by Medicare, Apple Health, and many private insurance carriers. All other benefit plans must be exhausted prior to the client accessing CFC funding, including the use of the carrier’s Exception to Rule (ETR) or Limitation Exception (LE) process.
		2. To access SAT through a Home Health Agency, the client should be referred to their primary medical provider who can write a prescription and refer them to an appropriate covered provider.
		3. CFC will not pay for services denied by an insurance due to improper billing or if services were never requested through their medical provider.

***There are two ways clients may access payment for Skills Acquisition Training services through CFC:***

1. Clients living at home may use their personal care hours to purchase Skills Acquisition Training from IPs, Home Care Agency providers, and Supported Living providers. SAT should be provided concurrently with the provision of assistance with ADLs, IADLs or health related tasks.
	1. Clients may NOT use their personal care hours to purchase Skills Acquisition Training for services provided by Home Health Agency providers.
2. Clients living at home or in a residential facility may use their annual limit of $500 per fiscal year to purchase SAT.
	1. If the client chooses to use the annual limit to purchase SAT Services from an IP, an Agency Provider, or a Supported Living provider, this must be noted in the fiscal year calculator and $20.17 per hour of SAT services should be deducted from the available annual limit without regard to the amount paid to the provider.
		1. The cost to the annual limit includes the provider’s salary plus fringe benefits and will be different than their actual paid rate.
		2. The current standard rate per hour is determined biennially and is based on budget considerations. The rate is subject to change every July 1st.
	2. If the client chooses to purchase Skills Acquisition Training Services from a Home Health Agency this must be noted in the annual limit calculator and the actual payment made to the provider should be deducted from the annual limit.
		1. All necessary insurance plan denials must be received prior to authorizing SAT through a Home health Agency.
		2. Home Health Agency services are generally more costly as these providers are licensed health care professionals such as Nurses, Physical Therapists, and Occupational Therapists.
			1. Use the Home Health agency’s rate to calculate how many hours the client may be authorized to receive to avoid payment errors or exceeding the limit.
			2. Before authorizing CFC services by a Home Health Agency, verify the client has exhausted the limit of any other payer source, such as Medicare, Apple Health, or private insurance.

**Exclusions and limits:**

* The annual limit of $500 is an aggregate total limit of expenses made for both Skills Acquisition Training and Assistive Technology.
* SAT does not include therapy such as Occupational Therapy, Physical Therapy, or Communication Therapy.
* SAT does not include nursing services or therapies that must be performed by a licensed Therapist or Registered Nurse.
* Training is for the sole benefit of the client and must be provided directly to the client receiving CFC services. Formal and informal care providers may participate in the training in order to continue to support the participant’s goal outside of the training environment. If a higher limit is medically necessary, the Case Manager may use the Exception to Rule (ETR) process only after exhausting services through HCA or their managed care insurance provider.
	+ These ETR requests are approved at the Headquarters level.

**Skills Acquisition Training Providers**

* + Individual Providers (IPs) ([LTC Manual - In-Home Providers](http://intra.altsa.dshs.wa.gov/docufind/LTCManual/) Chapter 7A)
		- Must have a current contract to provide Skills Acquisition Training with the Department; and
		- Must meet all other IP qualifications listed under Personal Care; and
		- May only provide IADLs and the ADL tasks listed for IPs above.
	+ Home Care Agency providers
		- Must have a current Department of Health (DOH) license, as defined in Chapter [70.127](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.127) RCW and Chapter [246-335](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-335) WAC ; and
		- A current contract with the Department or AAA; and
		- May only provide IADLs and ADL tasks listed for home care agencies.
	+ Supported Living providers
		- Must have a current contract to provide Skills Acquisition Training with the Department; and
		- A current contract with the Department; and
		- Meet all other Supported Living provider qualifications; and
		- May only provide services listed for supported living providers above.
	+ Home Health Agencies must have:
		- A current contract with the Health Care Authority (HCA); and a
		- Current Department of Health (DOH) license in good standing for the specialty being requested.

**Nurse Delegation Services**

Nurse Delegation Services allows Registered Nurses to delegate specific nursing tasks to qualified long term care workers when:

1. The personal care service is provided by a registered or certified nursing assistant, or a Certified Home Care Aide who has completed nurse delegation core training;
2. The client’s medical condition is considered stable and predictable by the delegating nurse; and
3. Services are provided in compliance with [WAC 246-840-930](http://apps.leg.wa.gov/WAC/default.aspx?cite=246-840-930).

***Nurse Delegation Service Parameters***

* A Registered Nurse Delegator assesses a client for program suitability and teaches, evaluates competency, and supervises the performance of a nursing assistant.
* The nursing assistant must meet additional educational requirements and performs the delegated nursing tasks for a client.
* These tasks may include:
	+ Administration of medications;
	+ Blood glucose monitoring;
	+ Insulin injections;
	+ Ostomy care;
	+ Simple wound care;
	+ Straight catheterization; or
	+ Other tasks determined appropriate by the delegating nurse.
* Services do not duplicate personal care.
* **Providers are paid only once for the same hour of service, even if providing services in a multi-client household.**

**Exclusions**

* Tasks may not include:
	+ Sterile procedures;
	+ Administration of medications by injections, except insulin injections;
	+ Maintenance of central intravenous lines; or
	+ Acts that require nursing judgement.

***Nurse Delegation Providers***

* Home Health Agency
	+ Licensed under [Chapter 70.127 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=70.127).
	+ Individual RNs employed by the agency must be licensed under [Chapter 18.79 RCW](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79) and [Chapter 246-840 WAC](http://apps.leg.wa.gov/RCW/default.aspx?cite=246.840).
* Registered Nurse
	+ Licensed under [RCW 18.79.040](http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79.040)

## Note: Licensed assisted living facilities (ALFs) formerly known as boarding homes contracted as Assisted Living Facilities (ALF) or Enhanced Adult Residential Care Facilities (EARC) may choose to offer Nurse Delegation, however ALTSA does not pay for ND services for clients living in these facilities because they are contracted to provide intermittent nursing services. Adult Residential Care (ARC) facilities are not contracted to provide intermittent nursing services and ND may be provided by CFC in only these specific Assisted Living facility types.

***Personal Emergency Response System (PERS) Backup Service***

PERS is an electronic device that enables participants to secure help in an emergency. The participant may also wear a portable “help” button to allow for mobility. The system is programmed to signal a response center once a “help” button is activated. Some PERS systems can also include medication reminders. The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone or with others who cannot summon help in an emergency, or who are alone or with others who cannot summon help in an emergency for significant parts of the day, and have no regular caregiver for extended periods of time.

All PERS equipment vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) or ETL safety standard for home health care signaling equipment. The UL or ETL listing mark on the equipment will be accepted as evidence of the equipment’s compliance with such standard.

The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

The emergency response communicator must not interfere with normal telephone use and may include cordless equipment that does not require a landline. The communicator must be capable of operating without external power during a power failure at the participant’s home in accordance with UL or ETL requirements for home health care signaling equipment with stand-by capability.

Installation and maintenance of the PERS system is included in the service.

Lost or damaged PERS equipment will be only be reimbursed after the contractor makes a good faith effort to recover or repair a lost or damaged unit. Covered items eligible for replacement include only the console unit.

Any loss must be reported within two weeks by the contractor to the case manager who will also attempt to recover the unit.  If the unit cannot be recovered or repaired, documentation of wholesale cost must be provided with the request for reimbursement. Only one console will be replaced per client’s lifetime. *Pendants are the responsibility of the provider to replace when required.* Reimbursement for equipment lost after termination of services must be submitted within 30 days of termination notice and must be paid using the last date of service on the authorization. Reimbursement for equipment lost after the death of the client is not permitted.

The standard PERS system is a covered service under CFC. The standard PERS system includes the base device that through a land line, a mobile phone line, a wireless phone line, or a cellular phone line calls the monitoring company for help when the device is activated by the client.

Additional add-ons to the standard PERS system include medication systems, fall detection units, or GPS units and are considered Assistive Technology. The vendor must bill for these add-on items separately from the standard PERS unit. In ProviderOne, the case manager should authorize the standard PERS unit on one line and then each add-on as an additional line under the same authorization using the appropriate code.

|  |  |
| --- | --- |
| Service | P1 Code |
| PERS Installation Fee | S5160 |
| PERS  | S5161 |
| * GPS Add-on to PERS (Assistive Tech)
 | S5161 – U2  |
| * Fall Detection Add-on to PERS (Assistive Tech)
 | S5161 – U1 |
| * Medication System Add-on to PERS (Assistive Tech)
 | S5161 – U3 |

The annual limit for assistive technology is $500 which equates to not more than $41.67 per month. If the cost of the add-on exceeds $41.67 per month, an ETR must be requested from headquarters to cover the cost of the item for the full fiscal year. If there are only a few months left in the year, the service may be authorized for the remainder of the fiscal year and an ETR would need to be requested for the following year when the total cost for that fiscal year would exceed $500.

Once authorized, personal care add-ons must be added to the annual limit calculator in CARE. The monthly cost of the add-on is multiplied by the number of months it will be used and the total annual cost should be charged to the client’s annual limit. Anyone adding a system mid-fiscal year would need to have their system pro-rated.

*Example 1 – no pro-ration:* The client received a PERS unit in June 2015 and will have the unit indefinitely. He has a standard PERS with a fall detection add-on that costs $15 per month. The monthly cost of $15 is multiplied by 12 months and the total of $180 is added to the calculator and counted toward the annual limit.

*Example 2 – with pro-ration:* The client received a PERS unit in January of 2016 and will have the unit indefinitely. She has a standard PERS unit with a GPS add-on that costs $20 per month. The monthly cost of $20 is multiplied by the number of months left in the fiscal year, which, including January would be 6 months. The total cost of $120 would be added to the calculator and counted toward the current annual limit. A tickler would then be added to the client’s file to show up in June to remind the primary case manager to add the cost of the add-on to the annual calculator on July 1 for the next year of service. At that time, the $20 per month would be multiplied by 12 months and the total of $240 would be added to the calculator and counted toward the next year’s annual limit.

**Personal Emergency Response System (PERS) Eligibility**

1. Standard PERS using a land line or using wireless technology: If the service is necessary to enable the client to secure help in the event of an emergency and if the client:
	* Lives alone in his/her own home; or
	* Is alone, in his/her home, for significant parts of the day and has no regular provider for extended periods of time; or
	* No one in the client’s home, including the client, can secure help in an emergency.
2. PERS with fall detection if the client:
* Is eligible for a standard PERS unit; and
* Has a recent documented history of falls.
1. PERS with GPS tracking device or an anklet/bracelet/pendant with locator capabilities if the client:
	* Has a recent documented history of short-term memory loss; and a recent documented history of wandering with exit seeking behavior; or
	* Has a recent documented history of getting lost in familiar surroundings and being unaware of the need or unable to ask for assistance; and
	* In addition, if the client is under the age of 12, there must be information presented at the assessment that due to the client’s disability the support provided for memory or decision making is greater than is typical for a person of their age.
	* PERS with GPS is the only PERS system that may be provided in a residential setting.
		1. The PERS system and all installation fees are a covered service.
		2. The GPS add-on is paid for using the client’s annual limit and is considered Assistive Technology.
		3. Clients must meet the eligibility for GPS and may not access a PERS without GPS capabilities in a residential setting.
2. A medication reminder if the participant:
	* Is eligible for a standard PERS unit; and
	* Does not have a caregiver available to provide the service; and
	* Is able to use the reminder system to take his or her medications.

**Exclusions and limits:**

* A PERS that does not include a GPS add-on may not be paid for through CFC in a residential setting.
* 24 hour nurse triage call center/nurse hotline services are not covered under the PERS contract.
* Electronic device or system add-ons (e.g., Tele Health, Well Being monitor, etc.) that monitor blood pressure, blood glucose levels, weight etc. are not covered under the PERS service contract.

**Assistive Technology (AT) Service**

Assistive Technology is defined as technology services and supports that enhance independence or substitute for human assistance which are not covered for the client by any other program (such as COPES) or funding source (such as Medicare, Apple Health, or a private insurance carrier). This service includes the training of clients and caregivers in the maintenance or up-keep of equipment purchased under this service.

Prior to receiving Assistive Technology devices, clients must get a recommendation from a professional. The professional must have knowledge of the client’s functional level, either through knowledge of the client or an assessment of the client, and must provide confirmation that the client is functionally able to use the item and would benefit from its use.

To obtain this recommendation, the client may use a provider they are currently using, or may use their medical benefits through Medicare, Apple Health, or a private insurance carrier to have an assessment to determine what AT items they may require. To use their medical benefits to obtain an assessment, the client should contact their primary medical provider for help with a referral. The medical provider should coordinate the appropriate assessments and follow up care needed.

Once the recommendation is received, the case manager will verify that the item is on the CFC Covered Items List and is within the $500 annual limit. The case manager may then order the item from a contracted vendor or may order by contacting headquarters (or an authorized agent of headquarters) if using a provider contracted through headquarters where instructions have been given to request purchases through headquarters or an authorized agent.

To determine whether an item is a covered item:

* Consult the “Covered Item List”.
	+ If the item is on the list, it may be purchased from a contracted provider using CFC.
	+ If the item is not on the list and it should be considered for addition to the list, contact your supervisor or JRP so that they may request consideration from the CFC Program Management Team for HCS and DDA.

Clients may purchase up to a combined limit of $500 per fiscal year of Assistive Technology and Skills Acquisition Training. Prior to authorizing payment, obtain documentation (receipt, invoice, etc.) which should be used to verify costs. Documentation should be placed in the client’s file.

For every purchase of Assistive Technology, the Case Manager will note the purchase date, type of purchase, and dollar amount in the annual limit calculator. Once the client has reached $500 in purchases of Assistive Technology and/or Skills Acquisition Training Services, they will have reached their limit. There is no edit currently available in ProviderOne to prevent authorizing greater than $500 per fiscal year. As such, the case manager must review all prior purchases, including PERS add-ons; to be sure the limit is not exceeded as this would result in an overpayment.

Examples of assistive technology:

* Devices that monitor movement and automatically turn off appliances if there is no motion detected within a specific timeframe.
* Devices that enhance sound or allow a non-speaker to achieve communication.
* Devices that monitor and sense motion to passively detect falls or loss of balance or to detect location of a person to substitute for supervision as long as the sub-eligibility criteria are met.
* Devices that magnify or read and speak small print to enable the reader to read things such as medication labels and care instructions.
* Portable computing devices that can, or have an application to increase an individual’s independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.
	+ - * Portable device purchases are covered at the base model level.
			* Clients may use private funds to purchase additional memory or capabilities.

**Exclusions and limits:**

* Any item or similar item with the same function may not be purchased more than once every two years.
* Portable computing device purchases include base model levels, additions such as added memory or storage, mobile wireless capabilities (cellular), and accessories such as keyboards, cases, sleeves, and decorative covers/coatings are not covered.
* The $500 limit cannot be carried over, divided, or combined between fiscal years.
* This limit cannot be used to supplement the rate paid by Medicare or Medicaid for a purchase.
* Purchases may not be solely for recreational purposes.
* If a higher limit is medically necessary, the Case Manager may use the Exception to Rule (ETR) process to request a higher limit.
	+ ETRs expire on June 30th every year. If your ETR is for an ongoing service, a new ETR will need to be submitted and approved before July 1st.
* Medicare, Medicaid, or any other third party payment source must deny payment for the item prior to payment from CFC.
* Exempted trust funds are not considered a third party payment source and clients must not be required to use these funds prior to using state or federal funding.
* Examples of items not covered under CFC Assistive Technology:
* Items considered Durable Medical Equipment (DME) or Specialized Medical Equipment (SME).
* Hearing aids, prescription eye glasses, reading glasses.
* Modifications to a home or living environment.
* Subscriptions or items that require a monthly recurring cost such as connection fees, internet service or data plans, are not covered (with the exception of Personal Emergency Response System add-ons).
* The service covers equipment only. Downloadable software applications (“aps”) are not covered; however, software that could be purchased, such as speech to text software may be covered as long as it appears on the CFC Covered Items List.
* Items covered by Medicare, Apple Health, or any other insurance or payment source.
* Items denied solely because of improper or untimely billing by the provider.

**Community Transition Services (CTS)**

1. Can be used if the participant is being discharged from a nursing facility, a state hospital, or an ICF/ID and if services are necessary for the participant to set up his/her own home. Services:
2. May include: Security deposits, utility set-up fees or deposits, health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to occupancy, moving fees, furniture, essential furnishings, and basic items essential for basic living outside the institution; and
3. Cannot be used for rent, recreational items such as TV, cable or VCRs.

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| **Note:** When Community Transition Services are furnished to individuals returning to the community from an institutional setting, the service is not considered complete and may not be billed until the participant leaves the institution and is enrolled in the CFC program.   |

***Community Transition Services Definition***

* Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional setting to a home and community based setting. Purchases may not be made for items that are required to be furnished by AFH, ARC, EARC or AL facility.
* Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:
1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
4. Services necessary for the individual’s health and safety such as pest eradication and one-time cleaning prior to occupancy;
5. Moving expenses; and
6. Activities to assess need, arrange for, and procure needed resources.
* This service includes the training of participants and caregivers, in the maintenance or upkeep of equipment purchased only under the service and does not duplicate training provided under other waiver services.
* Community Transition Services are furnished only to the extent that the:
	+ Services are reasonable and necessary as determined through the service plan development process, and
	+ Services are clearly identified in the service plan, and
	+ Person is unable to meet such expense, and
	+ Services cannot be obtained from other sources.
* Community Transition Services do not include:
	+ Monthly rental or mortgage expense;
	+ Room and board;
	+ Food;
	+ Regular utility charges;
	+ Home modifications or adaptations; and/or
	+ Household appliances or items that are intended for purely diversion/recreational purposes.
* Community Transition Services may not be used to furnish or set up living arrangements that are owned or leased by an AFH, ARC, EARC or AL facility.

***Community Transition Service Providers***

* The providers of CTS vary based on the needs of the individual client.
* Providers must meet any licensing or certification required by state statute or regulation to provide their services and be contracted with the AAA.
* Additionally, if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by the waiver beneficiary and detailed in the plan of care.

***Caregiver Management Training Service***

Caregiver Management Training is designed to help clients understand how to select, manage, and dismiss their personal care providers. Training topics include:

* 1. Understanding the Service Plan;
	2. Creating job descriptions;
	3. Locating employees;
	4. Pre-screening, interviewing and completing reference checks;
	5. Training, supervising and communicating effectively with employees;
	6. Tracking authorized hours worked;
	7. Recognizing, discussing and attempting to correct any employee performance deficiencies;
	8. Discharging unsatisfactory workers; and
	9. Developing a back-up plan for coverage of services when the regular care provider is not available or requires relief.

Training is provided in book, DVD, and web-based formats. Training should be provided to any client that requests this information. This training is designed to be self-study training.

Note in the Community First Choice folder in the CARE demographics tree the date when training materials were last provided to the client.



***Annual Limit***

Each client enrolled in CFC is eligible to receive Assistive Technology and Skills Acquisition Training services. Purchases of these items using the annual limit may not exceed $500 per fiscal year. This is an aggregate total of all purchases for Skills Acquisition Training or Assistive Technology. This limit applies only to the Skills Acquisition Training that is not obtained through the use of personal care hours or provided by a Home Health Agency.

This annual limit follows the state’s fiscal year and does not coincide with the client’s plan year. The fiscal year is defined as July 1 through June 30. When clients have annual or significant change assessments during the year, this limit is not reset. This limit resets once per fiscal year for each client on July 1st. Unused funds will not be available for use after July 1 and may not be combined with funds from other fiscal years. The limit is not pro-rated based on when services start.

Case managers will receive one tickler in June to remind them that the annual calculator will be reset for the following year. The tickler will include only one message, not one for each client.

1. Annual Tracking Calculator:
	1. When authorizing a purchase from the annual limit in ProviderOne, a note describing the purchase must be made in the notes section of the ProviderOne authorization.
	2. Once purchases are authorized, the case manager will use the annual calculator to note the type of purchase, date, and amount.
	3. When authorizing Skills Acquisition Training provided by an IP, an Agency Provider, or supported living agency the case manager will deduct the standard deduction per hour ($20.17 through June 30, 2016) regardless of the amount paid to the provider in the annual calculator. The provider does not get paid this rate; they get paid their standard rate. We use this rate in the calculator because:
		1. The state pays fringe benefits to IPs that amount to more than just the person’s hourly rate. This deduction reflects the total cost to the state and is not what the provider will be paid.
		2. The benefit available should be equitable between all clients regardless of the provider type they choose to employ.
	4. When authorizing Skills Acquisition Training provided by a Home Health Agency the case manager must:
		1. Document the denial of services through Medicaid, their HMO plan, the Health Care Authority, or their private insurance or other health plan.
		2. Authorize only up to the $500 limit (in combination with AT) in ProviderOne.
		3. Pay the provider at their contracted rate.
		4. Note the *actual amount paid to that provider* in the annual limit calculator in CARE.



**Exclusions and limits:**

* None of the $500 limit amount may be carried over between years. Any amount left at the end of the fiscal year may not be used in the next fiscal year.
* Aggregate purchases may not exceed the $500 fiscal year limit without a Headquarters approved Exception to Rule (ETR).
* Purchases must follow the guidelines provided for that benefit. See Assistive Technology and Skills Acquisition Training benefit descriptions above.

**Can clients switch between programs?**

**Clients on MPC who want to enroll in CFC:**

Any client who is on MPC wishing to enroll in CFC requires a functional eligibility determination before they may enroll in CFC. MPC eligible clients were determined not to meet institutional level of care criteria and do not qualify functionally for CFC services. If they are re-assessed and found to meet institutional level of care criteria, they *must* change programs from MPC to CFC as they are no longer functionally eligible for MPC.

**Clients on MPC who want to enroll in CFC + COPES:**

Any client who is on MPC and wishes to be enrolled in both CFC and COPES also requires a functional eligibility determination before they may switch to CFC + COPES. MPC clients were determined to not meet institutional level of care and do not qualify functionally for CFC services. If they are re-assessed and found to meet level of care criteria, they are no longer functionally eligible for MPC and must enroll in CFC.

In addition to functional eligibility, clients must have a financial eligibility review as the financial criteria for the COPES waiver is different than for the CFC program and financial services must approve eligibility before a client may be enrolled in the COPES waiver.

**MAGI-based Clients on ABP MPC who want to enroll in CFC + COPES:**

Because MAGI-based clients are not part of the Aged, Blind, Disabled population that is eligible for waiver services, the client must complete a Social Security disability determination (or the Non-Grant Medical Assistance (NGMA) process) before being considered for COPES or any other waiver service. These clients must also apply for SSI related medical using form [18-005](http://www.hca.wa.gov/medicaid/forms/Documents/18-005.pdf).

Clients who are on ABP MPC through MAGI-based programs who wish to be enrolled in both CFC and COPES and who have completed the disability determination process, require a functional eligibility determination as all MPC clients were determined to not meet institutional level of care and do not qualify functionally for any CFC program. If the client is re-assessed and found to meet level of care criteria, they are functionally eligible for CFC or for CFC + COPES.

In addition to functional eligibility, clients must have a financial eligibility review as the financial criteria for the COPES waiver is different than for CFC and financial services must approve eligibility before a client may be enrolled in the COPES waiver.

**Clients on CFC who want to enroll in CFC + COPES:**

**HCS Clients:**

HCS Clients on CFC who wish to also enroll in the COPES waiver are not required to have an additional functional assessment because the institutional level of care criteria applies to both CFC and to COPES.

**DDA Clients:**

DDA Clients who are enrolled in CFC have not been assessed to meet the same level of care criteria required by COPES. DDA clients wishing to enroll in COPES would need to have a new functional assessment to determine whether they meet the COPES functional eligibility criteria.

**Both DDA and HCS Clients:**

The financial criteria for CFC and COPES are different. Before the client is enrolled in COPES, financial must approve the enrollment; which may require a financial eligibility review. You must have an approval from a Financial Services Specialist before enrolling any client into COPES. Contact financial through Barcode form 07-104 as soon as you are aware the participant wishes to enroll in COPES.

Clients enrolled in COPES are required to continue to receive a service from COPES *every month* in order to maintain waiver eligibility. Clients who need a non-monthly service from COPES, such as medical supplies or equipment, may only remain on the waiver if they receive a monthly COPES waiver service.

Examples of COPES services that may occur monthly include:

* Wellness Education
* Home Delivered Meals
* Adult Day Services Programs
* Home Health Aide
* Skilled Nursing services

***Where can individuals receive CFC services?***

Clients enrolled in CFC may choose to receive services in one of the following Home and Community Based Settings:

* The home where the client resides
* Adult Family Home (AFH)
* Assisted Living Facility (ALF)
* Adult Residential Care Facility (ARC)
* Enhanced Adult Residential Care Facility (EARC)
* In community settings, personal care tasks specified on the service plan may be provided outside the client’s home:
	+ To support clients in community activities or to access other services in the community.
	+ To assist a person to function in the work place or as an adjunct to the provision of employment services.

## Use of the Acknowledgement of Services Form

By federal rules, clients who are functionally and financially eligible for CFC or both CFC and for waiver programs can choose to receive their care in an institution or in the community. The Acknowledgment of Services form ([DSHS 14-225](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/14-225.pdf))is the documentation that the program choices have been explained to the client and the client has acknowledged their choice of CFC state plan services and/or waiver services over nursing home or institutional care. For DDA, the Voluntary Participation form is [DSHS 10-424](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/10-424.pdf).

1. This form is mandatory as it provides documentation that the federal requirement has been met.
	1. CFC services and waiver services cannot be authorized without the client’s signature on this form.
	2. Check the box next to the appropriate program to indicate the client’s choice of Home & Community-based services (CFC, COPES, New Freedom, or Residential Support Waiver).
2. If the CFC and/or waiver client enters the nursing facility, services are terminated on that date.
	1. A new Acknowledgment of Services form is required if the client wants to return to the community on CFC and/or on waiver services. The 14-225 is documentation of the client’s choice to receive services outside of the nursing home.
	2. A new 14-225 is not required if the stay is short-term (e.g. 30 days or less, recipient is attending rehabilitation and will be returning to place of residence.)
3. Two copies are required - one copy is given to the client and a signed copy is placed in the client file by sending it to DMS.

# MPC and CFC (CN and ABP) for Regional Support Network (RSN) Clients

The Behavioral Health and Service Integration Administration (BHSIA) contracts with RSNs to provide medically necessary outpatient mental health services to Medicaid enrollees who meet the [Access to Care Standards](https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/Access%20to%20Care%20Standards%20v20150701.1.pdf). In addition, the RSNs provide crisis services; authorizing voluntary and involuntary inpatient mental health services. The CARE assessment must document what services the RSN will provide. CFC or MPC personal care services must not duplicate services the RSN is required to provide such as medication monitoring. If the client is on CFC, the RSN funds personal care services only, any other CFC services authorized would be funded by HCS.

ALTSA has an interagency agreement that allows HCS/AAA to share this information with the RSN without a signed release of information from the client.

MPC and CFC personal care and relief care services for individuals with a mental illness are funded in one of the following ways:

1. **RSN Reimbursement –** If all the personal care tasks the client requires are based solely on the mental health diagnosis:
	1. You must, prior to authorization, assemble a packet for RSN review. The packet consists of:
		* 1. A completed [13-712, Medicaid Personal Care Client RSN Transmittal](https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/13-712.pdf) form;
			2. CARE Service Summary and Assessment Details.
	2. The RSN will review the packet and determine if:
		* 1. The need is based solely on a Mental Health diagnosis;
			2. The client is currently authorized for services from the RSN; and
			3. The needs can be met by the RSN through other available services.
	3. The RSN must respond to requests for services from the HCS office within five working days of the request. This timeframe can be extended if agreed in writing.
	4. The RSN may not limit or restrict authorization for services due to insufficient resources.
	5. Denials must be documented in the written response to HCS.
	6. If the RSN agrees to the reimbursement, authorize the personal care service payment using the designated RSN reason code.
		* 1. The RSN pays only for personal care services, any other services are not funded by the RSN.
			2. Clients on MPC, CFC, and CFC + COPES may receive RSN funding for personal care services.
	7. The [13-712, Medicaid Personal Care Client RSN Transmittal](http://asd.dshs.wa.gov/FormsMan/FormPicker.aspx) form, indicating RSN approval, must be in the client’s file.
2. **RSN/ALTSA funded** – ALTSA may share funding if the personal care tasks the client requires are based on a combination of mental health and medical diagnosis. To obtain RSN approval, follow steps 1a through f, above. Authorize the payment in CARE using the designated reason code. If the RSN does not agree to share funding, authorize services using the ALTSA-funded reason code, below.
3. **ALTSA-funded** - If the client has a combination of mental health and medical diagnosis, which make him/her eligible for MPC or CFC and RSN denies funding, the cost of care will be paid by ALTSA. Authorize the payment in CARE using the ALTSA-funded reason code.

RSN Denials:

* Consult with your supervisor if you receive a denial for MPC or CFC personal care services funded through the RSN when you believe the personal care is based solely on a mental health diagnosis.
* If the RSN states the individual is not currently authorized to receive mental health services, a referral for an intake assessment by the RSN can be made. If the person meets the Access to Care Standards, the RSN can be asked re-consider the referral. If no referral is made or the client does not meet the [Access to Care Standards](http://www.dshs.wa.gov/pdf/hrsa/mh/Access_to_Care_Standards20060101.pdf) - authorize the payment to be paid by ALTSA.
* If the RSN states the need can be met using other RSN services, then the RSN must provide written documentation of how the needs will be met.

**Note**: Refer to your local area agreement with the RSN.