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WEBINAR
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This record of the captioning has been edited to correct spelling of names, people, and programs.

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>> OPERATOR: The Webinar will begin shortly. Please remain on the line.

The broadcast is now starting. All attendees are in listen-only mode.

>> Hello, everybody. This is Marilee Fosbre with Home and Community Services and we'll start today's Community First Choice Option Webinar. Here with me, I have Debbie Roberts from the Developmental Disabilities Administration and Jamie Bond, CFCO Program Manager from the Developmental Disabilities Administration and Tracey Rollins, Home and Community Service's Program Manager for the Community First Choice Option and we also have Linda Gardino, our technical assistance person with the Webinar today.

Before we start I want to read this paragraph about the fact that we'll be recording the Webinar and so we are required to inform everybody that the go to meeting Webinar you are about to view and/or participate in is being recorded. As such, it becomes a document and is subject to public disclosure under the public records act. We ask that no confidential or private information be discussed. If you interact with a presenter, meaning if you ask questions or make comments, you understand that your contributions become part of the public record. If you choose to do so, it implies your consent to being recorded. So the recording is on and we'll go ahead and get started.

>> During the last Webinar we realized we needed to start with

basic information about the Community First Choice Option.

This option was created a few years ago in the Affordable Care Act and it offers a new statement of authority for states to offer home and community-based services. In our state, in 2014 the Washington state legislature passed two bills directing DSHS to implement the Community First Choice plan for Washington State. One of the federal regulations is that when states implement the Community First Choice program, they use a planning and development work group to design the state plan amendment and design what the plan will actually look like.

So in Washington we've had six meetings with our work group. Our work group includes 16 people, over half of whom were clients, representatives of clients, caregivers, parents and a tribal representative. We began to meet in April and we have met six times. Our last meeting was last Friday and so this information is really hot off the presses, what the group decided.

So the work group was tasked with filling out the model of: What will CFCO look like in Washington State? They looked at how much choice and flexibility will be available in the model? Who should be qualified providers? What the services would actually look like? What the amount of service available would be, what the service will include, we looked at the settings that services can be provided in. And then we looked at what services, both the required services that we have to provide and what optional services would we include in the benefit plan as it is developed.

So, a little more background on the Community First Choice Option. For our state, it provides a much richer benefit for people who need support to remain in the community and a richer benefit than what is currently available in the Medicaid personal care program under the state plan.

It helps people relocate out of institutional settings back to the community and also offers support people need to remain in the community and avoid institutional placement. There are lots of opportunities in this service option to build new choice and flexibility for people and we think that it helps build a sustainable future in Washington because it leverages additional federal funds that aren't available in our other programs.

Last time we met and had a Webinar, there were many questions about, well, what will change? Is MPC going away and what will happen to the waiver? We started to start with a little bit of review of what our system currently looks like.

Right now in Washington and every other state we have state plan services and those are entitlements and that means that for any person who is eligible to receive that service, the state needs to provide it. So there are no enrollment limits. If people meet eligibility, the service is available to them. In our state, our entitlement programs are institutional entitlements and those include nursing

facilities and facilities for people with intellectual disabilities. Then we have some home and community-based services in the form of Medicaid personal care.

Then we also have other Medicaid services that Washington has chosen to provide in our state. Those include the waivers. So all waivers that the developmental disabilities administration offers and the waivers that home and community services division offers. Those are waivers like basic plus, the community protection waiver, and the new freedom waiver; for HCS, the brand new residential support waiver. Right now in Washington, right now in all states, including Washington, people are either receiving their services through the entitlements in the state plan, or on a waiver; and not on both. People can receive services through one or the other. People access service to state plans first and if there their needs can't be met by the state plan, they would access services through the waivers if there's a waiver spot available to them, but not on both.

That's what we look like currently. When we implement CFCO and our implementation date is scheduled to begin July 1 of 2015, so when that is implemented, we'll still have institutional entitlements of nursing facilities and facilities for people with intellectual disabilities but now instead of Medicaid personal care we'll have Community First Choice. And Community First Choice offers a much richer benefit package.

There are four required services and in Washington we'll be adding two additional optional services. It provides a lot of flexibility and what we think will be much improved outcomes for people living in the community and receiving our services.

Then on the waiver side we'll continue to have home and community-based waivers but they will look different in some cases so we'll be moving services out of waivers that can be provided under Community First Choice into Community First Choice and waivers will become more wrap-around for people who need those expanded services that can be offered under that authority.

The biggest difference is that people who are eligible for services in both programs, Community First Choice and in waivers, can be enrolled in both programs and receive services through both authorities.

Tracey Rollins will walk you through now the work of the workgroup, final work of the work group and the final model in Washington state that we'll be submitting to CMS.

>> TRACEY ROLLINS: Thank you. Thanks for coming and thanks for providing that history and background.

So the first concept, that is new, is service units in Community First Choice. Today we do care assessments and generate care hours. In the future, care is going to generate service units and those service units, instead of being an hour of service, will be 1/4 of an hour of service. So if they are eligible for 100 hours they would

get 400 service units. Easy math.

It's also; a service unit is also equal to approximately $4.81. Again, that is for a quarter of an hour and that is based on some numbers from right now so that may change.

How our model works... the new model will work, is we have these three different sets of service buckets. So, we have our service unit menu which is personal care, personal emergency response, skills acquisition, and management of care giver training.

Then we have an enhanced benefit menu, an additional benefit of $500. This can be used for assistive technology, specialized medical equipment, and more of any of the services in the box above can be purchased with that $500.

That is an annual benefit. So the service unit menu is a monthly benefit whereas the blue enhanced benefit is an annual, once-a-year benefit. The one to the right is a no service unit impact menu. Those items are things that they can get without impacting any of their service units. So they can independently study on how to manage care giver or community transition services are also included in that with no impact to the client.

So the way that, a good illustration, of how this works is the enhanced benefit, that money can be used to -- for any services in both these boxes; however, the reverse is not true. So service units that are assessed during the care assessment cannot be used to purchase assistive technology or specialized medical equipment.

So, moving on to the specific benefits. Personal care is pretty much the same as what you would expect to see today. Nurse delegation is included as well as IP mileage.

Skills acquisition training is a new benefit and this benefit is meant to promote independence. So it should be related to an activity of daily living, an instrumental activity of daily living, or a health-related task. Again, it is meant to promote independence.

Backup systems are personal emergency response systems. A standard PERS could be purchased, or one with fall detection, GPS, medication reminder and delivery system. Moving forward I imagine there will be other technology we might be able to add to that list.

Relief care is an alternate provider for the purposes of providing relief to the current and most frequently used worker.

Care giver management training, this is another service that is fairly new. The definition of this is voluntary training on how to select, manage, and dismiss attendants, (Attendants being personal care providers). This will be available to clients in a variety of sources so that they can determine whether it would be easier for them to watch a DVD, read a book and do a workbook or to look at something on the Internet. If they do the independent study version, there won't be any service unit cost to them at all.

If they decide that they would like individualized training,

they could purchase that with their service units. So they could have someone come to their home or whatever, however that will be offered. The cost would be determined by how much time that they would require with their trainer.

The optional services are: Community transition, we currently provide this service in a couple of our other programs as well so it's pretty similar. It's goods and services needed for transitions from institutional to community-based settings and this has an $850 annual limit. So for this program, they could transition once per year with a maximum $850 transition cost.

Assistive devices and specialized medical equipment are covered under the $500 enhance benefit so they could be purchased with that specific pot of money so that limits the pursuant to $500 annually. These are devices that by definition substitute for human assistance and also enhance independence.

So the $500 that we are talking about, that is an enhanced benefit, $500 per year or annually and may be used toward, again, personal care, backup systems, assistive devices, skills acquisition training, or individualized training on caregiver management.

So when the work group concluded their final meeting, our bubbles became quite a bit more populated. This is kind of the celebratory representation of the work they did over the six meetings. It is pretty small but, pretty much, you can see everything is in these bubbles. So this is what our program looks like now.

So what's next for us now that we have done all that work? A lot more work in developing the state plan and setting new rules and policies for that plan.

We are expecting to be able to train staff in May and June of 2015 and we're working towards what a training plan will look like now. Nothing is set in stone with regard to training at this point. Implementation of the program is expected on July 1st, 2015.

So that is pretty much where we ended our session. So we wanted to open this up to questions from people to see where we are with the history and where we've come so far.

>> We have one questioner asking if the caregiver management providers will be available to family members or guardians who may be hiring or managing care providers on behalf of our clients?

>> That's a good question.

>> That's a good question. As with all our services we need to be able to pay for them under the client's name. That won't be any different, but the family member or representative is definitely encouraged to participate in that training.

(Pause)

>> They are asking if you can send the PowerPoint.

>> Yeah, the PowerPoint will be available on our website and it should be available, probably not until tomorrow, but it should be available on the website. So that would be available.

If you need it before tomorrow, I'm certainly -- I would welcome you to e-mail me and let me know and I can send it individually. But they will be on the website tomorrow, as well as the transcript of today's call or Webinar.

>> Next one -- what --

>> It does go -- (inaudible)

>> If you can't read it or see it for some reason, please e-mail me and I'm happy to send you any information to get you into that website.

>> Okay. Is relief care the same as respite care?

>> No, relief care is different than respite. Respite covers a lot more providers and services and relief care is a basic, basic benefit. It's an alternate provider.

Are there any other things?

>> Relief care is basically, as Tracey said, personal care provided by an alternate provider so there were lots of discussions in the work group and outside of the work group and some disappointment when we had a meeting with CMS and understood we were not able to really provide respite care as we were hoping to under the Community First Choice option. So CMS was pretty clear with us that the service, all services, have to be geared toward ADLs and IADLs and health-related tasks. So they said no, not to full-blown respite care as we know it, especially in the DDA side of the house.

But that we could, in order to have that mixture – to make sure we have that conversation with families, list relief care as an option of using an alternate provider for times when family members need a break or need to be away. We have decided to include it as relief care.

>> They are saying: Just to confirm if there's a plan in place it doesn't change until the annual?

>> Well, I think we are working on how transition will occur and those decisions about how we will transition clients are currently being made.

>> What we are thinking right now is that when we are ready to implement, people will definitely receive their personal care through the Community First Choice option and any other services that they raised their hand for and asked for. But then, as we do reassessments, we'll start to really work with people to understand the full menu of options available and help them make those selections. So it will be a kind of combination of transferring services that are paid for, like personal care, to CFCO as soon as possible and then working individually as people are reassessed to start to access those other services.

>> How many people on the waiting list will be eligible for CFCO services beginning July 2nd, 2015?

>> We're talking waiting lists or paid services case load? This sets up a different level of eligibility. There is nursing

facility level of care, which is different than what MCC currently has; a little higher.

>> So for DD, the level of -- eligibility is institutional level of care, so for DDA, that would be ICFID level of care; for HCS it would be nursing facility level of care.

We know that there are no DD clients on Medicaid personal care today who don't meet that eligibility. They all meet that eligibility. It would just depend on the functional needs of people on the DD waiting list. If they have been already assessed and are eligible for a DD waiver they would definitely be eligible for the Community First Choice option.

>> They have to meet the financial requirement as well.

>> How are service units going to factor into the family home daily rate?

>> That's a good question.

>> That's a good question. The clients that are in residential facilities will not have care-assessed service units. They'll have a care-assessed daily rate and then have the $500 enhancement. Which is, the group did kind of a last-minute ask to us to change the $500; to translate it into service units. So it will probably be somewhere around 100 to 105 service units. So a residential client would receive their daily rate plus an extra 105 service credits which they could use toward only a certain number of those benefits that in-home gets. They couldn't get more personal care or a PERS because that's expected by the facility.

>> Can you give an example of why we would enroll someone in both a waiver and Community First Choice and how would we authorize that?

>> So there are a couple reasons why that would happen. One reason is there will be services available on the waiver that are not available in Community First Choice Options. For instance, on the HCS waivers, we offer skilled nursing, home-delivered meals, home modifications. On the DDA waivers, Debbie or Jamie, you want to give examples?

>> Behavior. Supported employment.

>> Yes.

>> Also respite. Since those things will not be available in the Community First Option, people can access the services if they need them from Community First Choice and then turn to the waiver for the other services. There is also a second reason that people can be on both.

We serve, in Washington; we serve a higher-income group on our waivers than we do in Medicaid personal care today. And so those people need to stay on the waiver and receive a monthly waiver service in order to be eligible for enrollment in the Community First Choice Option. That's something we're working on right now, is identifying monthly waiver services that would help to keep people on the waiver,

so they can continue to access personal care through the Community First Choice Option.

>> Will there be options for environmental modifications for clients? Also what if DME costs go over 500? Do clients have other options for getting DME?

>> Those are good questions; environmental modifications are not included in the Community First Choice option. Anything that goes over $500, if the person is eligible to receive waiver services or if there is an opening in the waiver, then they would be able to access that service through the waiver.

(Pause)

We're having a little technical difficulty here. Can you see questions?

>> I have one question up here that says… What is the resource/eligibility, income eligibility limit? So they are asking what the financial.

>> What's the financial eligibility?

>> The financial eligibility for CFCO is the person needs to be eligible for categorically needy program in the state plan that includes a nursing home option. I'm not probably going to say this in the right technical terms and we don't have anyone from the financial unit here with us but they need to be eligible financially for a state plan program that includes a nursing home option or if they're in that higher-income group, then they need to be eligible through the waiver. Just like now, those high-income people can receive Medicaid by virtue of being on the 1915 c waiver. That is still the case, so if they -- if their income is too high for CFCO they can enter Medicaid through the waiver and then access CFCO option and CFCO services as well.

>> Okay. I have the question. So the next one: Will waiver client training go away?

>> No, it won't.

>> Okay. Regarding the $500 enhancement --

>> Let me just say the reason that COPES waiver training will not go away is it's a broader service. Skilled acquisition training and CFCO is targeted only to ADLs, IADL's and health-related tasks and health client training is broader than that. So we want to keep that in place.

>> Okay. Regarding the $500 enhancement, does everyone who gets MPC get that money?

>> Everybody who is enrolled in Community First Choice option will have that annual benefit.

>> Who is qualified to train a service recipient on how to manage a provider?

>> So we have, that was the last piece of business that the work group tackled on Friday and their decision was to write the qualifications fairly broadly to describe the -- the person for that

service and for the skills acquisition training service to describe the qualifications as being able to demonstrate that they are -- have the skill, ability, and training to successfully provide that service. So that's something that we'll be fleshing out a lot more over the next couple months, really developing that standard. But instead of listing, like, different types of providers as we do for other waiver services, we're going to describe the definition of a qualified provider for that service and for skilled acquisition training.

>> Can clients use the $500 to pay adult family home providers?

>> No, that $500 is available to purchase assistive technology, specialized medical equipment, and for adult family home clients it would also be available to purchase the skills acquisition training.

>> CMs are currently able to authorize for a 12-month period. Will this new program require monthly authorization for all clients in case they want to use the units to purchase other services? What pragmatic applications are being considered to avoid overpayment?

>> So if we anticipate from most clients, it will be a yearly authorization because most clients will set up their services a year ahead. But there will be some clients that will want to use their enhanced service units or their needs change. Just like today, where there may be changes in the authorizations. As far as overpayments, you know, I don't think we are ready to answer that just now. I think we have the same protections we have now and the more protections that are coming with the implementation of provider one, so that's a good question and something that we'll think about more if there's more risk in this program than we currently have, then we definitely want to address that.

>> Has a decision been made regarding the 700 MPC clients mentioned at the last Webinar?

>> No, we have not made that decision yet but we haven't forgotten it. We are still working on that.

>> Do we know what responsibility will look like in front-door HCS plan enrollment? Will HCS need to set up all these ancillary services before transferring to AAA or will we just enroll folks and have the AAA follow up with the specific ancillary services?

>> I don't see that our current practice changes in any way. So, what we're doing now when we do the initial assessment and help people get set up with services would remain the same.

>> Does relief caretaker place when the regular formal caregiver is on vacation or any time?

>> It could be. Those could be reasons why someone would choose to have an alternate provider available.

>> There is a question asking for clarification of who would be on COPES. Basically if their needs can't be met by the services offered in CFC, then they could be on the COPES waiver in addition to Community First Choice or if they are not financially eligible

for Community First Choice without accessing it through that waiver service.

>> Okay. What kind of provider will be able to be used for skills acquisition?

>> I think we answered that one.

>> Will the role of nursing change?

>> No, I don't think the role of nursing will change. We'll still have, in Community First Choice option we'll still have nurse delegation, and so we'll pay nurse delegators through Community First Choice option. That will be not something that a person will have to use their service units for and then skilled nursing will still be available through the waiver just as it is today.

>> Okay. Who can be authorized to provide relief care? Other family members living outside or inside of the home? Is there eligibility criteria for relief care?

>> Relief care, to be really clear, is the same as personal care and would use the same providers as we use for personal care. So, individual providers and agency providers. It's possible that we will -- we're looking at using residential providers as relief care providers, too, so that's something that we are working on right now.

>> Okay. Will MPC as we know it then go away given that CFCO will become the state plan?

>> That's the plan, that CFCO will replace MPC as we know it.

>> Will we be able to move assessments to earlier in the year as we can do now and will it affect the $500 yearly benefit?

>> So the $500 yearly benefit is a 12-month benefit. That's a puzzle that we have to solve about how we will figure that out. It's not -- it can't be tied to the assessment plan period because that period can change in HCS when we do a significant change assessment that resets the plan period. So our current thinking is that it will be available probably on a fiscal year basis. Not tied to the plan period.

>> Okay. Can (inaudible) be used differently each month and how are units authorized?

>> Yeah, they can. Really good question. We're working on the details of how that will function, both in the system, and what the clients are able to do. But they could allocate their units differently by month. They would be authorized by the client asking you to do that essentially. There wouldn't be a separate authorization process.

>> Are we going to be moving some clients off their current waiver? What is the criteria for that?

>> Is that DDA or HCS?

>> Moving clients off current waiver.

>> (Speaking off-mic) remove people off the waivers if they are receiving a monthly.

>> If they are receiving a monthly waiver service there would

be no reason to move people off. If the only service they are receiving is personal care and they don't need to stay on the waiver in order to retain Medicaid eligibility, then they would be just receiving services through the Community First Choice option.

>> What is the resource income eligibility limit?

>> Did we answer that?

>> Resource eligibility.

>> Resource and income eligibility.

>> We won't be able to answer that question right now. We just don't have a financial person here with us and there have been recent changes in CMS rules we are still working out with CMS, especially about resource limits with the new eligibility group. So that's a question that we'll have to answer at a later date.

>> Will SSP be affected?

>> It will not. SSP is a separate program from MPC. What is going to be affected is MPC as we know it right now.

>> How do people access the $500? Does it need to be paid directly to a DDA contracted provider or will we have the option to reimburse people for items directly?

>> Actually, no, we will not be able to just pay anybody that. They would have to access a contracted provider in order to get whatever services they are going to purchase with that money.

>> Are we capping COPES waiver slots? I know there is a current cap. What is that cap? Will there be less slots when CFCO rolls in?

>> We do have -- all waivers have an enrollment cap. I believe that our current enrollment cap in, for COPES is about 45,000. I don't have that number in my head. In the past we have never started a waiting list. We just increased the cap so we have no reason to anticipate doing anything differently in the future. Now, DDA waivers are at their limit and they do waiting lists. This is going to offer people who are waiting for DDA services and other options to receive services and so it should take some pressure off the waiting list for DDA.

Just a little bit of housekeeping before the next question, I know that you can see all the questions on the screen, we usually don't do that but we have technical problems and in order to make sure you can see the captioning we went ahead and showed my screen. I didn't think it was a big problem to show the questions!

>> Okay.

>> Will the RSN be responsible for paying the CFCO services when the client's sole disability or disabling condition is their mental health?

>> That's the case today. I assume that will continue but I see Tracey writing that down on her to-do list so we're sure we address that question as we do our planning. So thank you for asking that. It's really hard to think of every little thing so these Webinars

are really helpful to us.

>> Is CFCO applicable to estate recovery?

>> I think its estate recovery applicable in that, yeah, it should be. Yeah.

>> Will they have to use service credits for COPES waiver service.

>> No, COPES is the waiver so anything they use under the waiver would be covered under the waiver so that won't impact service unit.

>> If a client does not spend his $500, can it roll over to the next year?

>> Nope. They won't be able to do that. They have to use it or lose it.

>> Did you say the $500 could not purchase additional hours?

>> No. The $500 can purchase additional hours unless someone is in a residential facility. If they're residential they get a daily rate. If they are an in-home client they could purchase additional in-home personal care.

>> Do you anticipate that the providers of skills acquisition and managing providers training will require training partnership, training and DOH credential?

>> So we don't anticipate DOH credentials for sure. We do think that that is one way to help build a provider pool is to offer training that people can take since the work group suggested it be something similar to the nurse delegation training now, where people take six or seven hours of training by a qualified trainer and then demonstrate the skill back to the trainer.

That is definitely something that we'll be looking at as one way to build a provider pool. We are also; the work group has instructed or recommended to DSHS that we define the qualified provider of both those services as people who have demonstrated ability to provide them. That is another way to make that, to qualify a provider for those services. We'll be looking at both avenues. We need to be able to do something immediately to get providers in place and then something long-term to start really building up those provider pools.

>> Will it be an actual contract or client's choice if a person or trainer meets the minimum requirements?

>> It will be a contractual decision so there will be a contract developed and then people need to meet requirements and have a contract with DSHS in order to provide CFCO services.

>> How will case managers keep track of the $500 dollars?

>> That's a really good question. We are working on that as we speak!

(Laughter)

I think we have some sketches of what we can do and we're looking at adding some tracking mechanisms into CARE.

>> Just as a piece of information, at some point you guys will

be involving case managers and giving you some suggestions. On some of that, implementing this.

>> Yeah, yeah.

>> Okay. Potentially could anyone do the training if qualified based on the determined requirement?

>> Anybody who meets the requirements outlined in the contract and who meets all of the other requirements that we have for contracted providers, background checks, over age 18, able to work legally in the United States, you know. So anybody providing any service has to be able to meet the contractual requirements.

>> Okay. How would you enroll a person on CFC? Would this be done in CARE?

>> Yes. Uh-huh.

>> Will nurse consultation and skin observations stay the same?

>> That should stay the same as it is today, yeah.

>> For DDA waiver clients not receiving MPC have CFCO?

>> Waiver client?

>> For -- replaces MPC. If someone is receiving MPC we would expect they would have CFCO. If they did not choose to receive MPC at this time and they are eligible, they can request to receive CFCO, but they are -- if they're eligible they can receive CFCO if they choose it.

>> So there are services, I'm thinking of PERS, that are not available. PERS is not available on a DD waiver so there may be DD clients who do not receive personal care right now so they wouldn't need personal care through CFCO but they might want or need to have a PERS so they could access CFCO to meet that need.

(Pause)

>> Did you just say clients can change their services units monthly? How will it -- the case manager be able to keep up?

>> That's a very good question. Again, we are trying to build functionality for tracking that into the CARE tool.

>> Yeah.

>> So we'll be putting more information and gathering more information about that as we go through it.

>> So it will be a change, and the work group, you know, made sure that when they landed on a final model, that it's -- that they considered and made sure they made the model the least burdensome for the field staff to implement. You know, so there were some pretty, really flexible, and you know, suggestions and lots and lots of choices that were considered to put into the model. But the work group really limited it at this time that to make sure that they considered the workload impact as they work with clients and helping them create their service plan for the year.

We think that many people will have a pretty stable service plan just as they do today. One benefit of CFCO is that now at least on the home and community side of the house, if someone has a need that

can't be met by MPC the field staff need to transfer them to COPES and get the COPES service to meet that need and then transfer them back to Medicaid personal care and all of that work will go away for the services that they can access through the Community First Choice Options. There are some tradeoffs. The work group made sure we developed the program so people can't change their service unit usage in the middle of the month. And we'll be looking at ways to really strengthen that and keep workload impact to a minimum as we go forward and figure out all the details of implementing the CFCO program.

>> Well, all in theory clients CFCO --

>> Will what?

>> N as in Nancy, the -- the ones that are categorically needy, the ones that would fit -- same ones that would be eligible for MPC would be eligible for CFCO.

>> They would just have to meet the functional eligibility requirements?

>> Some of the N series aren't categorically needy.

>> They have to be categorically needy and meet functional eligibility.

>> Sounds like one of our next steps might be to have a Webinar just about financial eligibility and really get the financial people in the room and we have had about three conference calls with CMS to try to understand how some of the new guidance they have issued about impoverishment will apply to CFCO, so there are still a few outstanding questions but I think we have pretty much nailed down most of it.

I think what we'll do, then, is schedule a Webinar in a month or two for everyone to really focus on all these financial questions and maybe, we'll just skip over the rest of them today because we are not the right people to answer some of this detail.

But we will get that information. There will be lots of training coming to make sure that everybody who needs to know that kind of detail when the time comes will have that information.

>> Are DDA waiver clients automatically enrolled in CFCO?

>> If they're receiving personal care on the waiver, they will be enrolled in CFCO. If they are on a waiver and not receiving personal care they will stay on a waiver and not get CFC.

>> It might be a good clarification to say that what is being refinanced is Medicaid-paid personal care.

>> Uh-huh.

>> So any personal care in COPES or some of the other waivers will be in CFCO only and pulled out of those waivers.

>> Yeah.

>> So if they are on a waiver, currently, whether that be COPES or ISS or any of the other waivers that are now coming, that will come into CFCO for the personal care and then waiver services will still be received through the waiver they are on.

>> Yes, that's accurate. We did recently make a decision to keep New Freedom because New Freedom is a budget-based program and it would be very complicate today to administer two budgets like this. New Freedom we're keeping to the side for the next year and then we will look at it and make a decision about how to address that. But every other waiver, people will receive personal care through CFCO rather than the waiver.

>> (?) Will be separate, too, right? PACE and New Freedom should be kind of carved out?

>> Uh-huh.

>> Is the goal of this program to enroll clients into CFCO as a preferred program before COPES, is eligible for COPES but they want to see if CFCO benefit? Do we have to toggle between programs like MPC to COPES and back to MPC?

>> Whoever asked that question really hit it on the, nail on the head. CFCO will be the preferred program. Just like today Medicaid personal care is the preferred program so if people are eligible to receive services through CFCO and if CFCO can meet their needs, that's the program they will be on. If they need a waiver service in addition to CFCO, then they can be on both programs.

The only thing that's a little bit different, though, is that there are some people who, because their income is higher than eligibility for CFCO, need to access Medicaid through a waiver and then they can get CFCO services. But you are absolutely right when you say CFCO will be the new priority program. That's what we'll turn to first just like we always turn to any state plan program before we turn to a waiver program. That will be the same with CFCO.

>> Will case managers have options of writing ETRs requesting additional units of care-giving hours like we can do now?

>> Yes, that process should not change.

>> If someone has excellent timing would it be possible to purchase an item using the $500 from 1 year and then pay the balance with the next $500 right at the beginning of the next year?

>> No!

(Laughter)

>> That's a really good question. You probably hear that out in the field, not that our clients would think to do that. I think if they finagled it, but that's not the intention.

>> We would need to make the payment in full I think. I mean, you know.

>> But you know they could, if a client is eligible for COPES or one of the other waivers that has some sort of benefit for durable or specialized medical equipment, they could just reach into the waiver to purchase that equipment without having to worry about their enhancement.

>> They would spend their enhancement first and then pay excess out of the waiver.

>> Will the contracting process be changed in order to contract more quickly?

>> I haven't heard of any changes to the contracting process. (Pause)

>> Will newly eligible adults from the Affordable Care Act be eligible for CFCO?

>> Yes, that's the MAGI group. They will be eligible but again that will be covered more I think in the financial as to how that will be affected.

>> Uh-huh.

>> Will anyone contracting be still required to provide additional rider for insurance? This prevents many folks from contracting.

>> We don't see any changes in contracting. Instead we think for the majority of providers we already have contracts in place for. The new service, skills acquisition training service, and the caregiver management training service we don't have contracts in place yet but everybody else we have current contracts. We need more of some for assistive technology, for instance. But we don't see any changes to contracting.

>> It's my understanding the $500 could be used for something like a communication device or program. That provider would need to be contracted. Who is or would be contracted for something like that?

>> Well, we're currently looking into contractors for that. There are contractors such as Washington -- University of Washington -- see if I can remember it, Washington Telecommunications Act program. I don't think I got it right.

>> WATAP, we used it before with the roads to community living program and they are statewide and they have programs for helping people determine what devices to use. I believe they do training as well but they do need to give us more information on what they can all do. But yeah they even have programs available for people to borrow equipment to see if it's something they would use before they make a full purchase. We would look to providers of that nature for that service.

>> When do you anticipate this change will occur and MPC will no longer be a term used but all will be on CFCO?

>> July 1, 2015.

>> Who does the work group consistent of?

>> Well, there are 16 members and we have a list of specific people that were on the board but they were 16 members and they were clients, representatives of clients, caregivers, tribal representation and parents of clients. So we had a really mixed group of people and so…

>> I happen to have that with me. I can tell you that we have, in addition to the people that Tracey just mentioned we have a

representative from AARP, from the ARC of Washington, from developmental disabilities council, from the Washington association of area agencies on aging; from the SEIU; I think that I got them all. So, and we made sure that we have representatives from different constituency groups. So we had people with physical disabilities, people who provide care with developmental disabilities. A person who provides care to someone with dementia. So we have quite a broad group, we have a broad group of representation.

>> Will the transition still be at the client's next annual assessment?

>> We answered that one. We are working on the transition but we'll -- I think we answered that one.

>> Has provider 1 been taken into consideration since clients may change units each month? Providers under P 1 will be able to get paid during a month instead of after a month so you need input at the beginning of a month. We have to work.

>> We'll have to determine in fact how that will be implemented.

>> Can a person choose not to receive personal care and still access the $500 only?

>> No.

>> If they don't access personal care are they eligible for our services?

>> We'll have to think about that question!

>> Tracey is writing it down.

>> Is nurse delegation a purchase -- for CFCO clients?

>> Nurse delegation is available to CFCO clients. They will not have to use their service units to purchase it. So it's there, and it's basically free, I guess one way to phrase it. We want them to have it. We don't want them to feel like they need to trade something in, in order to get it. So it will be made available to people.

>> Will DDA waiver aggregate amount change?

>> No. Not as far as I know. I don't believe there's any plan to make changes to the waiver other than to remove personal care related to CFCO.

>> Will this cause a (inaudible) for case resource managers within DDA?

>> Cause a what?

>> No, they are asking if the staff will be cut. I think no, absolutely not. I think probably the other way around if anything. There would be.

>> No, there are no plans for that.

>> Can you talk about what the workers -- what the package is or the --

>> Yeah, so part of the work group's work was to look at how some of the savings or the additional federal match the state, that

Washington will receive. When we receive it, how that will be reinvested into the long-term care and DDA service system. And one recommendation of the work group was to re-invest a good portion of that money back into positions to decrease the staff to client ratio of case managers and social workers to clients. So that's a recommendation that is being put forth to the joint legislative executive committee which is the committee that is looking at how to reinvest that extra -- that additional federal match that the state will get.

>> Will there be separate SSPS codes for the CFCO? In addition to the newly created SSPS codes for the waiver clients (inaudible) now allowed for (inaudible)?

>> I think SSPS codes would be all different for CFCO, yes. But they will mirror the ones that are existing.

>> Uh-huh.

>> Why aren't there any representatives from CRMs or SWs on the work group who could have provided an important perspective?

>> Uh-huh, so these Webinars are opportunities for that input. So we made sure that each time we have a work group, or had one, we also had a Webinar so that people who are not able to be on the work group would have an opportunity to provide input and comments.

>> They're asking did you have a DDA case manager or social service specialist to make -- on the plan work group?

>> No, we did not have case managers or social workers on the work group. We had representatives from developmental disability advocacy groups. ARC, developmental disability council and we had representation by the area agencies on aging.

>> We have had input from case resource managers and field staff that has been brought to the work group.

>> Absolutely. Some of the changes that, or some of the final results that you see… For instance, the ability for people to purchase one-on-one caregiver management training is a suggestion from field or from case management staff. There were a couple other ones that came forward to the work group and were adopted by the work group.

>> If a person is eligible for personal care but not using it because they don't have a provider can they still use the $500?

>> I think that's similar to the other question.

>> That's similar to the other question. We'll look at the answer to that question. I would think it's probably going to be yes but we'll have to think about that a little bit.

>> Okay. So the state sees this program as adding benefits and saving the state money due to the match?

>> Yes, we do see it as adding benefits because now our entitlement program provides only personal care. This new entitlement will provide personal care, backup systems, skills acquisition training, training on managing of care provider, specialized medical equipment and assistive technology. So

there's, we have, a much richer benefit package for people and we'll also receive additional federal match for providing these services.

>> Today MAGI services are not state recoverable. Could this be an issue for this group of CFCO clients?

>> We will put that on the agenda for the financial Webinar.

>> When you make your recommendation to use savings toward FTEs are you planning to designate non-waivers (inaudible) for those FTEs since CFCO will be a non-waiver program?

>> So the work group's recommendation did not get down into that kind of detail. It was to reinvest in case management and social workers.

>> Where someone currently is receiving MPC service from an agency, will the agency have to contract to retain the client who is now being moved over to CFCO? Can they still use the same agency?

>> Home care agencies will be a qualified provider for personal care under Community First Choice option. So there would be no reason for anything to change in that area.

>> Because of these additional services offered will the client's personal care services be reduced or is there no relation to the cost of care needed?

>> Say that again.

>> Because of these additional services offered, will the client's personal care services be reduced or is there no relation to the cost of care needed?

>> You talking about (inaudible)?

>> Yeah.

>> Yeah, they will still get the same number of, the same allotment from care and it will be up to them how they use it. There won't be a reduction in what their benefit is. They will just have a choice. If today someone on MPC would receive, for example, 100 personal care hours, tomorrow, on Community First Choice they will receive 400 personal, well, service units. And they will be able to use those towards personal care, skills acquisition training, a PERS system, things they can't currently purchase on MPC or get through MPC. So they will get the same benefit amount, they will just have freedom to use it in different ways.

>> Right.

>> Yes there will be a reduction in personal care hours if they choose to have --

>> Don't forget there's also the additional yearly benefit, so if someone wanted their full 100 hours of personal care and also wanted one of the other services, they can access that enhanced $500 yearly benefit to purchase the additional service.

>> If it becomes a possibility to obtain the $500 without receiving services and this is the stated purpose for the clients, can we do a brief assessment instead of a full CARE?

>> I think we have to continue to analyze that question before

we can answer this follow-up.

>> Yes.

>> With CFCO, the 75 to 1 CRM legislative requirement remain the same between state-only and waiver?

>> I don't think that's -- is that a legislative requirement? The 75-to-1.

>> I think it is for the waiver but what they're talking about are the 105 non-waiver clients to each case manager. There is not any mandate for that.

>> So, you know, I don't know that we have a clear answer to that other than to say we are working as hard as we can to keep case load ratios as low as we can keep them.

(Pause)

>> Has the process been started to have financial eligibility systems changed to support the new program plus the linkage of P 1?

>> Yes, that work is already under way. Work groups are addressing those issues.

>> When is -- is there a description on what the other services offer in detail and what they can use the units for?

>> So the description that we have is what we have in the PowerPoint. Where our next step is to write that up into full service descriptions that are similar to the way you would see a service description in the waiver. But you can expect that personal care will be described the same way as it is now. PERS backup systems will be described the same way. Specialized medical equipment… So, but they will be ready fairly soon to read because we're planning to submit this to CMS in January, so Tracey and Jamie will be -- their next step now is to write that and have that state plan completed to submit to CMS. Part of that includes writing service definitions. They have already gotten a start on it. Stuff they could write and things before the work group ended their work they have been working on. Since the work group just made their final recommendations on Friday, now they can really dive into that and get that completed.

>> Will the provider offering other services under CFCO be required or be prohibited to provide personal care while working with the client if not contracted?

>> If someone is a non-contracted provider we could not pay them to provide personal care. So if they're providing services under CFCO that would indicate that they are a contracted provider. I'm not sure. If you could type in a clarification, that would be helpful for us.

>> Will agencies have an opportunity to contract to offer other CFCO services?

>> Yes, they would. Anybody who meets the contractual requirements for service is eligible to contract.

>> Could CMS reject the work group's plan altogether or have you been working with CMS all along and feel confident your proposal

will be accepted as-is?

>> We have been working with CMS all along. We have weekly or every-other-week conference calls with them so we keep them posted as to what recommendations the work group is making and we have vetted everything through them so far. There's always a chance that when we actually write and submit this there will be more questions. But so far, they have been very encouraging to us. A little disappointing in the respite area because we were really hoping to do a much different service in that area but other than that, I think that we're in sync with CMS and really appreciate their work with us.

>> Those were all the questions that we received today. Again I think it's really great to hear these questions because over time I see the questions really changing. You know, they were -- they were much more focused today. I think people are really starting to understand what this model looks like and what it is going to mean for the field. You guys sometimes are a couple steps ahead of where we are, thinking about all these ways we could implement it like can you get something at the end of the year for $500 and use the next $500? There will be all kinds of stuff like that that you'll think of and that we'll need to consider so having this opportunity to hear your questions is really helpful to us as we sit down and actually write this and try to operationalize it.

We will have another Webinar. I think we'll make that financially focused but in the meantime you have the contact information there for Jaime, Tracey and Rob and we would love to hear from you. So any suggestions or continued questions you have, please feel welcome to contact us and we'll get answers out to you and consider your suggestions.

As Debbie Roberts said earlier, there will be opportunities to involve case managers and social workers in some of these work groups and planning as we get a little more clear beyond the direction we are going. So thank you again for all your time and interest in this.

>> Okay.

>> Looks like there are no more questions or anything.

Again, thank you for your participation today. We appreciate your time and energy. Thank you.

>> Thank you.

(Webinar concluded at 4:12 PM CT)

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