**Workgroup Members Present:** Aruna Bhuta, Sue Elliott, Gail Goeller, Darla Helt, Ed Holen, Mary Clogston, Dan Murphy, Leanna Ray-Colby, Sue McDonough,

**Workgroup Members Absent:** Jennifer Bliss, Penny Condoll, Gloria Kraegel, Ron Ralph, Pat Shivers, Misha Werschkul, Steven Wish.

**Others Present:** Kathy Leitch, Rashi Gupta, James Kettel, Sarah Miller, Patricia Hunter, Cathy Knight

**State Staff Present:** Bea Rector, Janet Adams, Marilee Fosbre, Grace Kiboneka, Debbie Roberts, Sandy Robertson, Tracey Rollins, Jaime Bond, Melissa Johnson, Luke Wickham, Cathy Fisher

**Facilitator:** Paul Dziedizic

**Introductions**

All attendees introduced themselves. No issues, concerns, or changes were noted.

Paul welcomed attendees and indicated that determining the amount, scope, and duration of services offered in the CFCO was the goal for the day. Additionally, the need to provide a recommendation about how to spend the additional 3% to the Joint Legislative Executive Committee on Aging and Disability was also a key decision for this meeting.

**Planning and Design Workgroup purpose, timeline, and process**

* Current time line remains unchanged
* The next stakeholder and staff webinar is scheduled for 9/22/2014 from 10:00-11:30 am
* There is the opportunity to be able to provide information about CFCO and updates on decisions the workgroup has already made to the Aging and Disabilities Joint Legislative Executive Committee which meets 9/15.

**Review direction from previous meeting items related to benefit design**

* At the last meeting the workgroup decided that a flexible benefit is what people want. The group wants to maximize client flexibility and minimize administrative burden.
* The required services are:
  + Personal care includes personal care attendant (agency or Individual Provider) and Nurse Delegation
  + Skills acquisition training for ADLs, IADLs, and health related tasks and may include evidence based programs
  + Back-up systems/supports includes Personal Emergency Response System and Relief Care
  + Training on how to select, manage, and dismiss attendants with optional “buy up” for individuals to get 1:1 training or attend in person classes
* Optional services are:
  + Community Transition Services, which are defined as goods and services for individuals moving out of institutional settings into community settings. This service is already being provided, so CFCO funding from the client’s service budget will not need to be used. Clarification was made that “community” includes residential settings where personal care is being paid for. Those settings include facilities such as AFHs, ALFs, and Supported Living, but do not include Skilled Nursing Facilities, Residential Habilitation Centers, or ICF/IDs. There is a current $850 annual limit on this benefit. The recommendation from DSHS is to keep the annual benefit limit the same as current.
  + Assistive Devices and specialized medical equipment that replaces human assistance. The discussion was a $500 annual limit on this benefit since that amount equates to the 3% increase in per cap provided under the state statute for CFC..
* Behavior supports were discussed. The group determined that at a previous meeting the decision to exclude behavior supports was made as the cost is too high, the benefit would have to be too small, and the service is available in some HCBS Waivers.
* Transportation as part of the benefit package was discussed. The workgroup discussed transportation previously and decided that it will not be included as it can be accessed in other HCBS waivers. There was concern around individuals in rural areas receiving sufficient transportation, and one member would like to keep transportation on the table for future discussion.

**Present and discuss possible benefit design options re: flexibility and services**

* Definitions for amount, scope, and duration:
  + Amount – The maximum allowable expenditure for the service or the maximum number of units of the service that will be furnished during the period of the service plan.
  + Duration – The maximum period of time over which a service will be provided or authorized unless the necessity of the service is re-established.
  + Scope – The definition of each waiver service must describe in concrete terms the goods and services that will be provided to participants, including any conditions that apply to the provision of the service.
* Currently, participants are assessed using CARE and a number of monthly personal care hours is generated. In order to have flexible model, the personal care hours would be represented as “service credits”
  + One Service Credit = 1 hour of personal care and is equivalent to approximately $13 at this time as an example, this number may change.

Two models were presented for discussion purposes. The purpose was to provide concrete examples of the models so that the group could formulate recommendations.

* Flexibility Model A was presented.
  + 100% of their current MPC hours would be turned into service credits and clients could use all of their service credits however they choose to purchase any of the required or optional services
  + In addition, all clients, in-home and residential, would be authorized $500 per year to purchase any service covered in the CFC state plan. The $500 is equivalent to 3% of the total allocation currently spent for personal care/other services provided under current waiver that could be put in the CFC plan divided by the number of clients served.
* Flexibility Model B was presented
  + Clients would be authorized 103% of their assessed service credits to purchase required and optional services in any way they choose.
  + Clients in residential settings would have a benefit based on the 3% in additional to the assessed daily rate. They could not use the service exactly the same as in-home clients because the daily rate includes certain services already (e.g. no need for a PERS).
* Scenarios were presented to provide examples of how each of the models would work.

**Discuss/develop Workgroup recommendation/s**

* All members initially indicated preference for Model A.
* Model A allows for flexibility, choice, and because everyone will have access to $500 it increases fairness to individuals with low acuity level who would not get as much if there allocation was only increased by 3%. This would address access to the additional services for all clients equitably.
* Concern was raised about whether increasing the number of transactions that case managers must do with the addition of more services being offered will increase the administrative complexity.
* There cannot be rollover of any unused portion of the $500 into the next 12 month period because that increases administrative complexity, would require a fiscal intermediary and does not fit into the state fiscal year budget cycle. .
* Concern was raised about personal care needs not being met if the service credits are used for something other than personal care. Some discussion occurred around whether there is a need to set parameters around how many hours can be exchanged to ensure that personal care tasks are being completed. Client choice and flexibility is the ultimate goal expressed by the workgroup and personal care needs could be met through skills acquisition training..
* Having a Person Centered Planning process is a new requirement for any program that uses HHS/CMS funding, so conversation occurred around how to create a benefit model that incorporates person centered planning, provides flexibility and choice, and keeps administrative complexity at a minimum. It was suggested that the person centered planning process occur ahead of time, prior to the functional needs (CARE) assessment so that goals and desires could be identified and the assessment could help put services in place to meet those goals. This is long range planning that DDC is engaged in with DSHS.
* CFCO is going to be a change to the way that we are used to thinking about services, so there is some concern about what information will be provided to clients/families, how it will be provided, who will provide it, and in what timeframe.
  + It is not the Department’s expectation that clients are going to be fully aware of and start using all options available to them in a fully flexible way until they understand the program. This was the case with New Freedom, as people became aware of options and their choices; they began using the program more flexibly over time.
  + There is no intent, nor is it realistic to have all ALTSA/DDA clients reassessed by July or shortly after, Information will be given to participants prior to the roll-out and periodically thereafter. Individual, detailed discussions will occur with participants at their annual or significant change reassessment.
  + There was a suggestion that families and clients be provided with a glossary of terms.
  + Another suggestion was using a “roadmap” to services to inform people how to access services and what they need to do to get started.

**Modified Model A**

* Discussion of a modified Model A occurred due to concern about too much flexibility creating administrative burdens.
* Discussion:
  + Some members want to limit using all of the service credits to only required services due to concern about personal care needs not being met if hours are allocated to the other two optional services. This would also reduce administrative burden. Discussed limiting flexibility to 20% of available service credits. At this time, the group decided to allow use of the $500 enhanced benefit on any of the services available under the program.
    - The group requested to potentially revisit this in the future and would like a statement to this effect for future CFCO council consideration.
  + The members want to make it known that 100% flexibility is something they want for the future of CFCO. “If we have the manpower to implement additional flexibility, then we want that to be known for the future.”
* The outcome of this discussion was that individuals will be able to use 100% of their assessed service credits to purchase only the required services and not optional services. The $500 would be available to purchase the optional services (assistive devices/medical equipment) plus more of any of the required services.

**What do we need to address with regard to providers that will need to be available for each of these services?**

* Provider Concern: The issue of the inability of the client’s representatives to also be a paid care provider was discussed. More information on processes will need to be considered to accommodate this requirement.
* Personal Emergency Response Providers: Provider pool exists within HCS Equipment provider pools exist for medical equipment and supplies.
* Technology Providers will need to be defined and determined.
  + It was brought up that the University of Washington staff have indicated a lack of Occupational, Physical, and Speech Language Therapy staff knowledgeable in and able to train clients on technological devices.
* Community transition has a current pool of providers and some processes are in place. There may need to be some new providers contracted as we move forward.
* Skills Acquisition Training is a new service. -Considerations are:
  + Possible providers: Individual Providers (IPs), Agency Providers, Supported Living Providers, Community Choice Guides, Employment Vendors, Residential Providers, Adult Day Providers, Teachers, Staff Assistants, Community Health Workers, or Mental Health providers.
  + Rate for services, training programs, and narrowing of provider scope needs to be determined.
  + Parents or family members as skills acquisition providers: Would they need specific training or additional training and what would they need?
  + Tasks need to relate to ADL, IADL, or health related task and not community integration. This is a CMS/Statutory requirement.
* Training for selecting, managing, and dismissing personal care providers considerations:
  + Basic training will be available in booklet, DVD, or streaming formats and would not require the client to use service credits to get this service.
  + If there is a potential for in-person or one-on-one training, possible providers could be: Community Choice Guides, Independent Living Centers. This may require the client decided to use part of their budget to purchase this service.
  + Consider that all learning styles need to be addressed.
  + What training is going to be necessary for these providers?
* Evidence Based Programs:
  + This benefit is tabled to be discussed at the next CFCO workgroup meeting for consideration to remove it from the initial state plan amendment due to administrative complexity.

Providers and the training and qualifications of providers will be discussed in more detail at the next CFCO Workgroup meeting. Discussions to address:

* Parent providers and Guardians
* People who can train clients to use assistive technology.
* Skills Acquisition:
  + Group believes there are not enough providers; should there be different pay ranges based on skill level and training?
  + Make the definition broad enough to encompass people like teachers and educational assistants.

**Developing a Workgroup recommendation on Home and Community Based items that could be funded under the “other 3%”**

By statute, the Joint Legislative/Executive Committee on Aging and Disability must get input from this workgroup regarding how to reinvest the savings from CFCO. Their next meeting is on 9/15/14. The group identified the following items in previous meetings for the use of the additional 3% generated by increased FMAP from CFCO. Five decision packages were received; topics were:

* Increase access and use of assistive technology under CFCO.
* Positive Behavioral Supports program
* Decrease staff to client caseload ratios
* Restore in-home client hours cut during recession
* Expand Family Caregiver Support Program

After discussion of each package, it was determined that the following are the workgroup’s recommendations to the legislative committee:

* Expand family caregiver supports
  + Current program is evidence based and works well at providing supports to those not yet served within the Medicaid or Long Term Care system.
  + Could incorporate behavioral supports and more respite benefits.
* Hire additional Case Management staff to reduce caseload ratios.
  + This would accommodate the new Person Centered Planning requirements put in place by the Center for Medicare and Medicaid Services (CMS).
  + Case Management would be able to do more efficient planning.
  + Case Management would have time to explain all programs and available services to each client to allow for informed choice and to make sure clients are using their benefits to the fullest extent possible.
  + Addresses that current caseloads make it difficult to implement CFC due to additional services required and the desire to have a flexible benefit design.
* Restoration of some of the in-home client hours cut with historical budget deficits.
* Behavior Supports
  + Available on the waiver, but not everyone is eligible for the waiver or may be on a wait list for waiver services.
  + Lowers costs in the long term by keeping individuals at home as behaviors are a major factor in the decision to place individuals in institutional-based settings.
  + This is a desired service that is often requested by the community, caregivers, and families of clients.

Documents from the September 15, 2014 Joint Legislative/Executive Committee on Aging and Disability meeting:

