CFCO stakeholders and tribes Webinar.
July 24, 2014.
>> The broadcast is now starting. All attendees are in listen-only mode.
>> TRACEY ROLLINS: So good morning, everybody. Thank you very much for taking time out of your schedule today to join us in this session about the new Community First Choice Option state plan amendment that Washington State is working on with the group of stakeholders and work group members to design our state plan benefit package. We really appreciate you joining us and wanted to say a special thank you to the people joining us from eastern Washington today and to let you know that you are very much in our thoughts.
So we're going to start by the Webinar by reading a disclaimer. And then Tracey Rollins will give you preliminary information about some work that the work group has done over the last few meetings.
>> The Webinar you are about to 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 the presenters, for example, 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 be recorded by staying on to this Webinar.
With that said, if you have questions, please write them down and hold them until the end of the Webinar when they will be taking questions. And if you questions haven't been answered during the Webinar, then please type them in at the end or if you want to ask them verbally, you can raise your hand and we'll unmute you and have you ask a question.
Marilee?
>> MARILEE FOSBRE: Okay. I forgot to introduce myself. I'm Marilee Fosbre with home and community services. And Tracey Rollins is the Community First Choice Option program manager here with Home and Community Services and she's going to begin today with the first slide.
>> TRACEY ROLLINS: Thank you. So as a refresher, the Community First Choice Option which we sometimes refer to as CFCO or CFC is a state benefit plan established by the affordable care act that allows the state to provide services. As we move forward, we work toward a CFC implementation date of July 2015. The last meeting of our work group -- at this last meeting of our work group, it was the fourth meeting. And the planning and the implementation work group have two more scheduled. We are holding these Webinars between meetings. They are open to DSHS, tribes, stakeholders and to the general public. And we wanted to let everybody know that we did have a conference call with CMS last week to give an idea of what we can provide through CFC and our scope was narrowed. As we move forward with CFC, we will need to work within those guidelines.
So one of the things that the work group had asked about was person-centered planning. And as you may know, CMS has developed new guidelines for person-centered planning and home community services. The new guidelines will be implemented across all programs once the work group develops the transition plan for any changes that may need to take place. So those changes shouldn't affect any plans with Community First Choice Option.
So at this point, the work group has been considering three potential models of benefit design. We discussed each of these designs in terms of the level of choice and flexibility it would provide to clients and family. We also discussed the level of administrative complexity that would be for case managers that work with clients receiving the services. By the end of the June 30th meeting, the group was leaning toward a more flexible model but there were questions that the group asked us to evaluate between meetings.
We were asked to come back with additional information to give them a sense of how simply the flexible benefit could be administered. The boxes that you see represent the three models the group is considering. And so as we move forward, Marilee Fosbre is going to to discuss some of the design possibilities in a little further detail.
>> MARILEE FOSBRE: Okay. So the work group is very much aware of two considerations as they move forward in planning with DSHS on what the Community First Choice Option benefit design will be. One of those is choice and flexibility for clients and families. We have heard loud and clear through HCS and DDA families and clients that choice and flexibility is a very, very important element in the design of CFCO.
And so with that in mind, we've come up with the three optional benefit models that Tracey showed you a second ago. And we know that in CFCO, there are four required services that all states who decide to develop a CFCO program must offer. And so those are personal care, backup systems, skills, acquisition training and voluntary training to manage and schedule your personal care providers.
So in looking at choice and flexibility, we've kind of made the continuum of what would be the least amount of choice and what would be the most amount of choice and flexibility. So the least amount of choice would be to develop the benefit package with only the four optional services and participants would only receive those four optional services in the amount that each individual is assessed to need in their service plan.
And then if we move toward high choice and high flexibility, the benefit package would contain the four required services and may also contain some additional optional services or we can also write the description of the four required services to be a little broader, to include some services that are included within the four required services but broadened in that definition. And to be the most flexible, we can design the package in a way that would allow people to allocate their benefit dollar between services. For instance, people could trade some of their personal care hours for more of another service rather than just getting -- just receiving the assessed amount of each service.
We'll talk a little bit more about that as we go along. And if you have questions about that, we'll be happy to answer them.
>> They're asking if you can repeat.
>> MARILEE FOSBRE: The four required services? Sure. The four required services that all states must provide in the Community First Choice benefit model are personal care. And personal care includes health-related tasks which in our state we're familiar with health-related tasks as nurse delegation. That's one required service, personal care and health-related tasks. The second required service is skills acquisition training, and that skills acquisition training is limited to the acquisition or maintenance of skills related to activities of daily living, instrumental activities of daily living and health related tasks. Backup plans, in Washington State, we are familiar in that area mostly with personal emergency response buttons, the devices that people can use to call for assistance if they've fallen. Medication reminders, you know, the medication dispensers that remind people when to take their medications are a couple examples of backup systems.
And then the fourth required service is voluntary training for people who use an individual provider. And that training is related to managing, scheduling and working with the individual provider. Those are the four required services -- so those are the four required services.
If we turn to the next slide and look at administrative complexity, this is an area that the work group is concentrating on very hard to make sure that whatever the benefit design ends up looking like, that it is not adding a lot of administrative complexity for our case managers and social workers to administer when it's implemented.
So we looked at several areas that we think add to administrative complexity and some areas that are connected with low administrative complexities.
And so those are -- we're thinking that if services are authorized for the duration of the plan and reauthorized only when a change is requested, that leads to low administrative complexity, reduces the need to evaluate how much of a service to authorize and to evaluate progress toward goals also is connected to low administrative complexity.
And, designing a service that allows clients or their representatives to make choices that stay within the 103% per cap that we have been instructed to stay within by the legislature, by trading off between available services to meet their self-identified priorities also leads to low administrative complexity.
And we can contrast that with a system that where the service amount is limited, and because of that limitation, it must be reauthorized periodically and reevaluated for authorization based on need and progress. And also, you know, adding a lot of new services that would add potentially new provider types that we don't already have contracted were identified adds to administrative complexity. Making decisions about how much of a service to authorize and having case managers manage that authorization to stay within the utilization limits of the 103% aggregate also adds to administrative complexity.
So that was a big discussion that the work group had at our June meeting. It was a really robust discussion and people were very comfortable. Leaning towards flexibility, they are definitely very interested in making sure that families have as much choice and as much flexibility as we can build into our program design. They're very interested in having the lowest complexity, administrative complexity, as possible. But at the same time, they're also thinking with us on how to make sure that we meet people's health and safety needs in a way that's responsible.

So we move from that discussion in June to our most recent meeting in July which was just held the other day. And we looked at and provided information to the work group about, well, what administrative complexity is there no matter what model CFCO will be offered under? So these are things that CMS requires of our state and also states who offer Medicaid programs, that we do an annual assessment for each person's level of care and service needs. If those needs change during the assessment year, we do a significant change assessment. Clients are expected to be able to make choices among services as their needs change.
We need to discuss all service options available to the client and their family at each assessment. And we need to monitor service delivery throughout the year by the case managers to make sure that services that are authorized and paid for with Medicaid money are actually delivered to the client. So no matter what, those are kind of the framework parameters that every model has to consider as it's being developed and those apply also to the Community First Choice Option.
So that as a starting point, we looked at how flexibily can the Community First Choice Option in Washington State actually be? And DSHS proposed to the work group that CFCO can support families to choose any combination of personal care, skills acquisition, backup systems and relief care that make sense to that family. And that's how flexible we think that CFCO can actually be. And that, of course, raised questions. How can we do that? How can we be just that flexible?
We think complexity varies by client. And our experience is that the majority of our clients are going to choose the vast majority of their services as personal care because we know that our clients need personal care and it's difficult to go through their day without receiving that.
We also think that administrative complexity can be offset in CFCO because today when people are receiving their services only through Medicaid personal care, if they need a service that is beyond what Medicaid personal care can provide, they have to transfer to a waiver. On the home and community services side, our waivers are not full and so there is an ability for people to move on to COPES to receive that service that's not through Medicaid personal care. That is administratively complex for the case managers and social workers to administer. They have to do all of the administrative duties that are required to make that transfer into the waiver and then to move the person back on to Medicaid personal care once that service need has been met.
Community First Choice will simplify that because many of the services that people access through the COPES waiver will be available in Community First Choice so there won't be any need to make those periodic transfers between MPC and the waiver.
We also feel that we can address health and safety assurances through policy and practice and by looking at the amount, scope and duration of the services that are provided through CFCO.
Skills acquisition training is a training that people are really interested in and very excited to see included in the Community First Choice Option. There's a lot of questions about it, a lot of interest in it. And we're thinking that we can reduce the administrative complexity of that service by allowing clients to select the topic of training based on their assessment rather than -- and doing that broadly rather than having clients and their case managers identify topic by topic, hour by hour what kind of scope acquisition training the individual will access. So we would do that in a broader way if people are assessed to need, have an unmet need in certain areas of ADLs or IADLs or health-related tasks and they can just select that topic as something that they would receive skills training on.
We would monitor that at the annual assessments, at significant change assessments and during our routine monitoring context with individuals. And we would help people understand that service by providing some really clear materials and other documents with families and clients, too. Understand how that service will be delivered and how they can access that.
We also think by establishing some rules to limit how often service plans can be changed to no more than once a month, effective the first day of the month following, that we can manage some of that complexity. We've learned from the new freedom waiver that frequent changes during the month have a high rate of complexity, and so we're looking at lessons learned from that waiver to see what we can bring to CFCO to simplify it.
If the model ends up being designed in way that does add some complexity, we would cost it out and see how much it would cost. The work group is very interested to see how that can be built into adding additional time for case managers to do assessments and work with families and clients to select the services in the service package.
So we move from that discussion to looking again at the three possible models, the first being we're only going to offer the four mandatory services. It would be very much like a waiver now where people are assessed. They're identified to need certain services, and they would get up to the maximum amount that can be provided to those services.
The middle model, the flexible four mandatory services but given in a flexible manner where people can select, their service package can cover so many personal care hours. They can trade those hours for more or less of the other services that are offered in the CFCO model. And then the third model is four mandatory services offered flexibly and what more would the work group like to see included in the panel, what additional services or expanded service definitions would we like to put into the package.
So we ended that discussion on Monday with a firm commitment from the work group that they definitely want to go in the flexible direction. So we've taken off the fixed amount mandatory service model. It has been taken off the table, so we're definitely in the middle model now. And now we're looking at, okay, if we're going to be flexible, how much more can we add to the modeling and still meet our requirements to stay within 103% per cap that the legislature has directed us to do and also to keep caseload growth at a certain level.
And so we've ended up with this choice and flexibility as our preferred model. The work group has asked us to come back to the next meeting with more of a fleshed out model of what that would actually look at -- look like when we start to add in the amount, scope and duration of services.
So we did come to this last meeting with our idea of what could and couldn't work well. And we looked at some of the -- some of the possible services or expanded definitions that we could put in Community First Choice Option including home modifications, behavior supports, specialized medical equipment and assistive technology. We consider that all of those may be too costly to include in CFCO and stay within the 103% cap. They may be too administratively complex to include in the CFCO at this time. Most of those services are available through our HCS and DDA waivers. Either current ones or the upcoming family support waiver through DDA and we could consider them adding to CFCO in the future.
So this is what we came to the meeting with, with the work group. The work group really thought about those recommendations, and they were really reluctant to let go of the assistive technology. And they've asked DSHS to come back to the next meeting with a model that would include a limited benefit for assistive technology. So we will do that.
So what we proposed as a jumping-off point to the work group was a model that would include this first service, which is one of the required services, assistance with ADL, IADLs and health related tasks. Skills acquisition training. That's a mandatory service. But we believe that in addition to that, we could expand the definition of that service to include some evidence-based programs such as fall prevention and chronic disease self-management if the work group decides they want to go in that direction.
One of the things Tracey mentioned, was we had a call with CMS the other day to really -- as the work group has gotten to this point, we wanted to check in with them to discuss the direction that we're going and get their feedback. And we really got some clear guidance from CMS about the services needing to be very closely tied to assistance with ADLs, IADLs and health-related tasks, either with somebody achieving independence in that area, somebody receiving assistance in that area or training to accomplish those tasks. And so they were pretty good with providing evidence-based programs that would lead to more independence in IADLs and ADLs. So falls prevention, that would build balance and strength, would lead to more independent transfers and ambulation and they were on board with that. Chronic disease self-management, which would help people manage their own health conditions and health-related tasks, they were on board with that. So we feel that we are able to include those if the work group decides to do that.
Backup systems to ensure continuity of support, also a required service, we now offer -- we're most familiar with that through the personal emergency response system that we offer. But we also had a discussion with CMS about, well, could we do under that service some kind of respite care benefit because this is something that we know across the state through both administrations, HCS and DDA, that this is a very much requested service.
CMS was very sympathetic to that need. Gave us some very narrow parameters about providing that through CFCO. So when we think of respite care now as a service that can provide supervision for people who have protective supervision needs or recreational opportunities for people, CMS said, no, that's something you need to stick with waivers to offer. But we can do a small relief care benefit which would mean that our people could choose to use some of their personal care hours for relief care that's focused primarily on providing ADL, IADL and health-related types of assistance. It doesn't really look a lot different than respite care. There may be benefit to families because of training requirements so the person providing that small service may be -- may have to take less training than somebody who provides complete personal care.
So there may be benefits to families and work groups thinking about whether or not that's something that would be a benefit to offer through CFCO.
Then we looked at two more services. So the first set of services would be services that people would trade their benefit package between those services, more of some, less of others and would need to stay within that 103% per cap.
But we also looked at two other services that we will offer outside of that. So if you want this service or are eligible to receive this service, it would be available to the individual outside of that 103%. And those services are: training on selecting, managing and dismissing personal care providers. If you remember, that's a required service in CFCO. We feel that we can offer that across the state in a simple way and a cost-effective way and that there is no need to have people trade off personal care hours for that service.
We also now offer community transition services across the state and DDA and HCS, we do that through waivers with Medicaid-matched funding. We also do that through state-only funding. So this is something that we're already helping people with. And we will continue to do that outside of that monthly -- monthly benefit model. If people are using -- needing that service to go on to CFCO, to move from an institution, to a home in the community, then that would be available to people outside of the monthly benefit model.
That was a huge step from the work group to make that shift from considering how flexible should the benefit model be and making a decision that it will be flexible. They've started to really consider what other optional services or expanded service definitions will be included in the benefit panel. They have asked DSHS to come back with a couple fleshed-out options to look at and work from, and we'll be doing that at the September meeting.
So the next -- the next piece of business, if you look -- if you want to maybe go to the last slide, Tracey. This is our model of, you know, all of the elements that need to be filled in before we're finished with the design of the Community First Choice Option. So we know on the top-left model, bubble, that we have to include those required services.
We know that we're going to ask CMS to improve the in home, AFH, ARC and assisted living in our model. We just now filled in the choice and flexibility bubble and decided that flexibility and choice will be included in the model. And so we're left with looking at optional services, amount, scope and duration and qualified providers.
At the next meeting, we feel we will be able to definitely make a final decision about how expanded the model will be, what optional services it will include. We will address amount, scope, duration of services and probably hopefully be able to have discussions about qualified providers which we will finalize at the October meeting.
The work group is moving along. It's doing a lot of really good thinking and planning and great discussions. You'll remember from the last Webinar that there are 16 people on the work group and 61% of the work group members are either family caregivers of people with developmental or physical disabilities or dementia or people who have disabilities themselves. And other members are people from different organizations across the state that are advocacy organizations, like the developmental disabilities council. There are representatives from the Washington AAA association, the SEIU. So it is a broad-based work group that represents lots of different perspectives in the state.
So that is pretty much the end of my part of the Webinar. We'll ask for questions in a minute. And Tracey has displayed when the next Webinar will be. We hope you will join us in September. And if you have any questions, Tracey is available to take those by email.
We also have a Web site where all of our information is listed. We're in a blackout zone right now because the Web site is being transferred to a new -- it is being migrated to a new DSHS site, so we're not able to post anything for the next week or two. But after that, that migration has occurred, we'll update the Web site with this latest Webinar and this latest set of slides and handouts from the last meeting.
So we are interested in your questions. Do you want to read them?
>> I have two so far. So go ahead and type them in. If you want to ask them verbally, then raise your hand.
First one is: Will this affect the support of living providers?
>> MARILEE FOSBRE: Supported living providers for the developmental disabilities administration will still be the same. Supported living services will be provided through the DDA waivers. This service is not something that will be included in the Community First Choice Option.
>> Will the CFCO be available for the entire state or limited area like the new freedom waiver?
>> MARILEE FOSBRE: That's a really good question. So the Community First Choice Option is not a waiver. It is a state plan amendment. States have the option to limit the geographic area that a waiver can be offered in and also limit the number of people that can enroll in a waiver. For instance, new freedom is offered only in Pierce county and king county and has an enrollment of 5,000 people.
Since Community First Choice Option is a state plan service, state plan services are an entitlement. So anyone who is functionally and financially eligible to receive services in CFCO can receive those services so the answer is, yes, it will be available across the state. And there are no enrollment limits.
>> And they're asking if they can get the PowerPoint?
>> MARILEE FOSBRE: Yes. The PowerPoint, we'll post on the Web site. Are we able to send it out, Linda? Do we have a way to send it out before then or not?
>> I could send it to everybody that registered. Now, if they are in a conference room, it would just be to whoever registered.
>> MARILEE FOSBRE: We can send it to those who have registered if you would like. Or if you wait just a week or so, it will be available on the Web site after the blackout period has ended.
>> The provider training is one of the four requirements. But then the definition states that it is voluntary. Can you clarify the intent?
>> MARILEE FOSBRE: Yes, I can. So what that means is the training for participants of CFCO to manage their individual providers is a service that all states are required to make available to participants. But whether or not a participant is interested in receiving that service is voluntary. So we have to offer it and all clients can choose whether or not they're interested in receiving it, all clients who employ an individual provider can decide whether or not they want that service.
>> Does skills acquisition apply to children and adults both?
>> MARILEE FOSBRE: Yes. So skills acquisition training for IADLs, ADLs and health-related tasks is a service that's available to anybody who's on CFCO.
>> It says slide 18 -- I don't know if you want to go to that. Slide 18 shows that qualified providers will be determined. Has there been discussion to providers contracted with DDA to provide supportive living services being qualified?
>> MARILEE FOSBRE: So the question is, has there been a discussion about supportive living providers being qualified providers. Supported living won't be offered through Community First Choice Option. So I'm not sure if I understand the question. Maybe if the question is could they be providers of other CFCO services, that's something that the work group can discuss and make a decision about.
>> This person says: I would like to advocate for having DME and medical supplies and environmental modifications as options, even on a limited basis. These two options account for the majority of program changes in our office.
>> MARILEE FOSBRE: Okay. So that person wants to advocate for DME being available for CFC. Thank you for that. That vote of support, we will bring that back to the work group.
>> What will the person-centered planning process look like from the DDA perspective? What is our responsibility?
>> MARILEE FOSBRE: So, we are -- DDA and HCS are working on those new rules for person-centered planning. That's a question that people are really interested in. Person-centered planning is part of CFCO, but it is going to be identical from CFCO to the COPES wafer to the basic plus waiver to the community protection wafer, RCL clients. So it is across the board for all of our programs. And it is not really part of the CFCO discussion.
But there is work being done on that, and there will be opportunities to provide comment and input on that process. We're looking at that right now, how to bring that perspective from across the state into that consideration.
>> This person says that they're on COPES self-directed. I would be able to budget funds for my personal care and DME?
>> MARILEE FOSBRE: So in Community First Choice Option, if DME is included in the option, then that would be a possibility. That decision has not been made at this point. So if somebody's on COPES, they could continue to access DME through COPES.
>> Will CFCO replace COPES and MPC or in addition to these services and who will manage it?
>> MARILEE FOSBRE: So CFCO will not replace COPES but personal care will move from the waivers into CFCO. And so people -- a big change for when the state, when we implement CFCO, is that people will be able to be on both a waiver and CFCO. Right now people cannot be on MPC and a waiver at the same time, so this is a big difference. People can -- when CFCO is implemented, people will receive personal care through CFCO and will be able to access the other services on the waivers that they're eligible for.

>> There was a slide that said something about 30 minutes of case manager time costs 250,000 to 500,000. Can you explain what that means?
>> MARILEE FOSBRE: Yes. So that -- in the context of that slide -- so let's see. What's the best way to explain this? The higher number would be the cost to add 30 minutes of case management time for every current MPC client. There's about 19,000 roughly current MPC clients. And so if we added 30 minutes to the annual assessment for all MPC clients, it would cost the higher amount which was, I think, $500,000.
If we say that we would need to add additional time to only half of the current MPC caseload, it would cost $250,000. So the thinking behind that slide is if the benefit design is – it adds complexity that doesn't already exist during the annual assessment, how much complexity is that? and how much additional time would it take if it were complex for case managers and social workers to conduct the assessment and have the discussions that aren't had right now?
So we think that, you know, it could go as high as everybody needing extra time. We don't know how much extra time that cost figure is per half-hour. So those are all things that will be looked at when the design is finalized.
We do know that right now the majority of our clients choose to access personal care and all of their personal care benefits. And so we don't expect that that will change considerably when we implement CFCO. But since we're going to do it in a flexible manner with as much choice as possible, there will be some discussion and complexity possibly that we don't have right now for some clients. Not for all clients.

>> Can you give examples of optional services that may be considered? Would that include adult day health, day programs or employment?
>> MARILEE FOSBRE: So definitely not employment. Employment is an excluded service. So when CFCO was written, there were mandatory required services. There were excluded services that you can't put in, and then some optional services you can choose to put in. So employment is excluded.
Adult day health and adult day care could possibly be considered under personal care or possibly under skills acquisition.
Was there another one?
And another example of optional services is the community transition service which we strongly believe should be included in the benefit. DME and home modifications could be considered an optional service. So all optional services, though, need to substitute for human assistance. So that's one of the requirements in the final statute.
>> For families who are interested primarily in skills acquisition, can they give up the waiver to get the service? And will the service now be added to waivers?
>> MARILEE FOSBRE: So families who are primarily interested in skills acquisition and who are already on a waiver can stay on a waiver and also access services through CFCO. So you wouldn't have to give up your waiver.
The one thing to think about that, we can't duplicate services so you can't get two of the same service, you know. If a service is offered through CFCO and a waiver, you would get it from the state plan service from CFCO and not get a duplicate service through the waiver.
>> Would you be able to trade all my personal care hours for another service?
>> MARILEE FOSBRE: That is such a good question. (laughter).
That's the question of the day. And so, yeah, the work group is asking that and everyone is thinking about, well, what would that look like? And I think that right now we're moving toward either requiring, you know, some additional review of a service plan that has some threshold of hours devoted to the other services. We don't know what that is. You know, maybe there's discussion of, well, 85% is for personal care and the remaining is for other services. Should we have an additional review and conversation with the person and the family to make sure that their personal care needs can really be met and health and safety needs are met.
So they're kind of starting from that point to, well, should we make a hard limit of you can have only so many of your hours devoted to the other services. That's a robust discussion that's happening right now and needs to be considered and decided on by the work group.
>> Do you anticipate any additional workload for clerical or individual provider contracting staff for CFCO?
>> MARILEE FOSBRE: I'm looking at some of my colleagues here to see if they have any thoughts on that. I think there could be -- I don't think there will be any additional requirements for any individual provider contracting or home care agency provider contracting for personal care. There may be -- depending on what services are included and what qualified providers are defined for the benefit, it is possible that there could be a new kind of provider that we haven't used in the past that we would need to develop a contract for and need to develop a provider pool for.
So depending on where we're going with the end result of the benefit package that could happen. But I think that just, you know, with a quick thing, most of the providers we'll need are probably already on contract or at least have that type of provider identified and contracted.
>> CFCO requires that persons who are financially eligible through the waiver need to continue to receive one monthly waiver service. Has DSHS decided what that monthly waiver service will be?
>> MARILEE FOSBRE: That's a good question. So for everyone who's not sure what that means, people who are on the waivers, some people have an income limit that is too high for personal care through CFCO or through Medicaid personal care and so those guys go on to the waivers to receive services.
CFCO allows people to remain -- requires people to remain on a waiver in order to access CFCO if their income is too high for CFCO. So I probably didn't explain that very well. So let's do it in a different direction.
If your income is low enough, you can be on CFCO and receive services. If your income is too high for CFCO, you can be on Medicaid by being eligible for a waiver like COPES. And then you can turn around and access CFCO. But in order to do that, you have to receive a monthly waiver service to stay on the waiver and then be able to access CFCO services.
And so, yes, we are looking at possible monthly waiver service that can be cost effective and beneficial to all waiver clients who are in that situation. And we have some ideas that I think are pretty good, but we haven't made a final decision on those.
If you're interested, why don't you send Tracey your name because if you have ideas, we'd love to hear them and we'd be happy to discuss the current idea that we have on that with you.
>> How is this program going to affect the people who are already on a DDA waiver or COPES program?
>> MARILEE FOSBRE: So I think -- I think we've answered that, but people who are on DDA waivers or the COPES or New Freedom waiver will continue to stay on those waivers and will access CFCO services through CFCO.
>> It says this is a follow-up to the question about supported living providers being qualified providers. Given supported living providers skill set, could a supported living provider be included in the qualified providers to provide services under the CFCO, specifically supported living providers do skills acquisition and behavior support already?
>> MARILEE FOSBRE: That's certainly something that the work group will look at when they get to the part of their work where they are looking at qualified providers. That's definitely something that they can consider.
>> If MPC clients will be moved to CFCO and will be eligible for a waiver, has there been any discussions about expansion of the waivers to allow additional needed services?
>> MARILEE FOSBRE: Not sure that I know what that question is about.
>> Let me see if is Mark who asked that question, if I could unmute him and see if maybe he could clarify it.
>> MARILEE FOSBRE: Sure.
>> Mark, can you hear us?
>> Mark: Yes, I can hear you.
>> MARILEE FOSBRE: Help us understand your question a little.
>> MARK: Right now obviously if you are on MPC, you're not eligible for a waiver so the only services that clients are setting up -- not the only service but we are setting up MPC services separately.
But if now if their services are going to be through CFCO and they are going to be eligible for a waiver and there are services that they need that they are currently not being provided through MPC, is there going to be an expansion of the waiver program to allow more people to get on the waiver to get those other services?
>> MARILEE FOSBRE: Yeah, so CFCO does not make you eligible for a waiver. So right now if you're on MPC and you are a HCS client and you have a need that can't be met by MPC, you can move on to a waiver to get that need met.
In DDA, because their waivers are full, think don't have that flexibility. But CFCO doesn't make you eligible for a waiver.
>> MARK: I guess I misunderstood. People get MPC would go to CFCO. And I thought you said that they would be eligible -- that they could be both on a waiver and CFCO. Is that correct?
>> MARILEE FOSBRE: No, they can be on both CFCO and a waiver but they can only be on a waiver if they need a waiver service and there is an opening in the waiver and they're eligible for the waiver. And CFCO doesn't make you eligible for the waiver.
>> MARK: Okay. But it will give us the options. That's part of my question. In the past, if they have just been on MPC, they didn't have the option of the waiver because you couldn't be on both. Now they could. So there possibly will be more referrals to the waiver because of that because now they have the option of the waiver. That's what I wanted to clarify.
>> MARILEE FOSBRE: So, Shannon.
>> Good morning, Mark. It is Shannon. Currently people access personal care in the waiver via a waiver personal care. The only thing they change to the perm waiver is they will now access it through CFCO. The waiver enrollment process we have in place is what will continue.
>> MARK: Okay. I thought perhaps there could be some expansion. Okay.
>> MARILEE FOSBRE: The good thing about CFCO when we think about it, one of the best benefits for our state in implementing it is that it makes those additional services an entitlement to everybody in the state. Right now MPC is our entitlement program and all people can get is personal care. But now when we implement CFCO, those additional services become an entitlement. So people who need a PERS can now have a PERS. People who need skills acquisition training can have skills acquisition training now, whereas in the past you had to settle for MPC if you couldn't get on a waiver or if you didn't qualify for a waiver. So it is -- it does expand services that are available to people in our state. And it is a really exciting opportunity, I think, for us to be able to implement this.
>> MARK: Okay. Thank you.
>> MARILEE FOSBRE: You're welcome.

>> I have a question on provider types. When you talked about residential facilities, adult family homes and assisted living, I also know you are looking at a new type of provider type with Tracey Adair's group. Will they be in that provider type as well?
>> MARILEE FOSBRE: No, they won't.
>> So that will be a stand-alone?
>> MARILEE FOSBRE: Right.
>> It says, our son has both DD and a rare metabolic disease which requires a low protein diet at this time for PKU. We are receiving waiver but someone is saying we would be eligible for DSHS monies. Can we use both services, or one? We are getting a waiver.
>> MARILEE FOSBRE: I think that it probably would be better to talk with you individually about the services that your family needs. You can email your contact information to Tracey and Bob Beckman at DDD, they will be happy to discuss that. I think it sounds like you have a complicated situation and we'd like to really think about it and work with you on that individually.
>> How will this work with adult family homes since it is a daily rate rather than an hourly rate?
>> MARILEE FOSBRE: Uh-huh. That's something we will have to figure out how to operationalize. It doesn't matter that it is a daily rate or an hourly rate. The service can still be delivered. Some of the mandatory services like the Personal Emergency Response System -- or the backup systems would not be included for people who -- would not be -- people -- in residential settings would not be eligible for those because residential settings meet those emergent backup needs. So more thought will have to be given to how we will operationalize that component of CFCO.

>> Could skills acquisitions be provided by a one on one provider aimed at the person's needs instead of a class or program?
>> MARILEE FOSBRE: Yes, yes. Skills acquisition training, we would envision to be provided one-on-one.
>> Will the functional eligibility for CFCO be different from the current programs?
>> MARILEE FOSBRE: The functional eligibility for CFCO is the same eligibility as the waiver. It is institutional level of care. So for HCS, it is nursing facility level of care. For DDA, it is ICF, ID level of care. And that's the same level of care that we have for COPES and the DD waivers.
>> I think this is clarification. Is MPC going away and replaced by CFCO?
>> MARILEE FOSBRE: MPC -- personal care will be provided by CFCO. So, yes, MPC will be replaced by CFCO.
>> Will case manager caseloads be different? I'm sorry. I guess I can't read that. Differentiated as they are now waiver versus non-waiver? Or will they be evened out?
>> MARILEE FOSBRE: So I think that question applies to DDA because HCS doesn't separate caseloads like that. It is part of that discussion that is occurring about administrative complexity.
Okay. That's all the questions that we have. If you think of any that you would like to send in, just use Tracey's contact information and send those in and we'll direct them either to DDA or the right person at HCS.
And anybody that has ideas or input that they would want to bring forward to us, we'd love to hear that and include that in our conversation.
>> We do have another question. Sorry. Will there be any changes to the care assessment with the implementation of CFCO?
>> MARILEE FOSBRE: Yes. We do anticipate some changes to the care assessment with the implementation of CFCO.
>> What would happen to the current MPC clients who don't meet waiver eligibility now?
>> MARILEE FOSBRE: Nobody will lose services. We don't know exactly which way we are going to go with that. But nobody will lose services as a result of implementing CFCO.
Okay.
>> That's it.
>> MARILEE FOSBRE: Thank you very much. And please come to our Webinar in September to get the latest update on the work group.
>> And they are asking for the PowerPoint. We can send it out to those that are registered.

If you want a copy of the PowerPoint, please email Tracey Rollins.
Thank you.

(End of Webinar.)

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