

Friday Morning Collaborative Webinar

Community First Choice Option: State Consideration and Implementation

Friday May 16, 2014



National Council on Aging

Friday Morning Collaborative

- American Association on Health and Disability
- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Federation of State, County and Municipal Employees (AFSCME)
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer's Association
- Bazelon Center for Mental Health Law
- Center for Medicare Advocacy
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Health and Disability Advocates
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- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Health Law Program
- National PACE Association
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- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Cerebral Palsy
- United Spinal Association
- VNAA – Visiting Nurse Associations of America



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Support From



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Community Living Policy Center University of California, San Francisco

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Power Point

- Can I get a copy of the Power Point?
- Will an Archive of the webinar be available?

YES! YES! YES!

- You will received copies in a follow up e-mail early next week. Please share wit others!
- www.ncoa.org/HCBSwebinars

Questions and Comments



**All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Function**

Webinar Overview

- Introduction
 - Joe Caldwell (National Council on Aging)
- Speakers:
 - Martha Beavers (Colorado Department of Health Care Policy and Financing) and Edward Kako (Mission Analytics Group, Inc.)
 - Kelly Williams (Montana Department of Public Health and Human Services)
 - Trisha Baxter and Mike McCormick (Oregon Department of Human Services)
- Questions and Answers (20 – 30 minutes)

Colorado Consideration of Community First Choice Option



**MARTHA BEAVERS
COLORADO DEPARTMENT OF HEALTH CARE
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**EDWARD KAKO
MISSION ANALYTICS GROUP, INC.**



Montana Community First Choice Option

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What is CFC

- Authorized by Health Care Reform, Affordable Care Act, Social Security Act §1915(k)
 - Regulations mostly finalized May 7, 2012
- Creates new home and community-based attendant services and supports opportunities
- Increases federal matching payments by 6%

CFC Goals

- Support Montana's rebalancing efforts to develop integrated home and community based services system
- Draw from and grow state successes
 - Personal Assistance Services programs
 - Home and community based waiver programs
- Increase funding for improved service delivery

Why is CFC a Good Fit for Montana

- Montana has provided Medicaid Personal Assistance Services under the State Plan since the late 1970's.
- Montana offers two options for personal care services.
 - “Agency-based” program, where enrolled provider agencies manage the services on behalf of the consumer.
 - Agency-with choice or self-directed PAS Program has been offered since October 1995. The program is designed to allow consumers to hire, train, manage, schedule and discharge their attendants.
- In June 2008, for the first time in the program’s history, the number of consumers in the self-direct option exceeded the number of consumers in the agency-based option. In 2012, 55% of consumers were selecting the self-direct service option to receive their personal assistance services.

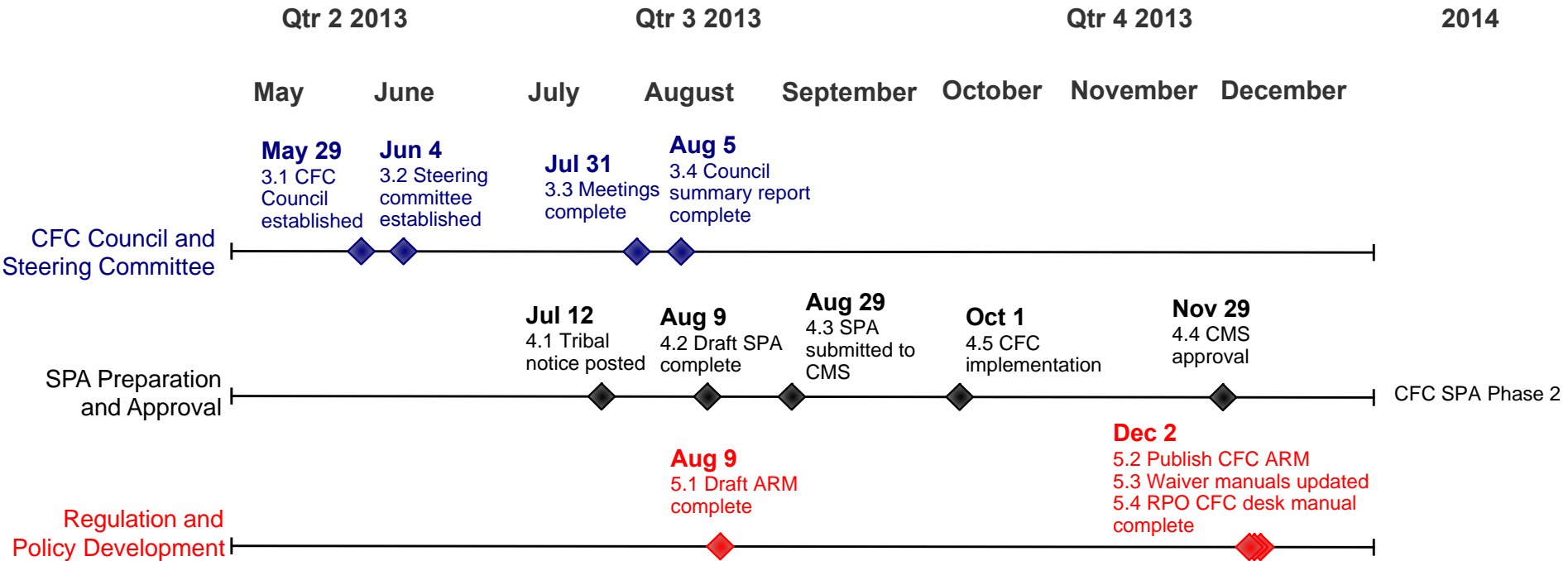
Why is CFC a Good Fit for Montana

- Montana has had an HCBS waiver since 1982.
- A money follows the person strategy has been employed since 2000 in Montana to rebalance long term care system transitioning nursing facility residents who want to move into community placements utilizing funding from nursing facility budget.
- Montana was awarded a 5 year Money Follows the Person Grant in 2012 to continue a broader effort at rebalancing.
- Montana's original estimate was 94-95% of current PAS program consumers would meet the CFC criteria and could be moved to the enhanced funding at 6%.

The CFC Process in Montana

- CFC analysis was complete in fall 2012 under a contract
- DPHHS presented CFC analysis to the 2013 MT Legislature
- Montana Legislature approved CFC funding May 2013
- CFC requires the state work with a CFC Council
- Governor and DPHHS appointed Advisory Council
- Hired a Facilitator to coordinate council & develop work plan
- Talked to other states implementing CFC- CA, Oregon
- Begin conversations with CMS on State Plan-July 2013
- Surveyed consumers and providers on CFC
- Starting work on State Plan Amendment and CFC policy

Draft Timeline – Best Case Scenario



SPA Contents-CMS Template Requirements

- Eligibility
- Service package
 - Required services
 - Permissible services
- Assessment and service plan
 - Person-centered planning
 - Opportunities for self-direction
- Quality assurance and improvement plan

CFC Core Components

The following are fundamental to all CFC services:

- ❖ Functional Assessment
- ❖ Person Centered Planning Process (PCP)
- ❖ CFC Provider
- ❖ CFC Facilitator
 - ❖ Case Manager, when assigned
 - ❖ CFC Provider, when no case manager
- ❖ Consumer Choice and Control
- ❖ CFC Planner/Consumer Agreement

CFC Eligibility

- Level of Care- Must meet LOC for nursing home or intermediate care facility for individuals with intellectual disabilities
 - Conducted by MPQH/QIO (for physically disabled, elderly and folks with serious disabling mental illness)
 - Conducted by DD Quality Improvement Specialist (for folks with developmental disabilities)
 - Reassessments are completed annually by the CFC Plan Facilitator during the **annual Person Centered Planning meeting**
- Medicaid Eligibility
 - Conducted by Office of Public Assistance
- Functional Need for hands-on assistance
 - Conducted by MPQH through CFC Functional Assessment

CFC Functional Assessment

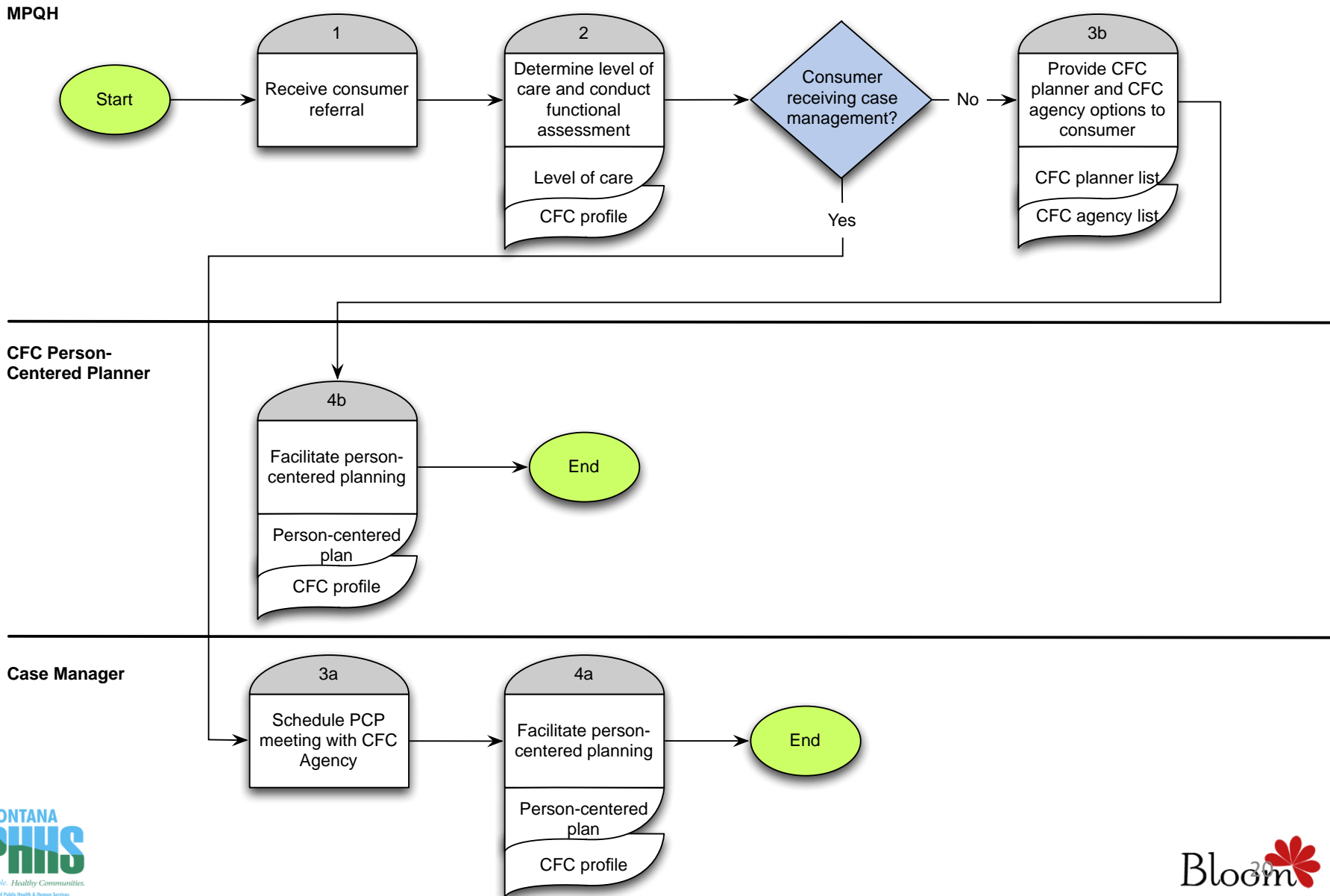
CFC Functional Assessment

- Expanded version of the current Profile/Overview
- Conducted by MPQH nurses
- Includes an initial screen for level of care
- Conducted annually (similar to current PAS process)
 - Initial in the consumer's home
 - Annual in home or over phone
- Assess for ADL needs
- Assess for IADL needs
- Assess quality assurance indicators
- Ensure choice and education regarding service options
- Provide authorization for all CFC services
- Authorization provided in two-week spans
 - Tasks authorized and reported similar to current process

CFC Service Options

- Self-Direct CFC (Agency Model with Choice/No Budget Authority)
 - Similar structure to current program
 - Consumer responsible for hiring, firing, scheduling and training workers
 - Consumer must pass capacity or have a representative pass capacity
 - Consumer must have a health care professional sign-off on the CFC service plan
- Agency-Based CFC
 - Similar structure to current program; with enhanced requirements for consumer-focus and options for consumer direction
 - Consumer has a say in the skill-set, training and preference for worker who delivers service
 - Consumer, or representative, sign the service delivery records
 - Agency hire, trains, orients and schedules workers
 - Agency provides nurse supervision of CFC services

Assessment and Planning



CFC Service Package

The following services must be performed by a qualified direct care worker:

- **Activities of Daily Living (ADL)**
 - Exactly same as current PAS program
 - Authorization will look the same on profile for each task
- **Instrumental Activities of Daily Living (IADL)**
 - Current services continue
 - Homemaker tasks
 - Laundry
 - Shopping
 - Additional Services include
 - Yard hazard removal
 - Correspondence assistant
 - Community Integration ActivityIncludes time for transit on community outings

CFC Service Package Cont.

The following IADL services must be performed by a qualified direct care worker:

- Medical Escort
 - Hands-on assistance to medical appointments
- Health Maintenance Activities
 - Same as current Self Direct PAS program
- Training, acquisition, and enhancement of skills necessary for the individual to accomplish activities of daily living and instrumental activities of daily living.
 - Consumer must be physically and mentally capable of achieving greater independence by performing the tasks for him or herself.
 - Support is time-limited and available only when there is a reasonable expectation that the individual will acquire the skills necessary to perform the task at the end of a three month time period.

CFC Service Package Continued

- Mileage
 - Reimbursement for mileage associated with medical escort and community integration
- Emergency Back-Up
 - Personal Emergency Response System (PERS), if necessary.
- ❖ Montana has not included any permissible services in the initial State Plan Amendment.

Service Limits

- ADL, IADL, and health related task services are limited to 84 hours (336 units) of attendant services per two week period per individual.
- IADL tasks are authorized in conjunction with direct personal care services
- IADL may not exceed one-third of the total CFC hours authorized or a maximum of 10 hours (40 units) per two week period, whichever is less.
- Medical escort service can exceed this limit without prior authorization.
- Services under the category of skill acquisition, maintenance and enhancement are limited to a three-month time-frame and may not exceed 25 hours per three-month time frame.
 - Services exceeding this limit may be re-authorized by the Department if significant progress has been made or if medically necessary and there is a reasonable expectation of skill acquisition.

CFC Service Planning- Plan Facilitator

- CFC Plan Facilitator
 - Conduct an annual visit to develop/review the person-centered plan
 - Incorporate the CFC Functional Assessment
 - Complete the CFC Plan Facilitator/Consumer Agreement
 - Complete the CFC Service Plan
 - Coordinate meeting with CFC provider and others (as determined by consumer)
 - Ongoing support when significant changes occur in the consumer's life related to their need for CFC services

CFC Person Centered Plan

- CFC Person Centered Plan Form-document that includes consumer strengths, goals, and preferences
- CFC Service Form- includes the type of service to be provided, the amount, frequency and duration of each service
 - Becomes the Service Profile (i.e., authorization for services)
 - Based on a two-week time period
- PCP incorporates the MPQH Functional Assessment
- PCP includes risk assessment, when necessary, for CFC service delivery related issues
- CFC Plan Facilitator is responsible for facilitating the planning process and ensuring appropriate paperwork completed
 - Not responsible for completing tasks for the consumer
 - Not responsible for acting as a case manager (for CFC providers)

CFC Planner Criteria

In order to comply with federal Conflict of Interest standards the following guidelines must be met:

- Must have at least one year experience in home and community based service delivery
- Must receive CFC Plan Facilitator Training
- In the case where the CFC Plan Facilitator is employed by the CFC Provider agency the following safeguards are in place

CFC Planner Criteria (continued)

Safeguards when CFC Provider is Facilitator

- The CFC Plan Facilitator is not related by blood or marriage to the individual, or to any paid caregiver of the individual;
- The CFC Plan Facilitator is not financially responsible for the individual;
- The CFC Plan Facilitator has no authority to make financial or health-related decisions on behalf of the individual; and
- The CFC Plan Facilitator will not benefit financially from the provision of assessed needs and services.
- The CFC Plan Facilitator will not be employed as a CFC direct care worker at the CFC Provider Agency;
- The CFC Plan Facilitator will not have the authority to authorize CFC services; except on a temporary basis (not to exceed 28 days);
- The CFC Plan Facilitator will go through CFC Plan Facilitator training, which includes a section on conflict of interest standards of practice; and
- The CFC Plan Facilitator will not have a majority ownership stake in the CFC Provider agency.

Quality Improvement (QI) Design

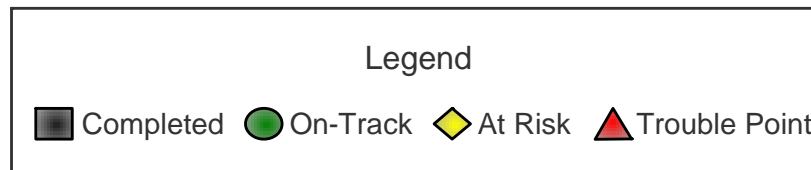
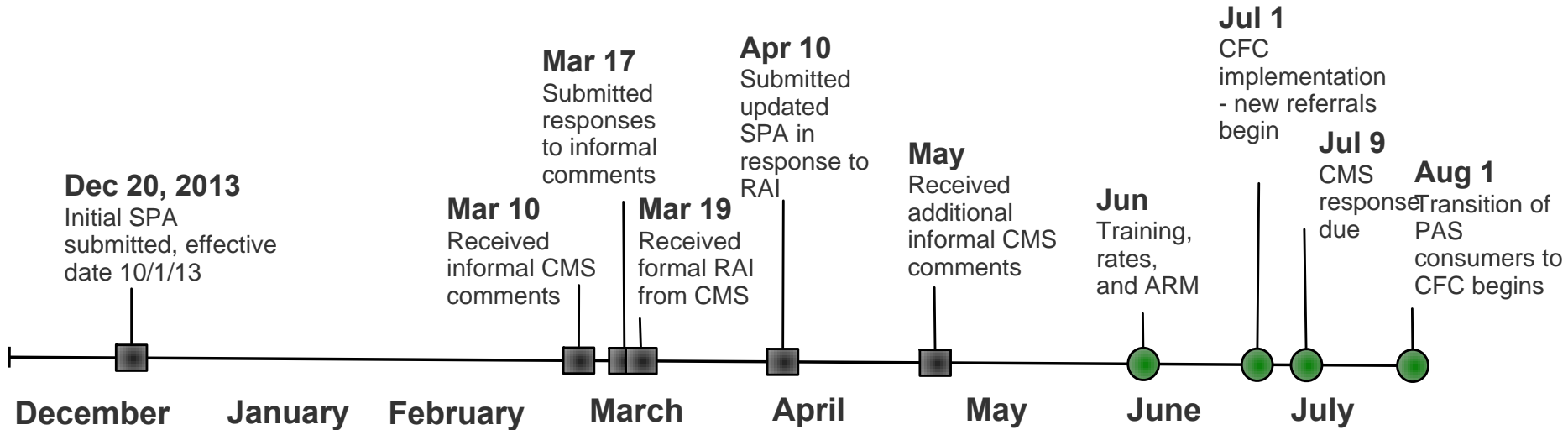
The CFC QI strategy includes the following components:

- **1) design; 2) discovery; 3) remediation; and 4) improvement.**
- **Key Quality Areas:** Intake, Assessment, Person Centered Planning (PCP), Independence and Choice, Service Plan and Delivery, Health and Welfare, Consumer Experience, Provider Qualifications, and Fiscal Accountability
- **Key Players:** MPQH, CFC Plan Facilitator, CFC Provider, CFC Consumer, Family, Representative(s), CFC Steering Committee, CFC Council Quality Assurance Staff: SLTC, DD and SDMI
- Process incorporates the key components outlined in the CMS Federal framework for HCBS services

Responding to CMS informal comments and formal Request for
Additional Information (RAI)

STATE PLAN AMENDMENT UPDATES

Timeline



(Schedule as of 4-9-14)

Current SPA Process

- **December 20, 2013-** Submitted CFC SPA with October 1, 2013 Effective Date
- Several calls with CMS Regional and Central Office
- Informal questions responded to by State
- **March 19, 2014-** CMS Stopped the Clock with Additional Formal Questions
- **April 10, 2014-** State Resubmits SPA pages with Responses to CMS's questions and agreed to edits
- **May 7, 2014-** CMS responds to States edits asks additional questions
- Weekly calls continue through the SPA process
- **July 9, 2014-** Second 90 Day Clock Ends

CMS comments

- Request for Additional Information:
 - 29 questions or comments received
 - Many requests for minor changes
 - Person-centered planning had most substantive questions

Next Steps

- CFC State Plan Approval
- Continue work with CFC Council
- Continue work with Person Centered Planning Work Group
- Develop CFC Administrative Rules (ARM)
- Submit CFC ARM for public comment
 - Update PAS ARM to correlate with CFC ARM
- Develop CFC Policy Manual
- CFC Training
 - Plan Facilitator
 - CFC Provider
- CFC Implementation-Retro to 10/1/2013
- CFC Program Evaluation
- CFC Phase II considerations- Additional

CFC Contact Information

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The Oregon State Plan K Option

From Concept to Reality

May 16, 2014



How We Began

- The Affordable Care Act Options
 - Enhanced funding of 6% was enticing to legislators and senior and disability advocates.
 - Preliminary regulations did not fully enable Oregon to take action (no institutional LOC requirement).
 - Final Regulations incorporated LOC requirements.
 - Oregon felt most of implementation requirements could be done administratively, rather than significant burden on delivery system.

Oregon's Pre-K (1915(k)) LTC Service Delivery

- Oregon has had a very comprehensive HCBS system for multiple populations.
 - Six 1915(c) Waivers
 - One waiver serving Oregon's aging and adults with physical disabilities (APD).
 - Five waivers serving various segments of people with developmental disabilities and intellectual disabilities.
 - Oregon also has comprehensive HCBS services offered through PACE, 1915(i) and 1915(j) options within the Medicaid State Plan.

Discussions with CMS

- Oregon began discussions with CMS in July, 2012.
- Submitted concept paper to CMS in August, 2012.
 - Original plan was to lift & place APD Services from the 1915 (c) into the 1915 (k) authority, leaving all other waivers and state plan authorities untouched.
 - Mostly accounting billing changes were expected.

CMS Feedback & Guidance

- 1915 (k) authority doesn't allow states to segment populations, as in the waivers.
- Formed and convened the *1915 (k) Implementation & Development Council* in August, 2012.
 - Council included consumers and stakeholders from multiple population based service delivery systems.
- First formal submission was Sept. 28, 2012. Oregon still was seeking July 2012 effective date.

CMS' Informal Questions

- In mid-November 2012, CMS presented Oregon with 58 informal questions related to the submission in the following primary areas:
 - Eligibility-Level of care & Special Income Group
 - Standard Funding
 - Statewideness
 - Comparability of service
 - Consumer rights & choices
 - Duplication with waiver services

Understanding How Medicaid Authorities Work Together

- Maintaining eligibility for Special Income Groups (required waiver service each month)
- Oregon attempted to bill the first “unit of service” to the waiver each month, then bill to the 1915 (k).
- Regular conversations with CMS
 - December 2012-Revised the formal submission & responded to the Informal Questions

Request for Additional Information

- Formal questions from CMS were provided to Oregon on December 28, 2012.
 - Six pages of questions related to:
 - Person-centered planning and choice
 - Service settings and the new HCBS definitions
 - Exhausting all state plan services prior to using waiver services

Another Approach-February 2013

- Move as much to the 1915 (k) as possible from all of the waivers but keep eligibility for those in Special Income Group.
 - All K Services available to all population groups who meet institutional LOC.
 - Leave unique services in each waiver
 - “Extended State Plan Services” in each waiver
 - 95% of these services would be covered by the 1915 (k)
 - 5% of these services would be covered by the 1915 (c)
- To make this all happen, all waivers and the K Plan effective date had to be the same.

Yet, Another Approach

- CMS suggested that Oregon send the Waivers and the State Plan Option as draft for informal discussion and comment.
- Began weekly calls to focus on each waiver or topic as necessary.
- CMS reviewed all State Plan Options, Amendments and Waivers.
- Oregon rules were reviewed for consistency with CMS submissions.

Final Proposal

- Through the informal discussions, CMS suggested:
 - Oregon pursue a single 1915 (c) service that can clearly be tied to keeping consumers out of institutions and maintain eligibility.
 - Case Management as a Waivered Service
 - Two 1915 (b)s were needed in conjunction with the 1915 (c)s to preserve the existing service delivery.
 - Nearly all HCBS services are in the 1915 (k)
 - The DD/ID Waivers maintained a few unique services

Approval!!

- Through the informal discussions and submissions, Oregon was able to meet CMS' requirements.
- Oregon's final submissions for all amended 1915 (c) waivers and the 1915 (k) were submitted the last week of June 2013.
- Oregon received approval on June 28, 2013 with an effective date of July 1, 2013.

Questions

