

# Community First Choice

May 3, 2012

# Entering Community First Choice

- Beginning in July 2013, Community First Choice will officially begin and certain aspects will be phased in to ensure continuity of services.
- At application and then annually, each person in a program gets a medical assessment.
  - Starting in January of 2013, AERS and the LHDs will complete the interRAI assessment instead of the STEPS, 3871B and DHMH 302 form.
- This medical assessment results in verification of medical eligibility and recommendations for services.
  - The service recommendations are then reviewed with the participant/applicant to develop their plan of service.
  - Offers a wealth of information that can be taken into account within the plan of service.

# Setting up Services

- Everyone develops a plan of service.
  - Who should be involved?
    - The participant selects the people they want to be included in the plan development (friends, family, providers, etc.).
    - A case manager (supports coordinator) is required to attend to complete documentation for the CFC program.
  - How do you develop a person-centered plan?
    - Should a formalized Person-Centered Planning tool be required?
      - PATH, MAPS, ELP?
    - What supports are available for the participant in the meeting?
    - Should we have a web-based planning tool that participants can track services and interact with?

# Case Management Role

- CFC can offer support beyond traditional case management services.
- Supports include:
  - Person-centered planning.
  - Training on self direction models.
    - How to hire, fire, train, and manage a personal care provider.
  - How to manage employer responsibilities with a fiscal intermediary.
    - Payroll, taxes, wage and benefit setting, conflict management.
- Should all of these supports be included in one role?
  - Option 1: A single supports coordinator is responsible for all of the above.
  - Option 2: Case management is supplemented by a self-direction specialist who coordinates additional supports.

# Developing the Budget

- How should the budget be set for items that substitute for human assistance?
  - Examples: cooking appliances, assistive technology, home modifications, and communication devices.
  - Should there be itemized limits? Category limits?
  - Should there be standard prices?

# Developing a Plan of Service – Personal Care

- Option 1. Agency Model
  - Hiring an agency
    - A list of agencies will be provided to the person.
    - Agencies are providers enrolled in Medicaid and must meet licensure requirements set by the State of Maryland (in particular, DHMH and the Board of Nursing).
    - The person may choose the staff person within an agency and may change agencies at any time.
    - DHMH pays a flat rate to the agency per unit of service.

# Developing a Plan of Service – Personal Care

- Option 2. Self-Direction
  - Hiring a provider.
    - A list of enrolled providers will be available to each program participant.
      - Enrolled providers must meet minimum standards set by DHMH and the Board of Nursing, (e.g., not a spouse, guardian).
    - Individuals can identify as their provider someone they know who is not already on the list of approved providers.
      - What qualifications for a provider can a person waive?
        - » Background check, age limitations, med tech certification, etc.

# Developing a Plan of Service – Personal Care

- How much can you pay the personal care worker?
  - DHMH will pay a certain amount per hour
    - Should there be a tiered payment system to allow the individual to choose among a set of rates?
    - Should the individual be able to set a rate outside of a tiered system?
      - Can they pay monthly or weekly rates?
      - How is an individualized rate reviewed and approved? Through the FI or DHMH?
    - Can the participant use part of allocation to pay for the worker's vacation time and fringe benefits?

# Developing a Plan of Service – Other Items

- Only certain items are approved by CMS for the program.
  - Examples: cooking appliances, assistive technology, home modifications, and communication devices.
  - All items must relate directly to an Activity of Daily Living (ADL) or Instrumental Activity of Daily Living (IADL).
  - All items must be documented in the plan of service.
- How does a person decide what they need?
  - How are items that are not in the recommendations from the medical assessment handled?
  - What limits should there be on spending within the overall budget amount?

# Spending the Budget – Fiscal Intermediary

- Participants use a fiscal intermediary to spend their budget.
  - Personal care workers would bill against the budget using the ISAS call-in system.
  - The person or their case manager/supports coordinator would submit an invoice/receipt to a fiscal intermediary for payment of other service expenses (transition funds, assistive technology, etc.).
  - The plan of service acts as preauthorization of expenses; Invoices for items not approved on the plan of service would be rejected.
- How can the person interact with the fiscal intermediary?
  - How do payment issues get resolved?
  - When does the Department get involved?

# Monitoring Services

- Nurse Monitoring
  - Nurse monitoring standards are set by DHMH and the Board of Nursing.
  - There will be standard requirements for nurse monitoring.
    - Should the participant be able to waive these requirements?
      - An annual assessment is not waive-able.

# Monitoring Services

- What tests on quality should be done?
  - Quality Assurance Tests.
    - Participant satisfaction.
    - Service utilization reviews.
    - Measuring health changes and service needs over time.
    - Reportable events.
- What should DHMH know about participant experiences?
- What is the best way to share this information?