Frequently Asked Questions
For Care Coordinators
About
Community First Choice (CFC)

*Note: These responses depend on final approval of the regulations authorizing the Community First Program. The anticipated target date is July 1, 2018.

See also "Public FAQs" posted on the Community First Choice webpage for details about CFC.

What are the responsibilities of a care coordinator to assist SDS in the implementation of CFC? The care coordinator has an essential role in the initial implementation of the Community First Choice Program. Waiver recipients already meet the level of care requirement for CFC. SDS will initiate the program by automatically enrolling all participants who are currently on a waiver and currently have State Plan PCS into CFC-PCS. Auto-enrollment in CFC-PCS is an internal administrative function for SDS. There will be no change to the direct care provided to recipients by the PCS provider agency and initially no change in services (though the PCS agency will start using a different billing code for CFC-PCS). When the CFC regulations are effective, the participant will have the option to request all of the services available through the CFC program.

What's the difference between CFC case management and waiver care coordination?
"Case management" also known as "Targeted Case Management" (TCM) for CFC is provided by a certified care coordinator. The level of service and involvement in "targeted case management" is somewhat less intense than in what we are familiar with in care coordination. Targeted case management is more attuned to the level of involvement that the person wants and requests, rather than a level of involvement that is dictated by regulation. . Case management is available to participants who are receiving services only from the CFC program.

The care coordinator assists an individual with the CFC application and, when institutional level of care has been established through an assessment, the care coordinator provides the following services:

- Pre-enrollment counseling to discuss the range of services and supports available to the participant.
- Assisting the participant to select and schedule a support plan team meeting
- Developing an initial support plan and an annual renewal support plan
- Submitting an amendment if the participant requests a change in CFC services during the support plan year
- Initiating contact with the participant during the support plan year if a problem arises or if contacted by the participant or a provider

CFC care coordinators request reimbursement for completing an application, submitting an initial support plan and a yearly renewal support plan. A monthly flat rate for case management may be reimbursed within a month when a problem is addressed or an amendment is submitted. **Please note that monthly monitoring is not required under CFC, and payment of monthly case management monitoring is only made for months when activities occur.**

If the participant is also receiving waiver services, the role of the care coordinator is unchanged. For waiver recipients, in addition to all the case management activities carried out as described above, waiver care coordinators are responsible for ongoing monitoring and participant contact each month. Care coordinators are reimbursed a monthly rate for the activities associated with ongoing monitoring, including preparing an amendment, when necessary.

What are the responsibilities of a care coordinator in the CFC program?
The responsibilities of a care coordinator for CFC recipients are very similar to the responsibilities that a care coordinator has for a waiver recipient. The care coordinator selected by the recipient completes and submits a CFC application, and may assist with scheduling an assessment. When the care coordinator receives notice that the level of care determination has been made and the applicant qualifies for an institutional level of care, the care coordinator works with the applicant to select a care plan team and schedule a meeting. Whether CFC only, waiver only, or both CFC and waiver, the care coordinator prepares and submits to SDS a support plan (previously known as a plan of care). During the support plan year, if an amendment is required, the care coordinator submits an amendment to the support plan. **SDS is required to provide adequate notice to recipients who are being automatically enrolled in CFC, and to provide an opt-out option.**

On April 27, 2018 a notice letter was sent to all participants who are receiving both waiver services and State Plan PCS. The letter informs the participants about the transition plan and their option to opt out. If a participant wishes to opt out, they were told to contact their care coordinator.

An approved form "Uni-17 Opt Out Statement" is being finalized and will soon be posted on the "Approved Forms Web Page" for use by the care coordinator. In the event a care coordinator is contacted by a service recipient who expresses a desire to opt out, the care coordinator should meet with the participant to ensure they are fully informed about CFC, and, if the participant is sure they want to opt out of CFC services, have them sign the form. The care coordinator is responsible to review the potential impacts of opting out with the participant and documenting that the decision is an informed and voluntary decision. The form includes instructions for submitting the form to SDS. The notice letter gave recipients a thirty day dead line for the receipt of their letter; the form can be submitted any time before July 1, 2018.

What should I tell my clients about transitioning to the Community First Choice Program?
Clients should be informed of the services available to them now. The Community First Choice webpage is available as a resource for participants, care coordinators, and the public.

How can my client receive all the services available in the Community First Choice Program?
A change in waiver or CFC services must be requested through the process of an amendment to the waiver or CFC-PCS service. A new assessment may be required. When the CFC regulations are effective, you may assist your client to submit an amendment requesting any of the CFC program services. Your client may also ask for an increase or addition of CFC services at the time the renewal plan of care is submitted.

How do care coordinators review the PCA plan and advise the client that they will or will not receive additional services?
At the present time there is no need for a care coordinator to review the PCS plan to assess whether or not the person is eligible because everyone who received the "opt out" letter is currently receiving both PCS and waiver services. Unless they opt out, they will continue to receive PCS at the same level they are

currently receiving. When the CFC regulations become effective, the level of care and need for assistance with ADLs and IADLs will be determined by the CAT assessment, which is the current practice. The specific criteria required to justify a request for skills acquisition training and/or extra hours for supervision and reminders will be included in a training for care coordinators which will be scheduled prior to the date that the CFC regulations become effective.

Can a client opt out of CFC now and then opt in later?
If a client opts out during the auto-enrollment transition period and then wants CFC services, it will be necessary to apply for the CFC program using the CFC application (the UNI-04).

How does the CFC program affect care coordination for those client that would still like a monthly visit?
For clients on a waiver program there is no change. Monthly (or in the case of recipients on the new Individualized Supports Waiver, quarterly) visits will continue to be the practice. The Care Coordination and Targeted Case Management (TCM) Conditions of Participation apply to all providers of care coordination or case management. If a care coordinator has a client that receives only CFC services, the care coordinator will provide case management, which has a different standard for the number of and need for contacts.

Does opting in to the CFC program automatically mean that the client is no longer eligible for EMODs and SME?
No, EMODs and SME are available under the waiver program. Opting into the CFC program makes more services available; it does not decrease any other services otherwise available to the recipient.

Who would start the PCS applications? Care coordinators, or does it stay with the agency?
All persons interested in receiving State-funded long term services and supports will be directed to an ADRC or a STAR. These agencies will conduct a Person Centered Intake (PCI). If the results of the PCI indicate that the applicant is likely to qualify for waiver or CFC services, they will be given a list of care coordinators to select from. When contacted, the care coordinator will assist the client to complete and submit an application to SDS. If the results of the person centered intake indicates that the individual would likely qualify for State Plan PCS, the person will receive a list of PCS agencies to select from. The client will be assisted at the PCS agency to complete an application for State Plan PCS services.

Does opting in automatically mean that they have to go to quarterly visits with TCM reimbursement rates? Or is TCM just for the ISW waiver?
No, care coordination for waiver services does not change. The participants who received the recent notice letters all receive waiver and PCS services. The care coordination standards for the current waivers will not change. Waiver recipients are eligible to receive CFC services, but it does not change their waiver services, which include care coordination with monthly (or in the case of recipients on the new Individualized Supports Waiver, quarterly) monitoring.