Report to Congress
Community First Choice:
Interim Report to Congress
As Required by the
Patient Protection and Affordable Care Act of 2010 (P.L. 111–148)
From the
Department of Health and Human Services
Office of the Secretary

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Introduction

The Affordable Care Act authorized the addition of section 1915(k) to the Social Security Act, allowing states the option of providing home and community-based attendant services and supports through their State Plans.[1] The "Community First Choice" (CFC) option went into effect October 2011 and is one of four options introduced or amended in the Affordable Care Act to provide long-term services and supports (LTSS) to individuals in their homes or communities rather than in institutional settings. All of these options reflect the goal of rebalancing Medicaid spending on LTSS to encourage a person-centered, long-term support system and to give LTSS beneficiaries the opportunity to decide where they live and have greater control over the services they receive.

Pursuant to section 1915(k)(5) of the Social Security Act the Secretary of the Department of Health and Human Services (the Secretary) is required to assess the effectiveness of services provided under CFC in allowing individuals to live independently to the maximum extent possible, the impact of such services on recipients' physical and emotional health, and the comparative costs of CFC services and those provided under institutional care. The law also requires the Secretary to submit these findings to the Congress in interim and final reports and make them available to the public.

This report summarizes interim findings on the CFC option. Interim findings include the status of states' submissions of State Plan Amendments for CFC as well as preliminary findings on the implementation and provision of services under CFC. An assessment of CFC's impact on the physical and emotional health of recipients, their ability to live independently, or the cost of services compared to those provided in institutional settings is premature, at this point in time. The data to analyze the cost effectiveness of CFC and its impact on beneficiaries' health and well-being were not available from states for inclusion in this interim report (see the Methods section for detail). These findings will be included in the final report to Congress.

Community First Choice: An Overview

[1] Ibid. § 2401, enacted on March 23, 2010. §2401 added a new §1915(k) of the Social Security Act to establish the Community First Choice option.

Community First Choice (CFC) is an optional Medicaid State Plan benefit that provides states a six percentage point increase in their Federal Medical Assistance Percentage (FMAP) for providing home and community-based attendant services and supports. As a "State Plan" benefit, the option is available to states without the need for special waiver authority. States that take up this option are required to use a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative. Attendant services—also called personal care and attendant care services—are one form of home and community-based services (HCBS) intended to enable people with disabilities and chronic conditions to remain in their homes and communities by providing them human assistance in performing tasks they could do independently were it not for their disabilities.[2] These tasks include activities of daily living, such as eating, toileting, grooming, dressing, and bathing; instrumental activities of daily living, such as meal planning and preparation, managing finances, light housework, and transportation; and health-related tasks, such as tube feedings, catheterization, range of motion exercises and medication administration.

States electing the CFC option must make hands-on assistance (actually performing a task for a person) or supervision and cueing available to eligible Medicaid beneficiaries so that they accomplish such everyday tasks for themselves. In addition to attendant services, CFC funds are used to support:

- Back-up systems or mechanisms to ensure continuity of services and supports (such as the use of beepers or other electronic devices);
- Voluntary training on selecting, managing, and dismissing attendants.

States also have the flexibility to cover the following under CFC:

- Transition costs associated with moving from an institution to home or a community-based setting, such as security deposits for an apartment or utilities, basic kitchen supplies, bedding and other necessities required for transition;

[2] Other types of HCBS include adaptive services, such as home and vehicle modifications; specialty services such as adult day care; habilitation services; assistive technologies, such as motorized wheelchairs and communication devices; family and caregiver supports, such as respite care, caregiver training and education; and case management / service coordination.

- Expenditures related to a need identified in an individual's person-centered service plan that increases independence or substitutes for human assistance.[3,4]

The statute excludes certain services and supports from being covered under CFC, including, costs related to room and board and special education. Costs related to assistive technologies, medical supplies and equipment, or home modifications are also excluded, except to the extent they are specified in an individual's person-centered care plan as necessary to increase independence or substitute for human assistance.

Individuals to be served through CFC are persons of all ages who choose to receive CFC services and supports, receive Medicaid eligibility through State Plan eligibility rules, and meet institutional level-of-care criteria. Individuals must be in an eligibility group that is entitled to receive nursing facility services, or if in an eligibility group that is not entitled to nursing facility services, have an income that does not exceed 150 percent of the federal poverty level. The level-of-care criteria determine whether individuals require a level of care such as that provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, institution providing psychiatric services for individuals under age 21, or institution for mental diseases for individuals age 65 or over. Level-of-care determinations are made by each state, and states have the ability to waive annual re-determinations based on certain criteria. States must provide CFC services and supports on a statewide basis and without regard to the individual's age, type or nature of disability, severity of disability (except as noted above with respect to the level-of-care requirement) or the form of home and community-based services and supports that the individual requires to lead an independent life. States, therefore, cannot target specific populations for inclusion or exclusion; however, states may set limits on the amount, duration and scope of services, as long as the amount, duration and scope are sufficient to reasonably achieve the purpose of the service and are applied without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

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3 Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS). 2010. *Understanding Medicaid home and community services: A primer, 2010 edition*. Washington, DC: ASPE. http://aspe.hhs.gov/daltcp/reports/2010/primer10.pdf

4 Pub. L. 111-148 §2401.

As an optional State Plan benefit, CFC must meet Medicaid comparability, statewideness, and free choice of provider requirements. CFC differs from pre-existing State Plan options in that it has a strong self-direction component, meaning that individuals, regardless of the service delivery model, have control to the maximum extent possible of how, when, where, and by whom the personal attendant services and supports are provided.

In order to participate in CFC, states must submit a proposed State Plan Amendment to the Centers for Medicare & Medicaid Services (CMS) outlining their approach for implementation and coverage. CMS evaluates the submitted State Plan Amendments to ensure they meet all federal requirements of the statute and implementing regulations. The State Plan Amendment must specify the eligibility criteria, the services and supports that will be covered under CFC, the plan for delivering the services and supports, the provider qualifications, and the quality assurance and improvement plan that will be used to monitor CFC. In addition, states must establish and collaborate with a Development and Implementation Council when designing the State Plan Amendment to provide CFC services. The majority of Council membership must comprise individuals with disabilities, elderly individuals, and their representatives. Participating states must also collect and report information for federal oversight and the completion of a federal evaluation of the program.

While CFC offers states an enhanced federal matching rate, it is important to note that section 1915(k)(3)(c) of the CFC statute requires states to meet a time-limited maintenance-of-effort requirement. For the first 12-month period of CFC implementation, states must maintain or exceed the level of state expenditures for home and community-based attendant services and supports to individuals with disabilities or elderly individuals attributable to the preceding 12-month period. This requirement includes provision of these services under sections 1115, 1905(a), 1915, or otherwise under the Social Security Act and applies to expenditures for or comparable to attendant services.

Methods

Qualitative and secondary data sources were used in the development of this report and include document review, semi-structured discussions with administrative staff responsible for the

implementation and oversight of CFC, data provided by the state that summarize key characteristics of the population receiving home and community-based attendant services, and a review of peer-reviewed and other published written material such as briefs and reports. Data obtained through these methods were collected, summarized, and analyzed by an independent evaluation team, contracted by CMS, to glean preliminary insight into the implementation of CFC and to identify domains and issues for further inquiry in the final report. Limitations in the timing and availability of data precluded an interim assessment of CFC's impact on the physical and emotional health of beneficiaries, their ability to live independently, or the cost of services compared to those provided in institutional settings as specified in the statute. The findings presented in this report provide an update on the status of CFC's adoption in states and a description of the early experiences in one state. The information included is preliminary and formative for subsequent analyses of CFC, yet is neither generalizable nor an assessment of the impact of CFC.

Preliminary Findings

Status of Community First Choice Implementation

As of December, 2013, eight states had submitted State Plan Amendments to CMS to implement the Community First Choice (CFC) option for home and community-based attendant services and supports, although two states subsequently withdrew their State Plan Amendments. Of the remaining six states, CMS had approved two State Plan Amendments (California and Oregon*), and four states were under review.

In 2012, AARP surveyed states about their plans to implement CFC. Seven indicated they were actively considering CFC, while 14 were planning not to pursue CFC; others did not know or did not answer.[5] A GAO report suggests several reasons why states may be hesitant to apply for CFC and the other options for home and community-based services included in the Affordable

*Oregon received approval of their CFC SPA on June 27, 2013 with a July 1, 2013 effective date. An evaluation of Oregon will be included in the final report.

[5] Cheek, M., et al.2012. *On the verge: the transformation of long-term services and supports*. Washington, DC: AARP. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/On-the-Verge-The-Transformation-of-Long-Term-Services-and-Supports-Report-AARP-ppi-ltc.pdf

Care Act.[6] These include budgetary concerns, lack of infrastructure, staff overburden and related hiring freezes, CFC's priority among all requirements and options authorized in the Affordable Care Act, as well as some states' present focus on broader Medicaid reform, such as implementing managed care. Early discussions between states and CMS also suggest states are weighing carefully the trade-off of proceeding under 1915(c) waivers, which allow states the ability to limit the number of participants, to target services on the basis of diagnosis and to extend eligibility to higher income populations in the community, against the value of the enhanced federal matching rate for CFC and other positive features of CFC.

Community First Choice Services and Implementation: California's Experience to Date

Interim findings on the implementation of the Community First Choice (CFC) option were limited to California, the only state with an approved CFC State Plan Amendment during our period of review. While a focus on California provides insight into a state's early experience with CFC, care must be taken in generalizing the applicability of these findings more broadly.

California submitted its SPA December 1, 2011, prior to the May 2012 release of CMS' final rule, which established the institutional level-of-care eligibility criteria. CMS approved California's initial CFC SPA on August 31, 2012, with the caveat that the state would submit a new SPA to comport with the institutional level-of-care eligibility criteria. California's CFC effective date was retrospectively set at the date of its submission, December 1, 2011.

In California, the CFC option has been incorporated into an existing infrastructure for home and community-based services and supports the state has made available through multiple Medicaid waivers and State Plan benefits. California's In-Home Supportive Services (IHSS) program has existed for over three decades and has provided home-based personal care services to individuals with limited incomes who a) are considered "medically needy" due to the share of income spent on medical expenses or b) meet the categorical requirements for Medicaid eligibility by being

[6] U.S. Government Accountability Office (GAO). 2012. *States' plans to pursue new and revised options for home and community-based* services (GAO-12-649). Washington, DC: GAO. http://www.gao.gov/assets/600/591560.pdf

either aged, blind or disabled and c) are unable to perform functional tasks. Importantly, individuals receiving IHSS do not require an institutional level-of-care determination.

IHSS has had a strong self-direction component, and the CFC option builds upon this historical focus. Self-direction is voluntary and allows participants to set their own provider qualifications, and train their personal assistance service providers.[7] At the core of this self-direction focus is an assessment process administered to beneficiaries and their representatives by county social workers that administrators in California described as paramount to decision-making about how services will be provided.

In California, the aim of implementing CFC was to improve Medi-Cal's ability to provide home and community-based personal attendant services and supports to seniors, persons with disabilities, and additional enrollees otherwise needing an institutional level-of-care. Officials in CDSS (California Department of Social Services) reported the additional 6 percentage point federal match CFC provides for qualified services was an opportunity to expand the IHSS program by increasing the range of services it can offer in the future and bolster its existing home and community-based services infrastructure. For example, with the enhanced FMAP, the State plans to offer skills trainings to CFC recipients, further promoting independent living.[8] Through this expansion of its home and community-based attendant services and supports, California administrators expect to see improved quality of life for individuals requiring personal assistance services, decreased long-term skilled nursing facility use, and decreased preventable hospital and emergency department use.

In FY 2012, Medi-Cal provided personal attendant services to 493,546 beneficiaries through CFC.[9] In the year prior to CFC, nearly all of these individuals received personal attendant services through the Personal Care State Plan optional Medicaid benefit. From FY 2011 to FY

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[7] Centers for Medicare & Medicaid (CMS). 2013. Self-directed personal assistant services 1915 (j). http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Self-Directed-Personal-Assistant-Services-1915-j.html

[8] Ibid.

[9] California Department of Health Care Services. 2013. Medicaid Management Information System- Decision Support System (MMIS-DSS). E-mail correspondence between NORC and Centers for Medicare & Medicaid Services staff, July 12.

2012, the State maintained consistent provision of home and community-based attendant services and supports under all waiver programs and State Plan options.[10]

As of the date we surveyed, nearly all (491,809) beneficiaries served through CFC have opted for a self-directed approach in which beneficiaries receive direct cash and financial management services to pay for services and supports; fewer than 1 percent (1,737) were served by an agency model, in which services were provided by home health entities under contract with the county.[11] All beneficiaries could select the personal attendant of their choice, including friends, relatives, neighbors or service providers on county-specific registries with specific qualifications and skills.

California's revised SPA, with the institutional level-of-care eligibility criteria, went into effect July 1, 2013. Under the revised SPA, California will serve only beneficiaries with a level-of-care determination, as established in the final rule. California officials estimated 41 percent of the current IHSS population would be eligible for CFC after the program adopted the level-of-care criteria. While the state will not receive an enhanced federal match for beneficiaries without level-of-care determinations, individuals otherwise eligible for IHSS will continue to receive personal care services, primarily through the personal care optional benefit.

Interim Conclusions

Due to the timing and conditions of states' CFC State Plan Amendment submissions and approvals, and subsequent timeline for implementing CFC-supported services, it is too early to assess the effectiveness of services provided under CFC in allowing individuals to live independently, the impact of such services on recipients' physical and emotional health, and the comparative costs of CFC services and those provided under institutional care. The evaluation of the provision of home and community-based attendant services and supports provided under CFC shall be conducted and the analysis of this information will be included in the final report to Congress.

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[10] Ibid.

[11] California Department of Health Care Services. 2013. Medicaid Management Information System- Decision Support System (MMIS-DSS). E-mail correspondence between NORC and Centers for Medicare & Medicaid Services staff, July 12.