

**Report to Congress**  
**Community First Choice:**  
**Final 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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**Secretary of Health and Human Services**  
**December 2015**

## Table of Contents

<b>Introduction and Background .....</b>	<b>1</b>
Services and Federal Match .....	2
Eligibility .....	3
Requirements .....	4
State Plan Amendments For CFC .....	5
<b>Methods.....</b>	<b>5</b>
Document Review.....	8
Enrollment Data .....	8
Key Informant Interview And Site Visits .....	9
Medicaid Claims Analysis .....	10
Limitations .....	12
<b>Findings.....</b>	<b>13</b>
National Status Of The Community First Choice Benefit .....	13
Key Factors In Decisions To Pursue CFC .....	14
Existing HCBS Infrastructure And Priorities .....	14
<i>States Implementing CFC</i> .....	14
<i>States Not Adopting CFC</i> .....	15
Advocacy From Key Stakeholders.....	16
Anticipated Effects On State Budgets .....	17
HCBS Services And Supports Under The CFC: Findings On Enrollees.....	18
Population Served.....	18
<i>California</i> .....	18
<i>Oregon</i> .....	19
<i>Maryland</i> .....	20
<i>Montana</i> .....	21
<i>HCBS Prior To And Following CFC Implementation</i> .....	22
<i>Population Served By Disability, Age, Gender, Education Level, and Employment Status</i> .....	23
Health and Welfare of Enrollees .....	27
<i>Clinical Characteristics</i> .....	28
<i>Inpatient Utilization</i> .....	31
<i>Emergency Department (ED) Utilization</i> .....	32
<i>Ability To Lead An Independent Life To The Maximum Extent Possible</i> .....	33
State Spending On CFC .....	34

Implementation Of CFC: Lessons From States .....	36
Service Provision.....	36
<i>Person-Centered Planning And Assessments</i> .....	37
<i>Service Delivery Models</i> .....	38
<i>Self-Direction Of Care</i> .....	40
<i>Service Needs For Persons With Physical Disabilities vs. Persons With</i> <i>Developmental Disabilities</i> .....	40
<i>Backup Systems And Supports</i> .....	41
<i>Changes To Services And Hours</i> .....	41
Administration.....	42
<i>Financial Considerations</i> .....	42
Monitoring And Evaluation.....	46
<b>Recommendations And Considerations For Future States</b> .....	<b>47</b>
<b>Conclusions</b> .....	<b>48</b>

## Table of Figures

<b>Figure 1.</b>	Number of Individuals Receiving HCBS in California .....	19
<b>Figure 2.</b>	Number of Individuals Receiving HCBS in Oregon.....	20
<b>Figure 3.</b>	Number of Individuals Receiving HCBS in Maryland.....	21
<b>Figure 4.</b>	Number of Individuals Served by CFC in Montana .....	22
<b>Figure 5.</b>	Percent of individuals served by CFC by age category .....	25
<b>Figure 6.</b>	Percent of individuals served by CFC by gender, FY 2014.....	26
<b>Figure 7.</b>	Percent of individuals served by CFC by race/ethnicity, FY 2014.....	27
<b>Figure 8.</b>	CFC, 1915(j) and State Plan Personal Care Benefit Expenditures for California, FY2011-2013 (in thousands of dollars) .....	36

## Table of Tables

<b>Table 1.</b>	Evaluation Questions and Corresponding Research Activities.....	7
<b>Table 2.</b>	Informant Interview Objectives .....	10
<b>Table 3.</b>	Measures Analyzed with Claims Data .....	12
<b>Table 4.</b>	National Status of CFC .....	13
<b>Table 5.</b>	Basis of Eligibility for Medicaid during the Most Recent Quarter of Eligibility, FY 2010-2011 .....	23
<b>Table 6.</b>	HCBS Quality Indicators for Avoidable Hospitalizations for CFC Enrollees and the Adult Medicaid Population Prior to CFC Implementation, FY 2011, Rate per 100,000 .....	30
<b>Table 7.</b>	Chronic Illness and Disability Payment System Classification for CFC Enrollees and the Adult Medicaid Population Prior to CFC Implementation, FY 2011 .....	31
<b>Table 8.</b>	Inpatient Utilization for CFC Enrollees Prior to CFC Implementation, FY 2010-2011 .....	32
<b>Table 9.</b>	Emergency Room Utilization for CFC Enrollees Prior to CFC Implementation, FY 2010-2011 .....	33
<b>Table 10.</b>	CFC Services Eligible for FMAP by State.....	37
<b>Table 11.</b>	Service Delivery Models by State.....	39

## **Introduction and Background**

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act)<sup>1</sup> added section 1915(k) to the Social Security Act (the Act), allowing states the option of providing home and community-based attendant services and supports through their State Plans.<sup>2</sup> Section 1915(k), also known as the Community First Choice (CFC) benefit, went into effect October 2011 and is one of the benefits 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. These benefits are consistent with and support the Centers for Medicare & Medicaid Services' (CMS') goal of rebalancing Medicaid LTSS spending; encouraging a person-centered, long-term support system; and giving enrollees the opportunity to decide where they live and to increase control over services received.

Pursuant to section 1915(k)(5) of the Act, established by section 2401 of the Affordable Care 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 enrollees' physical and emotional health; and the comparative costs of CFC services and those provided under institutional care. The Secretary is to submit these findings to the Congress in interim and final reports and make them available to the public. To fulfill the requirements of this assessment, CMS contracted with an independent research organization to conduct an evaluation of progress on the CFC benefit.

Following an interim report submitted to Congress in June 2014, this final report summarizes findings on the CFC benefit as of March 15, 2015, approximately three years following CMS' final rule.<sup>3</sup> Findings include the status of states' submissions of State Plan Amendments (SPAs) for CFC as well as preliminary findings on the implementation, provision of services, and where possible, outcomes under CFC.

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<sup>1</sup> Pub. L. 111-148 §2401.

<sup>2</sup> Ibid. § 2401, enacted on March 23, 2010. §2401 added a new §1915(k) of the Social Security Act to establish the Community First Choice benefit.

<sup>3</sup> Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid Program: Community First Choice Benefit. Final Rule. *77 Fed. Reg.* 88 (May 7, 2012): 26827-26903.

## ***Services and Federal Match***

The Community First Choice benefit increases states' Federal Medical Assistance Percentage (FMAP) by six percentage points for covered home and community-based services and supports (HCBS) provided through the state plan to Medicaid enrollees who require an institutional level of care. Covered services include attendant services and supports intended to support enrollee input and control over the services they receive. Specifically, CFC covers:<sup>4,5</sup>

- Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADL's) and health-related tasks through hands-on assistance, supervision, and/ or cuing;
- The acquisition, maintenance, and enhancement of skills necessary to accomplish ADLs, instrumental activities of daily living IADLs, and health-related tasks;
- Backup systems or mechanisms to ensure continuity of services and supports;
- Support system activities (such as needs assessment, assessment counseling, risk assessment and management, and person-centered service planning);
- Voluntary training on selecting, managing, and dismissing attendants.

In addition, states may opt to cover:

- Transition costs associated with moving from an institution to a home or a community-based setting, such as security deposits for an apartment or utilities, first month's rent, basic kitchen supplies, bedding, and other necessities required for transition;
- Expenditures related to a need identified in an individual's person-centered service plan that increase independence or substitute for human assistance.

CFC covers costs related to assistive technologies, medical supplies and equipment, and home modifications, only when they are included in the state's defined CFC benefit package and specified in an individual's person-centered care plan as necessary to increase independence or substitute for human assistance. CFC does not cover costs related to room and board or special education.

Attendant services—also called personal care or attendant care services—are intended to enable people with disabilities and chronic conditions to remain in their homes and communities by providing them

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<sup>4</sup> 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.

<sup>5</sup> Pub. L. 111-148 §2401.

human assistance in performing routine tasks. These tasks include ADLs, such as eating, toileting, grooming, dressing, and bathing; IADLs, such as meal planning and preparation, managing finances, light housework, and community integration, which may include transportation; and health-related tasks, such as tube feedings, catheterization, range of motion exercises and medication administration. Attendants provide hands-on assistance to individuals in accomplishing these everyday tasks or provide supervision and cueing so individuals may accomplish the tasks themselves. Other CFC services supplement attendant services by helping to coordinate personal care providers, develop a backup plan in case of an emergency, and provide physical adaptations to make the home an appropriate care setting.

In addition to CFC, other state plan benefits and waivers may be used to cover personal care and other home care services, including the State Plan Personal Care Services benefit, a 1915(c) waiver for home and community-based services, or a 1915(i) State Plan HCBS benefit. Historically, the use of waivers for providing home and community-based services and supports has been more prevalent than state plan benefits due to the flexibility waivers offer states in targeting services and populations.<sup>6</sup> CFC differs from the State Plan Personal Care benefit through its emphasis on self-direction—individuals have control of how, when, where, and by whom the personal attendant services and supports are provided—and its requirement for participants to require a level of care equivalent to that received in an institution.

### ***Eligibility***

Individuals served through CFC include persons of all ages who are eligible for Medicaid under the State Plan, are financially eligible, and require an institutional level of care. Under CMS' final rule on CFC, an individual must either be eligible for medical assistance under a State Plan in an eligibility group that includes access to the nursing facility benefit, or, if the individual is in an eligibility group that does not include access to the nursing facility benefit, then in addition to meeting the eligibility criteria for the Medicaid group, the individual's income may not exceed 150 percent of the Federal Poverty Level (FPL). It must be determined that without home and community-based attendant services, the individual would require an institutional level of care, such as that provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or an institution for mental diseases.<sup>7</sup> This level-of-care determination is made annually by a clinician using state-specific assessment tools. States have the option of waiving the annual determination if they determined that there is no reasonable

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<sup>6</sup> 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.

<sup>7</sup> Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid Program: Community First Choice Benefit. Final Rule. *77 Fed. Reg.* 88 (May 7, 2012): 26827-26903.

expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

### ***Requirements***

As a state plan benefit, CFC must meet the requirements of Medicaid comparability, statewideness, and free choice of provider, as well as all other requirements under section 1902(a) of the Act. In addition to meeting general Medicaid comparability requirements under 1902(a)(10)(B), states electing CFC must provide covered services and supports to all eligible enrollees in the state, without regard for age, type or nature of disability, severity of disability, or the form of home and community-based services and supports that the individual requires to lead an independent life. The statewideness criterion ensures that services are available to eligible individuals across the state. While the statewideness and comparability requirements prohibit states from targeting any specific population, states may set limits on the amount, duration, and scope of services available through the state plan. Those limits are permitted as long as the service allocation is sufficient to achieve the purpose of the service, and service plans are determined based on individual need and not on other factors such as eligibility category, age, or disability.

Moreover, enrollees receiving the CFC benefit must have the ability to choose their providers. Under federal law Medicaid enrollees may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services."<sup>8</sup> This provision is referred to as the "any willing provider" or "free choice of provider" provision. The CFC statute requires free choice of provider in order for states to receive the enhanced FMAP and supports self-direction by allowing participants control in choosing their providers. Under the agency-provider service model, individuals may receive services from any provider meeting state-specific provider qualifications, which may include friends and certain family members. The individuals may change providers at any time and have the ability to set additional provider requirements and administer individual-specific training to their providers. Under the self-directed model with service budget, the individual establishes the provider qualifications.

The CFC final rule implements the statutory requirement that the State maintain or exceed existing expenditures for medical assistance services provided to individuals with disabilities or elderly individuals services under sections 1115, 1905(a), 1915, or otherwise under the Social Security Act. For the first 12-month period of CFC implementation, the state must maintain or exceed the level of state expenditures for home and community-based attendant services and supports attributable to the preceding

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<sup>8</sup> §1902(a)(23) of Title XIX of the Social Security Act.



12-month period. The purpose of the maintenance-of-existing expenditures requirement is to prevent states from providing fewer services under CFC than under previous home and community-based service options, and, therefore, states adopting CFC cannot reduce the size of their program immediately after implementing CFC.

### ***State Plan Amendments For CFC***

In order to provide the CFC benefit, states must submit a proposed SPA to CMS outlining their approach for implementation and coverage. CMS reviews the SPAs to ensure they meet all federal and statutory requirements. The SPA must specify the services and supports that will be covered under CFC, the eligibility criteria, 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 SPA. The majority of Council membership must be composed of individuals with disabilities, elderly adults, and their representatives. Participating states must also collect and report information for federal oversight and a federal evaluation of the program.

### **Methods**

Evaluation of the CFC benefit focused on the four states with approved SPAs as of December 31, 2014—California, Maryland, Montana, and Oregon—and aimed to address the following questions:

- How many individuals received attendant services through the Community First Choice State Plan benefit?
- What is the demographic composition and disability profile of enrollees who received Community First Choice services?
- How many individuals received attendant services prior to the implementation of Community First Choice? Were these individuals previously served under other Medicaid home and community-based services waivers, state plan home and community-based services under section 1915(i) of the Act or state plan personal care benefits?
- How do states provide home and community-based services to eligible Medicaid enrollees? How has the provision of HCBS changed with the implementation of Community First Choice?
- What are the key factors motivating states' decisions to amend their State Plans to include the Community First Choice benefit?
- What is the impact of Community First Choice services on the physical and emotional health of individuals?

- How effective is receiving Community First Choice services in enabling individuals to lead an independent life to the maximum extent possible?
- How do the costs of home and community-based services compare with the costs of institution-based care in states with Community First Choice?

At the time of the evaluation, five states were in active discussions with CMS about their proposed State Plan Amendments: Texas was approved on April 2, 2015 and Washington was approved on June 30, 2015. As of July 17, 2015, Connecticut, Minnesota, and New York did not yet have approved SPAs. Due to the time of Texas and Washington's approvals and the active discussion still taking place in the other states, these five states were not included in data collection and analysis for the evaluation. Instead, to better understand the key factors motivating states' decisions to adopt the Community First Choice benefit, a subset of seven states that were not actively pursuing the benefit (Arizona, Rhode Island, Maine, Michigan, Massachusetts, New Mexico, and North Carolina) were interviewed as part of the evaluation. These states were purposefully selected because they (1) had expressed prior interest in CFC but had not submitted or had withdrawn their State Plan Amendment,<sup>9</sup> (2) were in the top 25 percent of states in terms of personal care service expenditures, share of Medicaid enrollees receiving personal care services, share of Medicaid spending on personal care services, or per capita personal care services expenditures,<sup>10</sup> or (3) had some other feature of their Medicaid program, such as a section 1115 demonstration waiver or managed long-term services and supports, that could be important factors in their decision to adopt CFC.

To answer the research questions above, the independent evaluator collected and analyzed qualitative and quantitative data from the following sources:

- Reviews of each state's approved State Plan Amendment and any presentations developed by the state to describe its Community First Choice program to the public or potential enrollees;
- Aggregate data from each state on Community First Choice enrollment;

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<sup>9</sup> Cheek M. et al. February 2012. *On the Verge: The Transformation of Long-Term Services and Supports*. Washington, DC: AARP Public Policy Institute.

<sup>10</sup> States had figures in the top quartile for the following: Total Medicaid expenditures on personal care services (\$270,636,523 - \$4,326,503,000); share of Medicaid enrollees who receive personal care services (2.56% - 4.82%), share of Medicaid spending on personal care services 3.71% - 11.17%), personal care services spending per participant (\$14,011 - \$28,848). Data from the Kaiser Family Foundation, 2008. Available at: <http://www.statehealthfacts.org/comparemaptable.jsp?ind=1007&cat=4>. Accessed October 2012.

- Interviews and site visits with state staff responsible for the oversight and operations of home and community-based attendant services, stakeholder groups for individuals who are aged or have a physical or developmental disability, service enrollees and caregivers, and personal care providers
- Medicaid claims data (Medicaid and Statistical Information System, FYs 2010 and 2011).

Table 1 shows the methods used to address each evaluation question. The sections that follow elaborate on each method employed for the evaluation..

**Table 1.** Evaluation Questions and Corresponding Research Activities

<b>Evaluation Questions</b>	<b>Document/ Other Secondary Source Review</b>	<b>Analysis of Enrollme ntData</b>	<b>Interviews/ Site Visits</b>	<b>Analysis of Medicaid Claims Data</b>
How many individuals receive attendant services through the Community First Choice State Plan benefit?		X		
What is the demographic composition and disability profile of enrollees who receive Community First Choice services?		X		X
How many individuals received attendant services prior to the implementation of Community First Choice? Were these individuals previously served under other Medicaid home and community-based services waivers, state plan home and community-based services under 1915(i) or State Plan Personal Care benefits?		X		
How do states provide home and community-based services to eligible Medicaid enrollees and how has the provision of HCBS changed with the implementation of Community First Choice?	X		X	
What are factors motivating states' decisions to adopt the Community First Choice benefit in their State Plans?			X	
What is the impact of Community First Choice services on the physical and emotional health of individuals receiving the benefit?			X	X
How effective is receiving Community First Choice services in enabling individuals to lead an independent life to the maximum extent possible?			X	
How do the costs of home and community-based services compare with the costs of institution-based care in states with Community First Choice?	X			

## ***Document Review***

The first step in the analysis of CFC was a review of each state's approved State Plan Amendment (SPA).<sup>11</sup> SPA analyses were supplemented by other documents provided to the evaluators by the states or available on the states' websites. Examples of these documents included assessments and training materials, presentations developed by the state for the public and those considering applying for CFC services, and minutes from Development and Implementation Council meetings. The materials, along with the SPAs, guided the development of discussion guides that were subsequently used for interviews.

## ***Enrollment Data***

Each state with an approved SPA as of March 15, 2015 provided the evaluation team with aggregate data summarizing key characteristics of the population receiving home and community-based attendant services. These data are outlined in the statute<sup>12</sup> and implementing regulations<sup>13</sup> and include:

- The number of individuals who received such services and supports during the preceding fiscal year;
- The specific number of individuals served by:
  - ▶ Type of disability
  - ▶ Age
  - ▶ Gender
  - ▶ Education level
  - ▶ Employment status
  - ▶ Race/ethnicity (not specified in statute);
- Information on whether the specific individuals were previously served under any other home and community-based services program under the state plan or under a waiver, including:
  - ▶ Section 1115 waivers
  - ▶ Section 1915(c) waivers
  - ▶ Section 1915(i) State Plan benefits
  - ▶ Personal Care State Plan benefit.

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<sup>11</sup> Summaries of each approved SPA are available in a 508-compliant format on the CMS website (<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html>).

<sup>12</sup> Patient Protection and Affordable Care Act, 42 U.S.C. § 2401 (2010).

<sup>13</sup> Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid Program: Community First Choice Benefit. Final Rule. *77 Fed. Reg.* 88 (May 7, 2012): 26827-26903.

### ***Key Informant Interview And Site Visits***

Evaluators conducted interviews with key informants in states with and without CFC to understand the context for home and community-based services in the state, gain insight into the implementation of CFC, assess the perceived impact of the program thus far, and identify issues for states to consider when deciding to move forward with CFC. Interviews were conducted with state Medicaid officials and staff who administer CFC; leadership from departments and agencies with responsibility for providing home and community-based services to Medicaid enrollees; stakeholder groups representing individuals who are aged, or have a physical, intellectual or developmental disability (I/DD); service enrollees and their caregivers; and providers and provider representatives. The purpose of these interviews was to gather descriptive detail from multiple perspectives about the implementation process within each state. This information included details on challenges encountered and strategies employed to overcome them, as well as programmatic details unlikely to be captured through quantitative data.

#### **State Departments and Agencies Interviewed\***

- Department of Health Services
  - Office of Adult and Physical Disability Programs
  - Office of Developmental Disability Services
  - Office of Mental Health Services
  - Waiver Unit
  - Long-Term Care Division
- Department of Social Services
- State Legislative Committee On Health and Human Services

\*Note: The exact name of these departments and agencies may vary slightly from state-to-state.

Table 2 below summarizes the interview objectives for each type of respondent.

**Table 2. Informant Interview Objectives**

<b>Informant type</b>	<b>Interview Objectives</b>	<b>Number Interviewed</b>
State Leadership/Staff in CFC States	<ul style="list-style-type: none"><li>■ Decision to apply for CFC</li><li>■ Development of CFC State Plan Amendment and approval process</li><li>■ Implementation approach and challenges</li><li>■ Future plans for CFC and HCBS</li><li>■ Perceived impact of program thus far</li></ul>	42
Stakeholder Groups	<ul style="list-style-type: none"><li>■ Role in the development of CFC State Plan Amendment and implementation</li><li>■ Expectations for CFC and perceived impact of program thus far</li></ul>	16
Service Enrollees and Representatives	<ul style="list-style-type: none"><li>■ Experiences applying for services under CFC</li><li>■ Implementation successes and challenges</li><li>■ Changes to services after CFC implementation</li><li>■ Impact on physical and emotional health</li></ul>	22
Providers	<ul style="list-style-type: none"><li>■ Impact of CFC on providing care</li><li>■ Implementation successes and challenges</li><li>■ Impact on physical and emotional health of their patients</li></ul>	21
State Leadership/Staff in States Not Pursuing CFC	<ul style="list-style-type: none"><li>■ Waivers/State Plan Benefit services available for enrollees</li><li>■ Decision not to apply for CFC</li></ul>	13

Interviews were conducted via telephone or in-person and lasted 30 to 60 minutes via telephone and 60 to 90 minutes in person. Whether conducted by phone or in-person, many interviews were led as group discussions, with up to 10 respondents per discussion. In-person interviews were conducted as part of one- to two-day site visits in three states —California, Oregon and Maryland—where at least eight months had passed since the approval of their CFC State Plan Amendment. With the informants’ consent, interviews were audio-recorded and summarized by a note-taker. Approval was received from the Office of Management and Budget (OMB Control Number 0938-1238) and NORC’s Institutional Review Board (Protocol 13.03.04) prior to these interviews.

The site visits gave evaluators the opportunity to meet with service enrollees and providers in the home and community-based settings where services are provided, observe Development and Implementation Council meetings, and view provider and participant trainings. This observational data augmented the information collected through various interviews.

### ***Medicaid Claims Analysis***

To supplement the qualitative data described above, evaluators secured a data use agreement with CMS to obtain claims data from the Medicaid Statistical Information System (MSIS) for California, Maryland,

Montana, and Oregon. Evaluators analyzed claims data to assess health and welfare and health care utilization among enrollees served through CFC.

MSIS data are the most recent Medicaid claims data available to CMS; however, due to processing, there are lags in the availability of data that vary across states. At the time of this report, MSIS data were not available for 2013 onward. This limits the analysis to the pre-CFC period and provides a baseline from which to assess impact of CFC in future years as claims data become available. In addition, as MSIS claims are raw data, they do not incorporate future adjustments to claims. Therefore, the evaluators adjudicated the claims used in this analysis to the extent possible by adjusting claims with adjustment submissions filed in subsequent periods. Claims without at least two quarters of subsequent data are considered incomplete and are excluded from the analysis as they could not be used to calculate reliable utilization measures. Because the claims could not be fully adjudicated, they could not be used to derive cost estimates, so claims data were supplemented by the 2015 Truven Report *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013*, which presented CFC expenditure data based on state-filed CMS-64 reports.<sup>14</sup> The MSIS data in this report only reflect encounter data for claims submitted under a fee-for-service delivery system. Table 3 lists the domains of interest and measures constructed using MSIS data. For states with multiple service delivery systems, there may be variation in the data presented in this report depending on how encounter data is reported.

Table 3 below summarizes the measures analyzed with claims data within each domain.

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<sup>14</sup> Eiken S, Sredl K, Burwell B, Saucier P. June 30, 2015. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>. Accessed July 17, 2015.

**Table 3. Measures Analyzed with Claims Data**

Domain	Measures
Disability Status	<ul style="list-style-type: none"> <li>■ Basis of Medicaid eligibility</li> </ul>
Demographic Characteristics	<ul style="list-style-type: none"> <li>■ Age</li> <li>■ Sex</li> <li>■ Race and ethnicity</li> </ul>
Health and Welfare of Home and Community-based Services Beneficiaries	<ul style="list-style-type: none"> <li>■ Potentially avoidable inpatient admissions for chronic conditions<sup>†15</sup></li> <li>■ Potentially avoidable inpatient admissions for acute conditions<sup>‡16</sup></li> <li>■ Chronic Illness and Disability Payment System diagnostic categories</li> </ul>
Health Care Utilization	<ul style="list-style-type: none"> <li>■ Percent of enrollees with inpatient admission</li> <li>■ Hospital Days Per 1,000 enrollees</li> <li>■ Number of inpatient admissions per 1,000 enrollees</li> <li>■ Percent of enrollees with emergency room visits</li> <li>■ Number of emergency room visits per 1,000 enrollees</li> </ul>

<sup>†</sup>Chronic conditions: diabetes complications, chronic obstructive pulmonary disease, hypertension, congestive heart failure, angina, uncontrolled diabetes, adult asthma, lower extremity amputations among people with diabetes

<sup>‡</sup>Acute conditions: dehydration, bacterial pneumonia, urinary tract infection

### ***Limitations***

This report is based on the four states (California, Oregon, Maryland, and Montana) that added the CFC benefit to their Medicaid State Plans as of December 31, 2014. Three of the four states had their SPAs approved in the latter half of 2013 and one in early 2014. This evaluation focuses on the implementation of CFC in these states and describes the population served through CFC prior to its implementation. As these findings pertain to the experiences and populations in a small number of states, they may not be generalized to all states. As more states adopt the benefit, additional analyses could provide important supplemental insight to the findings in this report. At the time of this report, three additional SPAs were approved, and other states were providing CMS with additional information about their proposed SPAs.

Analysis of the impact of CFC on health and the ability to live independently to the maximum extent possible was necessarily limited due to the recentness of CFC adoption and the lack of availability of timely claims data. To that end, this report describes health status and utilization of the CFC population prior to CFC's implementation. As claims data become available for years 2014 and beyond, analysis of health care utilization will help to assess the impact of CFC on enrollees' health and welfare. Similarly,

<sup>15</sup> Schultz E, Davies SM, McDonald KM. June 2012. Development of Quality Indicators for Home and Community-Based Services Population: Technical Report. Rockville, MD: Agency for Healthcare Research and Quality.

<sup>16</sup> Ibid.



CFC expenditure data were available only through FY 2013, which necessarily limited analysis of CFC expenditures to California, the only state with CFC at that time.

## Findings

Findings from the evaluation of CFC highlight the extent to which states have adopted the optional State Plan benefit three years following the final rule and summarize the steps states undertook to consider, apply for, and implement CFC. The findings also present a baseline analysis of the population served by CFC in each state to provide a starting point for future analysis of the impact of CFC following full implementation of the benefit in states. The Findings section begins with an update on states that have submitted SPAs for CFC and the key factors that states identified as influencing their decisions to pursue CFC. This section continues with a description of the population receiving CFC services, including information on their demographics, health status and health care utilization, and Medicaid expenditures for their medical and long-term care. Findings conclude with a description of how states have implemented CFC in their states.

### *National Status Of The Community First Choice Benefit*

As of July 17, 2015, 12 states submitted SPAs to CMS to implement the CFC benefit, three of which subsequently withdrew their SPAs (Louisiana, Arizona, and Arkansas). CMS has approved seven SPAs (California, Oregon, Maryland, Montana, Texas, Washington, and Connecticut), and two States are under review. Table 4 summarizes the status of all 12 states that submitted SPAs.

Table 4 below summarizes the state plan amendment status of states that have contacted CMS about CFC.

**Table 4.** National Status of CFC

State	SPA Status	Effective Date
Arizona	Withdrawn by state (Beneficiaries Medicaid eligibility is derived through an 1115 demonstration only)	
Arkansas	Withdrawn by state (State legislature did not approve implementation of the benefit)	
California	Approved - 8/31/2012, amended 7/31/13	12/1/2011, 7/1/13
Connecticut	Approved - 7/22/15	7/1/15
Louisiana	Withdrawn by state (State did not provide an explanation)	
Maryland	Approved - 4/2/2014	1/1/2014
Minnesota	Submitted, CMS requested additional information	
Montana	Approved - 7/8/2014	10/1/2013
New York	Under review	7/1/15
Oregon	Approved - 6/27/2013	7/1/2013
Texas	Approved - 4/2/2015	6/1/2015
Washington	Approved - 6/30/2015	6/30/2015

## ***Key Factors In Decisions To Pursue CFC***

Various factors that affected states' decisions to pursue CFC surfaced throughout evaluators' conversations with state officials and stakeholders. Existing HCBS programs, infrastructure and states' priorities for them; stakeholder advocacy; and anticipated budgetary impact were all influential in states' decisions to pursue CFC. Depending on the state context, these factors led states to determine that CFC could improve HCBS service provisions and budgets, or, they led to conclusions that CFC was not a viable option at the time.

## **Existing HCBS Infrastructure And Priorities**

### ***States Implementing CFC***

The four states that implemented CFC prior to March 2015 already provided HCBS to Medicaid enrollees through 1915(c) waivers, 1915(i) State Plan HCBS benefit, or a State Plan Personal Care benefit. Two of these states used the 1915(j) Self-Directed Personal Assistance Services authority to allow self-direction of either the State Plan Personal Care Benefit (California) or 1915(c) waiver services (Oregon). States then continued to provide attendant services to qualified participants from these programs through CFC, with modifications or adjustments to the benefit package as required or desired by the state. Often, states have multiple 1915(c) waivers to provide HCBS services to targeted populations, which was true of the four existing CFC states, so CFC provided an opportunity to bring these services under one umbrella. These states viewed CFC as a mechanism to provide more comprehensive services to more enrollees, with the enhanced FMAP as a potentially important resource for maintaining and expanding the existing infrastructure for HCBS in the state.

One infrastructure consideration that surfaced among states that ultimately adopted CFC was the administrative complexity that resulted from having multiple mechanisms to provide similar types of services across different populations. While different benefit authorities provide states the flexibility to target services and populations, the resulting inconsistency in the levels and types of services available across populations makes it difficult to manage and coordinate services across waivers with different eligibility criteria and different assessment tools in use. States noted that CFC could help reduce this complexity and burden as services would be available across populations, in accordance with need and regardless of the type, nature or severity of disability, and would make it possible to standardize eligibility and needs assessments and better coordinate services. However, importantly, CFC would not completely eliminate the need for different waivers, as individuals who would not qualify for CFC based on income criteria could continue to receive services through waivers, or in one state, through the optional State Plan Personal Care benefit. Additionally, individuals who qualified for medical assistance under the special

home and community-based waiver eligibility group would need to continue to receive some services under the 1915(c) waiver because in order to retain waiver eligibility, and thus Medicaid eligibility, they must need and receive at least one HCBS waiver service per month or they must need and receive at least one HCBS waiver service and monthly monitoring.

### *States Not Adopting CFC*

The need to maintain existing programs alongside CFC was mentioned by several states as influencing their decision not to implement this program. In addition, some states stated they achieved the goal of consolidated HCBS provision by collapsing multiple 1915(c) waivers into a global 1915(c) waiver or including HCBS in 1115 demonstrations, centralizing the oversight for HCBS under a single mechanism. For example, one state utilized the transition to an 1115 demonstration as a way to reduce the number of people entering Medicaid-funded nursing homes and increase the number of individuals utilizing HCBS. In many states, however, consolidation was not a priority as the agencies that administer physical disability programs are separate from those that administer programs for the developmentally disabled. Integrating and consolidating these programs would require significant realignment and reorganization of these state offices.

Moreover, some states noted that having multiple waivers and programs such as Money Follows the Person were preferred for HCBS, as they are not necessarily subject to the statewideness and comparability requirements for Medicaid benefits. A state may have one 1915(c) waiver for their developmental disability community and another for their physical disability community, allowing them to tailor requirements within the program and set separate enrollment caps and waiting lists for each population. CFC's comparability requirement does not allow for this tailoring, which some states expressed as a major part of their CFC consideration. Having the flexibility to tailor services to specific disability groups and set enrollment caps were important levers for controlling HCBS expenditures in these states.

Additionally, by statute, CFC is only available to individuals who are eligible for medical assistance under the State Plan. Consequently, states with 1115 demonstrations have found that Medicaid enrollees whose Medicaid eligibility is derived through the 1115 demonstration, and not through the state plan, would be ineligible for the CFC benefit even if the enrollees require an institutional level of care. For example, Arizona, a state that covers nearly all of its Medicaid-eligible population through an 1115 demonstration, withdrew its CFC SPA, after CMS conveyed that the majority of its state population requiring attendant services would not be eligible for CFC due to operating almost solely under 1115 demonstrations. Instead, it developed a program modeled after CFC under its 1115 demonstration and

was not eligible for the six percent increase in FMAP afforded to CFC programs within the Medicaid state plan.

Some states chose to forego CFC so they could allocate their limited staff and administrative capacity to pursue other opportunities, such as the Medicare-Medicaid Enrollees Financial Alignment Demonstration or the Balancing Incentives Program, which they determined could impact more individuals and save more money for the state than CFC, despite the additional 6 percentage points in FMAP. At least one state said its current resources were being used to renew its current waivers and state plan benefits and that pursuing a new SPA was not viable.

Other infrastructure concerns among states that did not pursue CFC included concerns about having sufficient workforce and HCBS-compliant dwellings to meet the anticipated demand for attendant services in their states. With multiple waiver programs and the State Plan Personal Care benefit, as well as a growing aging population and more enrollees seeking community-based living options, many states already felt pressure in meeting consumer needs.

### **Advocacy From Key Stakeholders**

Strong advocates, particularly those from the physical disability community, were critical in three states' decisions to pursue CFC. Consumer advocacy organizations and unions representing these groups viewed CFC as a way to increase the quantity and quality of services for their constituents. These advocates were highly vocal with both Medicaid officials and the legislature to encourage the state to look into CFC and continued to advocate as members of the statutorily required Development and Implementation Councils. Vocal advocates were not new in many states, as the 1999 Supreme Court decision in *Olmstead v. L.C.* concerning the rights of people with mental disabilities to live in the community generated strong stakeholder involvement in policies regarding home and community-based services prior to CFC.

In at least two states, advocates for individuals with physical disabilities were stronger supporters for CFC than was the developmental disability community. In these states, this meant stakeholders with physical disabilities and state officials who work on programs for this population led the effort to pursue CFC. In one state, stakeholders of the developmentally disabled community were involved early on in drafting the CFC SPA, but sometimes expressed hesitancy because they were content with the services they currently had and did not think CFC would improve those services.

## **Anticipated Effects On State Budgets**

In most states, the recession of 2007-2009 and other financial issues caused state budget cuts, including reductions in HCBS budgets and services. With aging populations, larger populations qualifying for HCBS services, and higher costs to provide services, states were forced to consider ways to curb spending. Thus, CFC and its enhanced FMAP were especially appealing to states struggling with HCBS service budget cuts.

States also saw CFC as a means to expand the availability and scope of LTSS by reinvesting the additional FMAP to provide new services or bolster existing services, including expanded support for ADLs, nonmedical transport, community integration, and environmental modifications.

Alternatively, when considering CFC, states expressed concerns about the financial impact on already-constrained state budgets. This was true of states that ultimately pursued CFC and those that did not. Even in states with existing HCBS infrastructure, states anticipated there would be new costs associated with CFC and the additional 6 percentage points in FMAP would not cover the costs of implementing, providing, and evaluating the CFC benefit. This concern was amplified by the statutory requirement that for the first 12-month period of CFC implementation, the state must maintain or exceed the level of state expenditures for home and community-based attendant services and supports attributable to the preceding 12-month period. In a time of uncertainty in state budgets, ambiguous or indeterminate costs prevented states from choosing CFC. In some states, there was uncertainty about future HCBS costs due to increasing populations of adults with intellectual or developmental disabilities (I/DD), of which, a large proportion reside in community-based settings. One state noted that more than 98 percent of enrollees with intellectual and developmental disabilities currently receive care in the community, with many of these individuals meeting the level of care for an ICF/IID and; therefore, eligibility for CFC. Most of this population live in group homes, with families, or independently. According to state officials, costs for this population are growing more than any other HCBS population because individuals with disabilities are living longer. At least two states that adopted CFC, and at least one state that did not, expressed a preference for covering the developmental disability population under 1915(c) waiver services rather than through CFC due to cost/utilization controls already discussed. These states expressed fear that the growing costs of providing services to this population under CFC would have a major impact on their already-strained state budgets. The states who have adopted CFC despite this concern are still evaluating the ways to control costs within the program restrictions.

## ***HCBS Services And Supports Under The CFC: Findings On Enrollees***

The population receiving HCBS through CFC meet an institutional level of care and require personal attendant services to live safely and independently in their homes. As such, they are a population with multiple and potentially complex needs.<sup>17</sup> To understand the diversity and complexity of the population served through CFC, the following section describes findings from enrollment data and claims based on demographic, disability and clinical characteristics, health status and health care utilization, and Medicaid costs in total and for long-term care.

### **Population Served**

The number of individuals served by CFC varies widely by state, which is attributable to differences in overall population size among the states examined (California, Oregon, Maryland, and Montana). In fiscal year (FY) 2014, a total of 306,766 individuals were served by CFC across the four states. In FY 2013, only two states (California and Oregon) were approved for CFC, and states reported that 244,962 individuals received CFC services. The number of individuals served in prior years is available by state in the following section.

#### *California*

California has the largest CFC program of the four states evaluated, which is expected, based on the size of the state and its Medicaid program (Medi-Cal). California was approved for CFC effective December 1, 2011, and the numbers of individuals receiving HCBS before and after the implementation of CFC remained fairly consistent. California had a very large HCBS program prior to the implementation of CFC and; therefore, did not serve any newly defined populations under CFC.

From December 1, 2011 to September 30, 2012, 486,587 individuals were served by CFC. From October 1, 2012 to June 30, 2013, this number increased only slightly to 487,565. For the remainder of FY 2013, 200,625 individuals received CFC services, increasing to 245,464 in FY 2014 (Figure 1). To understand the decrease in the number of individuals served by CFC in California, it is important to note that California had two SPAs for CFC. The first SPA was approved prior to CMS' Final Rule and therefore did not require all individuals to meet an institutional level of care requirement, as the proposed regulation only applied the level of care requirement to individuals with incomes above 150% of the FPL. The Final Rule applied the level of care requirement to all individuals. After the Final Rule was published, California submitted and was approved for a second SPA that included this requirement. As a

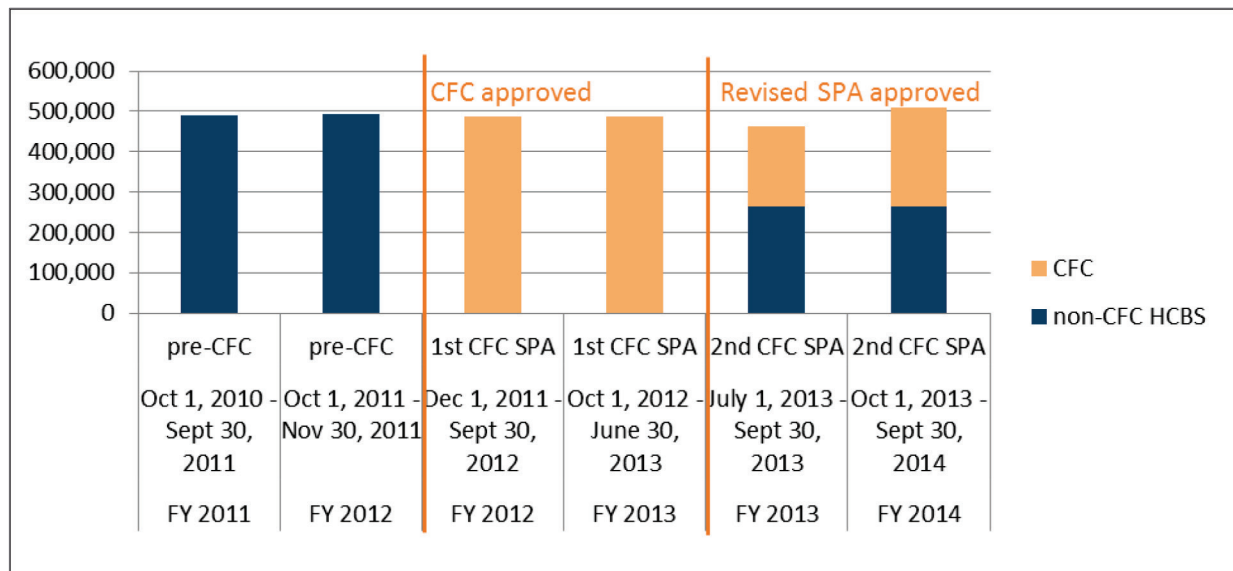
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<sup>17</sup> Konetzka RT, Potter DEB, Karon SL. December 2012. Assessing the Health and Welfare of the HCBS Population. Agency for Healthcare Research and Quality, Rockville, MD.. Available at: <http://www.ahrq.gov/professionals/systems/long-term-care/resources/hcbs/hcbsfindings/index.html>. Accessed January 15, 2015.

result, while the number served by CFC decreased on July 1, 2013, by FY 2014, the total population receiving HCBS in California increased to 508,292, and 48 percent of them were served by CFC. Individuals who were ineligible for CFC due to the revised level of care requirement were served by the State Plan Personal Care benefit, or the the 1915(j) Self-directed State Plan Personal Care benefit, or through a state program without match from the federal government.

Figure 1 below summarizes the number of individuals receiving HCBS in California.

**Figure 1. Number of Individuals Receiving HCBS in California**



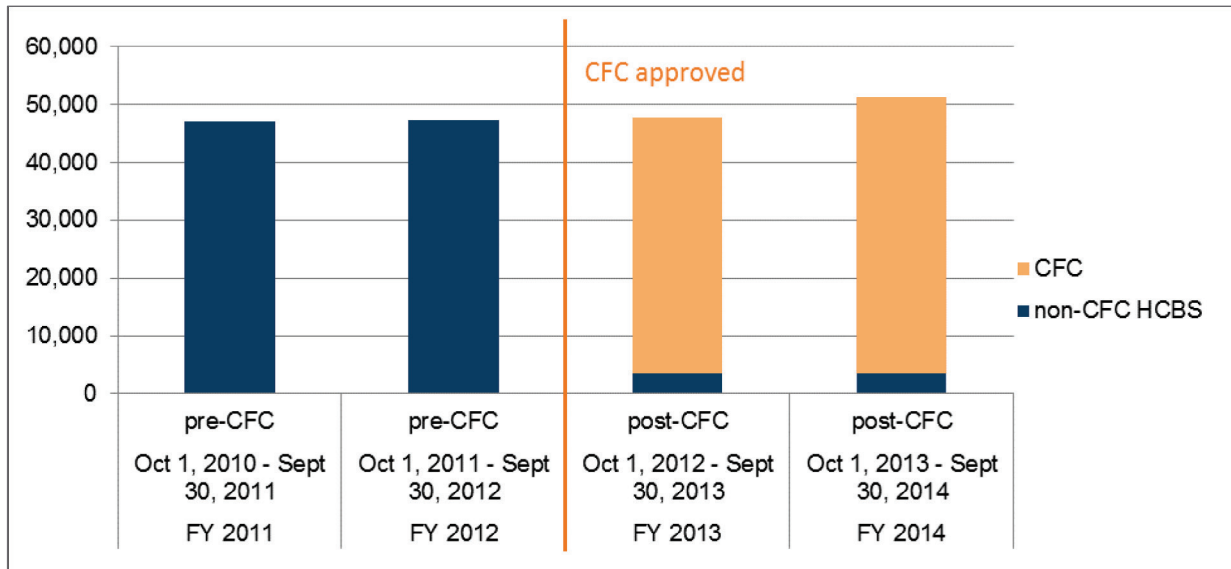
Source: Data provided by California Department of Health Care Services.

### *Oregon*

In Oregon, the number of individuals receiving HCBS increased after the implementation of CFC. In the year prior to the approval of CFC (FY 2012), 47,232 individuals received HCBS. In the first year of CFC (FY 2013), this number increased slightly (47,814) and close to 93 percent received services through CFC (44,337). From FY 2012 to FY 2014, there was an 8 percent increase in individuals receiving HCBS, with 93 percent served through CFC (47,825) and the number served by other programs (3,381) fell slightly (Figure 2). Oregon was able to increase the number of people who received attendant services provided in their home as well as provide new services, such as chore services and home modifications. These new populations and services likely explain the increase in individuals served after the implementation of CFC, and, in particular, the continued increase in CFC as implementation progressed.

Figure 2 below summarizes the number of individuals receiving HCBS in Oregon.

**Figure 2.** Number of Individuals Receiving HCBS in Oregon



Source: Data provided by Oregon Department of Human Services from the Oregon Datamart.

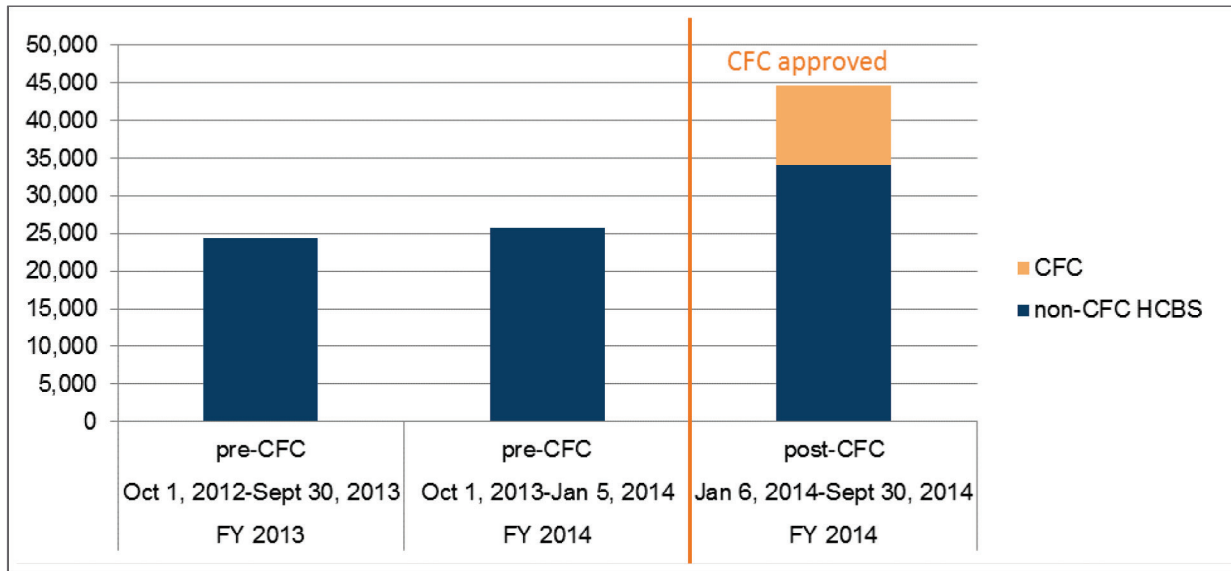
### *Maryland*

In Maryland, 10,576 individuals received CFC services from the time of their approval on January 6, 2014 through September 30, 2014, which represented a 42 percent increase in the total number of individuals receiving HCBS attendant services from the prior period. However, it should be noted that during this time period there was also a 25 percent increase in the number of individuals served through non-CFC programs and that CFC did not account for the full increase in services provided.

Figure 3 below summarizes the number of individuals receiving HCBS in Maryland.



**Figure 3. Number of Individuals Receiving HCBS in Maryland**



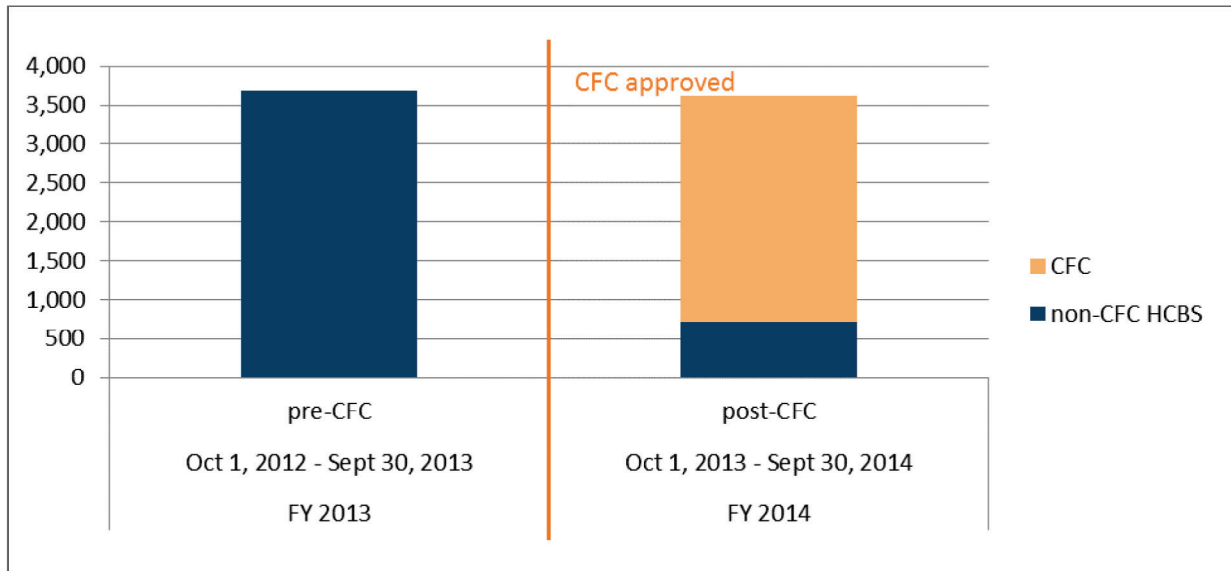
Source: Data provided by the Hilltop Institute on behalf of Maryland from Medicaid Management Information Systems claims data.

*Montana*

In Montana, 3,615 individuals received HCBS in the first year of CFC implementation (FY 2014); 80 percent of those individuals were covered by CFC (2,901 individuals.)

Figure 4 below summarizes the number of individuals receiving HCBS in Montana.

**Figure 4.** Number of Individuals Served by CFC in Montana



Source: Data provided by the Montana Department of Public Health and Human Services from Medicaid Management Information Systems claims data.

### *HCBS Prior To And Following CFC Implementation*

In all states, most of the individuals served by CFC were previously receiving HCBS under a different authority such as a 1915(c) waiver, 1915(i) State Plan benefit, or State Plan Personal Care benefit. In Oregon, the majority (97 percent) of CFC enrollees were served by a 1915(c) waiver prior to CFC. In Maryland, a portion of the beneficiaries receiving CFC services were previously individuals in the State Plan Personal Care benefit (referred to as Medical Assistance Personal Care) whom the state had identified as individuals who meet the level of care requirements of the CFC program. In Maryland, the individuals enrolled into CFC included: 29 percent previously served by the State Plan Personal Care benefit, 54 percent previously served by a 1915(c) waiver, and 17 percent previously served under an 1115 waiver. Data for the HCBS program serving CFC enrollees in California and Montana prior to implementation of CFC are not available. However, from interviews and secondary data<sup>18</sup>, California continues to serve its enrollees with developmental disabilities primarily through a 1915(c) waiver and 1915(i) HCBS State Plan benefit.

<sup>18</sup> Eiken S, Sredl K, Burwell B, Saucier P. June 30, 2015. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>. Accessed July 17, 2015..

In some states, individuals may have continued to remain in the 1915(c) HCBS waiver, 1915(i) State Plan HCBS benefit or State Plan Personal Care benefit for some of their services after transitioning to CFC. Some individuals receiving services through a 1915(c) waiver, chose to remain in the waiver in addition to CFC because it offered additional services not available under CFC, or because the individual was not categorically eligible for Medicaid. In the latter case, the individual must need and receive at least one waiver service within a set amount of time – either once per month or at least one service and monthly monitoring depending on the state – in order to remain eligible for the waiver and Medicaid.

*Population Served By Disability, Age, Gender, Education Level, And Employment Status*

**Disability Status.** An individual’s basis of eligibility for Medicaid is a helpful metric to assess the proportion of individuals receiving CFC services who are elderly or who have a disability. Overall, the majority of Medicaid enrollees served by CFC were eligible for Medicaid due to disability (56 percent blind or disabled), and this was consistent across states. In California and Oregon, approximately 40 percent were individuals over 65 years old who met the financial eligibility criteria (Table 5). In Montana and Maryland, this percentage was closer to 25 percent. The “other” category represents eligibility for Medicaid for reasons other than disability or being aged and financially eligible, such as adults under 65 and children who meet Medicaid’s financial eligibility criteria and did not become eligible for Medicaid due to disability.

Table 5 below summarizes the basis of eligibility for Medicaid during FY 2010-2011. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 5.** Basis of Eligibility for Medicaid during the Most Recent Quarter of Eligibility, FY 2010-2011

	All States		Oregon		California		Maryland		Montana	
	N	%	N	%	N	%	N	%	N	%
<b>Number of CFC Participants Identified in Claims Basis of Eligibility</b>	521,428		30,028		477,460		12,229		1,711	
Aged	206,117	39.5%	12,604	42.0%	189,947	39.8%	3,157	25.8%	409	23.9%
Blind or Disabled	291,223	55.9%	16,187	53.9%	267,272	56.0%	6,763	55.3%	1,001	58.5%
Other	24,088	4.6%	1,237	4.1%	20,241	4.2%	2,309	18.9%	301	17.6%

Source: Evaluators’ analysis of MSIS claims FY 2010-2011

Note: “Other” includes adults under age 65 and children who did not become eligible for Medicaid because of disability.

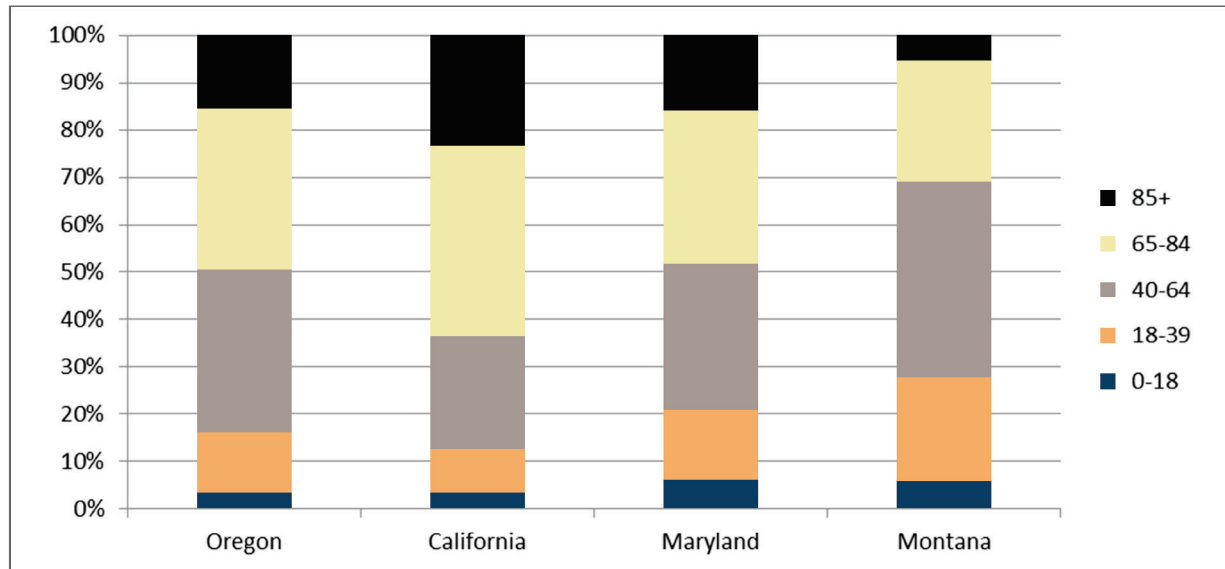
In addition to using basis of eligibility to understand the types of disability, evaluators requested from each state a breakdown of the types of disability among enrollees receiving CFC services; however, only two states were able to report these data, and on a limited basis:

- Oregon reported 32 percent of CFC enrollees in FY 2014 had intellectual or developmental disability (I/DD) and 26 percent were under age 65 with a physical disability. The remaining 42 percent were over age 65 without an intellectual or developmental disability.
- Maryland reported that 44 percent of CFC enrollees had a physical disability and 4 percent had an intellectual or developmental disability. No data were available from the state on the disability status for the remaining 52 percent of the Maryland CFC population.

**Age.** There is wide variation across states in the age distribution of individuals served by CFC (Figure 5). In Montana and Oregon, CFC enrollees tend to be younger (under 65) while in California and Maryland, they tend to be older (over 65), with 20 to 25 percent over 85. The differences in age distribution largely reflect the nature of disability of the CFC population in each state described above. For example, in Maryland and California, physical disability and older age are more prevalent among individuals served through CFC, while Oregon and Montana serve relatively more individuals with developmental disabilities who tend to be younger.

Figure 5 below summarizes the percent of individuals served by CFC by age category. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that may explain differences in utilization, so these data should not be used for comparison across states.

**Figure 5.** Percent of individuals served by CFC by age category



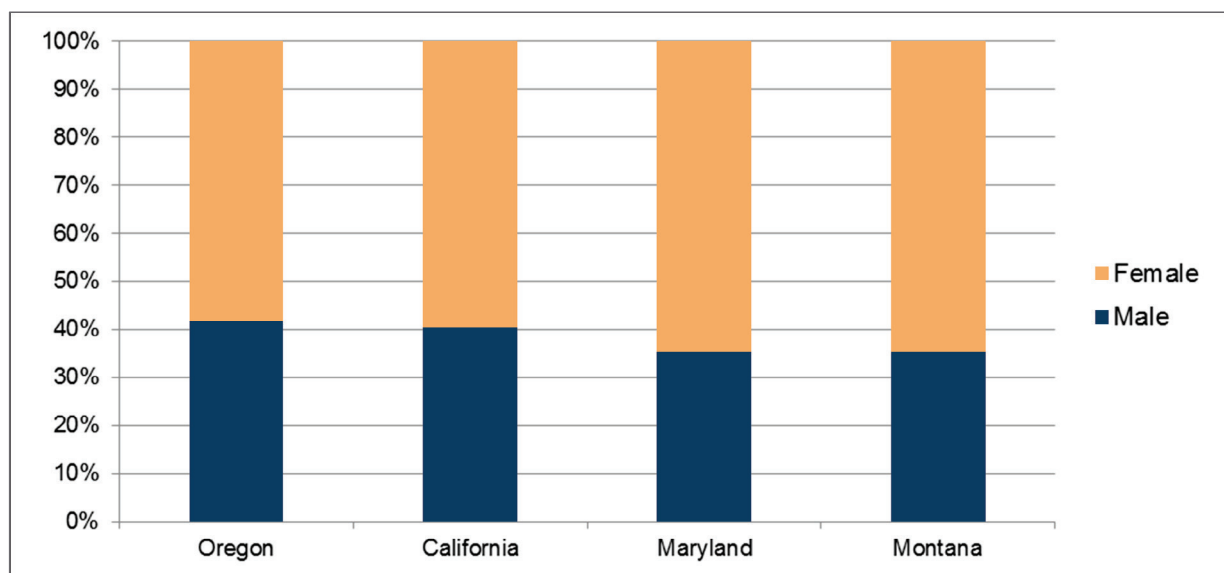
Source: Evaluators' analysis of MSIS claims data FY 2010-2011; calculated age as of age as of January 6, 2014.

**Gender.** In all four states, women accounted for a majority of the CFC population. In FY 2014, 60 percent of CFC enrollees were female (Figure 6). This is representative of the overall Medicaid population in these four states, where 56 to 62 percent of all Medicaid enrollees are female.<sup>19</sup>

Figure 6 below summarizes the percent of individuals served by CFC by gender, FY 2014. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that may explain differences in utilization, so these data should not be used for comparison across states.

<sup>19</sup> Medicaid Enrollment by Gender. Kaiser Family Foundation: State Health Facts. Available at: <http://kff.org/medicaid/state-indicator/medicaid-enrollment-by-gender/>. Accessed June 29, 2015.

**Figure 6.** Percent of individuals served by CFC by gender, FY 2014



Source: Data provided by the states (Oregon: Department of Human Services Datamart; California: Department of Health Care Services; Maryland: Hilltop Institute Medicaid Management Information Systems; Montana: Department of Public Health and Human Services Medicaid Management Information Systems).

**Race/Ethnicity.** The racial and ethnic composition of those served by CFC varies across states (Figure 7), as well as within states, when compared to the racial and ethnic composition of the overall Medicaid population. In Oregon, 85 percent of CFC enrollees are white, non-Hispanic, compared to 62 percent of all non-elderly Medicaid enrollees.<sup>20</sup> CFC enrollees in California are more likely to be Hispanic (29 percent) than in other states, though this figure is disproportionately lower than the 59 percent of non-elderly Medicaid enrollees in California who are Hispanic.<sup>21</sup> In Montana, the majority of CFC enrollees are white, and 19 percent fall into the “other” category; the majority of which is Native American. In Maryland, the largest proportion (44 percent) of CFC enrollees are black, which is similar to the proportion of non-elderly Maryland Medicaid enrollees who are black (45 percent).<sup>22</sup>

Figure 7 below summarizes the percent of individuals served by CFC by race/ethnicity, FY 2014. Note: The information provided reflects individual state level utilization; however, there are differences in

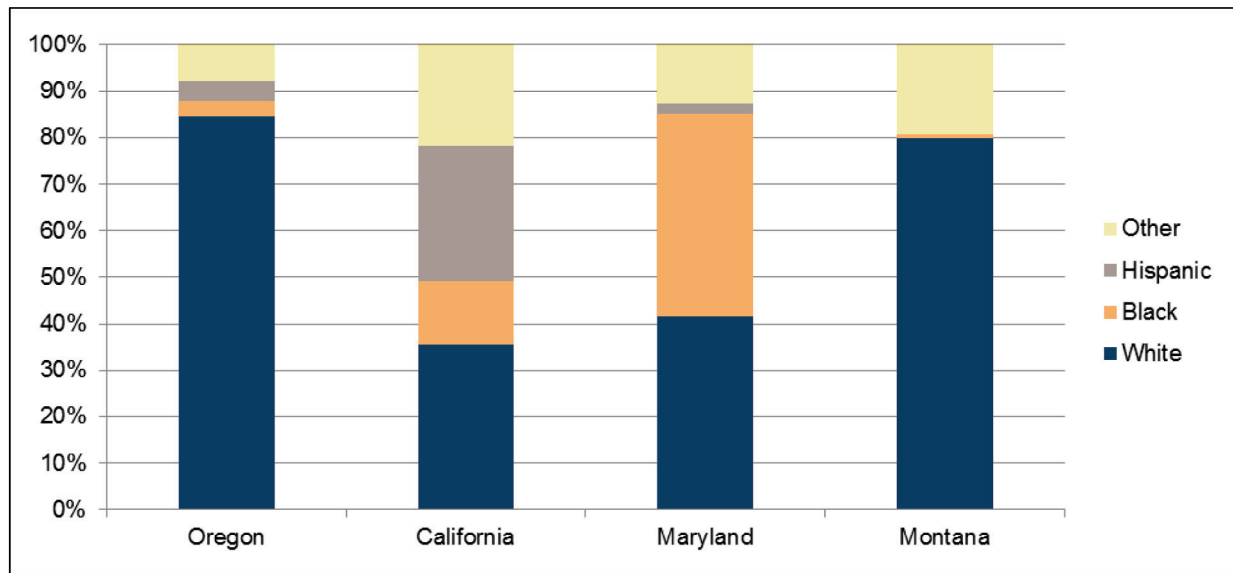
<sup>20</sup> Population Distribution by Race/Ethnicity. Kaiser Family Foundation: State Health Facts. Available at: <http://kff.org/other/state-indicator/distribution-by-raceethnicity/>. Accessed on June 29, 2015.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Figure 7.** Percent of individuals served by CFC by race/ethnicity, FY 2014



Source: Data provided by the States (Oregon: Department of Human Services Datamart; California: Department of Health Care Services; Maryland: Hilltop Institute Medicaid Management Information Systems; Montana: Department of Public Health and Human Services Medicaid Management Information Systems).

**Education And Employment Status.** The CFC statute requires the program evaluation to include an analysis of the education and employment status of CFC enrollees. These data elements are not traditionally collected by all Medicaid programs and there is inconsistency in the data available from states in which the information is collected. CMS will be issuing guidance to states about how to collect and report these data systematically for ongoing reporting efforts.

### **Health and Welfare of Enrollees**

To receive services through CFC, individuals are required to meet an institutional level of care. This requirement suggests that this subset of enrollees would tend to be sicker with complex medical conditions and higher health care utilization than the general Medicaid population. The following section describes results based on the evaluators' analysis of 2010-2011 MSIS claims data on the clinical conditions present in this population, their health care utilization, as well as indicators of their health and welfare prior to the implementation of CFC. As more recent claims data become available and more states are further along in their implementation of CFC, these measures can serve as helpful benchmarks to track the health and welfare of this population.

### *Clinical Characteristics*

Two measures of resource use and case mix, respectively, were used to assess the clinical characteristics of the CFC population prior to states' implementation: HCBS Quality Indicators for avoidable hospitalizations and the Chronic Illness and Disability Payment System (CDPS) clinical categories, which measures morbidity. The HCBS Quality Indicators on avoidable hospitalizations were developed by the Agency for Health Research and Quality (AHRQ) to measure the health and well-being of individuals receiving HCBS through the Medicaid program.<sup>23</sup> They apply only to adults 18 and over and are based on existing AHRQ Quality Indicators (QI). The HCBS QI set includes a variety of hospitalization events reflecting chronic disease progression, development and progression of acute events, and exacerbations of pressure ulcers and injurious falls. Many of these indicators are based on ambulatory care sensitive conditions. In both the general and HCBS populations, it is hypothesized that these conditions can be effectively managed at an outpatient setting, preventing avoidable hospitalization. Although not every hospitalization for these conditions is preventable, these indicators are intended for use as metrics of the health and well-being of HCBS beneficiaries.

The CDPS is a diagnostic classification system that Medicaid agencies use to make capitated payments for Temporary Assistance for Needy Families (TANF) and Medicaid beneficiaries with disabilities enrolled in managed Medicaid plans.<sup>24</sup> CDPS classifies beneficiary diagnoses into nineteen distinct clinical categories.<sup>25</sup> In addition to CDPS, there are two other publicly available risk adjustment models: Adjusted Clinical Groups and the Hierarchical Condition Category. However, compared to the other systems, the CDPS performs better in predicting utilization or expenditures for people with disabilities and for TANF beneficiaries. CDPS has also been successful in excluding many ill-defined and high-frequency, low-cost diagnoses.

**HCBS Quality Indicators For Avoidable Hospitalizations.** The HCBS indicators for avoidable hospitalizations represent the rate of potentially avoidable inpatient admissions per 100,000 HCBS participants. The numerator is the number of potentially avoidable CFC inpatient admissions and the denominator represents the number of CFC HCBS participants divided by 100,000. This analysis defines

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<sup>23</sup> Schultz E, Davies SM, McDonald KM. June 2012. Development of Quality Indicators for Home and Community-Based Services Population: Technical Report. Rockville, MD: Agency for Healthcare Research and Quality.

<sup>24</sup> Chronic Illness and Disability Payment System. University of California, San Diego. Available at: <http://cdps.ucsd.edu/>. Accessed June 29, 2015.

<sup>25</sup> Murar T, Teska C. Medicaid Risk Adjustment – Collaborative Efforts Between Altegra Health and UPMC. Available at: <http://www.ahcahp.org/Portals/0/Vendors/altegra%20risk%20adjustment%20vendor%20educ%20ACAP%20Presentation%20021412.pdf>. Accessed June 29, 2015.



the denominator as the number of enrollees receiving CFC services and is focused on measures of potentially avoidable admissions due to chronic conditions, acute conditions, and overall.

*Ambulatory Care Sensitive Conditions (ACSC): Acute Conditions* is a composite measure of the rate of potentially avoidable admissions due to any of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection. *ACSC: Chronic Conditions* measures admissions due to diabetes long-term or short-term complications, chronic obstructive pulmonary disease (COPD), asthma, hypertension, congestive heart failure (CHF), angina without a procedure, uncontrolled diabetes, or a lower-extremity amputation among patients with diabetes. *ACSC: Overall* is any admission due to any of the acute or chronic conditions included in the other two measures. They are summarized in Table 6 for CFC enrollees and compared to the same indicators for the adult Medicaid population.

These measures are indicators of the health status of individuals receiving CFC services in the baseline period prior to CFC implementation. In FY 2011, prior to the implementation of CFC, these indicators varied by state, with the health status of California's CFC population (prior to CFC implementation) most closely resembling the general adult Medicaid population, and Oregon's, Maryland's, and Montana's CFC populations with higher rates of admissions for acute conditions than the general adult Medicaid population, but slightly lower for chronic conditions. Maryland and Montana's rates of admission for acute conditions (and overall) are higher than the general Medicaid population.

Table 6 below summarizes the HCBS quality indicators for avoidable hospitalizations for CFC enrollees and the adult Medicaid population prior to CFC implementation, FY 2011. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 6.** HCBS Quality Indicators for Avoidable Hospitalizations for CFC Enrollees and the Adult Medicaid Population Prior to CFC Implementation, FY 2011, Rate per 100,000

Measure	Oregon*	California*	Maryland*	Montana*	Adult Medicaid Population†
ACSC Composite: Acute Conditions	1,452	1,263	2,638	2,287	1,290
ACSC Composite: Chronic Conditions	1,901	2,187	3,557	1,935	2,176
ACSC Composite: Overall	3,245	3,451	6,195	4,223	3,466

\*Source: Evaluators' analysis of MSIS claims data, FY 2011.

†Source: Schultz E, Davies SM, McDonald KM. 2012 June. Development of Quality Indicators for Home and Community-Based Services Population: Technical Report. Data source: numerator calculated from 2005 SID, primary or secondary payer is Medicaid (includes dual eligible persons). Denominator based on estimate of total adult Medicaid population from Kaiser State Health Facts Website (<http://www.statehealthfacts.org/>). States included: AR, CT, GA, IL, IN, KS, KY, MA, MD, MI, MN, MO, NC, NE, NJ, NV, NY, OR, SC, TN, TX, UT, VT, WA, WI, WV.

**Morbidity.** Using the Chronic Illness and Disability Payment System diagnostic classification system, CFC enrollees were grouped into 19 clinical categories based on their diagnostic information (Table 7). There was variation across states in the clinical characteristics of their targeted CFC population. The targeted CFC population had high prevalence of chronic illness (cardiovascular disease, renal disease, diabetes, pulmonary disease) and functional impairment (skeletal and connective disorders, central nervous disorders). Mental health disorders (psychiatric) were more common than developmental disabilities in this population. Most common mental health disorders included depression, anxiety, mood disorders, and post-traumatic stress disorder. In all states, mild to severe (or unspecified) intellectual disabilities and Down's syndrome were the most common developmental disability diagnoses.

Table 7 below summarizes the chronic illness and disability payment system classification for CFC enrollees and adult Medicaid population prior to CFC implementation, FY 2011. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 7.** Chronic Illness and Disability Payment System Classification for CFC Enrollees and the Adult Medicaid Population Prior to CFC Implementation, FY 2011

Category	Oregon	California	Maryland	Montana
Cardiovascular	39.3%	41.5%	56.1%	33.4%
Central Nervous System	34.4%	16.6%	37.3%	49.6%
Renal	33.3%	13.2%	38.2%	21.6%
Psychiatric	30.2%	11.6%	24.9%	28.1%
Skeletal and Connective	28.0%	23.4%	34.9%	35.8%
Diabetes	23.6%	18.3%	29.2%	23.1%
Pulmonary	22.4%	18.0%	24.5%	27.6%
Gastrointestinal	16.1%	12.2%	20.9%	17.4%
Skin	13.3%	5.8%	16.2%	14.2%
Metabolic	11.4%	4.1%	13.6%	12.1%
Eye	9.8%	7.6%	15.6%	9.2%
Cerebrovascular	6.9%	6.3%	13.1%	9.7%
Developmental Disability	11.4%	4.1%	3.0%	12.1%
Cancer	4.9%	5.4%	6.6%	6.3%
Infectious Disease	3.8%	3.0%	7.0%	3.3%
Substance Abuse	3.6%	1.8%	4.1%	2.4%
Genital	3.1%	2.4%	5.0%	2.3%
Hematological	1.9%	1.3%	3.6%	1.7%
Pregnancy	0.2%	0.2%	1.2%	0.5%

Source: Evaluators' analysis of MSIS claims data, FY 2011

### *Inpatient Utilization*

Prior to CFC implementation, the percentage of enrollees in each state with an inpatient admission ranged from 13 to 26 percent; inpatient admissions decreased in all states from 2010 to 2011 (Table 8). Maryland had the highest percent of individuals with an inpatient admission (26 percent in 2010 and 23 percent in 2011), while California had the lowest (17 percent in 2010 and 14 percent in 2011). These figures are intended to provide a baseline figure of inpatient utilization prior to CFC, as claims data were not available after CFC had been implemented (see Method section). Future analysis is needed to determine the impact of CFC on inpatient utilization.

Table 8 below summarizes inpatient utilization for CFC enrollees prior to CFC implementation, FY 2010-2011. Note: The information provided reflects individual state level utilization; however, there are

differences in populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 8.** Inpatient Utilization for CFC Enrollees Prior to CFC Implementation, FY 2010-2011

<b>Inpatient Utilization</b>	<b>2010</b>	<b>2011</b>
<b>Oregon</b>		
Percent of Enrollees with Admission	16.8%	14.2%
Hospital Days Per 1,000 Enrollees	1,405.2	1,113.3
Number of Admissions per 1,000 Enrollees	254.9	202.1
<b>California</b>		
Percent of Enrollees with Admission	13.4%	12.7%
Hospital Days Per 1,000 Enrollees	1,232.1	1,167.3
Number of Admissions per 1,000 Enrollees	240.8	216.0
<b>Montana</b>		
Percent of Enrollees with Admission	25.1%	19.2%
Hospital Days Per 1,000 Enrollees	1,989.6	1,295.0
Number of Admissions per 1,000 Enrollees	423.1	273.3
<b>Maryland</b>		
Percent of Enrollees with Admission	25.7%	23.0%
Hospital Days Per 1,000 Enrollees	2,884.0	2,199.7
Number of Admissions per 1,000 Enrollees	534.0	418.9

Sources: Evaluators' analysis of MSIS claims data, FY 2010-2011

Note: For the purposes of this analysis, multiple claims for the same beneficiary with the same date of admission/beginning date of service were considered a single visit.

### *Emergency Department (ED) Utilization*

Prior to CFC implementation, the percent of enrollees in each state with an emergency department (ED) visit ranged from 10 percent to 43 percent; all states saw slight decreases in ED utilization from 2010 to 2011 (Table 9). Maryland had more ED visits per 1,000 enrollees than the other three states (2,876.8 in 2010 and 2,685.1 in 2011 vs. the state with the next highest number of visits per 1,000 enrollees, Montana, with 1,049.7 in 2010 and 875.7 in 2011). Oregon had 995.2 ED visits per 1,000 in 2010 and 878.2 in 2011, and California had fewer ED visits per 1,000 enrollees (375.8 in 2010 and 350.9 in 2011). These figures are intended to provide a baseline figure of ED utilization prior to CFC, as claims data were not available after CFC had been implemented (see Method section). Future analysis is needed to determine the impact of CFC on ED utilization.

Table 9 below summarizes emergency room utilization for CFC enrollees prior to CFC implementation, FY 2010-2011. Note: The information provided reflects individual state level utilization; however, there

are differences in populations served between states that that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 9.** Emergency Room Utilization for CFC Enrollees Prior to CFC Implementation, FY 2010-2011

<b>Emergency Room Utilization</b>	<b>2010</b>	<b>2011</b>
<b>Oregon</b>		
Percent of Enrollees with Visit	36.5%	34.0%
Number of Visits per 1,000 Enrollees	995.2	878.2
<b>California</b>		
Percent of Enrollees with Visit	10.3%	9.9%
Number of Visits per 1,000 Enrollees*	375.8	350.9
<b>Maryland</b>		
Percent of Enrollees with Visit	42.9%	41.4%
Number of Visits per 1,000 Enrollees	2876.8	2658.1
<b>Montana</b>		
Percent of Enrollees with Visit	35.2%	33.4%
Number of Visits per 1,000 Enrollees	1,049.7	875.7

Sources: Evaluator’s analysis of MSIS claims data, FY 2010-2011.

Note: For the purposes of this analysis, multiple claims for the same beneficiary with the same date of admission/beginning date of service were considered a single visit.

*Ability To Lead An Independent Life To The Maximum Extent Possible*

Evaluation of the health and welfare of CFC enrollees includes an assessment of enrollees’ ability to lead an independent life to the maximum extent possible. While states had plans to conduct surveys of their enrollees to assess their experience and satisfaction with CFC services, states had not fielded these surveys at the time of this report. CFC evaluators held discussions with enrollees, advocates, caregivers, and family members to assess their perceptions of the role of CFC and HCBS in general to facilitate enrollees’ independence.

Discussions highlighted the importance of CFC in enabling participants to live independent lives within their communities. To these individuals, independence means the opportunity to receive required or desired services in their own homes or communities, allowing them to live where they desire, rather than in an institution. Since CFC does not permit caps on the number of individuals served, these stakeholders perceive more residents have been able to access HCBS under CFC, as individuals are coming off of waiver waitlists. In addition, those who were previously served through the Personal Care State Plan

benefit reported that once they transitioned to CFC they were able to receive additional service hours. One participant described how additional attendant services helped her feel safer when she ran errands and allowed her to continue to use community services and businesses. A parent explained how CFC has supported her daughter's needs at home, as she was unable to receive day services due to behavioral issues. Others compared their life in an institution to that which they currently lead in their own community and detailed the advocacy work and community participation that they now enjoy, citing the independence offered by in-home services as an important benefit of CFC. One man noted an increased amount of independence under CFC; without the program he would have to live in an assisted living facility where errands outside the facility only occur when a majority of residents need to go to the same place, hampering personal movement and community interaction. Another described how living at home under CFC allowed him to be productive, rather than lying in bed for a majority of the day in a nursing facility. The ability to hire, train, and fire providers was also noted as a benefit of CFC, even though for many, the duties required a learning curve. One individual stated, "I think that [to make] my home a happy place as much as I can, being the employer is extremely important, I have to have a plan [for] what the person is going to do during the day." Additionally, CFC enrollees stated that in-home care offered more personalized services. As one individual stated, "In your own home, it's the one-on-one situation, care providers can focus on the care you need and make sure you get the level of care you need. You feel like a human instead of a statistic."

### **State Spending On CFC**

A report on Medicaid LTSS expenditures finds that in FY 2013, for the first time, Medicaid spending on home and community-based services (HCBS) accounted for over half of Medicaid LTSS spending and is consistent with a general trend toward shifting LTSS spending away from institutional care to community-based care.<sup>26</sup> The percentage of LTSS spending on HCBS was 51.3 percent, or \$74 billion compared to \$71 billion for institutional LTSS. The shift towards HCBS was due to both an increase in HCBS spending and a slight decrease in institutional spending.<sup>27</sup> HCBS accounted for 72 percent of spending on services for people with developmental disabilities, 40 percent of spending for services targeting older adults or people with disabilities, and 36 percent of spending on services for people with severe mental illness or serious emotional disturbance.<sup>28</sup>

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<sup>26</sup> Eiken S, Sredl K, Burwell B, Saucier P. June 30, 2015. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>. Accessed July 17, 2015.

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

The four states that implemented CFC have higher proportions of their LTSS expenditures on HCBS than the national average. Oregon, for example, is among the highest with 79 percent of their LTSS in FY 2013 for HCBS. California is also high with 63 percent of LTSS for HCBS. In Montana and Maryland, 56 and 54 percent of LTSS expenditures, respectively, are for HCBS. The four states follow the same general pattern in terms of the balance of spending across population groups, with some notable exceptions. For people with developmental disabilities, all four states have very large shares of their LTSS expenditures for HCBS (90 percent in Montana, 100 percent in Maryland and Oregon, and 80 percent in California). For older people or those with physical disabilities, there is less consistency. Oregon (62 percent), California (57 percent), and Montana (37 percent) are above the national average (40 percent), while Maryland (25 percent) is below. Similarly, for people with severe mental illness or serious emotional disturbance, three states with CFC are higher than the national average (36 percent): Oregon (72 percent of LTSS spending for people with severe mental illness is for HCBS), Maryland (68 percent), and Montana (59 percent).

California was the only state to report CFC-specific expenditures.<sup>29</sup> In California, CFC expenditures in FY 2012 were \$4.2 billion, representing 30 percent of all LTSS expenditures and 51 percent of HCBS expenditures. In FY 2013, CFC expenditures totaled \$4.6 billion, and were similarly 30 percent of all LTSS and 49 percent of HCBS. All CFC expenditures in California were for services for older people or people with physical disabilities<sup>30</sup> and were offset by spending decreases for personal care (\$3.95 billion) and Section 1915(j) (\$236 million).<sup>31</sup> Figure 8 shows the shift in expenditures from other programs to CFC in California from FY 2011 to FY 2013.

Figure 8 below summarizes CFC, 1915(j) and state plan personal care benefit expenditures for California, FY 2011-2013.

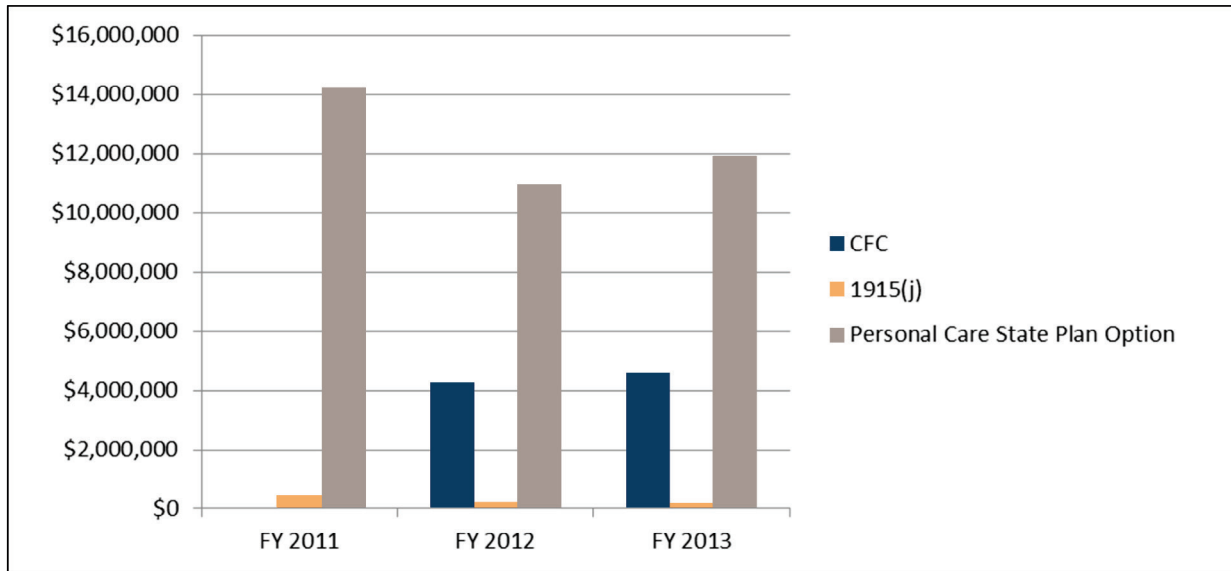
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<sup>29</sup> Ibid.

<sup>30</sup> In California, HCBS for individuals with developmental disabilities are covered by 1915(c) waivers and 1915(i) HCBS State Plan benefit.

<sup>31</sup> Ibid.

**Figure 8.** CFC, 1915(j) and State Plan Personal Care Benefit Expenditures for California, FY2011-2013 (in thousands of dollars)



Source: Eiken S, Sredl K, Burwell B, Saucier P. 30 June 2015. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>. Accessed 17 July 2015.

### ***Implementation Of CFC: Lessons From States***

While CFC has several requirements that all states must abide by—such as meeting statewideness and comparability and providing assistance with activities of daily living and instrumental activities of daily living—it also allows for flexibility in what services are provided and how. For example, there are a number of optional services that only some states have chosen to adopt. Also, states can set their own requirements around provider qualifications, assessment tools, and other critical elements in order to allow CFC to fit into their current HCBS structure. The following section outlines the variations that exist across the CFC programs in California, Oregon, Maryland, and Montana.

### **Service Provision**

The scope of services included under CFC differed by state. States indicated that they wanted to continue to provide all of the services previously available under other waivers or the State Plan Personal Care benefit. In at least one state, CFC was used as an opportunity to expand services. However, at least one state noted that they wanted to start with the required services and later expand services once initial implementation was complete. Table 10 shows the services receiving the enhanced FMAP by state. All



states are providing all required services; two states (Oregon and Maryland) also provide both optional services. California and Maryland do not receive the additional six percent FMAP for some activities, as they do not meet the Medicaid “free choice of provider” requirement and as such these are provided as administrative activities. For example, two states only use state or local governmental staff to provide voluntary training.

Table 10 below summarizes the CFC services eligible for FMAP by state. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 10. CFC Services Eligible for FMAP by State**

	California	Oregon	Maryland	Montana
<b>Required Services:</b>				
ADLs, IADLs, health-related tasks	√	√	√	√
Acquisition, maintenance and enhancement of skills	*	√	√	√
Development of Backup systems	*	√	√	√
Voluntary Training	*	√	*	√
Support-system activities	*	√	√	√
<b>Permissible CFC services provided by state:</b>				
Expenditures for services substituting for human assistance	-	√	√	-
Expenditures for transition costs	-	√	√	-

\*Activity is provided as an administrative activity and therefore enhanced FMAP is not available.

- This is not a required service and is not provided by the State under CFC.

### *Person-Centered Planning And Assessments*

Once an individual receives a level of care determination, enrollees receive a functional needs assessment to identify the individual’s service needs, preferences, strengths, and goals. This assessment is state-specific and may be conducted by a state employee or independently contracted employee, depending on the regulations set by the state.

CFC enrollees are required to receive this assessment annually. From this assessment, an individual’s care team develops a person-centered service plan. Results from the assessment help the plan coordinator work with the individual to allocate the appropriate number of hours and types of services; the service plan outlines which providers will be used for each service and, in some states, how hours will be distributed

across various providers. For at least one state, this represents a shift from previous HCBS systems, where enrollees were allocated a lump sum of hours, based on severity of need, and could decide how to allocate those hours. From the perspective of some in the developmentally disabled community, this shift decreased self-direction under CFC, rather than expanding it. However, proponents of this shift note that a revision of the assessment tool allows the state to provide a direct link between the individual's needs and the assigned hours, and in many cases increases the number of hours for which an individual can be eligible. Some states have utilized CFC as way to enhance current HCBS options, by applying CFC funding towards assistance with activities of daily living, freeing other HCBS funds to go toward community integration or other socialization efforts. Additionally, CFC enhances the person-centered process, which helps states better address health issues and educate enrollees by bringing together all of the enrollees' providers, care planners, representatives, and others involved with their care and facilitates them directing and modifying their care to best meet their needs. Person-centered planning is one of the key attributes of the CFC program and is vastly considered to be a foundational element of home and community based services. Further information about the CFC program's person-centered planning requirements can be found at 42 CFR 441.540. In at least one state, CFC was the first program that required all of these individuals to meet in person at the same time. In this state, all providers are also required at the annual check-in meeting, in which attendees provide information on an enrollee's unique health concerns and discuss all available resources and programs to address those concerns.

### *Service Delivery Models*

Under the CFC statute, states may provide CFC under an agency-provider model, defined as “a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports” or another type of model, which “may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.”<sup>32</sup> This provision is clarified by the Final Rule, which states:

States are required to use a person-centered service plan that is based on an assessment of functional need and allows for the provision of services to be self-directed under either an agency-provider model, a self-directed model with service budget, or other service delivery model defined by the State and approved by the Secretary. States may offer more than one service delivery model.<sup>33</sup>

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<sup>32</sup> Pub. L. 111-148 §2401(k)(6)(C).

<sup>33</sup> Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid Program: Community First Choice Benefit. Final Rule. *77 Fed. Reg.* 88 (May 7, 2012): 26827-26903.

According to regulation, individuals receiving services under CFC must have the ability to direct their own care, as further outlined below. Under the self-directed model, individuals act as the employer of record for their personal care attendant. This model also includes the use of a service budget, which states may choose to provide via “vouchers, direct cash payments, and/or the use of a fiscal agent to assist in obtaining services.”<sup>34</sup> The agency-provider model can include two different approaches. In a traditional agency model, the agency is the attendant’s employer yet the individual retains hiring and firing authority of their personal care attendants. In an agency-with-choice model, the individual and the agency are “co-employers” with the agency operating solely as a fiscal intermediary. Under the traditional model, the employment relationship between the provider and the agency does not change; however, under the “co-employment” model, the agency-provider definitions can be altered to better reflect various services provision arrangements.<sup>35</sup> States may also choose to offer other service delivery models, if approved in their state plan amendment. For example, Maryland offers a model similar to the self-directed model, but where the fiscal intermediary acts as the employer of record for the purpose of managing the payroll tasks for the participants’ employees.<sup>36</sup> All states had an agency-provider model (Table 11). California also offered a self-directed model with service budget, which served nearly all of its CFC enrollees.

Table 11 below summarizes the service delivery models used by states. Note: The information provided reflects individual state level utilization; however, there are differences in populations served between states that may explain differences in utilization, so these data should not be used for comparison across states.

**Table 11. Service Delivery Models by State**

	<b>Agency-Provider Model</b>	<b>Self-Directed Model with Service Budget</b>	<b>Other Model</b>
Oregon	√		
California	√	√	
Maryland	√		√
Montana	√		

Source: CFC State Plan Amendments for Oregon, California, Maryland and Montana.

<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> Maryland State Plan Amendment.

### *Self-Direction Of Care*

CFC provides the opportunity for enrollees to provide direction over all aspects of their care. All enrollees are permitted maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.<sup>37</sup> Enrollees may determine the amount of oversight they have over direct day-to-day management of their attendants, and may share this responsibility with an agency, if preferred. Some enrollees choose to act as the employer of their providers with support from a provider agency or a financial management entity.

Some individuals would like assistance directing their own services. In these cases, enrollees may opt for assistance from an agency. Under this model, the agency is responsible for hiring and training employees in accordance with state regulations and with feedback from the enrollee. The agency may also be responsible for scheduling hours for the enrollee, as well as tracking and paying employees. The enrollee still may express desired changes in providers or how services are delivered, but the communication with the providers is done by the agency.

### *Service Needs For Persons With Physical Disabilities vs. Persons With Developmental Disabilities*

Across states, developmental disability advocates have expressed concern that the needs of the developmental disability community are different than those of the physical disability community. These stakeholders hold the opinion that these diverse needs may not be adequately met through the assessment approach inherent to the CFC regulations. In particular, developmental disability advocates claim that using assessments based on the ability or inability to accomplish specific ADLs or IADLs focuses on the limitations of an individual rather than on the abilities. Advocates preferred the goal-setting assessments used under waiver programs for the developmentally disabled. For example, one state official said,

*I use the terms [activities of daily living] and [instrumental activities of daily living] more in the last three months here than I have in the past 10 years of my career, because in [developmental disability] systems, that's not how we talk about supports and services. It's not [activities of daily living and instrumental activities of daily living], it's, "Let's have a person get a goal. Let's meet their goal with a service." And so now everything is couched in terms of activities of daily living and instrumental activities of daily living.*

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<sup>37</sup> Ibid.

CFC represented a major shift in how members of the developmental disability population were determined eligible for their services and many advocates did not view it as a positive change.

### *Backup Systems And Supports*

CFC regulation requires provision of backup systems and plans, a new service in at least three of the CFC states. When something prevents an enrollee of CFC from receiving her/his scheduled service, the backup system and plan provide alternative solutions to delivering care. This plan can include an array of possible technologies, personal emergency response systems, mobile communication devices, and individuals identified as backup supports. For example, if an individual receives a meal preparation service but his/her usual provider is ill, the backup plan might outline other providers or a family member the enrollee can call to assist with meal preparation. Some states indicate this CFC requirement can be problematic when there are insufficient provider networks in a geographic area, as there are not always enough providers to fulfill backup plans for every enrollee. States continue to work to resolve this issue throughout their implementation process.

### *Changes To Services And Hours*

Consumers in general saw little disruption to services in states that rolled over their HCBS program from one funding mechanism to another, with few changes to programs themselves. Within these states, the consumer experience changed little, with the exception of additional services, such as increased hours, emergency backup planning, person-centered planning, or assistance with additional activities of daily living.

For example, in one state, enrollees with developmental disabilities saw an increase in their hours as services that were once capped are now allocated based on need. In other states, enrollees with physical disabilities also saw hours increase and new services added. Prior to CFC, physically disabled enrollees received personal assistance services either through Medicaid State Plan Personal Care benefits, 1115 demonstrations, or 1915(c) waivers, which often had lower service caps. Those with severe physical disabilities were often unable to receive support to remain at home, preventing them from staying in their communities. With CFC, individuals are now able to access community-based care to meet complex needs. Some enrollees in waiver systems, however, experienced reductions in hours under CFC, due to new methodologies that better match services with assessed needs.

States used different approaches for transitioning existing personal assistance services to CFC, depending on the extent of change to existing services that was necessary to comply with CFC regulations. Some

states consolidated HCBS waivers and revised assessment tools and person-centered planning processes. Another state aligned its Personal Care Services with CFC to make it easier for individuals to move between programs as their needs and functional status changes. States noted that state-specific approaches provided consistency across diverse populations, as slight alterations to existing processes promoted homogeneity in processes over time. Additionally, one state noted that pre-existing infrastructure for populations who are aged or have physical disabilities more easily integrated into CFC regulations while infrastructure for populations with developmental disabilities required more adjustments. Criteria for services, needs assessments, and case management were markedly different for enrollees in the developmental disability waivers compared to enrollees in aged and physical disability waivers. Thus, more adjustments were required for developmental disability programs to comply with CFC requirements than other programs. Some states used the transition to CFC as a time to implement other programmatic changes; however, because these were concurrent with the implementation CFC, consumers attributed any changes made during that time to CFC. Therefore, some stakeholders reported that the transition to CFC was difficult or tumultuous, despite relatively little change in the services offered to them, or the providers to which they have access.

### **Administration**

Though substantial time went into Development and Implementation Council meetings, SPA development, and program planning, barriers continue to arise throughout the CFC implementation process. The following section details the challenges states encountered with the administrative components of CFC implementation and how states addressed these concerns.

### *Financial Considerations*

Unlike other HCBS populations, the nursing facility level-of-care requirement results in a CFC population with a large and expensive care burden, often due to aging cohorts that require more intensive care. In many areas, this burden is increasing, as the elderly population continues to grow and live longer with complex needs. In one state, officials noted, “even though the CFC is 39 percent of our population, the cost is around 62 percent because as you see, these [enrollees over 85] have the... high hours.” Therefore, the six percentage point increase in FMAP is critical to states for both program implementation and covering increasing enrollee hours, as states address expanding financial burdens. Some states note the 6 percentage point increase in FMAP is insufficient to cover populations that move from waivers or the State Plan Personal Care benefit into CFC, because of the additional hours individuals receive. In addition, new enrollees have enrolled under CFC. In states experiencing an upsurge in enrollment, CFC

implementation has led to increased costs, well beyond the additional 6 percentage points in federal service match.

Other states report any additional revenue from CFC is directly reinvested into programs serving CFC populations. For example, funds are used to expand caregiver training programs, teaching individuals how to identify at-risk elderly people and people with disabilities, and connect them to CFC, so they can remain in communities as long as possible. States also use CFC funds to increase the payment rates for home care workers, aiming to encourage new entrants to the workforce. With diverse budgetary concerns, states vary on whether CFC is viewed as a financially sustainable path to serve individuals in their communities.

#### *Collaboration Across Medicaid And Other HHS Departments*

To facilitate CFC implementation, state and local agencies reconfigured relationships internally and with external agencies. States have experienced shifting roles in many areas. For example, in some states, prior to CFC, the county, state, or local public health department assigned a staff member to manage the service plan and direction of service hours or provide case management services. With CFC, that role was replaced with a participant-selected supports planner who may be employed by a contracted agency. Additionally, other components of care systems outside of CFC were strained as a result of increased enrollment. Specifically, county-level programs for enrollees with developmental disabilities, brokerage systems, and case managers experienced significantly higher caseloads due to an increase in the number of individuals applying for and receiving community-based services. While states described extension of services as a positive and preventative opportunity, they also indicated that case managers and service coordinators were initially overwhelmed by the increased workload as well as the frequency of contact. Additionally, one state noted that in the past, nurses would conduct intake home visits, often conducting multiple visits in one area in one day. Now, multiple individuals including a plan facilitator, a nurse, a provider, and family members may be required at initial and annual meetings, requiring coordination amongst various providers for a single meeting.

Coordination efforts with existing waivers posed challenges to the implementation of CFC. Consolidating waivers into a singular CFC program has proven difficult in some states because it limits a state's ability to cap enrollment or target specific populations to control costs, as prohibited in CFC. Additionally, in some states, gaps in existing programs due to budget constraints led to fragmentation in delivery systems, especially for care coordination, with states citing this as an area for growth under CFC.

In one state implementing CFC, concurrent managed care, managed long-term support services (MLTSS), and coordinated care initiatives are also taking place. One state is leveraging the shift towards managed care as a cost saving mechanism, transitioning programs away from fee-for-service to managed care payment models. Within this state, some argue that managed care options can best provide HCBS services cost effectively, but advocates for person-centered plans are working to preserve the ability to keep existing providers. As one stakeholder noted “If you give authority of [HCBS] to a managed care plan, there is fear [enrollees] may lose access to some services they get today and there is concern about safeguards to protect that.” In states shifting towards managed care, stakeholders have many questions if CFC later falls under that umbrella. These questions include: where will CFC funding be directed; will the Medicaid agency or managed care agencies oversee the funds; which agency will conduct assessments; and how will program changes or improvements be decided upon? States are working to address these questions, while maintaining the provider, number of service hours, and level of care to which residents are accustomed.

### *Assessments*

According to the CFC statute, enrollees are required to meet an institutional level of care, which states may not have required for the State Plan Personal Care benefit. In addition, states are required to conduct functional assessments as part of the person-centered care planning process. The functional assessments may be a novel requirement for some populations, such as individuals with intellectual and developmental disabilities (I/DD) who may be accustomed to strengths-based assessments. Assessments are often conducted within residents’ homes, and utilize a variety of tools to measure ADLs, IADLs, and health-related tasks. Other states outsource level of care assessments to health care organizations, such as the quality improvement organization or contracted case management agencies. The actual assessment tool used differs by state, with state officials determining which instrument holds the most validity and reliability for their HCBS population needs.

If an enrollee is assessed to require an institutional level of care, he or she is then enrolled in the program, provided the option to pick a care provider, is informed of the number of hours and works with the state to determine authorized services allotted per month. Typically, the state provides the final level of care determinations and other technical and clinical supports. Many states have had to make staffing increases to accommodate the new assessment requirements. In some states, an entirely new position was created to accommodate the additional demands.

While assessments help to standardize eligibility requirements, some advocates in the I/DD community note that the new tool is invasive and focuses on impairments rather than strengths, goals, or methods to



acquire skills and independence. Additionally, advocates argue that prior to CFC, enrollees had more autonomy in allocating funds from their specified budgets for various services, whereas after implementation of CFC, funds were strictly allocated based on results of the assessment. This can disproportionately affect populations who may not have consistent needs, such as those whose ADLs or IADLs are significantly influenced by their current mental health status. State officials also indicated that populations with more complex care plans may be assessed and qualify for a sufficient amount of hours. Conversely, the assessment may not adequately identify all service needs for groups with less extensive or visible impairments. For those who require IADL services, such as cueing, community integration, and socialization—such as many mental health enrollees—hours may fall short for their specific needs based on variability in the degree of impairment. Furthermore, states may also have a variety of assessments depending on a participant’s residential setting (e.g., foster care vs. in-home), the level of care (e.g., nursing home vs. ICF-I/DD), or the information desired (services needed vs. hours required).

### *Systems Changes*

Systems changes implemented with CFC had the potential to pose new challenges. At least one state required in-person, coordinated provider visits with multiple service providers as well as case managers and service coordinators to discuss the service plan. This state believed these coordinated provider visits were a critical component to their interpretation of person-centered planning. Some providers noted this requirement was difficult to achieve, especially for complex clients requiring multiple providers, or those living in rural, hard-to-reach areas. Further, states noted that CFC could require additional provider visits compared to previous programs, and officials remained uncertain whether the enhanced FMAP would sufficiently cover the added cost. States also noted that additional forms and the administrative time to complete all CFC requirements was onerous for both staff and providers and detracted from client time. The combination of additional time, increased administrative duties, and non-reimbursable hours for the CFC planning process could make it difficult to acquire providers in some locations. This was especially true for clients who were allocated fewer hours, because the small number of reimbursable hours made them less attractive as clients.

Under CFC, some states incorporated billing or timesheet changes. These included billing modifications to track provider hours more accurately, changes to Medicaid payment processes, and implementation of automated systems. Changes have helped states decrease the likelihood of fraudulent hour reporting, though providers indicate the new systems can be burdensome.

## **Monitoring And Evaluation**

Each state has selected state and county staff and contracted agencies to conduct quality assurance and quality improvement activities. In all states, this includes a group of state employees who lead the quality assurance and improvement efforts, sometimes called a quality assurance team. This group is tasked with monitoring program integrity and system improvement by conducting data analysis, either electronically or through on-site activities, including chart review and patient interviews. They are also tasked with making decisions for system and quality improvement activities and for assigning remediation strategies. This team may be aided by other stakeholders at the local level, such as county employees, providers, or field staff, who can help to complete local assessments, conduct home visits, and monitor remediation activities.

While each state uses its own assessment tools for quality assurance and improvement activities, most states have attempted to use or work towards a standardized statewide assessment tool that is used across waiver programs and state plan benefits for HCBS. There are often statewide governing boards that provide high-level oversight of the quality assurance and improvement process across the statewide Medicaid programs (and in some cases CHIP), which may include councils or steering committees overseen by the state Medicaid agency, licensing boards to oversee facility licensing, or quality assurance program managers.

In addition to ongoing monitoring, each state has a plan to conduct additional evaluation activities and patient satisfaction surveys. The states have chosen performance measures on which they will measure the success of CFC in their state. Measures exist for each stage of CFC including referral, assessment, person-centered care planning, choosing a setting and provider, service planning, and delivery. Some of the measures include ensuring that: 1) all CFC enrollees meet level-of-care requirements, 2) the person-centered care plan is updated annually, 3) consumers receive and sign all appropriate paperwork, 4) providers complete applicable trainings, and 5) all services are billed by qualified providers. Data sources may include results from functional assessment tools, state-specific quality assurance and improvement reporting systems, MMIS data, the CFC provider file, notes from the CFC Development and Implementation Council meetings, and consumer interviews and case reviews. The results of these monitoring efforts were not available at the time of evaluation.

Consumer experience is another important measurement category. Each state chose a different evaluation tool. Service evaluation surveys range from Money Follows the Person (MFP) Quality of Life survey, amended with several questions from the Participant Experience Survey (PES) to Customer Service Evaluations to provider-administered consumer surveys.

States utilize dashboards to track quality assurance and improvement information, collecting quality assessment indicators throughout the year, though states vary on specific reporting requirements. In some states, poor response rates to conducted surveys have hindered tracking capability.

## **Recommendations And Considerations For Future States**

Stakeholder and state officials had many recommendations for other states that may be considering CFC implementation. While several recommendations stemmed from individual state challenges, there was also valuable feedback on how new states could improve program implementation. The broader recommendations aligned with the themes of reinforcing existing structures, developing a strong stakeholder base, and assessing whether CFC is financially and administratively viable.

Several states expressed difficulty merging new CFC regulations into entrenched HCBS systems. States recommended that new states develop mechanisms and practices of strong communication between entities serving individuals with physical disabilities and those serving individuals with developmental disabilities, which may currently work separately. Additionally, promoting effective communication between multiple levels of administration—local, state, and federal—could facilitate implementation and improve understanding of new administrative requirements. States indicated that since health care happens at the local level, having an administrative entity at the local level—whether through CFC, managed care, or another HCBS option—creates efficiencies in care coordination. State officials and stakeholders also noted—through CFC implementation, HCBS experience, and research—that one program is not sufficient to provide effective and accessible home and community based services. Instead, states require a “patchwork” of programs and Medicaid expansion to help residents remain in their communities. HCBS waivers are still required to ensure some individuals are eligible for Medicaid and may access CFC; the State Plan Personal Care benefit provides services for those who do not meet an institutional level of care; Medicaid expansion grants working-age adults access to Medicaid HCBS without having to wait for a disability determination; and 1915(i) programs provide HCBS for individuals with mental illness. Due to the complex interaction of these multiple programs, one entity suggested that new states should consider developing a policy guide and a “frequently asked questions” document before implementation, as a reference for public and state-level stakeholders. Overall, states felt the integration of new CFC policies with existing policies, as well as the administrative transition could have been more seamless and new states could facilitate that progression.

Additional feedback focused on ensuring that diverse stakeholders have early and ongoing input in the implementation process so the program truly addresses the needs of those it aims to serve. Respondents noted the importance of adequately describing the vision of the program and gathering buy-in from

enrollees, individual providers, state officials, agencies, and advocates. Additionally, respondents recommended the development of targeted platforms for each of the aforementioned stakeholders so that specific issues can be communicated in a constructive environment. Some stakeholders felt their voice was not heard or incorporated into the implementation process, suggesting that new states could work to ensure that multiple perspectives are considered. Stakeholders also noted the importance of extending the Development and Implementation Council meetings beyond the planning process and into the first years of implementation and monitoring to ensure consistent input from these voices.

Finally, much of the feedback and recommendations focused on the fiscal and administrative impact of the CFC benefit. States that have implemented CFC strongly recommended that those considering the program calculate the fiscal impact, as well as associated regulations. Most states experienced changes to their administrative structure and respective responsibilities and encouraged new states to identify the details of these impacts early on and assess whether they are viable, both financially and structurally. Additionally, states should consider ways to track and monitor both the medical and economic impact new regulations could have on the quality of services' number of providers, capability of providers, nursing home levels of acuity, or costs savings.

Concerns about a sufficient workforce were also mentioned, suggesting that new states should assess the quantity and quality of providers to ensure it can accommodate new service enrollees. States may also want to consider alternative ways of managing some of the service requirements, such as utilizing teleconferences for joint provider visits in rural areas. If utilized, these suggestions may facilitate a smoother transition to the CFC benefit for those states considering implementation.

## **Conclusions**

Community First Choice is one of several benefits available to states to provide home and community-based services to Medicaid enrollees requiring institutional levels of care. Three years following CMS' final rule on the CFC benefit, seven states have been approved to receive the enhanced FMAP for supports planning and/or personal attendant services: California, Maryland, Montana, Oregon, Texas, Connecticut, and Washington. Minnesota and New York submitted State Plan Amendments (SPAs). Three states, Arizona, Arkansas, and Louisiana, submitted CFC SPAs, but opted to withdraw the applications.

Primary reasons for implementing the CFC benefit include: the elimination or reduction of waitlists for HCBS; the expansion of HCBS access for populations that were excluded from or underserved in the State Plan Personal Care benefit and HCBS waivers; the expansion of HCBS service options; and the

enhanced federal spending match. Overall feedback of the program remains positive, though long-term fiscal and health impact on diverse populations requires continued evaluation, as outcome changes occur over time.

Most enrollees receiving CFC attendant services were previously served through existing personal care services benefits or waivers. For those who met the level-of-care requirement, enrollees had the option of retaining existing waiver or personal care benefit services, or transitioning into the CFC program to receive these services. Individuals who qualified for medical assistance under the special home and community-based waiver eligibility group had to continue to receive some services under the 1915(c) waiver in order to retain waiver eligibility, and thus Medicaid eligibility. This requirement has been identified as being administratively burdensome for states who have implemented the CFC benefit. It has also been identified as a deterrent for states who are considering implementing the CFC. As a result, the FY 2016 President's Budget for the Department of Health and Human Services included a legislative proposal would provide states with the option to make medical assistance available to individuals who would be eligible under the state plan if they were in a nursing facility for the purpose of receiving CFC services.

States used CFC and its enhanced FMAP to expand state plan HCBS services to new populations, such as individuals with intellectual and developmental disabilities and those on waitlists for 1915(c) waiver services. States also used CFC and the enhanced FMAP to build HCBS infrastructure for training and other provider supports. The impact of CFC on populations and services varied across states, and to determine the full impact of CFC implementation on the size of HCBS service populations, continued monitoring and analysis are needed.

The majority of individuals served by CFC are adults and children under the age of 65, although a sizable minority were elderly. While the age distribution varies by states, in all but one state at least half of the population receiving CFC was over 65 years old. Information from states suggests that most individuals served by CFC have physical disabilities, with some states serving relatively higher numbers of individuals with developmental disabilities.

There is a high prevalence of chronic illness, functional impairment, and mental illness among enrollees served through CFC. CFC enrollees tend to have high inpatient and emergency department utilization prior to CFC enrollment, as well as high rates of potentially avoidable hospitalizations for conditions such as dehydration, bacterial pneumonia, or urinary tract infection.

States that have not pursued CFC cite competing priorities or resource constraints as the primary reasons. States are also hesitant to assume the financial risk and lack of flexibility implicit in adopting a state plan benefit. Because of the comparability requirement, states are unable to cap enrollment, target specific populations, or limit services on the basis of 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 individuals may receive. States weigh current home and community-based service offerings with those they can make available through CFC. Moreover, the program's related administrative requirements, such as requiring back-up systems and the establishment of a Development and Implementation Council can render the CFC benefit less cost-effective for states than other HCBS benefits, such as 1915(c) waivers.