Centers for Medicare and Medicaid Services
Long-Term Services and Supports
Open Door Forum
Moderator: Jill Darling
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2:00 p.m. ET

Operator: Good afternoon. My name is (Christina), and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Long-Term Care Services and Support Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thanks, (Christina). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communication and welcome to today's Long-Term Services and Support Open Door Forum. Before we get into the topic for today, I have one announcement.

This Open Door Forum is not intended for the press and remarks are not considered on the record. If you are a member of the press, you may listen in. But please refrain from asking questions during the Q&A portion of today's call. If you have any inquiries, please contact CMS at press@cms.hhs.gov, and so now, I'll turn the call over to Kenya Cantwell, who's the Technical Director in the Division of Benefits and Coverage and the Disabled and

Elderly Health Programs at CMS, and she'll go over the Community First Choice State Plan Option.

Kenya?

Kenya Cantwell: OK, thanks – yes, thank you, Jill. Good afternoon, everyone. I want to thank you for the opportunity to talk with you today about the 1915(k) Community First Choice State Plan Option. On December 30th of 2016, CMS issued a Community First Choice Guidance Package to further assist states with implementing and operating a CFC benefit. You will find that package on Medicaid.gov. It contains three documents. We issued a State Medicaid Director's letter, a State Plan Amendment Pre-Print and a Technical Guide and all of those things provide information to assist states with completing a proposal to implement the CFC benefit.

These documents represent new sub-regulatory guidance and should be used in concert with the CFC final regulations that was published in May 7, 2012 and the final regulation for home and community-based setting requirements that was published January 16, 2014. In addition to providing the additional guidance related to our Federal Regulatory requirements for CFC, we tried to address and provide information about common questions and issues that have arisen during CMS review and technical assistance for states that have submitted or considered doing a CFC SPA.

So, I just wanted to make sure that that information was shared and, again, it is located on Medicaid.gov. So, for today, I'll be providing a brief overview of the Community Choice Program and key features, and I also would like to offer some practical tips along with coordination with delivery of long-term services for states to consider, if they are looking to implement the CFC benefit and how coordination with implementing the home and community-based services regulations would come into play as well.

So, 1915(k) is a state plan option and the goal of this option is to provide person-centered home and community-based personal attendant services and support. The program is focused on providing these services for individuals who have an institutional level of care. The services are to be provided to

individuals in their homes and communities. Again, it is a home and community-based service with the focus on consumer direction.

So, the services are provided in a manner that highlights consumer direction, person-centered planning and flexible service delivery option, and the services must be provided in settings that are home- and community-based in nature.

Because it's part or located in Section 1915 of the Social Security Act people sometimes believe that it is a waiver and it is not. It is a state plan option and so there are standard requirements that must be met as with any other state plan service, and what that means is that, these services must be provided in a manner that is consistent with all state plan requirements including Freedom of Choice and Comparability and it must be provided on a statewide basis.

There isn't the ability to limit the number of individuals served and there is no targeting that is allowed and then to provide this comprehensive benefit, providing personal attendant services, states receive a 6 percentage point increase in their federal match rate for providing CFC services.

So, I'm going to into the eligibility piece of this benefit because I had touched on it earlier when I mentioned that the service is for individuals who need an institutional level of care, and along with that requirement, there are some other programs requirements for individuals that they must meet in order for them to receive the benefit.

And one of the things that's really important is that individuals must be eligible for medical assistance under the state plan meaning there is no pathway to Medicaid eligibility for CFC. It is just like any other Medicaid benefit where an individual must be eligible under an eligibility category included in the state's overall Medicaid Program. So, there is not an independent eligibility path that exists for CFC.

Individuals must meet an institutional level of care for services that would be furnished in a hospital providing long-term care services, a nursing facility and intermediate care facility for individuals with intellectual disability, an institution providing psychiatric services for individuals under page 21 and an

institution for mental disease for individuals age 65 and over if the cost could be reimbursed under the state plan.

So, this is – I'm going to take a little bit of time and focus on the different levels of care. Again, when a state decides to implement the CFC benefit, they must have a process to make a determination on all of these levels of care and so a CFC benefit could not be created to focus on individuals that just meet a nursing facility level of care for example. It must be available to anyone that needs any of these levels of care.

The next program eligibility criteria is that the individual must be part of an eligibility group that is entitled to receive nursing facility services which where most Medicaid Programs, this is already included because this would be a requirement for individuals who are categorically eligible. They have as part of their Medicaid package or the Medicaid Program of services available to them, have access to nursing facility services if they needed it. However, there are other eligibility groups and which nursing facility services are not mandatory if they are optional, usually you're medically needy, for example. Most states do offer nursing facility services to that eligibility group wherein the case of the state does not then individuals their income cannot exceed 150 percent of the FPL.

We really have not in our discussions to state – one state that had to develop a process to make sure that individual's income did not exceed 150 percent of the FPL that's because most states include nursing facility services for – on both their categorically and medically needy population. And then as with all state plan services, enrollment and receipt of CFC services is voluntary. So, this could not be (amend). It's not a benefit that's you can require individuals receive services.

So, the – Community of First Choice Benefit does come with a set of required services that regardless of your service delivery model that you choose, every CFC benefit must include these following services. It must include assistance with activities of daily living and ensure manual activities of daily living and health-related tasks through hands-on assistance supervision and/or cuing. All of those different modes of assistance needs to be available in your – in CFC

benefit, acquisition maintenance and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and helpful with the task.

Now, this is an area in which and this is new. We view the CFC benefit as an enhanced Personal Care benefit. It's very similar to that because the focus is on the provision of personal attendant services and support with the goal of allowing people to remain in community and be supported and have and integrate – be integrated into their community. So, you're going to offer your ADLs and your IADLs but this acquisition, maintenance and enhancement of skill is new.

It's something that's not available under your traditional state plan Personal Care benefit and this is where I think it's one of the services that's included that makes us more enhanced benefit that really allows for more support available to individuals that want to remain in the community. So, you'll hear or we have discovered in talking with states that they like to call this the habilitation service that's available on CFC.

I just want to be mindful and point out that this is allowing for the acquisition, it's allowing for teaching and new skills to individuals, but the focus of it is directed towards allowing individuals to accomplish their own ADLs, IADLs and health-related tasks. So, it's not as broad of a habilitation activity or service that might be available under a 1915(c) Home and Community-Based waiver.

The third required activity is the back-up system such as electronic devices or mechanisms to ensure continuity of services and support.

And last the voluntary training to individuals on how to select, manage, and dismiss attendants. This is, again, a very important piece here because this benefit has a very strong consumer direction requirement to it.

You will – we'll talk about it later about the different service delivery model but available but you will see that regardless of the service delivery model that the – is being included in the CFC benefit that there is an expectation that individuals will have as much control over the service delivery and the

services that they received and how they received them in the CFC benefit. So, the voluntary training that's developed is – on how to select, manage, and dismiss attendant is critical piece.

So, in addition to required services, they have the option to provide permissible services and support that are linked to an assessed need or goal and the individual person-centered service plan. This is optional. So, what I just reviewed are things that all CFC benefits must include and at this stage choice, they can include these two additional activities. The first one is funding for transition cost such as security deposits for an apartment or utilities, purchasing bedding, basic kitchen supplies and other necessities required for transition from an institution; and the second optional service is expenditures relating to a immediate identified – I'm sorry, related to a need identified in an individual person-centered plan that increases independence or substitutes for human assistance to the extent the expenditures would otherwise be made for the human assistance.

States have a choice of including just one of these or they can include both and I think that that's something that's important to look at as states contemplate whether CFC would be a nice addition for their long-term service and support system. You can start really basic with CFC and say, you know, "we're really are looking at providing something more enhanced than our State Plan Personal Care. Or, "We'd really love that consumer direction opportunity and we want to offer that."

States just want to maybe start at a very – at a basic level and then build upon and add some of these additional optional services. And I think that when you look at it as a whole, there are many opportunities for state to create a system that's going to be comfortable for them to implement and then build as you go if that's – or you can just start and do everything that's available and that would be great too.

There are some services that are statutory excluded and that's in statute and there – such room and board which is excluded from all Medicaid benefits unless it's an institutional service. CFC cannot cover special education and related services provided under IDEA and vocational rehab. There are in

statute. There were three exclusions that have an exception. So, those excluded services or assistive technology devices and assistive technology services, medical supplies and equipment and home modification.

So, they are excluded but may be provided with an exception. They can be provided if they meet the requirements of permissible servicers described in the last slide – I'm sorry, in the – what I just reviewed with you. So, when we talk about the permissible services that are either the expenditures related to a need identified in the individual person-centered plan that increases his or her independence or substitutes for human assistance – you could have a home modification or you could have a medical supply and equipment and you could have assistive technology and devices and services that fit that description, and if they do, and they are tied to an assessed need, then they could be coverable under the CFC benefit.

So, the CFC benefit also offer three service delivery models that the state could include in their benefit. The first one is an agency provider model. The second is self-directed model with the service budget, and the last one is what we call other. It's another service delivery model that can be approved by the secretary. States have a choice of offering all there or they can offer one, they can offer two. Again, this is another area that they have flexibility on how to develop their CFC benefit and you could start with just an agency model and then as self-directed or we have a state that only does the self-directed model with a service budget. So, again, there's a lot of flexibility there.

So, the agency provider model is where you have an agency that provides or arranges the services. Even though there is an agency involved, there is a requirement and then expectation that the individual has a significant role and selection and dismissal of employee for the delivery of their care and the services and support identified in their person-centered service pan.

There is a requirement for there to be a person-centered service plan and there's next to patient that the individual receiving their services is the driver of that discussion with the person-centered service plan and the delivery of services.

In the agency model, states established the provider qualifications (qual). OK. So, we have an agency model. They are – that provides the services directly or they arranged for the provision of services, and it's the state exercise what the provider qualifications for this delivery model is.

The second model is the self-directed model with service budget and this one is what we – when we've talked about self-direction, this is what we know. This is your typical self-directed model with the individual has provided the maximum control of – has the maximum level of consumer control. They have the authority to recruit and hire or select attendant care provider, dismiss care providers, they supervise providers including assigning duty, managing the schedule, training, evaluation, determining wages and authorizing payment.

So with the agency model and I didn't talk about that, I failed to mention it, but not only does the state determine the provider calls but the state also establishes what the page would be for the individuals providing those services. So those providers, how much they're paid for the service, that is established by the state.

Under the self-directed model with service budget, an individual is given a budget and they can determine what the wage is and how much they're going to pay the individual for the provision of services. The self-directing model with service budget must include a financial management activity.

States must make available for those who want it and they must provide this to individuals who cannot manage this option without assistance. It's at the state's discretion whether they issue cash or if they use vouchers or if there's another system that they would like to set up for individuals to receive their budget and manage the money available to them for these services.

So, I had mentioned earlier there is a service planning process for the Community First Choice benefit. All individuals must have an assessment of functional needs. If they met the assessment of functional need, will see the person-centered planning process and thus, the person-centered service plan.

So that is a very high-level overview of the Community First Choice benefit about the services.

I do want to also add some other activities that must occur prior to the submission of a SPA. State must develop an implementation council, the development and implementation council and the majority members of that council need to be individuals who are disabled or elderly or their representative.

And the goal of that is to discuss and get feedback or information related to what the CFC benefit could look like in their state. CFC – the CFC benefit or activities that are related in addition to that, is that there needs to be a quality insurance program. There are some performance measures that need to be developed to monitor the health and safety of individuals receiving the Personal Care benefit.

There is also some data requirements, some standard data requirements that must be collected annually. The implementation guide that we issued goes into all of these requirements in detail. We're hopeful that with that, it would – the information that we would look for – for what you would need to do is in there and of course we're available to provide technical assistance. But we think that the implementation guide along with the pre-print and SMDs is a really good start, and try to take a deeper dive into the requirements of the CFC benefit.

So you know when a state think about or if there are advocates out there that are looking to talk to their state about developing a CFC program we do want folks to think about the existing system of delivering long-term services and support, and how CFC can fit in with enhancing the availability of long-term services and support in the community. There also needs to be some thought about coordinating with your other – with other existing authorities and then thinking about the state-wide transition plan too and that's really to the home and community-based settings requirement.

Stakeholder engagement is, as we mentioned with the development and implementation council, but it doesn't have to be limited to them too. There,

you know, stakeholder engagement is really important as well and we are available to provide technical assistance as early as possible as you review the guidance that we issued and you have – have questions.

So, the 1915(k) benefit also must meet the home and community-based settings requirement that we issued in January 2014. So for CFC, those requirements which are the same as for 1915(k) and 1915(i) but for CFC they are found at 42 CFR 441.530. All settings with CFC services maybe provided, must be determined to be compliant with home and community-based setting requirements before we can approve a CFC SPA.

There is no opportunity for transition plans with CFC. It's a new benefit and so there's an expectation that all settings must meet the settings requirement before the benefit can be implemented.

Now, there is – this is another area of – where there is some flexibility and what we have done because – what we – what we have been able to do is – that as states are looking to do a CFC but they're also working on transition of their existing settings and going through their state plan, transition process.

We had states that have really wanted to be able to offer CFC and not necessarily have to wait until their other settings had come into compliance with the – their settings regulations. And so you know we point out that CFC, all settings must meet these settings requirement.

And so, there has been and there is the opportunity for settings that – for CFC to be available to individuals that are in settings, that are determine to be compliant with – while there are other settings that are still the state is working on bringing it in to compliance. So we have some states that at this time has started their CFC benefit where the services are in – in individual's home because that is at this time the setting that they can confirm, meet the settings requirement.

So, you can begin the services when the person is at home and with the compliance settings and – and they can transition over settings as they become compliant. There are states though that have – a state could come in and say,

look, here all of our settings and they all meet the settings requirement and there is a conversation that occurs with the state.

So it's – there is a determination that needs to be made to make sure if the settings do meet the requirements but there is some flexibility as states are – are working through all of the settings in their states. They may be able to start with a smaller group of folks that they know are residing in settings that meet the requirements, so.

I want to talk about the – just a few things to keep in mind about the quality improvement system and this is related to the settings is that we expect that the quality improvement system that much we described in the SPA, that it includes a description of the state's process and content for ongoing monitoring of compliance with the home and community-based settings requirement.

We can – the guidance has been issued for the settings also applies to 1915(k), so there is a lot of information, medicaid.gov, that is available to states as they go through their assessments of their settings and trying to make a determination of which settings can be available to individuals receiving CFC services.

So some things to think about, so consider the need for outreach and training and education through the process as you're considering implementing CFC. Do this during your design and implementation, consider timing for trainings and build in to timelines for program development and delivery. Training is key. CFC is the newer benefit.

It is important – but it is something, although the benefit is new, the provider pool is probably the same that exist, that maybe providing Personal Care benefits, that maybe providing home health benefits, maybe providing services through your 1915(k).

So, education of providers is really important and your teams that are out there doing the assessments and understanding the services that are available in CFC and the delivery options and provider enrollment, all of these things that

is very important to have clearly laid out prior to enrolling the – implementing the CFC benefit.

If there are any new state policies and procedures, it's important to educate your providers on that too. There are some similarities with CFC with some of the other benefits with their – not everything is identical and so it's important for everyone that's involved to understand the differences between k and c and i.

So at this time, we have eight states that are approved – that have approved CFC SPAs. They are California, Oregon, Maryland, Montana, Washington, Texas, Connecticut and there is one more that's escaping me right now. So, we have California, Oregon, Maryland, Montana, Texas, Washington, New York and Connecticut. And all of their SPAs if you want to take a look, they're all different.

If you want to look at them, they're all available on medicaid.gov. We are providing technical assistance to two states right now and we are available to provide technical assistance to any states that is considering CFC. You know, this is a program that it's more like a program I should say than a service.

But it really can be beneficial to a state that's looking to enhance their current long-term care services and support service delivery and there are the different opportunity that are available within their state for individuals to have control over their personal attendant services and support and people who want to remain in the community.

So you know with that, I guess I will just end by again reminding people that we have – the SMDs are on medicaid.gov, along with an implementation guide and a pre-print. And the pre-print I think will be really helpful in taking a look at that because you will see the type of information that needs to be provided to us but also it is a good outline to guide you as you think about possibly implementing the CFC benefit.

One thing that I failed to mention is that we – but you would see it if you look at the different SPAs that are online is that CFC can be used concurrently with

some of our other Medicaid authorities. It could be used with the managed care authority. We've had states that have used the 1915(b)(4) for selective contracting of some the activities and that was around the – like person-centered planning and the support activities.

They have used the 1915(b)(4) and using that around states to claim service match for those activities rather than an admin match. And then it can be used alongside with a section 1115 Medicaid demonstration. Using other authorities though, especially with the 1115, that for there to be the enhanced match, then you have to meet all the requirements of CFC. So, that's important to point out that for the enhanced match to be available, then all of the requirements of CFC need to be met and there is no leaving of those requirements and still being able to secure the enhanced match.

If states want to do a CFC-like benefit which we have had discussions with states about offering a package like the – like CFC but to individuals that don't meet an institutional level of care, I think that has been a conversation that we had related to the – an 1115 Medicaid demonstration authority but enhanced match would not be available. So the statute is pretty clear about when at the enhanced match is available and all of the requirements in the statutes have to be met for that.

So I am going to end there and I can open it up for questions.

(Crosstalk)

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your question to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may again press star one to rejoin the queue.

Your first question comes from Sarah Triano from Centene. Your line is open.

Sarah Triano: Thank you. Given that the CFC has included in the American Health Care Act and is up for repeal, can you comment on what the future of the program is?

Kenya Cantwell: I actually can't, so yes, you're correct. It was mentioned in the American Care Act but that is separate from what we can – we're working on now. It is up for negotiation, so we have no idea what's going to happen until whatever is final, it is finalized. So for now it's in play and you know we're moving forward with implementing the CFC benefit for any state that's interested in doing it.

Operator: Again, if you would like to ask a question, please press star then the number one on your telephone keypad.

There are no further questions at this time.

Jill Darling: Great, everyone, thank you, this is Jill Darling. Thank you, Kenya, for your presentation today and thanks everyone for joining us. The next Long-Term Services and Support Open Door Forum is to be determined, so you will receive an e-mail letting you know when the next one is scheduled. So thanks everyone, have a great day.

Operator: Thank you for participating in today's Long-Term Care Services and Support Open Door Forum Conference Call. This call will be available for replay beginning at 5:00 p.m. Eastern Standard Time today, March 14th, 2017 through midnight on March 17th. The conference ID number for the replay is 56383997. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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