Medicaid Program:

Community First Choice (CFC) Option Proposed Rule Overview

Section 2401 of the Affordable Care Act (ACA)

The National Resource Center for
Participant-Directed Services (NRCPDS)

March 2011

INTRODUCTIONS

Purpose of this Presentation

- Provide NRCPDS Members (State Agencies and the National Participant Network) with an overview of the Community First Choice proposed rule

- Communicate to Members the process in which to provide comments in collaboration with the NRCPDS

Commenting Process

Comments welcomed from the public
<u>on all issues</u> in the proposed rule

- The NRCPDS will be submitting comments on the proposed rule
- Both membership groups are encouraged to submit their comments (bullet format is fine) to the NRCPDS by April 7th
- NRCPDS staff are available for individual discussions and group teleconferences to discuss the content of the proposed rule
- If you plan to also submit comments individually, they are due to CMS by 5pm on April 26, 2011 (see proposed rule for process)

Please Note

- This overview only covers Section II of the proposed rule
- Some of the language (within sections) is re-ordered/ shortened
- See proposed rule if you are seeking clarification of language
- The NRCPDS has also produced a document that includes more detail than what is found here

To submit your comments to the NRCPDS (due April 7th)

State Membership Contact:

- Molly Hurt at molly.hurt@bc.edu or 617.552.1663
- Please "cc" Bill Ditto WILLIAMABDITTO@aol.com and Erin McGaffigan erin.mcgaffigan@bc.edu

National Participant Network Contact:

- Scott Goyette at scottcgoyette@gmail.com or 802-310-8037
- Please "cc" Althea McLuckie althea.mcluckie@bc.edu and Erin McGaffigan erin.mcgaffigan@bc.edu

Section II. A. Eligibility (§441.510)

- Individuals must be eligible for Medicaid under an existing eligibility group covered by the State plan
- Regular rules for determining income eligibility apply, including income disregards used by the State for that group

For those whose income exceeds 150 percent Federal Poverty Level:

- Those who would otherwise require care in a hospital, nursing facility, intermediate care facility, or institution for mental diseases, the cost of which would be reimbursed under the State plan
- Two specific examples are provided for clarification on income eligibility (working disabled and HCBS waiver, p. 10739)

Annual income verification for all individuals

Section II. B. Statewideness (§441.515)

- The CFC Option must be available statewide and based on need
- Services must be provided in the most integrated setting appropriate to the individual's needs and without regard to:
  - age
  - type or nature of disability
  - severity of disability
  - form of home and community-based attendant services and supports the individual requires in order to lead an independent life

Section II. C. Required Services (§441.520)

- Assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADLs), and health-related tasks through hands on assistance, supervision or cuing
- Acquisition, maintenance, enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks
- Back-up systems or mechanisms to ensure continuity of supports
- Voluntary training on how to select, manage, and dismiss attendants
- Person-centered planning process
- Individuals' authority to hire, fire, and train attendants to provide services tailored to the individuals' needs

Section II. C. Required Services (§441.520)

STATES MAY ALSO ALLOW:

- Transition costs (such as rent and utilities, bedding, basic kitchen supplies, and other necessities)

- Items that increase independence or substitute for human assistance, to the extent that the expenditures would otherwise be made for human assistance and are related to the need identified in an individual's person-centered service plan

People would not have to save for purchases

Section II. D. Excluded Services (§441.525)

- Room and board
- Special education
- Vocational rehabilitation
- Assistive technology
- Medical supplies and equipment
- Home modifications

There are some exceptions to these restrictions (next slide)

Section II. D. Excluded Services (§441.525)

Room and board exceptions:

- Will allow transition costs
- Attendant services and supports may be provided in a residential setting in the community, but only the costs of the services and supports are covered under the CFC Option
- Services provided in an inpatient setting are not covered

Special education and related services exceptions:

- Will only pay for services determined to be medically necessary
- Only services related to education are excluded

Section II. D. Excluded Services (§441.525)

Exceptions for assistive technology, medical supplies and equipment, and home modifications*

- Items and services are necessary for an individual to transition from an institution to a community setting, or they increase independence or substitute for human assistance
- Expenditures that are related to a specific need identified in an individual's plan for services
- Cannot include services furnished through another benefit or section under the Social Security Act
- Cannot be the only needed service in an individual's plan

States determine at what point the amount of funds to purchase such devices and adaptations place them in statutory excluded categories

*Language is unclear at points (and will need clarification)

Section II. E. Setting (§441.530)

The following are <u>not</u> considered home and community-based settings:

- Nursing facilities
- Institutions for mental diseases
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Buildings that are publicly or privately operated, which provide inpatient institutional treatment or custodial care
- Buildings on the grounds of, or immediate adjacent to, a public institution or disability-specific housing complex, designed around an individual's diagnosis that is geographically segregated from the larger community, as determined by the Secretary

Section II. F. Assessment of Need (§441.535)

- Conduct an assessment of individuals' functional need on which to base the person-centered plan and budget
- Face-to-face meeting with individual (and representative, when appropriate)
- Assessment tool not prescribed, but to include standardized set of data elements, functionality, and workflow sufficiently comprehensive to:
  - support determination that individual would require attendant care services and supports under CFC Option
  - develop the subsequent service plan and budget

Section II. F. Assessment of Need (§441.535)

Assessment core elements*

- Needs
- Strengths
- Determination of available unpaid and paid supports, including family
- Health conditions
- Personal goals and preferences for the provision of services
- Identified functional limitations
- Age
- School participation status
- Employment
- Household
- Other factors relevant to the provision of services and supports

*Unclear what would be required and what is encouraged

Section II. G. Service Plan (§441.540)

Required components of the person-centered planning (PCP):

- Include people chosen by the individual
- Provide necessary support to ensure the individual has a meaningful role in directing the process
- Occur at times and locations of convenience to the individual
- Reflect cultural considerations of the individual
- Include strategies for solving conflict or disagreement within the process, including conflict of interest
- Include opportunities for periodic and ongoing plan updates as needed or requested by the individual
- Offer choices to the individual regarding the services and supports they receive and from whom

Section II. G. Service Plan (§441.540)

There is a minimum list for policies and procedures pertaining to the administration and development of the service plan*

These policies <u>should</u> ensure:

- Responsibilities for assessment and service plan are identified
- Participant's needs are assessed and services meet the needs

These policies <u>must</u> ensure:

- Guidelines for timeliness
- Conflict of interest standards for assessment and service plan development for all individuals and entities, public or private

*Given duplication in message seen with the use of "must" and "should," not clear what is and is not required

Section II. G. Service Plan (§441.540)

Parts of the PCP process that become part of the written services and support plan, also known as plan of care:

- Goals (e.g., relationships; community participation; employment; income and savings; health care and wellness; education; and others)
- Personally-defined outcomes
- Preferred methods for achieving outcomes
- Training supports
- Therapies
- Treatments
- Other services

Section II. G. Service Plan (§441.540)

Service Plan resulting from the process <u>should/must</u> (partial list):

- Correspond to the level of need and reflect strengths and preferences
- Be reviewed/revised upon reassessment (at min. 12 months, when needs change significantly, and at individual's request)
- Reflect risk factors and measures in plans to minimize risk, including back up strategies when needed
- Be understandable to the individual and his/her supports
- Be finalized and agreed to in writing by all, including individual/ rep.
- Identify the individual or entity responsible for monitoring the plan
- Be directly integrated into self direction when individual budgets exist

*Given the use of "must" and "should," not clear what is and is not required

Section II. H. Service Models (§441.545)

Requires that CFC be provided under an agency-provider model or "other" model:

State may choose one or more of the service delivery models defined in the statute. Models categorized into two main groups:

(a) Agency Model

(b) Self-Directed Model with Service Budget

- Financial Management Entity
- Direct Cash Option
- Vouchers

Section II. H. Service Models (§441.545)

(a) Agency Model

- Services and supports are provided by entities through a contract
- Individual retains hiring and firing authority of personal care attendants
- Includes the model of "agency with choice," utilizing a co-employment relationship between the individual and an agency

Section II. H. Service Models (§441.545)

(b) Self-Directed Model with Service Budget

Financial Management Entity: Requires specific functions not limited to the following:

- Collect and process worker timesheets and process payroll
- Withholdings, filing and payment of applicable Federal, State, and local employment related taxes and insurance
- Maintain a separate account for each individual's budget
- Track and report disbursements and balance of individual's funds
- Process and pay invoices for services in the service plan
- Provide individual periodic reports of expenditures and the status of the approved service budget

Section II. H. Service Models (§441.545)

(b) Self-Directed Model with Service Budget

Direct Cash Option: Disperse cash prospectively to individuals self-directing their CFC Option. If the state elects this option, it must:

- Ensure compliance with all applicable requirements of the Internal Revenue Service, FICA, FUTA, and State unemployment tax
- Permit individuals (or representatives) to use the financial management entity for some or all of the functions
- Make available a financial management entity to an individual who has demonstrated, after additional counseling, information, training, or assistance that s/he cannot effectively manage
- If the cash option is the only model offered, State may require the use of the financial management services, but must provide conditions under which this would be enforced

Section II. H. Service Models (§441.545)

(b) Self-Directed Model with Service Budget

Vouchers

- State must ensure compliance with all applicable requirements of the Internal Revenue Service

Section II. I. Additional Service Plan Requirements for Self-Directed Model with Service Budget (§441.550)

Service plan conveys authority to the individual to perform, at a minimum, specific tasks:

- Ability to recruit, hire (including specifying worker qualifications), fire, supervise, and manage workers
- The expectations for managing workers (including determining worker duties, scheduling workers, training workers in assigned tasks, evaluating workers' performance)

Section II. I. Additional Service Plan Requirements for Self-Directed Model with Service Budget (§441.550)

It is proposed that the Service Plan:

- Describe the ability of the individual to determine the amount paid for a service, support, or item, as well as the ability to review and approve provider invoices
- Encompass the general decision-making authority that an individual has
- Outline the individualized services and supports to address the individual's needs, abilities, preferences and choices

It is the approval of the service plan that authorizes the individual to undertake these activities as part of the self-directed service delivery model

Section II. J. Support System (§441.555)

- Requirement that the State have a support system in place, but specific system is not prescribed

- Proposed minimum list of activities for which individual may need information, counseling, training, or assistance, but states may offer additional activities:
  - Participant rights
  - How the self-directed model of service delivery operates

Section II. K. Service Budget Requirements (§441.560)

- There is a specific service budget requirement based on experience with 1915(j)
- A service budget amount is the cap on the amount of funds available to an individual with which to purchase self-directed CFC services and supports
- Require that service budget be developed and approved by the State, and include specific items such as:
  - specific dollar amount
  - how the individual is informed of the amount
  - procedures for how the individual may adjust the budget

Section II. K. Service Budget Requirements (§441.560)

Budget methodology is to:

- Be objective and evidence-based
- Be applied consistently to individuals in the program
- Be included in the State plan
- Include calculations of expected costs of CFC services and supports if those services and supports were not self-directed

If a State places monetary limits on self-directed CFC services, State must have a process in place that describes:

- The limits and the basis for the limits
- Any adjustments that will be allowed and the basis for such

Section II. K. Service Budget Requirements (§441.560)

The State must put into place budget safeguards. These include:

- A method for notifying participants of the amount of any limit that applies
- Procedures to adjust a budget when a reassessment indicates a change in medical condition, functional status, or living situation
- A method to ensure the budget does not restrict access to other medically necessary care and services furnished under the State plan and approved by the State, but not included in the budget

Section II. L. Provider Qualifications (§441.565)

Responsibility of the State:

- Provide assurance that necessary safeguards have been taken to protect the health and welfare of the enrollees in the CFC Option
- Develop adequate standards for all types of providers of attendant services and supports under the option
- Define qualifications for providers of attendant services and supports under the agency model

Section II. L. Provider Qualifications (§441.565)

Given the participant direction nature of the CFC Option, individuals:

- Can choose any qualified provider to provide services, including family
- Retain the right to train workers in specific areas of support based on personal preferences and needs
- Retain the right to establish additional staff qualifications based on needs and preferences

Section II. M. State Assurances (§441.570)

For the first 12 months the State chooses to offer this option in the State plan, the State's share of Medicaid expenditures for individuals with disabilities or elders must remain at the same level or be greater than expenditures from the previous year

- This requirement is limited to personal care attendant services
- States will need to identify the existing programs' related expenditures to be monitored for this requirement and calculation

Section II. M. State Assurances (§441.570)

States are required to comply with the Fair Labor Standards Act of 1938 and applicable Federal and State laws (regardless of chosen model). This includes:

- Withholding and payment of Federal and State income and payroll taxes
- Provision of unemployment and workers compensation insurance
- Maintenance of general liability insurance
- Occupational health and safety

Section II. N. Development and Implementation Council (§441.575)

- Requires the State to work with a Development and Implementation Council
- Council is to include a majority of members with disabilities, elders, and their representatives
- State to consult and collaborate with their Council during the development and implementation of the State plan amendment
- Seeking comment on how States can achieve robust stakeholder input, including transparency in the selection process and the activities of the council

Section II. O. Data Collection (§441.580)

States are required to provide CMS with the following data for each fiscal year services and supports are provided:

- The number of individuals who are estimated to receive CFC Option during the fiscal year
- The number of individuals that have received such services and supports during the preceding fiscal year
- Specific number of individuals served, by:
  - type of disability
  - age
  - gender
  - education level
  - employment status

Future guidance on the format is forthcoming

Section II. O. Data Collection (§441.580)

States are required to collect and report information for the purposes of approving the State plan amendment, providing Federal oversight and conducting an evaluation of the provision of the Community First Choice Option

- The data collected through this requirement and the quality assurance system will help determine:
  - how States are currently providing HCBS
  - cost of those services
  - whether States are currently offering individuals with disabilities who otherwise qualify for institutional care under Medicaid the choice to instead receive home and community-based services

Future guidance on the format is forthcoming

Section II. P. Quality Assurance System (§441.585)

State must establish and maintain a comprehensive continuous quality assurance system

The system must employ measures for:

- Program performance and quality of care
- Standards for delivery models
- Mechanisms for discovery and remediation
- Improvements proportionate to the benefit and number served

Section II. P. Quality Assurance System (§441.585)

- The system must include a quality improvement strategy that reflects the nature and scope of the benefit
- Stakeholder input and feedback is to be incorporated
- Information regarding quality assurance system is to be provided to each individual served

Section II. Q. Increased Federal Financial Participation (§441.590)

- States receive an increased FMAP of 6 percent for the provision of services under the CFC Option

- Effective October 1, 2011, or later under an approved State plan amendment

Thank you!

- A more detailed overview (PDF version) is also available to members
- Comments to the NRCPDS by April 7th
- The NPN is hosting a call on March 21st to discuss comments from its members
- Molly Hurt will follow up with State Agency members on next steps