April 30, 2012

CMS Releases Community First Choice Final Regulations;
Seeks More Input on When Housing Is "Community-Based"

As it continues implementation of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) has released final regulations for the Community First Choice option (CFC).[1]

CFC provides an incentive for state Medicaid programs to offer more extensive home and community-based services (HCBS): specifically, CFC increases the federal Medicaid match by six percent for HCBS that meet CFC standards. [2]

CFC could be a game-changer for Medicaid beneficiaries in need of HCBS; because CFC is provided through a state-plan amendment rather than a waiver, CFC benefits must be made available throughout a state, not limited by (for example) enrollment caps or geographical restrictions. CMS estimates that ultimately 30 percent of eligible persons who would want CFC coverage, will be residing in states that offer it.[3]

An unresolved issue is how to define community-based settings. CMS's intent is to develop regulations on the community-character issue that will apply equally in all HCBS settings, with release of the final regulations anticipated in late 2012 or early 2013.[4] *NSCLC currently is analyzing the proposed regulations, and will develop comments on the relevant issues to share in the near future with advocates and then with CMS.*

Definition of "Community-Based" Settings

In stakeholder discussions of CFC implementation, one of the most visible issues has been the definition of a "community-based" setting. Because CFC is designed as a mechanism to move Medicaid beneficiaries out of nursing facilities and other institutions, arguments have been made that HCBS funding should not be available to beneficiaries living in assisted living facilities, in housing adjacent to nursing facilities, or in other settings with arguably institutional characteristics. CMS flagged this issue twice in 2011, in the release of proposed regulations for CFC and for HCBS waivers.[5] At this point, however, CMS is not prepared to finalize regulatory language on this issue. Instead, CMS is releasing proposed regulations on the issue as part of the regulations for the HCBS State-Plan Option, and will be accepting comments in the 60-day period ending on or about July 3, 2011.

Services

In defining CFC-authorized services, the regulations generally track statutory language. Mandatory services include assistance with daily activities and health-related tasks; in addition, states have the option of covering transition costs from an institution, or in incurring expenditures that would increase beneficiary independence.[6] One regulatory wrinkle is in the

treatment of home modifications, which are flatly excluded in the statute, but allowed in the regulations to the extent that a home modification can qualify as a support "linked to an assessed need or goal in the individual's person-centered service plan."[7]

Service Providers

Emphasizing the benefit of state flexibility and beneficiary control, CMS has declined to establish federal standards for service providers. Individual beneficiaries are given discretion to set standards for service providers, with the additional requirement in the agency-provider model that states "define in writing adequate qualifications for providers."[8] Providers of "health-related services" — for example, injections or medication administration — must comply with any relevant state laws relating to delegation of tasks by health care professionals.[9]

Accordingly, family members can be hired from a service budget, as long as the family member has been trained to the beneficiary's satisfaction. CMS points out that CFC services are not subject to existing regulatory provisions that, for Medicaid state-plan personal care services, generally prohibit legally responsible relatives from being paid to provide services. In states offering only an agency-provider model, CMS encourages agencies to employ family members.[10]

Service Models

The CFC statute requires that CFC services be made available through an agency-provider model, or through a consumer-directed model that might utilize cash payments, vouchers, or use of a fiscal agent.[11] As reported by CMS, many commenters had argued that a state should be required to offer multiple service models, and specifically that beneficiaries should be given a choice of an agency-based model and a consumer-directed model. CMS concluded, however, that the statutory language does not support such a requirement; therefore, CMS is encouraging states to offer a choice of service models, but the new regulations allow states to offer only one.[12] If a state chooses to offer a self-directed model with a service budget, the beneficiary must have the right to appeal the amount of the budget, and the system must allow for an adjustment to the budget in case of a change in the beneficiary's situation.[13]

Eligibility

Regarding beneficiary eligibility, CMS did an about-face from its position in last year's proposed regulations. The CFC statute authorizes eligibility for persons whose income does not exceed 150 percent of the federal poverty level (totaling $1,397 in 2012) or, alternatively, does not exceed the state's special income limit for persons needing nursing facility care (generally 300 percent of the federal SSI benefit, totaling $2,094 in 2012). In the *proposed* regulations, CMS interpreted the statute to require that a beneficiary need care at the nursing facility level only if the beneficiary qualifies financially through the special income limit. The final regulations, however, require a nursing facility level of care for all beneficiaries, including those who qualify by having income of less than 150 percent of the federal poverty level.[14]

In another contested eligibility issue, many commenters had maintained that the CFC statute creates its own eligibility group – specifically, that a person could qualify for having income less than 150 percent of the federal poverty limit, even if the state Medicaid program did not otherwise grant eligibility based on an income below 150 percent of poverty. CMS continues to disagree with this proposition and accordingly, under the final regulations, CFC eligibility requires that a person be eligible for Medicaid in the first place. If Medicaid eligibility is predicated upon receipt of HCBS waiver services, the beneficiary must continue receiving at least one waiver service each month.[15]

Assessments

The final regulations generally require face-to-face assessments, although with some specified exceptions for telemedicine or a similar technology. Assessments must be performed at least every 12 months and more frequently as warranted by changed circumstances.[16] CMS notes that it will be developing universal core assessment elements under the Balancing Incentive Payments program and other initiatives, but in the meantime states have substantive discretion to develop and/or choose assessment tools.[17]

Service Plans

The final regulation lays out numerous helpful standards for the required person-centered service plans – for example, that the process includes persons chosen by the beneficiary, and a plan reflect the beneficiary's strengths and preferences.[18] Conflict-of-interest standards apply both to assessments and service plans, neither of which can be *conducted by* family members, any persons "who would benefit financially from the provision of assessed needs and services," and other specified persons and entities.[19] CMS notes that these provisions apply only to the persons and entities conducting assessments and service plans, and do not prohibit family members from being *involved in* the planning process.[20] Additional standards for person-centered planning will be provided by CMS through sub-regulatory guidance, to be applied to CFC and other Medicaid programs providing HCBS.[21]

As to the content of service plans, natural supports (e.g., family members) "cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant." [22] Beneficiaries have the right to appeal service plan decisions through Medicaid fair hearing processes.[23]

State Program Development

In developing a CFC benefit, a state must consult with a stakeholder council containing a majority of members who have disabilities or are elderly, or who are representing those constituencies.[24] CMS is willing to consider implementation of CFC through a managed care model.[25]

Monitoring

A state must establish and maintain a comprehensive continuous quality assurance system, and additionally must collect and report information for federal oversight and evaluation of CFC.

The quality assurance system must monitor each beneficiary's health and welfare, measure individual outcomes in reference to individual service plans, and set standards for appeals. CMS is working to develop a coordinated quality assurance system to apply across HCBS programs.[26]

For the initial 12-month period of a CFC benefit, the State must expend at least the amount of money expended for HCBS during the preceding 12 months.[27]

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[1] The CFC regulations currently are available for review at www.ofr.gov/inspection.aspx. They are scheduled to be published formally in the Federal Register on or about May 7, 2012, and at that time will be available for review at http://federalregister.gov/a/2012-10294.
[2] Affordable Care Act, § 2401.
[3] CFC Regulation Release at 277.
[4] CFC Regulation Release at 89, 104-107. The proposed HCBS State-Plan Option regulations currently are available for review at www.ofr.gov/inspection.aspx. They are scheduled to be published formally in the Federal Register on or about May 3, 2012, and at that time will be available for review at http://federalregister.gov/a/2012-10385.
[5] 76 Fed. Reg. 10,736 (Feb. 25, 2011) (proposed CFC regulations); 76 Fed. Reg. 21,311 (April 15, 2011) (proposed HCBS waiver regulations).
[6] 42 U.S.C. § 1396n(k)(1)(B)-(D); 42 C.F.R. 441.520; CFC Regulation Release at 287-88.
[7] 42 C.F.R. §§ 441.520(b), 441.525(e); CFC Regulation Release at 72, 287-88.
[8] 42 C.F.R. §§ 441.565; CFC Regulation Release at 200-201.
[9] 42 C.F.R. §§ 441.505; CFC Regulation Release at 31, 201, 284.
[10] CFC Regulation Release at 205-206.
[11] 42 U.S.C. § 1396n(k)(1)(A)(iii).
[12] 42 C.F.R. §§ 441.545; CFC Regulation Release at 161-63, 292-94
[13] 42 C.F.R. §§ 441.560(a)(6), (f); CFC Regulation Release at 194, 297-99.
[14] 42 C.F.R. § 441.510(c); CFC Regulation Release at 43-44, 285-86.
[15] 42 C.F.R. § 441.510(a); CFC Regulation Release at 46-47, 285.
[16] 42 C.F.R. § 441.535; CFC Regulation Release at 288-89.
[17] CFC Regulation Release at 110, 112, 128.
[18] 42 C.F.R. § 441.540(a)(1), (b)(2).
[19] 42 C.F.R. § 441.555(c).
[20] CFC Regulation Release at 156.
[21] CFC Regulation Release at 130, 132-34, 138.
[22] 42 C.F.R. § 441.540(b)(5); CFC Regulation Release at 145-46 (discussion of issue).
[23] 42 C.F.R. §§ 441.555(b)(2)(vii), 441.585(a)(4); CFC Regulation Release at 123, 139, 150, 295, 302.
[24] 42 U.S.C. § 1396n(k)(3)(A); 42 C.F.R. § 441.575; CFC Regulation Release at 220-21.
[25] CFC Regulation Release at 19.
[26] 42 C.F.R. § 441.585; CFC Regulation Release at 243, 246, 302-303.
[27] 42 U.S.C. § 1396n(k)(3)(C); 42 C.F.R. § 441.570(b); CFC Regulation Release at 300.