



Community First Choice State Plan Option
Technical Guide

Community First Choice State (CFC) Plan Option

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DEVELOPMENT AND IMPLEMENTATION COUNCIL

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K 42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to indicate that it has established a Development and Implementation Council as required by statute and has consulted with this Council before submitting a CFC State Plan amendment (SPA) to CMS.

Background

Both the statute and regulations require that the state establish a Development and Implementation Council for the purpose of consulting and collaborating with the state in the development and implementation of the state's CFC benefit. The regulations at 42 CFR 441.575 specifically require that the majority of the Development and Implementation Council members be comprised of individuals with disabilities, elderly individuals, and their representatives. The regulations require the state to consult and collaborate with the Council when developing and implementing a SPA to provide CFC services and supports.

States are required, under 42 CFR 441.530 to provide CFC services in home and community-based settings. Thus, as part the requirement found at 42 CFR 441.575 (required consultation and collaboration with the Development and Implementation Council throughout the development and implementation), the state should review its home and community-based settings assessment with its council prior to SPA submission. This includes the council's prior review of any intended request for heightened scrutiny. We also strongly encourage states to include public input as part of its process for assessment of settings. This additional effort will be of great assistance during the SPA review process in which CMS determines if the settings meet the regulatory requirements.

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Development and Implementation Council

- First, indicate the name of the state's Development and Implementation Council.
- Next indicate the date of the first Council meeting.

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Next, check a box affirmatively assuring that the state has consulted with its Development and Implementation Council before submitting its CFC SPA.

Review Criteria

To show that this requirement has been met, the state should submit a list of Council members and dates of council meetings that have occurred prior to the effective date of the SPA and the SPA submission date.

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COMMUNITY FIRST CHOICE - ELIGIBILITY

Statute: 2401 of the ACA which added 1915(k) of the Social Security Act (the Act) establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K
42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to identify the categories of individuals and populations eligible for CFC services. The state will also identify the process for informing potentially eligible individuals about the availability of the benefit and will provide various assurances pertaining to benefit availability and eligibility.

Background

The CFC benefit at section 1915(k) of the Act is an “optional” benefit rather than a “mandatory” benefit under the Medicaid state plan. Under section 1915(k) and regulations at 42 CFR 441 subpart K, a state may at its option provide, through a SPA, for the provision of medical assistance for home and community-based attendant services and supports. Medicaid beneficiaries eligible for CFC are those who are in an eligibility group entitled to nursing facility services under the State plan or who are not in an eligibility group entitled to nursing facility services but whose income is at or below 150 percent of the Federal poverty level. CFC is only available to individuals who are considered “full-benefit” Medicaid eligibles. CFC is not available to individuals who receive a limited Medicaid benefit such as Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs).

The statute and regulations require that all individuals be determined to require one of the following institutional levels of care to qualify for the receipt of CFC services: long-term care hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases (IMD) for individuals age 65 and over. The state may choose to permanently waive the annual level-of-care recertification for CFC eligible individuals under the conditions specified in the regulations at 42 CFR 441.510(c) (1) and (2).

The statewideness and comparability requirements under the State plan are not waived by section 1915(k). Therefore, under the statute, states which elect this option must provide CFC services statewide and must cover the Categorically Needy eligibility groups without regard to the individual’s age, type or nature of disability, severity of disability or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life. Also, states choosing to offer the CFC option can continue to provide home and community-based services

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provided under other Medicaid authorities such as section 1915(c) waivers, section 1115 demonstration programs, and section 1905(a) State plan benefits.

Instructions

Categories of Individuals and Populations that Qualify for Community First Choice Services

Select the categories or groups of individuals for whom the CFC benefit will be available.

- Check the box to indicate that individuals are eligible for medical assistance under an eligibility group identified in the state plan.
 - The statute requires the state to cover all Categorically Needy eligibility groups in their CFC benefit.
 - If the state has a Medically Needy program, then the state should indicate if it will also be covering Medically Needy eligibility groups in the CFC benefit.
 - If Medically Needy groups will be covered in the CFC benefit, then the state should specify if all Medically Needy groups will receive the same services that are provided to the Categorically Needy eligibility groups.
- Indicate that the state is assuring that individuals eligible for the CFC benefit are either:
 1. in an eligibility group entitled to nursing facility services under the State plan; or
 2. are not in an eligibility group entitled to nursing facility services but whose income is at or below 150 percent of the Federal poverty level.

Level of Care

- Check the box to indicate that the state affirmatively assures that without CFC's home and community-based attendant services and supports, individuals would require an institutional level of care.
- Indicate ("y" or "n") if the state has chosen to permanently waive the annual recertification requirement for individuals in accordance with the regulations at 42 CFR 441.510(c) (1) & (2).
 - Check all boxes that indicate the level of care being waived as applicable. Choices include long-term care hospital, nursing facility, intermediate care facility for individuals

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with intellectual disabilities, institutions providing psychiatric services for individuals under age 21, and IMDs for individuals age 65 or over.

- Finally, describe the process for determining an individual's level of care. The state process may differ among the different levels of care.

Review Criteria

The description of the process to be used for determining an individual's level of care should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's process covers all levels of care included in the CFC benefit.

Technical Guidance

Level of Care Requirement (42 CFR 441.510)

Individuals must meet one of the following institutional levels of care (LOC): a long-term hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), an institution providing psychiatric services for individuals under age 21, or IMD for individuals age 65 or over. If the state does not have long-term hospitals in their state, then they will not be required to include that type of institutional level of care. Likewise, if a state does not provide the optional benefits of ICF/IDD or IMD for individuals over the age of 65, the state does not have to make a determination for those LOCs. However, determinations are required under the EPSDT mandate for ICF/IDD services and inpatient psychiatric services for individuals under the age of 21.

States may not target specific populations to receive the CFC benefit, and therefore, states should assure that they are assessing individuals against the level of care for the setting in which the individuals would have received institutional services. For CMS to determine that the state's process to determine level of care for all potential populations adequately meets federal requirements, the state should provide a summary of their process for each level of care defined in 42 CFR 441.510.

Individuals eligible for Medicaid via enrollment in a 1915(c) home and community based waiver

Individuals receiving 1915(c) waiver services are also eligible to receive State plan benefits if there is a need for such services. As CFC is a state plan benefit, individuals enrolled in a 1915(c) waiver have access to CFC if all CFC eligibility requirements are met, and there is an assessed need for CFC services. It is important to note that individuals eligible for Medicaid under 42 CFR 435.217, must continue to meet the eligibility requirements for the 1915(c) waiver in order to maintain eligibility for Medicaid and CFC. As articulated in the 1915(c) waiver technical guide, states have the option of requiring individuals to maintain waiver eligibility, the need for and receipt of at least one monthly waiver service, OR the need for and receipt of at least one waiver service (at some other frequency greater than monthly) and monthly monitoring. Please see the 1915(c) waiver technical guide for additional information on waiver

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eligibility requirements. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html>

Informing Individuals Potentially Eligible for the Community First Choice Option

42 CFR 441.515 requires states to provide CFC to individuals on a statewide basis and in a manner that provides services and supports in the most integrated setting appropriate to the individual's needs and without regard to the individual's age, type or nature of disability, or the form of home and community-based attendant services and supports the individual needs to lead an independent life.

Instructions

- For CMS to determine that the state informs individuals in a manner that complies with 42 CFR 441.515, the state should indicate how individuals potentially eligible for CFC services and supports will be informed of the benefit's availability and services whether by:
 - letter;
 - e-mail; and/or
 - Other method. Please describe the method.
- In addition to identifying type of communication used above, the state should describe the process used to inform the individual of the CFC benefit.

Review Criteria

The description of the process for informing individuals potentially eligible for the CFC benefit about the benefit's availability and services should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

- Check all boxes affirmatively assuring that the following statutory and regulatory requirements are met:
 1. CFC services are provided on a statewide basis;
 2. Individuals make an affirmative choice to receive services through the CFC benefit.
 3. CFC services are provided without regard to the individual's age, type or nature of disability, severity of the disability, or the form of home and community-based attendant services and supports that the individual needs to lead an independent life; and
 4. Individuals receiving CFC services will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.
 5. During the five-year period beginning January 1, 2014, spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under 1915(k).

If the state does not check these boxes, this will trigger a request for additional information.

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Spousal Impoverishment Determination

Section 2404 of the Affordable Care Act mandates that, for the five-year period beginning January 1, 2014, the definition of an “institutionalized spouse” in section 1924(h)(1) of the Act (the spousal impoverishment statute) includes married individuals who are eligible for, among other things, “medical assistance for home and community-based attendant services and supports under section 1915(k). . . .” On May 7, 2015, CMS issued guidance to states on how this provision should be applied (“Affordable Care Act’s Amendments to the Spousal Impoverishment Statute”). CMS instructed in the guidance that, for married individuals not otherwise eligible for Medicaid who indicate a need for HCBS at application, states should apply the clinical and targeting criteria for any 1915(c), (i), or (k) available under a state’s Medicaid program in the individual’s eligibility determination phase in order to determine if the financial eligibility rules of section 1924 of the Act will apply. CMS wants to remind states that are interested in adopting, or have adopted, the 1915(k) benefit that Medicaid eligibility for married individuals should be determined in a manner consistent with the May 2015 guidance, which can be found at: <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD050715.pdf>

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SERVICE MODELS AND SERVICE BUDGET

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; 42 CFR 441 subpart K
42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to identify the type of service model(s) that will be used in the CFC benefit; to identify and describe the support systems the state will use to inform and assist individuals to best meet their needs through the CFC benefit; and, if the state will be using a self-directed model with service budget, to describe how various features and required elements pertaining to the service budget will be addressed.

Background

Regulations at 42 CFR 441.545 permit States to use various types of service models in their CFC benefit. The regulations specify that the state may use one or more of the following types of service models: an Agency-Provider model; a Self-Directed model with Service Budget; or Other Service model defined by the state (and approved by CMS). The regulations at 42 CFR 441.545 require that the state make available financial management activities/services to individuals when the self-directed model with service budget is used, and allow states using this type of service model to disburse cash prospectively and/or by issuing vouchers to individuals. Definitions of each service model are located in the Technical Guide section following the instructions below.

Regulations at 42 CFR 441.560 describe various requirements related to “service budgets” for states that choose to use a self-directed service model with service budget.

Instructions

Service Models

The state may choose one or more of the following types of service models that will be used in their CFC benefit:

1. Agency-Provider model;
2. Self-Directed model with Service Budget; and/or
3. Other Service Model. If the State selects “Other Service Model,” then the State must define it and CMS must approve it.

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Review Criteria

The description of an “Other Service model” should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

Self-Directed Model with Service Budget Provisions

If the state will be using a self-directed model with service budget, or an “other” service model that includes a service budget, then the state would complete the following sections:

Financial Management Services (FMS)

States using a “Self-Directed Model with Service Budget” are required by the regulations at 42 CFR 441.545(b) to make available financial management services to all individuals with a service budget.

- First, for states using a “Self-Directed Model with Service Budget,” indicate whether the financial management activities will be claimed:
 - as a Medicaid service; or
 - as an administrative activity.

Note that while costs claimed as a medical service are eligible for the enhanced six percentage point increase in the FMAP rate for CFC services, the federal requirements for claiming medical services, such as ensuring free choice of provider under the State plan must be met.

- Check the box indicating that the state “assures that FMS activities will be provided in accordance with 42 CFR 441.545(Bb)(1).”
- Next, if the state will be using a “Self-Directed Model with Service Budget,” indicate how FMS will be provided:
 - Internally by the State Medicaid agency, or
 - Another agency to which the function has been delegated (please identify such agency), or
 - A Vendor Organization (which must be described).

Other Payment Methods

If the state will be using a self-directed model with service budget, indicate which one or both of the following methods will be used for paying for CFC services:

- Direct cash method; and/or
- Vouchers

Provide a description of the method(s) used.

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Review Criteria

The description of the “Direct Cash” or “Voucher” method should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements and that the state is ensuring compliance with applicable IRS and State employment/taxation rules as required by 441.545(b)(2)(i).

Service Budget Requirements

For states using a “Self-Directed Model with Service Budget” or “other” service model that includes a service budget, provide the information requested below pertaining to service budget requirements.

- Describe the budget methodology the State uses to determine the individual's service budget amount. Also describe how the State assures that the individual's budget allocation is objective and evidence-based utilizing valid, reliable cost data and can be applied consistently to individuals.
- Describe how individuals are informed of the specific dollar amount they may use for CFC services and supports before the person-centered service plan is finalized.
- Describe how the individual may adjust the budget, including how he or she may freely change the budget and the circumstances, if any, which may require prior approval of the budget change from the State.
- Describe the circumstances that may require a change in the person-centered service plan.
- Describe how the individual requests a fair hearing if his or her request for a budget adjustment is denied or the amount of the budget is reduced.
- Describe the procedures used to safeguard individuals when the budgeted service amount is insufficient to meet the individual's needs.
- Describe how individuals are notified of the amount of any limit to the individual's CFC services and supports.
- Describe the process for making adjustments to the individual's budget when a reassessment indicates there has been a change in his or her medical condition, functional status, or living situation.

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Review Criteria

Descriptions should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election(s) meets applicable federal statutory, regulatory and policy requirements.

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States may choose one or more of the following service delivery models for the provision of personal attendant services:

1) **Agency Model.**

The agency model is to be used for arrangements in which a provider agency operates under a contract or provider agreement with the State Medicaid agency, and the agency acts as the employer of the attendant, either by providing the services directly through their employees or arranging for the provision of services under the direction of the individual receiving services. Individual attendants with a contract or provider agreement with the State Medicaid agency could be identified under this service model.

Individuals receiving CFC services under this model do not have a formal employer role. The agency model may also be used when states want to allow for an “agency with choice” model, whereby the participant is supported by an agency that functions as the common law employer of workers recruited by the participant. The participant directs the workers and is considered their co-employer. The agency performs financial management services and tasks, rather than the individual. The agency must hold a provider agreement with the state in order to submit billings and receive payments for the services furnished by workers.

2) **Self-directed model with service budget.** A self-directed model with a service budget is one in which the individual has a service budget based on the assessment of functional need. States may choose to disburse cash prospectively or issue vouchers, but neither is required. The self-directed model with service budget provides individuals the opportunity to have both Employer and Budget Authority and must make available financial management activities to support individuals who receive services under this model.

- a. *Employer Authority* – The individual acts as the employer of record and examples of tasks the individual would perform through Employer Authority as it relates to the provision of CFC services and supports include: (1) Establish provider qualifications, recruit, hire and dismiss attendant care providers; (2) Schedule, supervise, manage, determine duties, train and evaluate attendant care providers.
- b. *Budget Authority* – Examples of tasks an individual would perform through Budget Authority as it relates to the provision of CFC services and supports include: (1) Determining the amount paid for a service, support, or item, in accordance with state and federal compensation requirements; (2) Reviewing and approving provider payment requests and (3) financial management functions described in 441.545(b)(1)(i)-(v).

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- c. *Financial Management Services* - Under the self-directed model with service budget, the regulations require that the state make available financial management services (FMS) to individuals who do not wish to perform all employer duties. The minimum activities that must be included in FMS are described in 42 CFR 441.545(b)(1)(i)-(vii).

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CFC REQUIRED AND OPTIONAL SERVICES & PROVIDER QUALIFICATIONS

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K; 42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to identify and describe the specific services and supports that it will include in its CFC benefit. The state also will provide assurance that the services and supports required by statute and regulations will be covered under the benefit.

Background

The statute and regulations identify the services and supports that are mandated to be covered under the CFC benefit, those which are excluded from coverage, and the “optional” services and supports the state may choose to include in its CFC benefit. Section 1915(k)(1)(B) identifies the mandatory services and supports. Section 1915(k)(1)(C) identifies the excluded services and supports and section 1915(k)(1)(D) identifies the optional services and supports which the state may choose to cover under its benefit. The regulations at 42 CFR 441.520 specify the mandatory and optional services and supports while 42 CFR 441.525 specifies the services and supports excluded from coverage under CFC.

Instructions

Note: The “Provider Type” text box is only completed if applicable.

Mandatory Services and Supports

- First, the template is pre-populated to indicate that assistance with Activities of Daily Living (ADLs), Instrumental ADLs (IADLs) and health-related tasks through hands-on assistance, supervision or cueing are required services under the CFC benefit. (Note that ADLs, IADLs and health-related tasks are defined at 42 CFR 441.505 for purposes of the CFC benefit.)
 - Identify one or more of the following specific kinds of home and community-based attendant services that will be covered in providing assistance with ADLs, IADLs and health-related tasks:
 - Personal Attendant services;
 - Companion services;

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- Homemaker/Chore services; and/or
- Other services. If “Other” services will be covered then identify and describe each such service.

Review Criteria

The description of “Other” kinds of services to be covered should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

- Next, the template is pre-populated to indicate that acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks are required services under the CFC benefit.
 - Identify and describe the specific kind(s) of attendant services that will be covered in acquiring, maintaining and enhancing these skills.

Review Criteria

The description of the specific kinds of services to be covered should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

- Next, the template is pre-populated to indicate that “individual back-up systems or mechanisms to ensure continuity of services and supports” are required to be covered under the CFC benefit.
 - Indicate which one or more of the following specific back-up systems and mechanisms will be covered under the benefit:
 - Personal Emergency Response Systems;
 - Pagers; and/or
 - Other mobile electronic devices. If “Other mobile electronic devices” will be covered, describe the device(s) or mechanism(s).
 - Other. The state will use this option to allow persons identified by an individual to be included as backup supports.

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Review Criteria

The description of “Other” kinds of mobile electronic devices/mechanisms to be covered should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

- Next, the template is pre-populated to indicate that “voluntary training on how to select, manage and dismiss attendants” is required to be covered under its CFC benefit.
 - Check the box designating whether the state will claim costs associated with voluntary training as a Medicaid service or an administrative activity.
 - Describe the voluntary training program the state will provide and who is providing this activity.

Review Criteria

The description of the voluntary training program provided by the state to train individuals on how to select, manage and dismiss attendants should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

CFC Provider Qualifications

Background

The regulations at 42 CFR 441.565(a) give the individuals receiving CFC services the right to train and establish additional qualifications for attendant care providers in order to meet their needs and preferences, regardless of the service delivery model selected by the state. Regulations at 441.565(b) require that for the agency-provider service model, the State must define (in writing) the qualifications for providers of CFC services. The regulations at 441.565(c) require that for the self-directed service model with service budget, individuals who receive CFC services be given the option to permit family members or any other individuals to provide CFC services and supports as long as these providers are qualified.

Technical Guidance

Provider Qualifications

This section only applies to states that will be using an “Agency-Provider Service Model” and possibly an “Other” service model described by the state.

- If the state will be using an Agency-Provider service model in its CFC benefit the system will automatically display each of the services covered by the CFC benefit.

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- If the service is not provided by an Agency-Provider model, then this section on **Provider Qualifications** does not need to be completed by the state.
- For each type of service that is provided by the Agency-Provider model, the state will describe the qualifications of providers who will provide the service as follows:
 - Identify the type of provider that can provide the service; and
 - Indicate (“y” or “n”) if the provider will be required to:
 - have a License;
 - have a Certificate (including a description of the type of Certificate required);
 - meet an Education-Based Standard (including a description of the standard); and/or
 - meet Other Qualifications (including a description of these other qualifications)

Review Criteria

The description/s of the State’s qualification requirements should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

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1. ADLs, IADLs, and health related tasks are required and must be provided through hands-on assistance, supervision and /or cuing, based on the individual’s needs. In accordance with discussion of these modalities in the regulation, CMS reminds states that all three ways of delivering assistance with ADLs, IADLs and health related tasks must be made available. States may not limit the scope of this benefit to offer less than all three.
2. *Activities that allow for the acquisition, maintenance and enhancement of skills necessary for an individual to accomplish ADLs, IADLs and health-related tasks.* Many states refer to these activities as habilitation services, but section 1915(k) does not use the term “habilitation. The overall purpose of the CFC benefit is to provide for home and community-based attendant services and supports to assist in accomplishing ADLs, IDLs, and health-related tasks. Therefore, the services that are provided under this section must tie directly back to that purpose, and the services are not as broad as habilitation services provided under other Medicaid authorities.
3. Back-up systems or mechanisms to ensure continuity of services and supports. This includes electronic devices used to ensure continuity of services and supports. These items may include an array of available technology and personal emergency response systems. Individuals, such as informal caregivers or back up attendant workers, can also be identified as back-up support.

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4. Voluntary training on how to select, manage and dismiss attendants. This service should be available to all individuals receiving the CFC benefit regardless of the service delivery models included in the CFC benefit.
5. Provider Qualifications.
 - a. Agency Model – As provided in our regulation, states are required to establish provider qualifications when services are provided under the agency model. The individual may establish additional provider qualifications based on the individual’s needs and preferences and individuals retain the right to train attendant care providers on how they want services performed.
 - b. Self-direction Model with Service Budget - Under the self-directed model with service budget, individuals receiving CFC services establish provider qualifications, not the state.
 - c. All providers (regardless of service delivery model) – The state must ensure, in accordance with section 1903(i) of the Act, that Medicaid payment shall not be made for items or services furnished by individuals or entities excluded from participating in the Medicaid Program.

Instructions

Optional Services and Supports

There are two categories of optional services and supports under the CFC benefit: transition costs for transitioning from an institution to a community-based setting; and services or supports for a need identified in an individual’s person-centered service plan that increase an individual’s independence or substitute for human assistance.

- First, indicate if “Transition Costs” will be covered under the benefit.
 - If so, provide a detailed description, including any limitations or restrictions, for any of the following Transition costs which are covered under the state’s CFC benefit:
 - Rental security deposits;
 - Utility security deposits;
 - First month’s rent;
 - First month’s utilities;
 - Basic kitchen supplies;
 - Bedding;
 - Other household items; and/or
 - Other coverable necessities linked to an assessed need to enable the transition from an institution.

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Review Criteria

The description including any limitations on the (optional) transition costs covered should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

- Indicate if the CFC benefit will cover “Services or supports for a need identified in the individual’s person-centered plan of services that increase an individual’s independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.”
 - If such services or supports will be covered, provide a description including any limitations on the amount, duration or scope of the covered services and supports. (See Technical Guidance section below for examples of covered services and supports.)

Review Criteria

The description including limitations on the amount, duration and scope of services/supports covered in the individual’s person-centered service plan should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements.

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At the State’s option, the state may include permissible services and supports. Permissible services and supports include:

- (1) Transition costs to allow for an individual to transition from a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities, to a home and community-based setting. Such costs may include first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities an individual may need to transition to the community;
- (2) Services and items that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance, covered under the CFC benefit. For example, meal preparation performed by an attendant is assistance with an IADL, and therefore, considered a covered CFC activity. In lieu of having the attendant prepare all meals for the individual, the individual indicates through the person-centered service plan that he would like to prepare his own meals and can do so by using a microwave. Under this

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activity, the state could cover the cost of the microwave, so an individual can prepare his own meals, instead of having an attendant prepare the meal.

It is up to the state to establish the criteria for what they will permit to be covered as an item that increases independence or substitutes for human assistance. In 2009, CMS issued a State Medicaid Director's letter (<http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-11-19-09.pdf>) providing guidance to assist states in their development of criteria, for the similar activities allowed under the sections 1915(c) and (j) of the Act. The issuance of that SMD letter predates the creation of the CFC state plan option. Due to the similarities between the authorities, CMS has adopted the same guidance for the 1915(k) state plan option.

It should be noted that a key criterion is that the purchase be related to a need or goal identified in the participant's state-approved person-centered service plan. By requiring a link to the person-centered service plan, states ensure that the goods and services purchased are consistent with a participant's State-approved service plan and promote the integrity of the Medicaid program

Criteria

States should determine that all of the following criteria are satisfied. The goods, services, supports, equipment, supplies, or items:

- Are related to a need or goal identified in the State-approved person-centered service plan;
- Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;
- Promote opportunities for community living and inclusion;
- For self-directed model with service budget, are able to be accommodated within the participant's budget without compromising the participant's health or safety; and
- Are provided to, or directed exclusively toward, the benefit of the participant.

Examples of optional services include: small kitchen appliances such as microwave ovens; accessibility ramps/home modifications; and durable medical equipment (if not covered under the Medicaid home health benefit). This list of examples is not intended to be exhaustive, and

States may consider other items based on a participant's person-centered service plan and individualized budget plan.

Examples of items that may not be covered under this category include: services covered by third parties or services that are the responsibility of a non-Medicaid program or service; room and board - including rent payments and mortgage payments - outside of items permitted under transition costs; experimental treatments; social or recreational purchases that are not related to a need or goal identified in the person-centered service plan; or, vacation expenses (except for the cost of covered services the participant may need while on vacation).

- 3) **Other Service Delivery Model.** The other service delivery model option allows states to propose models that are not defined above, for approval by the Secretary. An example of how this

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service model has been used by states is to offer a service budget model where the state establishes minimum qualifications for all personal attendants. Another example is where a state offers a self-directed service budget, but establishes the wage that personal attendants are paid.

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CFC HOME AND COMMUNITY-BASED SETTINGS

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulations: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K and January 16, 2014 final regulation on Home and Community-Based Settings Requirements for CFC 42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to indicate/describe the home and community-based settings in which CFC services and supports can be provided, and how the state assures compliance with home and community-based settings criteria.

Background

Section 1915(k)(1)(A)(ii) states that CFC services and supports be provided in a home or community setting which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with an intellectual disability. Implementing regulations found at 42 CFR 441.530 define and set forth requirements that all home and community settings must adhere to. Each individual receiving CFC services and supports must reside in a home or community-based setting and receive CFC services in community settings that meet the requirements of 42 CFR 441.530.

The home and community-based setting provisions of the final rule are designed to establish a more experiential definition of home and community based settings, rather than one based solely on a setting's location, geography, or physical characteristics.

To demonstrate compliance with these requirements, the state should respond to the Standard Review Questions related to Home and Community-Based Settings Criteria for 1915(k) CFC SPA on page 25 of the CFC Technical Guide. The questions are part of the SPA process, however, the responses are submitted as a separate document and are not part of the CFC SPA template.

Instructions

- Check the first box affirmatively assuring that CFC services and supports will be furnished to individuals residing in a home or community-based setting and receiving CFC services in a community setting that meets the requirements of 42 CFR 441.530.
- Next, indicate by checking the applicable box if CFC services and supports may be provided to individuals living in provider owned or controlled settings.
 - If the answer is “yes” to allowing CFC services in provider owned or controlled settings, then for each type of provider owned or controlled setting identify the type of setting (i.e.,

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Assisted Living Facility, Adult Family Home, Supported Housing, etc.). Setting types for all non-residential settings should also be identified.

- Lastly, check the box next to each assurance confirming adherence to the regulatory requirement.

Review Criteria

The state's response to the standard review questions should be sufficiently clear, detailed and complete to permit the reviewer to determine that the setting(s) comply with the regulatory requirements specified at 42 CFR 441.530.

Technical Guidance

1. CMS must determine that a state's SPA meets all regulatory requirements, including the settings, requirements before the SPA can be approved. A state must demonstrate compliance with regulatory requirements by providing sufficient information during the SPA process for CMS to determine if the settings meet the requirements. The home and community-based settings requirements are designed to establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The requirements apply to residential settings where individuals receiving CFC services reside and non-residential home and community-based settings where CFC services are provided. If a beneficiary is residing in a setting not receiving HCBS funds, but going to a day provider who is, the residential setting also needs to adhere to settings requirements.
2. Optional Exploratory Questions to assist states in the assessment of both residential and non-residential HCB Settings can be accessed at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-re-settings-characteristics.pdf> and <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf>. These questions are only suggestions, but may assist the state in structuring its analysis of the HCB requirements as applied to both residential and non-residential settings.
3. The complete Settings Requirements Toolkit can be accessed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html>
4. States may conduct specific site evaluations through a variety of standard processes including, but not limited to licensing reviews, provider qualification reviews, and support coordination visit reports to assess settings. States may engage individuals receiving services, as well as representatives of consumer advocacy entities in the assessment process. States may conduct

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or develop a tool for qualified entities to conduct site specific evaluations of settings, and/or may also administer surveys to providers. For additional information on these and other assessment options, please refer to CMS Statewide Transition Plan Toolkit for Alignment with the HCB Final Regulations' Setting Requirements, Issued September 5, 2014.

<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/statewide-transition-plan-toolkit.pdf>

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Home and Community-Based (HCB) Setting Criteria for 1915(k) Community First Choice (CFC) SPA Standard Review Questions

When responding to Questions 6 and 9, please make sure to provide information regarding both residential and non-residential assessment.

1. Please identify all settings in which an individual may reside.
2. Please identify all non-residential settings that will provide services under the CFC benefit.
3. Please identify whether the state's assessment process is reflected in the State's HCBS Statewide Transition Plan applicable to 1915(c) waivers and 1915(i) programs. If so, please reference the specific sections.

Settings Assessments

The assessment process should demonstrate how the settings in which CFC services will be provided meet the federal regulatory requirements listed below:

- a. The setting is integrated in and supports full access of individuals receiving CFC services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals who do not receive Medicaid HCBS;
 - b. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board;
 - c. An individual's rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
 - d. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;
 - e. Individual choice regarding services and supports, and who provides them, is facilitated.
4. Systemic Assessment Process - Please describe the process the state used to conduct the systemic assessment (e.g., a review of state statute(s), regulations, policies and provider contracts) to determine settings are compliant with HCB regulatory requirements and describe the outcomes of the review. Please assess regulations or other governing documents for these settings and provide a crosswalk of the components that address specific characteristics of the settings requirements, indicating whether the state documents comply, do not comply, partially comply or are silent on the federal regulation. Describe the changes the state has made to ensure that where the regulations

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are silent, do not comply and/or are partially compliant to ensure full enforcement of the federal regulation.

5. Site Specific Assessment Process – If applicable, please describe the process the state used to conduct site specific assessments (e.g., licensing reviews, provider self-assessments, support coordination reports, consumer advocacy entities) to determine settings are compliant with HCB regulatory requirements. When the state uses provider self-assessments as part of its site specific assessment process, there must be a validation process in place for CMS to accept the provider self-assessment. Therefore, describe the validation methods used by the state to confirm results of provider self-assessments. Please describe the outcomes of the review, including which settings/sites are compliant and will be included in the 1915(k). When discussing the site specific assessment process please identify the entity or entities that conducted the site specific assessments.

Provider Owned or Controlled Residential Services Additional Questions

6. For provider owned or controlled residential settings, please provide a description of the State process to ensure the additional regulatory requirements listed below are met. In the description, please identify:
 - a. Whether this process is reflected in the State’s HCB Statewide Transition Plan. If so, please reference the specific section;
 - b. Whether the initial process is a component of the State’s CFC Quality Assurance Improvement Plan (in accordance with § 441.585);
 - c. Whether the setting requirements utilized in the assessment are reflected in licensure or certification requirements, and/or other state documents or other official requirements. If so, please reference the specific citations.

The following regulatory requirements should be addressed in the response.

- i. The unit or dwelling is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state, county, city or other designated entity;
- ii. If there are settings in which landlord tenant laws do not apply, the State ensures that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law;
- iii. Each individual has privacy in their sleeping or living unit. Units have lockable entrance doors, with appropriate staff having keys to doors as needed;
- iv. Individuals sharing units have a choice of roommates in that setting;
- v. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- vi. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

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- vii. Individuals are able to have visitors of their choosing at any time;
 - viii. The setting is physically accessible to the individual.
7. In relation to provider owned or controlled residential settings, §441.530(a)(vi)(A) specifies that above-mentioned criteria must be met. However, the regulation also recognizes that, at times, modification to these requirements on an individual basis may be necessary and specifies at §441.530(a)(vi)(F) the following requirements that must be met and documented in the plan when modifications are used as noted below. Please describe:
- a. How the State will assess the appropriateness of such modifications and how the State will ensure adherence to the requirements below.
 - b. The State process that will be used to ensure that such modifications are supported by a specific assessed need and documented in the person centered service plan.
 - c. How will the state ensure that the following requirements are adhered to?
 - i. Identify a specific and individualized assessed need;
 - ii. Document the positive interventions and supports used prior to any modifications of the person-centered service plan.
 - iii. Document less intrusive methods of meeting the need that have been tried but did not work;
 - iv. Include a clear description of the condition that is directly proportionate to the specific assessed need;
 - v. Include regulation collection and review of data to measure the ongoing effectiveness of the modification;
 - vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
 - vii. Include the informed consent of the individual; and
 - viii. Include an assurance that interventions and supports will cause no harm to the individual.

Settings Presumed to be Institutional/Heightened Scrutiny

8. 42 CFR 441.530(a)(2)(v) describes settings that are presumed to have qualities of an institution. States may submit information to CMS for review that presents the state's analysis that the settings have the qualities of home and community-based settings, and therefore overcome the presumption of being institutional. The process for CMS' review includes sharing the submitted information with federal partners who have 14 days to review the state's information and provide comments to CMS. CMS has final approval authority.
9. Please explain the state's process for assessing settings to identify settings presumed to have institutional characteristics (e.g., use of geo mapping, surveys, provider self-assessment, etc.)
10. Based on the state's assessment, please answer the following questions for settings in which individuals receiving CFC services may reside or where CFC services may be delivered. Please respond to the following questions with either a yes or no. For each question to which the state answered yes, please provide information to evaluate through a process of heightened scrutiny that

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the setting does not have the qualities of an institution and has the qualities of home and community based settings.

Are any of the settings in which an individual may receive CFC:

In a building that is also a **publicly or privately operated facility** that provides inpatient institutional treatment? Examples of sharing a building include (but are not limited to) a use of a wing within a facility, or a physical space that shares one building entrance or exit with a facility.

In a building on the grounds of, or immediately adjacent to, a **public institution**? Examples of buildings on the grounds of or immediately adjacent include (but are not limited to) buildings separated by a breezeway or that share an outside wall, but have separate entrances and exits, and separate licensure; or building that are on the same campus or grounds, regardless of whether they are physically connected.

In any other setting that has the effect of isolating individuals receiving home and community-based services from the broader community of individuals not receiving these services? For additional guidance in evaluating these other settings, please refer to Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS from the Broader Community,” which is located within the HCBS Toolkit. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf>

11. If the state answered yes to any of the above questions, then it should submit evidence to CMS for the application of the heightened scrutiny process for settings that are presumed not to be home and community-based if the state wishes to use the setting and believes it overcomes the institutional presumption.

12. CMS will determine if the evidence is sufficient to demonstrate the setting does not have characteristics of an institution and does meet the home and community-based settings requirements. Evidence of a site visit by the state, or an entity engaged by the state, will facilitate the heightened scrutiny process. CMS will consider input from the state and information provided by other stakeholders as part of the heightened scrutiny process. If the state sought public input on this process, please provide a summary of that input and description of how the state responded to the input. CMS has posted Frequently Asked Questions related to the heightened scrutiny process on the CMS website: <https://www.medicaid.gov/medicaid/hcbs/guidance/index.html>

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Ongoing Monitoring of Settings

13. Please provide a description of the state’s oversight and monitoring process for ensuring continuous compliance of settings. *Note: This information should also be included in the Quality Assurance and Improvement Plan section of the SPA*

Please address the following:

- i. Ongoing evaluation and monitoring process for both existing settings and newly identified settings
- ii. Frequency of monitoring efforts
- iii. Summary of findings
- iv. Activities to address findings—(e.g. quality improvement plans and/or corrective action plans including temporary or provisional licensure or certification).

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CFC SUPPORT SYSTEMS

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; 42 CFR 441 subpart K
42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to identify and describe the support systems the state will use to inform and assist individuals to best meet their needs through the CFC benefit.

Background

Regulations at 42 CFR 441.555 require that states provide, or arrange for the provision of, “support systems” to inform and assist individuals in enrolling in the CFC benefit and in accessing and managing the services that are available through the CFC benefit.

Instructions

- Check the box indicating that Support Services are provided in accordance with the requirements at 42 CFR 441.555.
- Next, describe how these support services will be provided and who will be responsible for their provision.
- Next, specify in a text-box any tools or instruments used to mitigate risks identified under a risk management agreement as required by 42 CFR 441.555(b)(2)(xi)(A).
- Next, provide the state’s description of how the state is meeting the Conflict of Interest standards described at 42 CFR 441.555(c). Further information about these conflict of interest standards can be found on the next page.
- Last, indicate if the state is invoking the conflict of interest exception. If invoking the geographical exception to the conflict of interest (COI) requirements, please describe COI standards for assessment of need and the person-centered service plan development process that apply to all individuals and entities, public or private.

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Review Criteria

The description of the tools/instruments used to mitigate risks identified under a risk management agreement should be sufficiently clear, detailed and complete to permit the reviewer to determine that the State's election meets applicable federal statutory, regulatory and policy requirements. The conflict of interest protections must include separation of assessment/planning and CFC provider functions within the provider entity, unless the exception is invoked. If the state can justify why the exception is necessary, the state should document firewalls to ensure protection against conflict of interest. The description should also show that individuals are provided with a clear and accessible alternative dispute process.

Technical Guidance

- At a minimum, as provided in the CFC regulation, conflict of interest standards must ensure that the individuals or entities conducting the assessment of functional need and person-centered service plan development process are not:
 - (1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.
 - (2) Financially responsible for the individual.
 - (3) Empowered to make financial or health-related decisions on behalf of the individual.
 - (4) Individuals who would benefit financially from the provision of assessed needs and services.
 - (5) Providers of State plan home and community-based services for the individual, or those who have an interest in or are employed by a provider of State plan home and community-based services for the individual, except when the State demonstrates that the only willing and qualified entity/entities to perform assessments of functional need and develop person-centered service plans in a geographic area also provides home and community-based services, and the State devises conflict of interest protections including separation of assessment/planning and CFC home and community-based provider functions within provider entities, which are described in the State plan, and individuals are provided with a clear and accessible alternative dispute resolution process.

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CFC ASSESSMENT OF NEED AND SERVICE PLAN

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K 42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to describe the assessment of need process and the person-centered service planning process.

Background

Section 1915(k)(1)(A)(i) of the Act requires the state to conduct an assessment of the individual's functional need on which to base the person-centered service plan. The state must conduct face-to-face assessments of the individuals' needs, specifically their strengths and preferences.

Instructions

- Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences and goals for services and supports provided under the benefit.
- Check the box if the state plans to allow the use of telemedicine or other information technology medium in lieu of a face-to-face assessment.
- Indicate if the state will claim costs associated with the CFC assessment as a service or an administrative activity.
- Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. For each selection, specify qualifications.

The State may use the following as guidance for this section:

- Registered nurse, licensed to practice in the state, acting within scope of practice under State law;
- Licensed practical nurse or vocational nurse, acting within scope of practice under state law;
- Licensed physician (e.g., MD or OD), acting within scope of practice under state law;
- Case Manager (specify qualifications);
- Social worker (specify qualifications); and/or
- Other (specify what type of individual and their qualifications).

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- The State will indicate the frequency of reassessments in increments of time less than 12 months. (e.g., six months, nine months, 12 months, or other).
- The State will describe the reassessment process to be used when there is a significant change in the individual's needs or the individual requests a reassessment. The state will indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed.

Review Criteria

The description of the assessment of need process should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's process meets applicable federal statutory, regulatory and policy requirements.

Person-Centered Service Plan

Background

Section 1915(k)(1)(A)(i) of the Act requires a person-centered approach to establishing a service plan, based on an assessment of need developed in collaboration with an individual or the individual's authorized representative.

The service plan must reflect what is important to the individual and what is important for his or her health and welfare. The person-centered approach is a process, directed by the individual, or by another person important in the life of the individual who the individual has freely chosen to direct the process. It is intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The person-centered process includes the opportunity for the individual to choose others to serve as important contributors to the planning process to enable and assist the individual in identifying and gaining access to a personalized mix of paid and non-paid services.

Instructions:

The state will indicate who is responsible for collaborating with the individual in developing the CFC person-centered service plan and for its final development as well as specify their qualifications.

Describe the process that is used to develop the person-centered service plan, including:

- Specify the supports and information that are made available to the individual (and/or family or authorized representative, as appropriate) to direct and be actively engaged in the person-centered service plan development process and the individual's authority to determine who is included in the process.
- Indicate who develops the person-centered service plan, what other individuals, other than the individual receiving services or their authorized representative, are expected to participate in the person-centered service plan development process, and how the state assures that the individual has the opportunity to include participants of their choice.

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- Describe the timing of the person-centered service plan development to assure the individual has access to services as quickly as possible; describe how and when it is updated, including mechanisms to address changing circumstances and needs or at the request of the individual.
- Describe the state’s expectations regarding the scheduling and location of meetings to accommodate individuals receiving services and how cultural considerations of the individual are reflected in the development of the person-centered service plan.
- Indicate how the service plan development process ensures that the person-centered service plan addresses the individual’s goals, needs (including health care needs), and preferences, by offering choices regarding the services and supports they receive and from whom.
- Describe the strategies used for resolving conflict or disagreement within the process.
- Indicate how the person-centered service plan development process provides for the assignment of responsibilities for the development of the plan and to implement and monitor the plan.

Under the regulations , the service plan must be reviewed and revised upon reassessment of need at least every 12 months and/or when the individual’s circumstances or needs change significantly, or at the individual’s request.

Indicate the frequency the person-centered service plan is reviewed and updated (i.e., six months, nine months, 12 months, or other).

Lastly, describe the person-centered service plan review process the state will use. In the description please indicate if this process is conducted in the same manner and by the same entity as the initial service plan review process or if different procedures are followed.

Review Criteria

The description of the assessment of need process should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s process meets applicable federal statutory, regulatory and policy requirements.

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CFC SERVICE DELIVERY SYSTEMS

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K 42 CFR Part 430, Subpart B

Introduction

The purpose of this section to identify the type of delivery system(s) that will be used to deliver services to individuals in the CFC benefit. The state may use a fee-for-service, managed care, and/or other type of service delivery system.

Background

In accordance with section 1915(k)(1) of the Act, when a state elects to include the CFC benefit as part of its Medicaid state plan program, the state must submit a SPA to receive the enhanced FMAP associated with the CFC benefit. Thus, the CFC benefit is required to be available under a fee-for-service delivery system. A state must submit a reimbursement page (attachment 4.19-B) identifying the payment rates for the CFC activities eligible for claiming at the Federal Medical Assistance Percentage (FMAP). In submitting the plan amendments, States must comply with the public notice requirements of 42 CFR 447.205. Additionally, the CFC benefit may be part of a service package available in a managed care arrangement. For a state to receive enhanced FMAP for CFC services, a SPA is still required even when services are provided through a managed care arrangement.

Instructions

Select one or more of the following kinds of service delivery systems that will be used in the CFC benefit:

- Fee-for-Service (mandatory selection);
- Managed Care;
- Other type of service delivery system

For the Fee-for-Service delivery system, indicate if the delivery system is a:

- Traditional State-Managed Fee-for-Service system; and/or
- Services Managed under an Administrative Service Organization (ASO) Arrangement

The state must also submit an Attachment 4.19 B page to describe the payment methodology for services for which the state will claim service match.

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If the state will be using a Managed Care delivery system, then the state must specify this choice by checking the box.

If the state will be using an “Other” type of delivery system, describe this “Other” type of delivery system.

Review Criteria

The description of an “Other” type of service delivery system should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state’s election meets applicable federal statutory, regulatory and policy requirements. The state must submit a 4.19 B page. The payments listed on the 4.19 B page must match the services and providers described on the coverage page (Attachment 3.1K).

Technical Guidance

States providing CFC services in a managed care arrangement and including a CFC payment in a health plan capitation rate will include a separate CFC section in their capitated rate Actuarial certification that is submitted to the CMS Regional Office and outlines the following:

- A description of the program in which CFC services will be provided and any program changes based on the inclusion of CFC services in the health plan benefits
- Estimates of, or actual (base) costs to provide CFC services (including a detailed description of the data used for the cost estimates)
- Assumptions on the expected utilization of CFC services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Adequate descriptions of the methodology used to calculate the amount of the final capitation

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CFC QUALITY ASSURANCE SYSTEM

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K
42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to describe the elements of the quality assurance system established and maintained for the CFC benefit.

Background

Both the statute and regulations require that the state establish and maintain a comprehensive, continuous quality assurance system for the CFC benefit. Regulations at 42 CFR 441.585 specify a number of key elements, measures and standards which should be established, monitored and maintained as part of its quality assurance system.

Instructions

- Describe the state’s quality improvement strategy.
- Describe the “methods the state will use to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.”
- Describe “how the state measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered service plan, particularly for the health and welfare of individuals receiving such services and supports.” These measures must be reported to CMS upon request.
- Describe “the standards for all service delivery models for training, appeals for denials, and reconsideration procedures for an individual’s person-centered service plan.”
- Describe the “methods used to monitor provider qualifications.”

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- Describe the “methods for assuring that individuals are given a choice between institutional and community based services.”
- Describe the “methods for assuring that individuals are given a choice of services, supports and providers.”
- Describe the “methods for assuring that services and supports are appropriate.”
- Last, the state’s Quality Improvement System should include a description of the state’s comprehensive process and content for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes.

Choice and Control

- Describe the “quality assurance system’s methods that maximize consumer independence and control and provide information about the provisions of quality improvement to each individual receiving such services and support.”

Stakeholder Feedback

- Describe how the state will elicit feedback from key stakeholders and others.
- Next, check the box affirmatively assuring that in accordance with 42 CFR 441.585(c) the state will elicit feedback from individuals and their representatives, disability organizations, providers, families individuals with disabilities or elderly individuals, and members of the community to improve the quality of the community-based attendant services and supports benefit.

Technical Guidance

CMS must determine that the state’s quality assurance system meets the requirements set forth in 42 CFR 441.585. The state’s description of its quality assurance system should include the following:

- Assurance that the state has a system that on an ongoing basis, identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
- The state system should include an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.
- The state system should have policies and procedures to ensure that the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

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Review Criteria

The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. The state's Quality Improvement System must include a description of the state's comprehensive process and content for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes.

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CFC STATE ASSURANCE – MAINTENANCE OF EXISTING EXPENDITURES

Statute: 2401 of the ACA which added 1915(k) of the SSA establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K, 42 CFR 441.570(b)

42 CFR Part 430, Subpart B

Introduction

The purpose of this section is for the state to provide information to support the state’s compliance with the CFC Maintenance of Existing Expenditure requirement for the CFC benefit.

Background

Section 1915(k)(3)(C) of the Act specifies that for the first full fiscal year in which the SPA is implemented, the state must maintain or exceed the level of expenditures for services provided under sections 1905(a), 1915, or 1115 of the Act, or otherwise, to individuals with disabilities or elderly individuals attributable to the preceding fiscal year. Through implementing regulations found at 42 CFR 441.570(b), CMS interpreted the statutory language to mean that, for the first full calendar year in which the State chooses to offer CFC in the State plan, the State’s share of Medicaid for home and community-based attendant services and supports provided under sections 1115, 1905(a), 1915, or otherwise, under the Act, to individuals with disabilities or elderly individuals must be the same or exceed the level of state expenditures attributable to the preceding 12 month period.

Instructions

To demonstrate compliance with this requirement the state shall submit to CMS, with the submission of a new CFC SPA, the state budgeted amount for the following services provided under 1905(a), 1915(c), 1915(i), 1915(k)¹ and 1115, if applicable. The state should also include the state budgeted amount for services listed below that are provided under Sections 1915(a) or 1915(b) that are not co-occurring with any of the authorities listed above. This information is submitted as a document separate from the CFC SPA template.

1. Personal Care/Personal Attendant Care Services
2. Home Health Aide
3. Durable Medical Equipment
4. Homemaker
5. Home Delivered Meals
6. Assistive Technology

¹ Expenditures for 1915(k) are only for Year 1 implementation. There won’t be any 1915 (k) expenditures for the year prior to implementation.

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7. Services related to the acquisition, maintenance and enhancement of skills necessary to accomplish ADLs, IADL's and health related tasks.
8. Respite Care (non-institutional)
9. Home Accessibility Adaptations
10. Vehicle Modifications
11. Non-Medical Transportation
12. Specialized Medical Equipment and Supplies
13. Personal Emergency Response Systems
14. Community Transition Services

After the completion of the first year of implementation, the state will need to show its Year 1 implementation expenditures (state portion only).

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CFC STATE ASSURANCE – DATA COLLECTION REQUIREMENTS

Statute: 2401 of the ACA which added 1915(k) of the Act establishing the Community First Choice (CFC) State plan option in Medicaid

Regulation: May 7, 2012 final regulation on CFC; (CMS-2337-F); 42 CFR 441 subpart K 42 CFR Part 430, Subpart B

Background

Section 1915(k)(5)(b) and implementing regulations at 42 CFR 441.580 specify the data collection requirements to which all CFC benefits must adhere. Our definitions for some of the data elements are delineated below. States must collect the information annually and provide the information to CMS upon request. At this time CMS is not prescribing the format in which the information must be submitted.

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For each Federal fiscal year, states are required to collect the following data:

- (1) The number of individuals estimated to receive services through the CFC state plan option;
- (2) The number of individuals who received services through the CFC state plan option in the previous Federal Fiscal Year; This information must be broken down by:
 - a. Type of Disability – In response to comment in the final CFC regulation, CMS interpreted “type of disability” to include “developmental disability, physical disability, traumatic brain injury, etc.” However we recognize that state systems may not categorize disability in the same manner. For consistency, we are instructing states to use the Type of disability categories used for TMSIS reporting. The categories can be found at: www.reginfo.gov/public/do/DownloadDocument?objectID=37031001
 - b. Age
 - c. Gender
 - d. Education Level - using the following categories:
 - i. Less than High School
 - ii. High School Diploma or Equivalent
 - iii. Some College, No degree
 - iv. Associate’s Degree
 - v. Bachelor’s Degree
 - vi. Master’s Degree
 - vii. Doctoral or Professional Degree
 - e. Employment Status – using the following categories:

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- i. Employed – Individuals are considered employed if they did any work at all (at least 1 hour) as a paid employee; worked in their own business, profession, or on their own farm;
 - ii. Unemployed – Individuals are classified as unemployed if they do not have a job, are actively looking for work, and are currently available for work;
 - iii. Not in the labor force – Individuals who do not have a job and are not looking for one.
- (3) The number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Act, or the personal care state plan option. – states should only provide information related to individuals who received personal attendant services and supports under the aforementioned authorities and who are now only receiving personal attendant services and supports under the CFC benefit.
- (4) Data regarding how the state provides CFC and other home and community-based services – This requirement can be met by reporting which of the following authorities the state used to provided home and community-based services: (1) 1915(c) waivers, (2) 1915(i) HCBS state plan option, (3) 1115 Demonstration Authority to provide LTSS, and (4) state plan personal care.
- (5) The cost of providing CFC and other home and community-based services and supports.
- (6) Data regarding how the state provides individuals with disabilities who otherwise qualify for institutional care under the state plan or waiver the choice to receive home and community-based services in lieu of institutional care. This requirement can be met by reporting which of the following authorities the state used to provide home and community-based services: (1) 1915(c) waivers, (2) 1915(i) HCBS state plan option, (3) 1115 Demonstration Authority to provide LTSS, and (4) State plan personal care.
- (7) Data regarding the impact of CFC on the physical and emotional health of individuals – this requirement can be met through the use of a consumer satisfaction survey. States have the choice of issuing the survey to each individual receiving CFC services, or issuing the survey to a sample size of the total CFC population. If the state employs a sampling method, the state should ensure that the sample size is statistically significant and includes individuals from each institutional level of care included in the CFC benefit.