Community First Choice (CFC) Proposed Participant Transition to Waivers - Frequently Asked Questions

A Message About This Document

This document provides responses to the most frequently asked questions the state agencies are hearing from CFC participants, families, advocates and other key stakeholders regarding the proposed transition of CFC program participants to a home and community-based waiver or another authority It is a dynamic document that will be updated as needed. The state is committed to a thoughtful approach to the proposed transition that includes input from all parties to ensure there is continued access, choice, and quality of life for those currently on CFC and those who will be seeking state services for the first time in the future.

General Information

(Q1) What is changing?

Response:

The Governor is proposing to transition CFC participants from a State Plan Option to an existing 1915(c) Medicaid home and community-based (HCBS) waiver, or a new waiver or some other authority.

(Q2) Why aren't remedies other than a planned transition being proposed?

Response:

- **For years, the state has tried to address issues with CFC, investing significant amounts of time and financial resources.** For years, the state has tried to address the persistent administrative challenges with CFC for both consumers and personal care attendants (PCAs). Despite the state's efforts, the program's increasing administrative complexities remain. Transitioning the CFC program is meant to stabilize the home and community-based services system and provide Medicaid participants with true choice for care in their homes and communities. Steps taken to date include:
- **Replacing the fiscal intermediaries (FIs) –** The state procured a single fiscal intermediary across the Departments of Aging and Disability Services, Social Services and Developmental Services. The new FI has struggled to meet the program's complex operational requirements and rapid caseload growth. Instead, their time has been spent on addressing hundreds of grievances, leaving little time and resources to address systemic issues.
    - **Implementing support and planning coaches** – In collaboration with 1199 and its Training and Upgrading Fund (TUF), over 170 support and planning coaches have been trained to assist consumers having chronic difficulty self-directing their services, including managing their budgets, care plans and staff time.

Implementing the support and planning coach assistance has been challenging on several fronts. First, matching coaches and clients has proved difficult because of the individualized needs of each client. Next, PCAs who provide services to clients may not serve as their support and planning coach, as this arrangement violates federal guidelines. Also, the costs for coaches are paid from members' personal care budgets and not every member chooses to spend their budget for this support. Finally, members who might benefit from a planning coach must also employ the coach and the PCA, which can prove difficult for members already struggling to navigate self-directed services.

  - **Moving from paper timesheets to electronic visit verification** (EVV) – this change helped to eliminate timesheet errors and the need to fax timesheets.
  - **Making significant investments in the workforce** – the state has worked with 1199 to establish a competitive wage for PCAs and address workforce recruitment and retention issues as well to support training to improve service quality.

- **Need to address access to home and community-based services for the entirety of the service system** – to ensure access to quality home and community-based services for older adults and individuals with disabilities living in the community now and in the future, the state must engage in thoughtful strategic planning around the reinvestment of Medicaid home and community-based service dollars. Such strategic planning must include ongoing communication with and feedback from key stakeholders including CFC participants, advocates, agency-based providers and the union.

Impact on CFC Participants

(Q3) When will CFC participants transition from CFC to another authority?

Response:

The Governor's proposed budget reflects an effective date of April 1, 2027. The intent is that CFC participants will be transitioned to an appropriate authority to avoid any service interruption.

(Q4) How many CFC participants will be transitioned from CFC to another authority?

Response:

- DSS estimates there are approximately 7,200 individuals currently receiving services under CFC and, of those, approximately 49% (3,500) are already on a waiver, including approximately 900 already active on one of the three DDS waivers, leaving the remaining 51% (3,700) who are on solely CFC State Plan services that will need to transition to a waiver or other authority. A portion of those on waivers, may need to transition to a different waiver or other authority to continue receiving supports from a PCA.
- CFC participants will have the option of retaining self-directed services under a waiver or other authority to receive services through a traditional agency-based model if they prefer.

(Q4) How will DSS and DDS determine which authority each CFC participant will be transitioned to?

Response:

DSS and DDS will conduct a thorough review of all CFC participants and their needs to determine the most appropriate authority for them. During this time, the agencies will also determine whether a new waiver needs to be established to ensure CFC participants have access to appropriate services based on identified need. The intent is that CFC participants will be transitioned to an appropriate authority to avoid any service interruption.

(Q5) What will change for CFC participants?

Response:

There will be some changes. Many of the changes will improve the program experience for consumers. The bullets that follow then reinforce this statement.

- **More narrow scope of responsibility that falls on the consumer** – participants transitioning to DSS administered waiver programs will no longer have budget authority and will only have employer authority. They will retain the ability to hire, fire, train and maintain staff, but won't have the flexibility to set monthly and annual hours. Budget changes will need to be approved in advance, but consumers will no longer have to worry about maintaining their budgets.
- **Greater participant choice** – participants will be able to elect to receive their services through a traditional agency-based model or self-direction. Stand-alone CFC consumers will no longer be required to be employers to receive services under the waivers—if a consumer does not want to self-direct, then they do not have to.
- **Access to case management** – all participants will now have access to case management services under the waivers to assist with managing their responsibilities if they choose to continue self-direction but also for other guidance and supports to remain in the community.

(Q6) Will CFC participants, especially those with high-cost care plans, experience a loss of service hours and be forced into nursing homes because waivers require care plans to be cost neutral?

Response:

No, the state anticipates being able to design the waivers in such a way that no current CFC consumers experience a service reduction as a result of transitioning to a waiver. The facts are:

- To address high-cost care plans, the state will be exploring waiver amendments to adjust the levels of care in the waiver(s) or build a new waiver for complex care.

- The assumption that CFC does not have cost "caps" is incorrect. CFC does have cost limitations; they are just not tied to CMS' requirement for budget neutrality like they are in the 1915(c) waivers. CFC also allowed for higher levels of care than the waivers, which allowed for larger care plans. As part of the transition process, the state will review all waivers and either amend the existing waivers or build a new waiver to address complex care needs.
- For CFC participants who do not naturally fall under an existing waiver, DSS will need to amend an existing waiver or create a new waiver option to support their needs. This new waiver option and/or waiver expansion will be developed with stakeholder engagement.
- The intent is that CFC participants will be transitioned to an appropriate authority to avoid any service interruption.

(Q7) Will individuals on waitlists with lower-level service needs receive priority status for future waiver slots?

Response:

No. The current Medicaid home and community-based system is designed with a strong preference for and investment in self-directed services through Community First Choice. This planned transition offers an opportunity to examine the entire array of home and community-based service options available to Medicaid participants, and to develop a plan for reinvestment of funds informed by data, study of national best practices and stakeholder input that will address the broader system.

(Q8) Will CFC participants who are currently receiving 24-hour care under their care plans be able to continue receiving 24-hour care after they are transitioned to a waiver? And will future waiver participants be able to receive 24-hour care when they come onto the waiver?

Response:

All CFC participant care plans will be reviewed, including those requiring 24/7 care to determine the most appropriate service option to meet the participant's individual needs.

(Q9) Won't sunsetting the CFC program have a significant negative impact on the state's rebalancing efforts and result in more people having to enter nursing homes?

Response:

No, we do not anticipate that it will increase nursing home usage as we do not believe that persons on CFC would automatically be in a nursing home without these services.

(Q10) How can I trust DSS and DDS to effectively implement the transition from 1915(k) State Plan option to 1915(c) waivers?

Response:

- The state has vast experience operating waivers and prior to the implementation of CFC in 2015, self-direction was only available through waivers. Given the state's familiarity with operating self-direction, including currently within existing waivers, transitioning from the 1915(k) back to the waivers is not expected to be a problem.
- The state agencies will develop a plan for ongoing communication and engagement with CFC participants and other key stakeholders throughout the transition process.

Impact on Waiver Waitlists

(Q11) What is going to happen to people currently on waiver waitlists? This seems unfair.

Response:

This is not just about saving money, it's also about opening slots and opportunities on the waitlists for all individuals, including those that have been waiting years but cannot or do not want to self-direct. Waivers provide the opportunity to be more equitable in addressing service needs. It's also about making the program work—the current system is not serving consumers or PCAs optimally.

DSS and DDS will be taking the following steps to address the existing waiver waitlists:

- Conducting reviews and updating all waiver waitlists to ensure they are current.
- Examining how a portion of anticipated future year cost savings resulting from the sunsetting of CFC could be reinvested to address waitlists.

(Q12) What will happen to people who need home and community-based services in the future if CFC no longer exists and waivers have waitlists?

Response:

The state will develop cost models to explore the feasibility of maintaining additional waiver slots for the waivers that support the transition from CFC State Plan services to waiver services.

Additionally, CFC is just one of many services and supports offered to Medicaid members. There is an array of home and community-based service and home health benefits currently available to members that remain available.

Home Care Workforce

(Q13) Won't sunsetting CFC have a negative impact on the self-directed workforce?

Response:

- All consumers currently receiving self-directed services will have the option to continue to self-direct and retain their own staff.
- Because self-direction will be a service option under the waiver choices provided to these consumers, new individuals requiring HCBS will still have access to self-directed services.
- Due to better budget controls and more narrow consumer budget authorities under waivers, issues with non-payment due to budget overruns or Medicaid eligibility, and spenddown status will be significantly less frequent and potentially prevented altogether.
- It is anticipated that some consumers may select agency-based services and no longer self-direct. This selection may slightly reduce the size of the workforce and result in the following:
    - Allow the FI to focus on corrective actions to stabilize service delivery.
    - Since agencies are expected to require additional staff to meet demand, PCAs whose consumer-employers choose to no longer self-direct may be able to find agency-based employment opportunities.

(Q14) How are agency-based home providers supposed to serve an influx of new waiver participants when they do not have the workforce to address increased demand? How can they compete with the higher wages paid to PCAs who work in the self-directed model of service delivery?

Response:

State agencies have identified agency-based service providers as key stakeholders in this transition process and will engage the industry to identify challenges and potential solutions to address barriers impacting participant access to agency-based services.