**What is the Community First Choice (CFC) Option?**

CFC is a new Medicaid entitlement state plan option established by the Affordable Care Act (ACA) that allows states to receive an additional six percentage points on their current federal match for approved services (56% instead of 50% match, for our state). Washington State’s current entitlement state plan option is Medicaid Personal Care (MPC).

**What services are required?**

* Personal care
* Skills acquisition, maintenance and enhancement necessary for the individual to accomplish Activities of Daily Living, Instrumental Activities of Daily Living and health related tasks (scope can be limited by states)
* Back-up systems and supports (can include things such a falls alert, GPS locator or emergency response button)
* Voluntary training on how to select, manage and dismiss attendants

**What services are optional?**

* Transition costs required for an individual to transition from a nursing facility, Residential Habilitation Center, or psychiatric hospital to a community-based home setting.
* Services that increase an individual’s independence or substitutes for human assistance, to the extent expenditures would otherwise be made for human assistance.

**How is eligibility determined?**

* Meet functional eligibility equal to Institutional Level of Care; and
* Be in an eligibility group that includes Nursing Facility services, or
* Have income below 150% of federal poverty level if in an eligibility group that does not include Nursing Facility services, or
* Receive medical assistance under the special home and community-based waiver eligibility group and receive at least one 1915(c) home and community-based waivered service per month.

**How can state general fund savings be maximized and achieved?**

* Leverage federal match by assuming all personal care services (state plan and waiver) and some ancillary waiver services are provided through CFC;
* Establish limits on amount, duration, scope and costs of services within standards of sufficiency and reasonableness required by CMS.
* Control caseload growth, by designing the model to maintain current service delivery model and policies related to training and background check requirements and other provider qualifications.
* Design services in a manner that allows the state to control per capita increases (mandated by the legislature).

**Why must the state reinvest some of the state general fund savings into CFC services?**

* CFC has a maintenance of effort requirement that the state spend the same *state* funds as in the year prior to implementation.
* CFC requires additional services be offered to eligible clients, which will somewhat increase per capita costs. The legislature has mandated that increases in costs not exceed 3% of current spending.
* Like the current MPC program that it would replace, CFC is an entitlement program and enrollment cannot be capped. Some of the savings needs to be available to address new caseload growth in excess of forecast.
* Staffing costs associated with program management, IT support and caseload growth (assumed by the legislature).
* Functional eligibility is higher than current Medicaid personal care program, based upon negotiations with the Centers for Medicare and Medicaid services funding may be necessary to ensure those currently served in MPC that are not eligible for CFCO do not lose services.

**What direction has the Legislature provided to DSHS?**

* 2746 directs DSHS to refinance Medicaid personal care under a community first choice option. The CFCO shall be designed in such a way to meet the federal minimum maintenance of effort requirements and all service requirements specified in federal rule. Optional services may also be included in the benefit package.
* The per capita cost of CFCO, as well as the cost of new optional services, shall not exceed a 3% increase over the per capita costs of personal care in the fiscal year prior to full implementation of CFCO. (3% limit does not apply to the following cost increases: regular caseload growth that would have otherwise occurred, case mix changes, inflation, vendor rate changes, expenditures necessary to meet state and federal law requirements, and any adjustments made pursuant to collective bargaining.)
* The CFCO will be designed to create state general fund savings that is intended by the legislature to be reinvested in home and community services for individuals with developmental disabilities or individuals with long-term care needs, including specific items in SB 6387 for developmental disabilities services.
* The CFCO option must be fully implemented no later than August 30, 2015.
* The Joint Legislative and Executive Committee on Aging and Disability will make recommendations about how to invest savings prior to the Department submitting its State Plan CFCO application.
* The state must submit the State Plan CFCO application to the Centers for Medicare and Medicaid Services (CMS) not later than January 1, 2015 to meet the implementation deadline.

**What are the role and responsibilities of the CFCO Design and Planning Work Group?**

* The Planning and Design Workgroup must have 51% membership of consumers/their representatives.
* The workgroup will develop recommendations to DSHS on the following topics:
	+ The amount, duration, scope of required services.
	+ Whether any optional services should be explored: What services, what amount, duration and scope?
	+ Consideration of qualified providers for each identified service.
	+ Recommendations around benefit design: How much choice and flexibility will there be in the benefit design?
	+ Ideas for monthly waiver services that would permit waiver eligible individuals to access some benefits through CFCO?
	+ Are there ways to leverage CFCO to maximize function/independence, self-management and ability for clients to work towards health goals?
	+ Recommendations of potential investments for any remaining general fund-state savings from the CFCO in home and community based services for individuals with developmental disabilities or individuals with long-term care needs. (Note that recommendations will also be made by the Joint Legislative Executive Committee on Aging and Disability.)