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COMMUNITY FIRST CHOICE: SUMMARY OF FINAL REPORT TO CONGRESS

Georgia Health Policy Center

Medicaid Policy and Business Team

POLICY UPDATE

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The Affordable Care Act, which created the 1915(k) Community First Choice Option Program, requires that the Secretary of the Department of Health and Human Services (HHS) provide interim and final reports to Congress on the effectiveness, impact, and costs of the 1915(k) program. The secretary submitted an interim report to Congress in June 2014 and a final report in December 2015. The final report assessed the program as of March 15, 2015. The final report covers the 1915(k) program in the four states who had approved State Plan Amendments (SPAs) as of December 31, 2014—California, Maryland, Montana, and Oregon, as well as several states who did not adopt SPAs. Highlights of this report include:

- At the time of the report's writing, five additional states were in talks with CMS about their proposed 1915(k) SPAs—Texas (approved April 2, 2015), Washington (approved June 30, 2015), Connecticut, Minnesota, and New York. The latter three were not approved as of July 17, 2015. Arizona, Arkansas, and Louisiana had submitted applications that were subsequently withdrawn.
- The four states reviewed—California, Maryland, Montana, and Oregon had existing HCBS waiver programs. In addition, these states allotted a higher proportion of their LTSS spending on HCBS services compared to the national average for states.
- Analysis of 1915(k) programs' impact on health status and costs were limited due to the lack of availability of timely claims data. Therefore, the secretary was unable to report on the health impact of the 1915(k) program.
- Of the four states reviewed, the 1915(k) program did not eliminate the need for HCBS waivers. Because of its income requirements, some waiver participants would not qualify for the 1915(k) program. In addition, some waiver participants have to receive HCBS services through a waiver program in order to qualify for Medicaid benefits.

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- In both participating and non-participating states, consolidation of HCBS services was not necessarily a priority due to the different state agencies that had authority over different waivers. Coordinating a consolidation among these various agencies was seen as an insurmountable challenge for many states.
- States that did not adopt 1915(k) were generally concerned with the costs associated with a SPA and did not feel that the 6% FMAP increase was enough to offset additional costs. These states also seemed to prefer the flexibility afforded by their existing HCBS waiver programs. The four 1915(k) states that were reviewed for this report confirmed that their costs had risen with the implementation of their SPAs.
- 56% of 1915(k) beneficiaries from the four states were blind or disabled, and 60% were women. In addition, there was a high prevalence of mental health or other chronic conditions in the four state 1915 (k) population.
- States expressed difficulty in applying the same sets of standards to both the behaviorally disabled and developmentally disabled. There was quite a bit of push back in states by advocates for the developmentally disabled, citing the differing needs of this population. Specifically, advocates felt that different needs of the developmentally disabled population were not adequately met by required assessments of the ability or inability of a patient to meet certain Activities of Daily Living (ADLs) or Incidental Activities of Daily Living (IADL). Instead, advocates favored the individual goal-setting assessments used in 1915(c) waiver programs.
- Consumers already receiving HCBS through a waiver program saw little disruption in services, whether they remained in a waiver program or were transferred into 1915 (k) coverage.