State of Connecticut Department of Social Services & Department of Developmental Services
Questions and Answers about the new Community First Choice Option
Updated July 2018 to Provide Additional Clarification

The letter references a redesign in the Community First Choice (CFC) benefit. Why was CFC redesigned?

On December 30, 2016, CMS issued a State Medicaid Director letter (https://www.medicaid.gov/federal-policy-guidance/downloads/smd16011.pdf) providing additional clarification regarding CFC including the new technical guide: https://www.medicaid.gov/medicaid/hcbs/downloads/authorities/cfc-technical-guide.pdf

The guidance details a more limited CFC benefit related to habilitation than what was initially envisioned. Specifically, the CFC benefit must directly correlate to the accomplishment of activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks. This may result in a decrease in the funding available for certain people under CFC.

The changes due to the new federal guidance were implemented for all CFC assessments and reassessments effective January 19, 2018. The changes are not related to the Personal Care Attendant (PCA) wage increases included in the 2018 PCA collective bargaining agreement in Connecticut.

How is the CFC benefit different from when it was initially released in 2015?

When the CFC benefit was initially released, funds were authorized for community participation activities such as socialization which do not directly tie back to the accomplishment of ADLs, IADLs and health-related tasks. These funds were occasionally authorized in addition to waiver supports which were authorized for a similar purpose. This is no longer permitted.

In addition, the initial budget for CFC assumed that the participant lived in an independent setting. Accounting for voluntary support was not applied in a consistent manner. The standard of medical necessity was not applied. Now, all CFC service authorizations must meet the standard of medical necessity. Additionally, the State is ensuring a consistent approach to applying levels of voluntary, informal support to service authorizations.

If I am not authorized to receive services under CFC will the waiver cover all of my needs?

No, neither waivers nor CFC will necessarily cover all of your needs. Unmet needs are identified through the assessment process, which takes into consideration your home situation, informal supports, and other services you may be receiving. The assessment also considers all clinical information before determining a level of need and appropriate funding. CFC services are authorized by DSS based on medical necessity.

Why are people who are on DDS' waiver for employment and day supports (EDS) being denied CFC for cueing and supervision related to ADLs?

To be compliant with new federal guidance, CFC service authorizations must meet the standard of medical necessity. Additionally, the State is ensuring implementation of a consistent approach to applying levels of voluntary, informal support to service authorizations. All needs, including the need for cueing and supervision and hands-on assistance with ADLs, are taken into consideration during the assessment process. From the needs assessment, a level of need (LON) is determined. LONs range from 1 to 8, with 8 representing the highest need. If someone already has an established LON and an authorized budget, DSS' assessment will determine if there is a need for additional services based on medical necessity. If additional support for cueing and supervision or for other needs related to ADLs, IADLs or health-related tasks is medically necessary, then services will be authorized.

How will I know if I meet the functional criteria to receive additional support under CFC?

The assessment process determines eligibility for CFC supports and the level of funding. If you are receiving waiver services, then a comprehensive assessment was already completed. DSS reviews the comprehensive assessment as well as the existing budget allocation as part of the assessment process. While the comprehensive assessment considers needs related to ADLs, IADLs, and health-related tasks, budget allocations for DDS' EDS and Individual Family Support (IFS) waivers do not typically include funding for residential hands-on ADL needs. Prior to the establishment of CFC, needs related to residential hands-on ADL support for these waiver participants were covered through DSS home-health aide services and subject to medical necessity. CFC is now an option to cover these needs in lieu of home health aides. To determine an appropriate level of additional funding for hands-on ADL needs, DSS may use an abbreviated version of the assessment specifically focused on this area of need. This does not change the LON which was already established with the comprehensive assessment. It is important to note that the CFC assessment process does not solely depend upon the abbreviated version of the assessment to determine if additional funding is required. Other factors after review of the comprehensive assessment include, but are not limited to, a change in caregiver status, change in living arrangement from a dependent family setting to an independent setting, change in health or function, etc.

Why is a reassessment necessary?

DSS must reassess all CFC participants to ensure compliance with new federal guidance; DSS will utilize the new assessment tool.

Who will contact me?

You will be contacted by your Universal Care Manager (UCM) who will schedule a time for your reassessment. Your UCM is from a local Access Agency, such as Connecticut Community Care Inc.

When will you contact me?

The reassessment process will begin with those applicants who have submitted a service plan but who have not yet hired all of their staff. At the same time, all CFC participants who are active in the program will be reassessed as of their annual review date using the new assessment tool and based on the new

federal guidance. We expect the reassessment process will take 4 months. If you are waiting to hire staff and have not received a call within the next month, please call 1-888-992-8637.

Will my budget change?

Not all budgets and service plans will be impacted by this new guidance. The Department will determine if budget and service plan changes are required based on your individual assessment.

Will the wage increases associated with the PCA Collective Bargaining Agreement (CBA) reduce the hours in my service plan?

No. Your budget will increase to cover the wage increase associated with the CBA as long as you continue to need the same level of service. Please keep in mind that the assessment process determines your need for hours of support. If it is determined that you require fewer hours of service than what was authorized in your previous plan, then your hours may be reduced. This determination is separate from the wage increase.

What will happen at my reassessment visit?

Your UCM will complete your assessment and discuss how CFC can cover your unmet needs. If your funding is different as a result of the assessment, your UCM can help you complete a new budget during the visit. We encourage you to have your support team at the reassessment visit so that paperwork can be completed quickly. If you prefer to wait and complete the paperwork independently or with someone else, please keep in mind that the revised budget must be returned to the UCM within 14 days of the reassessment visit.

What happens if my budget expires before I get a phone call?

If your budget expires before your reassessment is scheduled, you will receive a new temporary budget. The amount of funding in the temporary budget will be the same as what you had the prior year. Unused funds cannot be used after the budget expires.

All current service plans will remain in place without interruption of services until and unless an individual's needs change or the Department of Social Services determines, based on the above criteria, that revisions are necessary.