Data Brief
September 2017

The Hilltop Institute
analysis to advance the health of vulnerable populations

Community First Choice Implementation in Maryland, 2014-2016

Background

Community First Choice (CFC) is an optional Medicaid state plan program authorized by the Affordable Care Act (ACA) that enables states to provide home- and community-based services (HCBS) to Medicaid-eligible individuals through their state plan and receive a 6 percent increase in their federal match. The services offered through CFC enable participants to live and actively participate in their communities. These services assist participants in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Services offered under CFC include personal assistance, supports planning, consumer training, personal emergency response systems (PERS), items that substitute for human assistance, environmental assessments, nurse monitoring, and transition services.

Maryland began transitioning individuals into CFC services in 2014, phasing in different groups of participants over the next several years. First, the state transitioned the services of recipients enrolled in existing HCBS waiver programs, essentially "carving out" CFC-eligible services from the 1915(c) waiver programs and placing them in the state plan. Next, the state began transitioning participants receiving services under the prior Medicaid state plan personal care program who also met CFC's level of care requirements. The state then reached out to individuals on the state's HCBS registry who were seeking services. This data brief examines CFC program participation, utilization, and expenditures in Maryland thus far. It also addresses the observed longitudinal variation in participants' informal supports.

CFC Enrollment Changes and Demographic Distribution

CFC enrollment has increased each calendar year (CY), primarily due to the transitioning of services for individuals enrolled in 1915(c) waivers or receiving other state plan HCBS. In CY 2014, there were 6,639 participants enrolled in CFC. By 2016, that number increased 74 percent, reaching 11,573 participants. As with most HCBS, the majority of recipients were female, which was consistent across each calendar year (Figure 1).

Figure 1. Number of CFC Participants, by Gender, CY 14 – CY 16

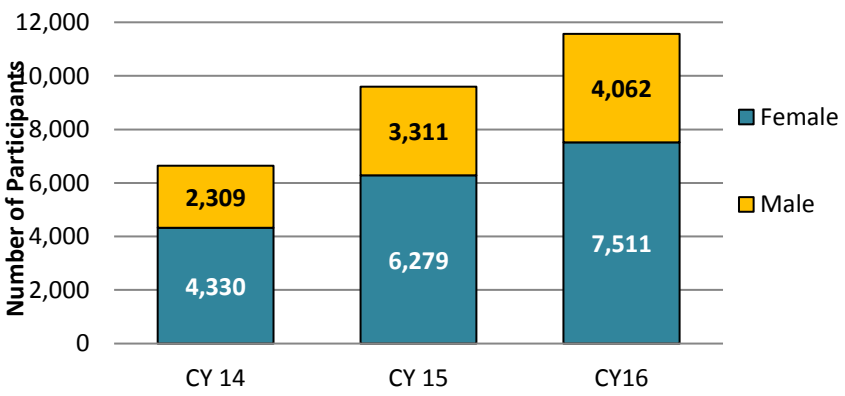
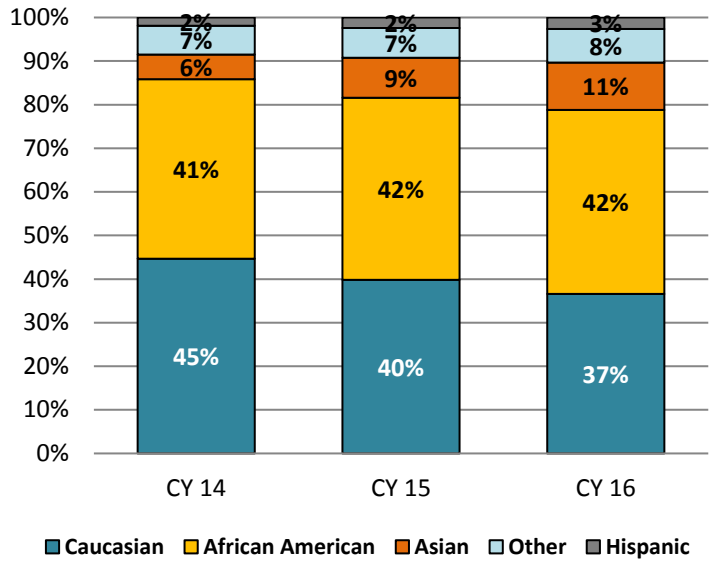


Figure 2. Distribution by Race, CY 14 – CY 16



In CY 2016, the majority of CFC participants were female (65 percent), African American (42 percent), and over the age of 65 (55 percent). See Figures 1 through 3. The demographic composition of CFC changed somewhat over the reporting period, likely due to the phased-in enrollment.

When CFC was first implemented in 2014, individuals tended to be over the age of 65 (67 percent) and dually eligible for both Medicare and Medicaid (73 percent). As enrollment progressed, a greater number of younger individuals and participants eligible only for Medicaid enrolled in CFC. In CY 2016, there were only slightly more individuals over the age of 65 than individuals under 65 (55 percent vs. 45 percent). Medicaid-only individuals enrolled at a higher rate between CYs 2014 and 2016; however, dual-eligible participants continued to be the majority enrolled in CFC by CY 2016 (65 percent vs. 35 percent). See Figures 3 and 4.

Figure 3. Distribution by Age, CY 14 – CY 16

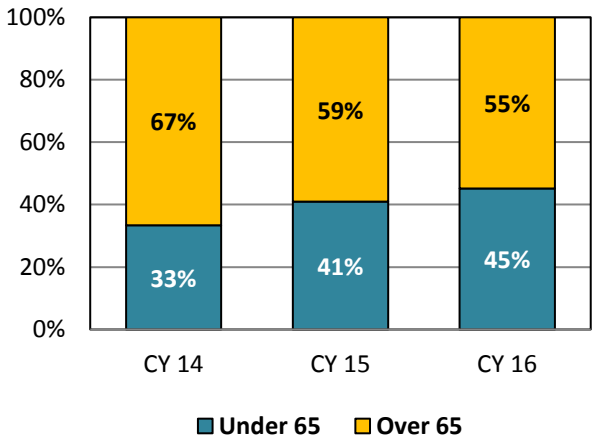
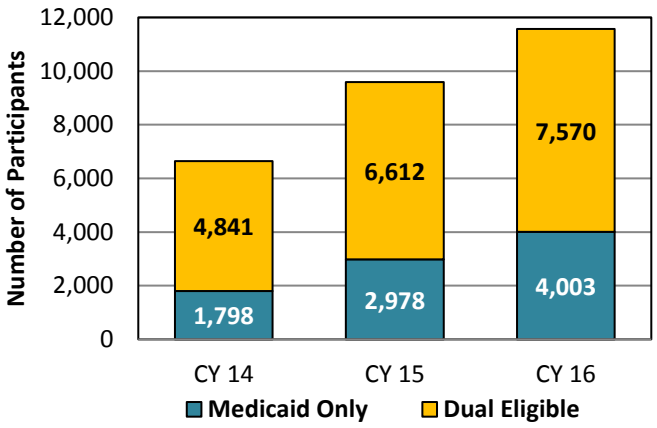


Figure 4. Number of Participants, by Dual Eligibility Status, CY 14 – CY 16



CFC Expenditures

Expenditures increased at approximately the same rate as participants enrolling in CFC. Consequently, per member per year (PMPY) expenses remained stable between CYs 2014 and 2016 (Table 1). Total expenditures were $140.5 million in CY 2014 and $247.5 million by CY 2016 (Figure 5).[1]

[1] These figures do not include pre-participation administrative coordination services.

Table 1. CFC Expenditures, CY 14 – CY 16

	Number of Participants	Total Expenditures	Per Member Per Year (PMPY)
2014	6,639	$140,478,083	$21,160
2015	9,590	$195,396,768	$20,375
2016	11,573	$247,537,508	$21,389

In CY 2016, the vast majority (87 percent) of CFC expenditures were for personal assistance services (Figure 6). Expenditures for coordination, monitoring, and training services totaled $24 million (10 percent of total expenditures), while items that substitute for human assistance cost $8.2 million (3 percent of total expenditures). Transition services accounted for less than 1 percent of expenditures. Expenditures by service were consistent across calendar years.

Figure 5. Total CFC Expenditures, CY 14 – CY 16 (in millions)

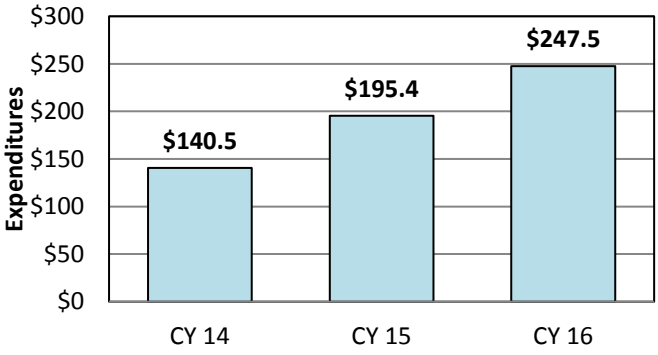
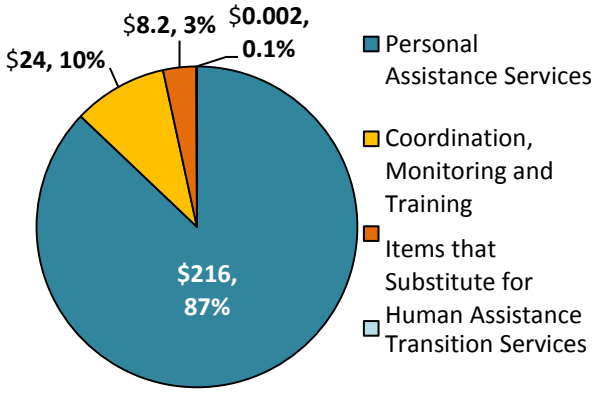


Figure 6. Expenditures by Service, CY 16 (in millions)



Informal Supports

Informal supports are family, neighbors, friends, or co-workers that help individuals who require assistance with ADLs and IADLs. In some situations, informal supports may be an alternative to more costly, formal care.[2]

To gauge the effect of CFC services on the use of informal supports, Hilltop compared the average number of hours of informal care per week before and after CFC enrollment, as reported by participants' interRAI home care assessments. The initial interRAI assessment, completed to determine eligibility for the program, was used as a proxy to determine pre-CFC hours of informal support, while the first annual interRAI assessment post-enrollment was used to determine post-CFC hours. In total, 3,090 participants were included in this analysis because only participants who had completed both an initial and annual interRAI assessment and were not receiving HCBS through another Medicaid program were included.

The mean number of informal support hours per week before CFC participation was 35.9. Informal supports decreased to 28.3 hours per week after one year of CFC participation. The minimum number of hours per week was 0, and the maximum was 168—for both pre- and post-CFC. There was wide variation in hours

[2] Cecchini, M. (in press, corrected proof). The hidden economics of informal elder-care in the United States. *The Journal of the Economics of Ageing.*

of informal supports received, as indicated by the standard deviation: 43.3 hours for pre-CFC and 35.1 hours for post-CFC. See Table 2.

Table 2. Hours of Informal Supports, Pre- and Post-CFC

	Number of Participants	Mean Hours	Standard Deviation	Minimum	Maximum
Pre-CFC	3,090	35.9	43.3	0	168
Post-CFC	3,090	28.3	35.1	0	168

There were differences in utilization by race, although participants of all races saw a decrease in the use of informal supports post-CFC. Overall, Caucasian participants saw the smallest decrease in their level of informal supports (4.7 hours), while Hispanic participants experienced the largest decrease (14.5 hours).[3] See Table 3.

Table 3. Hours of Informal Support, by Race, Pre- and Post-CFC

	Number of Participants	CFC Status	Mean Hours	Difference (in hours)	Percentage Change
Asian	395	Pre	34.8	-8.1	-23%
		Post	26.6		
African American	1,281	Pre	38.3	-8.7	-23%
		Post	29.6		
Caucasian	1,094	Pre	30.8	-4.7	-15%
		Post	26.1		
Hispanic	95	Pre	53.5	-14.5	-27%
		Post	39.0		
Native American	*	Pre	38.0	-17.7	-46%
		Post	20.3		
Pacific Islands/ Alaskan	*	Pre	59.5	-14.0	-24%
		Post	45.5		
Unknown	212	Pre	40.9	-10.5	-26%
		Post	30.4		

* Not reported due to small cell sizes

Before CFC, individuals who were under 65 years of age received significantly more hours of informal supports (46.5 hours) than individuals over 65 years (27.4 hours), likely due to the availability of informal support providers—typically parents—for younger individuals. After CFC, there was a greater decrease in informal support hours for younger individuals than older individuals (10 hours versus 5.6 hours); however, the percentage decrease was comparable (22 percent versus 20 percent). See Table 4.

[3] Native American and Pacific Islands/Alaskan also experienced a large decrease in hours; however, due to small cell sizes, extreme values could have influenced the mean.

Table 4. Hours of Informal Support, by Age, Pre- and Post-CFC

	Number of Participants	CFC Status	Mean Hours	Difference (in hours)	Percentage Change
Under 65	1,367	Pre	46.5	-10.0	-22%
		Post	36.4		
Over 65	1,723	Pre	27.4	-5.6	-20%
		Post	21.9		

Males received more informal supports pre-CFC than females (41.1 hours and 33.3 hours, respectively) and continued receiving more informal supports post-CFC. The difference in hours pre- and post-CFC, as well as the percentage decrease in number of hours, were comparable between genders. See Table 5.

Table 5. Hours of Informal Support, by Gender, Pre- and Post-CFC

	Number of Participants	CFC Status	Mean Hours	Difference (in hours)	Percentage Change
Female	2,073	Pre	33.3	-7.2	-22%
		Post	26.1		
Male	1,017	Pre	41.1	-8.3	-20%
		Post	32.9		

Individuals who were eligible only for Medicaid received more hours of informal support, both pre- and post-CFC enrollment. For Medicaid-only recipients, pre-CFC informal support hours were 45.7 and post-CFC hours were 35.9. Individuals who were dually eligible received 30.7 hours of informal support pre-CFC—which is less than the post-CFC utilization for Medicaid-only recipients—and 24.1 hours post-CFC. Both groups decreased by the same percentage (21 percent) after CFC enrollment. See Table 6.

Table 6. Hours of Informal Support, by Status, Pre- and Post-CFC

	Number of Participants	CFC Status	Mean Hours	Difference (in hours)	Percentage Change
Dual-Eligible	2,010	Pre	30.7	-6.6	-21%
		Post	24.1		
Medicaid-Only	1,080	Pre	45.7	-9.8	-21%
		Post	35.9		

Rural CFC participants had one of the smallest decreases in informal supports pre- versus post-CFC, possibly due to the limited availability of formal supports in rural areas. Individuals living in rural areas received 41.8 hours of informal support per week before CFC enrollment and 35.4 hours after CFC enrollment, which represents a 15 percent decrease. However, individuals living in urban areas experienced a 23 percent decrease in informal supports. See Table 7.

Table 7. Hours of Informal Support, by Location, Pre- and Post-CFC

	Number of Participants	CFC Status	Mean Hours	Difference (in hours)	Percentage Change
Rural	707	Pre	41.8	-6.4	-15%
		Post	35.4		
Urban	2,383	Pre	34.1	-7.9	-23%
		Post	26.2		

Personal Assistance

As mentioned above, personal assistance services accounted for the vast majority of CFC expenditures. The mean per member per week (PMPW) hours of personal assistance services were 43 in CY 2014 and 29 in CY 2016 (Table 8). As with the changes in program participation and demographic distribution noted earlier, this is likely due to the change in the mix of participants as different populations have transitioned into CFC.

Table 8. Hours of Personal Assistance, CY 14 – CY 16

	Number of Participants	Mean Hours (PMPW)	Standard Deviation	Percent Change (since CY14)
CY 14	6,639	43	48	-33.1%
CY 15	9,590	32	33	
CY 16	11,581*	29	26	

*The total number of participants varies slightly from the numbers reported elsewhere in this data brief due to an additional month's worth of data in MMIS at the time this analysis was completed.

In CY 2014, CFC participants under the age of 65 received more hours of personal assistance services per week than individuals over 65. However, by the end of the three-year enrollment period, individuals over the age of 65 were receiving slightly more hours of personal assistance services per week than those under age 65. CY 2016 enrollees received, on average, fewer hours of personal assistance services than CY 2014 enrollees, regardless of age (Figure 8).

Dual-eligible individuals consistently used more personal assistance services per week than Medicaid-only individuals across all calendar years. The mean number of personal assistance hours declined each year for both dual-eligible and Medicaid-only participants, with the decline being more pronounced for Medicaid-only participants. (Table 9).

Figure 8. Hours of Personal Assistance (PMPW), by Age, CY 14 – CY 16

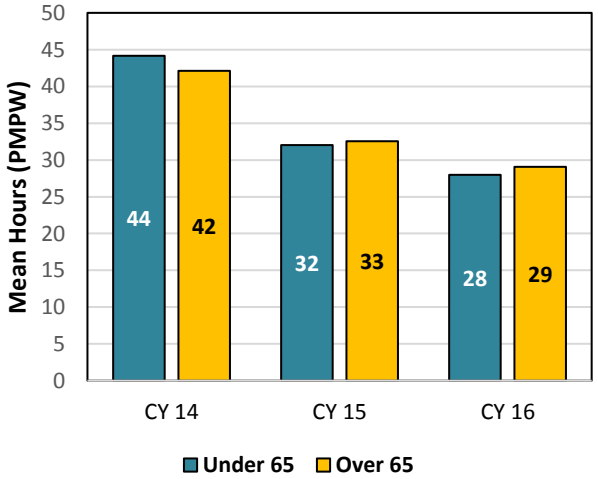


Table 9. Hours of Personal Assistance, by Status, CY 14 – CY 16

		Number of Participants	Mean Hours (PMPW)	Standard Deviation	Minimum	Maximum	Percent Change in Mean Hours (from CY 14)
Dual-Eligible	**CY 14**	4,830	43	47	0.0	187	-29.9%
	CY 15	6,617	33	32	0.0	159	
	CY 16	7,599	30	26	0.0	140	
Medicaid-Only	**CY 14**	1,809	42	51	0.0	184	-39.8%
	CY 15	2,973	30	32	0.0	153	
	CY 16	3,982	25	24	0.0	145	

Summary

Maryland began implementing CFC in 2014, gradually transitioning selected HCBS, such as personal assistance, from existing state programs. First, services for individuals in 1915(c) waivers were transitioned, followed by services for individuals receiving services through a state plan personal care program, and finally individuals new to services from the HCBS registry. This data brief presents data on CFC program participation, expenditures, and service utilization during the three-year enrollment period. While there were significant changes in CFC between 2014 and 2016, these changes should not be interpreted as a true "trend" because of the gradual phase-in of different groups of participants.

In CY 2016, 11,573 individuals received CFC services, with total program expenditures of $247.5 million. The majority of the participants were African American, female, over the age of 65, and dually eligible for both Medicaid and Medicare. Personal assistance was the most used CFC service, with dually eligible participants as well as those over 65 using slightly more hours per week. Informal supports decreased after participants were enrolled in CFC, but it is important to note that this decrease does not necessarily mean that CFC services substituted for existing informal supports. A much more rigorous statistical evaluation would be needed to determine the existence and size of any causal substitution effect.

About The Hilltop Institute

The Hilltop Institute at UMBC is a non-partisan health research organization—with an expertise in Medicaid and in improving publicly financed health care systems—dedicated to advancing the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis.

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The Hilltop Institute

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