Improving Support for Health Maintenance in Home and Community-Based Services

How States Adapt Nursing Rules for the Community First Choice Program

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Executive Summary

Many people with disabilities and older adults get paid help with daily activities, often through state Medicaid programs. Some also need help with health maintenance tasks, such as ostomy care, ventilator management, bowel and bladder care, tube feeding, insulin injections, and management of other medications. In many states, laws prohibit paid workers without nursing or other medical licenses from performing such tasks. In others, nurses or other licensed healthcare workers are permitted to delegate such tasks to these personal assistance services (PAS) workers. In some instances, such workers can perform health maintenance tasks under the direction of the consumer, without nurse delegation or supervision. The more restrictive regulations found in many states can increase the cost and reduce the availability of the health maintenance support that people need. They might be forced to do without, ask untrained family members to help, or struggle to do the tasks themselves.

The Affordable Care Act created a new Medicaid Program, known as Community First Choice (CFC), that provides an incentive for states to change laws and regulations to allow PAS workers to perform health maintenance tasks. This report takes a detailed look at how three states adapted, or are thinking of adapting, their laws and regulations related to nursing scope of practice to improve availability and lower costs of supporting health maintenance for people who receive home and community-based services. We identified the following promising practices:

Oregon's Long Term Care Community Nursing Services

This program allows nurses discretionary authority to teach people with disabilities who self-direct their care or their family members how to perform health maintenance tasks. They can also delegate certain tasks to non-family members or paid care providers, then monitor how the tasks are being performed over time. This model promotes a holistic approach that supports individuals with ongoing health maintenance needs in their own home settings. In addition, state officials view this approach to nursing as an expansion of the field because it offers nurses new practice opportunities.

New York's Consumer Directed Personal Assistance Program

This mandatory, statewide program makes it possible for people with disabilities, or another adult approved to manage care, to hire PAS workers and train them to perform tasks such as suctioning tracheostomies, injecting insulin, or administering medications that the person cannot self-administer. This flexibility was achieved when the law that established the predecessor program, the Patient-Managed Home Care demonstration, also amended the nurse practice act (NPA) to allow the program's PAS workers to perform health care tasks that, in the traditional system, could be performed only by registered nurses, licensed practical nurses, or certified home health aides assigned by health agencies.

February 2018
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New York's Advanced Home Health Aide (AHHA) Job Classification

CFC presented New York with the opportunity to increase community-based, self-directed long-term services and supports (LTSS) for people with disabilities. Among many requirements, the CFC called for certain services and supports, including health maintenance tasks that were only available through Medicaid waiver programs. The NPA limited who could perform the health-related tasks included in the set of services that the CFC required. Only registered nurses or certified home health aides working under nurse supervision could perform these tasks. Advocates called for an amendment to the NPA that would allow nurses to delegate certain health-related tasks to PAS workers who met new training requirements.

In June 2016, the New York State legislature passed bills amending the NPA and creating the AHHA job classification. Under the new law, individuals with at least one year's experience working as a home health aide or personal care worker can be trained as an AHHA. Following training, workers who nurses deem competent and proficient can perform advanced health-related tasks, such as injecting insulin and administering medication. The AHHA legislation created a path for CFC-eligible people with disabilities and seniors to receive assistance with health maintenance tasks in the community.

Introduction

This paper examines how laws and regulations governing nursing scope of practice intersect with federal funding opportunities that support independent community living, consumer choice, and health-related tasks that PAS workers who do not have healthcare licenses or certifications are allowed to perform for people with disabilities and older adults. We specifically explore how New York, Oregon, and Colorado have considered or undertaken the Community First Choice benefit[1] enacted as part of the 2010 Affordable Care Act,[2] as well as the role nursing scope of practice rules have played in these states' deliberations as to whether or not to participate in the program.

Nursing Scope of Practice Laws and Regulations

An estimated 11 million people living in the United States receive assistance with daily tasks from family, friends, or paid workers, and that number will increase dramatically as the population ages.[3] Medicaid pays for most long-term services and supports for an estimated 4.8 million people with disabilities who are low-income.[4] Medicaid LTSS includes both institutional and home and community-based services (HCBS), and beneficiaries run the gamut from medically fragile children to adults over age 65 with multiple medical conditions. Beneficiaries also include working adults with significant physical disabilities, people with advanced dementia or severe mental health disorders, people with intellectual and developmental disabilities, and children and adults who experience autism.[5] Adults aged sixty-five and older represent 45 percent of Medicaid LTSS beneficiaries, and 16 percent are under age twenty-one. The remaining 39 percent range in age from twenty-one to sixty-four.[6]

In 2013, federal HCBS spending exceeded institutional care spending for the first time.[7] Within HCBS, many state Medicaid programs offer participants the option to self-direct their care by hiring and training their own workers. In other programs, home health agencies or other intermediaries provide these workers. PAS workers can assist consumers with daily activities such as bathing, dressing, toileting, meal preparation, eating, and maintaining a household. However, health maintenance tasks such as ostomy care, ventilator management, bowel and bladder care, tube feeding, insulin injections, and management of other medications have historically fallen under the authority and responsibility of licensed nurses. State nursing scope of practice laws, referred to as nurse practice acts, play a central role in determining under which circumstances a nurse can delegate these tasks to assistive personnel such as PAS workers. These laws vary widely state to state, sometimes exempting certain

workers altogether from licensure or certification requirements.

People with disabilities and older adults overwhelmingly prefer to live in their own homes or in other unrestrictive community settings while receiving services that enable them to work, attend school, interact with family and friends, worship, and participate in their communities freely.[8] As the population ages, the number of people who will require LTSS is expected to increase substantially.[9]

As more people with disabilities and older adults living in home and community-based settings self-direct their care, they are increasingly viewing health maintenance tasks as routine activities that PAS workers should be able to manage, rather than nursing tasks that must be carried out or supervised by a licensed professional.[10] In response to this growing trend, and because LTSS provided in home and community-based settings is less costly than institutional care, many states have exempted consumer-supervised PAS workers from NPA licensure and other requirements. In support of consumer autonomy in health maintenance, some states have adopted policies that permit nurses to either delegate required tasks to paid PAS workers while monitoring them or teach the workers how to carry out those tasks independently.

People with disabilities and older adults living in states that have not adopted such policies may experience limited access to assistance with everyday tasks necessary for health maintenance. At best, rather than relying on their regular PAS workers, they may need to wait for special visits from a nurse or a specialized aide whose only job is health maintenance tasks. In some instances, they might be limited to services from a home health agency and not given the choice to direct their own workers. Such arrangements can be costly and unnecessarily restrictive due to the scheduling requirements of nursing staff that must supervise aides as well as carry out certain tasks themselves. The services also may simply not be available if the consumer lives in an area with a limited number of home health agencies, or if agencies have staffing limitations that prevent licensed or certified personnel from carrying out required tasks on a daily basis. If the use of PAS workers to perform these tasks is impermissible, and if family members are not available or willing to step in, consumers' only option may be to move to a nursing facility with on-site licensed personnel.

Nursing scope of practice rules therefore can either facilitate or potentially act as a barrier to people who require health maintenance tasks in order to live independently in community settings of their choice. In response to this changing landscape, nursing organizations are progressively finding ways to adapt and apply their extensive skill sets. Recent research on nurse delegation in home care shows that consumers experience improvement in both quality of life and quality of care, with no negative outcomes reported. Moreover, nurses are reporting that delegation in the home care setting is a valued option.[11] They are becoming aware of new professional opportunities made available once they adapt their practice methods to ensure that PAS workers perform health maintenance tasks safely and responsibly.[12] With this support, nurses have more time and opportunity to care for people with complex needs who require advanced nursing skills.

Health care practitioners, policy makers, and other key stakeholders face an ongoing challenge to reconcile legitimate consumer health and safety concerns and traditional practice methods, with the desire and indeed the right of people with disabilities to direct their own care and make autonomous life decisions. It will be important for stakeholders to recognize that technological advances and extensive community experience are creating a path for PAS workers to safely and independently carry out diverse health maintenance tasks. Under certain circumstances, the skills and capabilities of nursing professionals might best be applied to training such workers who are not directly under their supervision to carry out tasks responsibly and consistently. Models such as the one Oregon designed, described later, could encourage collaboration among nursing professionals, PAS workers, and people with disabilities. This could lead to clearer channels of communication and more effective health-related task management

while also reducing the need for some people to undergo institutionalization.[13]

Community First Choice Benefit

The Affordable Care Act amended Section 1915(k) of the Social Security Act to allow states the option of providing home and community-based attendant services and supports statewide to individuals who would otherwise require an institutional level of care. Known as the Community First Choice benefit, this new program provides states with the option to expand LTSS through their State Plans. The CFC benefit increases states' Federal Medical Assistance Percentage (FMAP) by six percentage points for HCBS. These benefits help to rebalance Medicaid LTSS funding in order to provide consumers with the opportunity to exercise control over their services and living arrangements. The CFC emphasizes providing services based on functional need rather than diagnosis or age; it was designed to ensure that LTSS are provided in a manner that promotes independence and personal direction in accordance with the U.S. Supreme Court *Olmstead* decision.[14] The CFC does not allow enrollment caps or waiting lists, and only supports services in home or community based-settings (prohibiting its use in restrictive settings such as nursing facilities, institutions for mental disease, or intermediate care facilities for individuals with intellectual disabilities).

Covered services include attendant services and supports that promote consumer control and involvement. Certain services are required, such as assistance with daily living and community participation activities. Others are optional such as help to set up a home in the community when an individual transitions from an institution.

Eligibility

The CFC final rule also delineates who is eligible for CFC, should states include the option. Individuals of all ages who are eligible for Medicaid under the State Plan, qualify financially, and require an institutional level of care are eligible for CFC services. In order to receive CFC services, an individual must be eligible for medical assistance under the State Plan in a group that includes access to the nursing facility benefit; or, if the individual is not in such a group but still meets Medicaid eligibility criteria, his or her income may not exceed 150 percent of the Federal Poverty Level. The state must also determine that, without home and community-based services, the individual would require an institutional level of care.[15]

Health-Related Tasks

The CFC also specifically requires hands-on assistance, supervision, and/or cuing with health-related tasks such as tube feedings, catheterization, range of motion exercises, and medication administration.[16] The final regulations implementing the CFC recognize the intersection of the rule's health-related provisions with delegation provisions under NPAs. The rule states, "Health-related tasks means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant."[17] The regulation notes,

> The definition of "health-related tasks" specifies that tasks delegated or assigned by licensed professionals may be provided under CFC as long as the task being delegated is done in accordance with the State law governing the licensed professional delegating the task. Recognizing the variance among State laws governing the specific tasks licensed health-care professionals may delegate, we do not believe we should impose requirements that could cause a licensed professional to be out of compliance with the State law in which they provide services. We do acknowledge that this State variance will lead to a varied scope of activities meeting the definition of "health-related tasks."[18]

Indeed, the wide variation in state NPAs has presented challenges for some states that want to take full advantage of CFC, while earlier efforts by other states to expand nurse delegation assured that their NPAs would not present any barriers.

As of November 2017, the Centers for Medicare and Medicaid Services (CMS) has approved CFC State Plan amendments for California, Connecticut, Maryland, Montana, New York, Oregon, Texas, and Washington.

New York

New York has been a leader in developing Medicaid consumer-directed personal assistance programs, launching the first program for its residents in 1980 at the insistence of disability rights advocates. The program grew substantially over the next ten years and legislation was passed in 1992 that established the Patient-Managed Home Care demonstration.[19] The law that established the demonstration also amended the state's NPA[20] to allow the program's PAS workers to perform health care tasks that, in the traditional system, could be performed only by registered nurses, licensed practical nurses, or certified home health aides.[21] In 1995, the program, renamed the Consumer Directed Personal Assistance Program (CDPAP), [22] became mandatory statewide. The purpose of the CDPAP is "to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services."[23]

When initially conceived, CDPAP was open to almost everyone receiving Medicaid home care services, which ranged from private-duty nursing to assistance provided by unskilled aides. By amending the NPA, the state functionally eliminated these hierarchies of care for CDPAP participants, along with the requirement that their aides be certified in any type of home care. Eligible people with disabilities were no longer required to receive care only from aides assigned by home health agencies. Instead, the individual, or another adult approved to manage care, could hire PAS workers and train them to perform the required health maintenance tasks.[24]

New York also operates a Medicaid Personal Care Services program that provides a personal care aide who assists eligible people with nutritional and environmental support, as well as personal care functions. Under this program, aides and attendants are only allowed to perform unskilled tasks.[25] Other health maintenance tasks must be carried out by certified home health aides working under a registered nurse's supervision.[26]

Community First Choice Benefit in New York

The New York disability rights community has long advocated for reforms that would end the Medicaid program's institutional bias, which forces some people with disabilities to be institutionalized unnecessarily. The Community First Choice benefit therefore presented an important opportunity for New York to increase community-based, self-directed LTSS for people with disabilities by requiring services and supports that were only available through Medicaid waiver programs such as CDPAP. In 2011, New York announced its intention to seek approval from CMS to add the CFC benefit and establish community-based State Plan services for people who require an institutional level of care. New York proposed its State Plan amendment to CMS in late 2013 and negotiations on CFC details commenced.

One barrier to fully implementing the CFC was New York's NPA, which prohibits agency-employed workers without licenses or certifications from performing certain health-related tasks that are included in the set of services that the CFC requires. Either registered nurses or certified home health aides working under nurse supervision must perform these tasks. However, those same tasks can be legally performed either by consumers' family members or paid PAS workers providing assistance under the state's CDPAP program. In order to remove this barrier to community integration and achieve the greatest fiscal benefit, advocates called for an NPA amendment that would allow nurses to delegate certain health-related tasks to PAS workers who met new training requirements. This amendment would relieve the anticipated additional burden on the limited number of nurses, while meeting the service needs of the expanded population of people with disabilities who would be eligible for CFC.[27]

Advanced Home Health Aide

During 2014, two bills were introduced to amend the NPA. The bills intended to establish a new worker classification, the Advanced Home Health Aide, and allow those workers to perform health-related tasks for CFC consumers. Neither bill advanced during the legislative session, although Governor Andrew Cuomo and the State Department of Health supported the proposed changes.

Later in the same year, a workgroup formed to advise the Department of Health on which tasks AHHAs would be permitted to perform. Diverse stakeholders participated in this group, including disability advocates, consumers, nurses, home care agency representatives, and academic researchers. The workgroup submitted a final report to the Department of Health early in 2015, and the governor included a budget line item proposing an AHHA job classification amendment to the NPA. However, this provision was dropped from the final 2015–2016 state budget.

CMS finally approved the CFC State Plan amendment in October 2015, even as the New York legislature failed to pass the required NPA amendment. While CMS viewed this barrier to full implementation solely as a state matter, it forced people eligible for CFC services who were unwilling or unable to self-direct their care to receive health-related services from costly registered nurses via home health care agencies. Advocates worried that the cost of skilled nursing services, combined with a limited nursing workforce, would prevent people from leaving institutions or contribute to the unnecessary institutionalization of CFC-eligible consumers.

However, a coalition[28] of leading New York stakeholder organizations representing older adults, people with disabilities, families, providers, and labor achieved a last minute victory in June 2016. The legislature, over a span of three days, passed bills amending the NPA and creating the AHHA job classification, which are slated to go into effect in May 2018.[29] This new legislation represents four years of effort by the coalition along with consistent support from the governor, who signed the bill later in 2016.[30] Stakeholder representatives commented on the victory:

> We are thrilled that the Legislature has passed the law that will create AHHAs. This bill will dramatically expand access to health-related tasks for people with disabilities and seniors in New York.
> — *Adam Prizio, Manager of Government Affairs, Center for Disability Rights*

> The advanced home health aide bill passed by the Legislature will allow more New Yorkers with age-related and other disabilities to live safely and independently in their communities. Working together, our state leadership has significantly enhanced the long-term supports and services available to vulnerable New York State residents.
> — *George Gresham, President, 1199SEIU*

> Members of our community, all across New York State, have been forced into institutions because the assistance they need with health-related tasks is not available. The Advanced Home Health Aide legislation creates a way for people with disabilities and seniors to receive assistance with these tasks in the community. It is a significant advance toward the full integration, equality, and civil rights of people with disabilities.
> — *Bruce Darling, organizer with disability rights group, ADAPT* [31]

Under the new law, individuals with at least one year's experience working as a home health aide or PAS worker can be trained as an AHHA. Following training, the individual will be expected to demonstrate competence in performing advanced health-related tasks to the satisfaction of a registered nurse. Only nurses employed by home care agencies, hospice programs, or enhanced assisted living residences may order advanced tasks and supervise AHHAs who perform them. Nurses retain the authority to determine whether to assign advanced tasks, and consumers may refuse care provided by an AHHA if they so choose. The new job classification helps ensure that CFC-eligible consumers have the opportunity to receive the

necessary health-related services to leave an institutional setting or remain safely at home or in certain community-based settings. The AHHA classification also creates a much-needed new opportunity for home health aides and PAS workers to pursue career advancement.

The New York State Department of Education, in consultation with the State Department of Health, is charged with developing regulations that define the advanced health-related tasks that AHHAs may perform. The Department of Education also is required to consider recommendations by the stakeholder workgroup that convened to provide guidance on these questions. In addition, the regulations will establish the qualifications, training, and competency requirements for AHHAs. The legislation requires that the Department of Education issue a report by October 1, 2022 describing the AHHA initiative implementation, including how many home health aides became AHHAs and how many AHHAs became licensed practical nurses.[32]

New York's CFC benefit adoption and creation of the AHHA job classification has far-reaching implications for both consumers and workers. Arguably the most important implication is the extension of home and community-based services, free of waiting lists and other administrative restrictions, to all financially eligible New York residents who require nursing facility level of care. By safeguarding the right to these services, states create the expectation that people with disabilities and older adults can choose to self-direct their care, live in home and community-based settings, and maintain active, engaged lives in those environments, rather than becoming unnecessarily institutionalized. People who require health-related services may choose to receive them in their own homes, provided by their own authorized workers (now AHHAs). These new policies have the potential to tear down several long-standing and seemingly intransigent barriers to independent living, consumer choice, and control over day-to-day decisions. They also offer a new career ladder to PAS workers who have few other options for advancement. The progress of these initiatives in New York should be closely watched and evaluated in order to accurately inform future public policy.

Oregon

Oregon was the second state (after California) that CMS approved to include the CFC benefit, or "K" Plan, in a State Plan amendment. At the time Oregon applied for permission to amend its State Plan, over 80 percent of older adults and people with disabilities in Oregon's Medicaid Long Term Care program were receiving services at home or in community-based settings. The state recognized that CFC could increase funding for these programs, while simultaneously providing greater opportunities for people to receive services in integrated home and community-based settings. In addition, Oregon saw an opportunity to help more individuals transition out of nursing facilities and into the community.[33]

Unlike some other states, Oregon was well situated to implement the CFC benefit. The state already had been offering eligible people who require nursing home level of care equal access to HCBS, and it had maintained a long-established legal and administrative framework that enabled nurses, consumers, and PAS workers to work together effectively. This collaborative environment exists because Oregon's strategy for advancing home and community-based services centered on reforming the NPA and other regulations.[34] Because mechanisms allowing nurses and consumers to collaborate already existed, the state only had to take minimal regulatory action to effectively meet CFC consumers' health-related needs.

Oregon is among only a few states that afford registered nurses discretionary authority to delegate nursing tasks to non-medical persons such as PAS workers. While some states exempt consumer-directed PAS workers altogether from NPAs, many other states either limit discretionary authority or do not confer it at all, thus restricting or prohibiting nurses from the choice to delegate.[35]

Oregon amended its NPA several times, beginning in 1987. The Oregon State Board of

Nursing (OSBN) adopted the first nurse delegation regulations in 1988 in order to capitalize on the benefits delegation offered older adults and people with disabilities living in community-based settings. In the late 1980s, Oregon established the Contract Registered Nurse Service, comprised of registered nurses employed as independent state contractors. These nurses led an innovative community nursing program involving teaching and delegating certain health-related advanced care tasks to non-medical personnel and providing ongoing monitoring.[36] The Contract Registered Nurse Service laid the foundation for what became known in 2010 as Long Term Care Community Nursing Services (LTCCNS), which played a critical role as Oregon rolled out the CFC benefit.[37]

The OSBN periodically modified nurse delegation regulations through 2004, including a modification permitting non-medical workers to administer intravenous medication under certain circumstances.[38] Beginning in 2006, the OSBN made LTCCNS available to residents in adult foster care and to people with intellectual and developmental disabilities. During 2013, the board established standards and procedures for nurses enrolled with the Department of Human Services (DHS) as Medicaid providers and who provide LTCCNS to eligible individuals receiving Medicaid home and community-based services in a home-based or foster home setting.[39] DHS amended the rule twice in 2014, once to update certain definitions and to codify LTCCNS eligibility for individuals under the CFC "K" Plan, and again to start allowing individuals enrolled in brokerages to receive LTCCNS. In Oregon, a brokerage is an entity or operating unit within an existing entity that plans and implements support services for individuals with intellectual or developmental disabilities, within a framework of self-determination.[40]

The Oregon model is important because, from the outset, a number of key principles characterized the state's approach to creating LTCCNS. For example, the state clearly defined the differences between the teaching and delegation of a nursing task. LTCC nurses were permitted to teach consumers who self-direct their care or their family members how to perform nursing tasks. They could also delegate certain tasks to non-family members or paid care providers, then monitor how the tasks were being performed over time. The scope of practice was also limited to locations where nurses are not regularly scheduled and/or available to provide direct supervision, such as private homes. LTCC nurses would not provide direct nursing care services themselves; they could not be held legally liable for civil damages incurred by a PAS worker's actions unless the worker was following the nurse's explicit instructions or no instructions had been provided when necessary. The model promoted a holistic approach that supported individuals with ongoing health maintenance needs in their own home settings. State officials viewed this approach to nursing as an expansion of the field, as it offered nurses new practice opportunities rather than limiting them.[41]

Oregon administrative rules define LTCCNS as follows:

- Evaluation and identification of supports that help an individual maintain maximum functioning and minimize health risks, while promoting the individual's autonomy and self-management of healthcare.
- Teaching an individual's caregiver or family [who] is necessary to assure the individual's health and safety in a home-based or foster home setting.
- Delegation of nursing tasks to an individual's caregiver.
- Providing case managers and health professionals with the information needed to maintain the individual's health, safety, and community living situation while honoring the individual's autonomy and choices.[42]

Oregon Community First Choice: Long-term Care Community Nursing Services

Oregon's CFC State Plan benefit amendment went into effect on July 1, 2013. LTCCNS[43] are an integral component of the amendment, ensuring that PAS workers and other caregivers receive the required training and oversight so they can safely perform the health-related tasks that people receiving CFC services require. The CFC State Plan benefit amendment states,

"These services are designed to assist the individual and care provider in maximizing the individual's health status and ability to function at the highest possible level of independence in the least restrictive setting."[44]

Only certain Medicaid providers are permitted to provide LTCCNS, including licensed registered nurses who are self-employed providers, licensed home health agencies, and licensed in-home agencies.

The CFC State Plan amendment identifies the following specific LTCCNS services:

- Evaluation and identification of supports that minimize health risks, while promoting the individual's autonomy and self-management of healthcare.
- Medication reviews.
- Collateral contact to the person-centered plan coordinator regarding the individual's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered service plan.
- Delegation of nursing tasks, within the requirement of Oregon's Nurse Practice Act, to an individual's caregivers so that caregivers can safely perform health-related tasks. "Delegation means that a Registered Nurse authorizes an unlicensed person to perform a task of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed person and reevaluating the task at regular intervals."[45]

Oregon policy, which allows nurses discretion about when and under what circumstances to delegate nursing tasks, has been instrumental in enabling safe and independent living in home and community-based settings for people who require PAS workers to perform health-related tasks. Unpublished data from the Oregon Department of Human Services Aging and People with Disabilities Program indicate that, among 29,071 people in the Aging and People with Disabilities (APD) system who are enrolled in CFC, about 3,427 used LTCCNS in the 2015–16 fiscal year, suggesting that almost 12 percent benefitted from Oregon's progressive LTCCNS program.[46]

The constellation of Oregon's nurse practice delegation and exemption laws and policies, along with the vast experience of nurses who have been successfully teaching and delegating, has established a model framework that other states, such as Colorado, are examining as they consider ways to improve access to home and community-based services for their populations.

Colorado

Colorado began exploring the feasibility of adding the CFC benefit in 2012. The state is one of sixteen that do not currently offer personal care services under their Medicaid State Plan. The CFC benefit presented a potential method to improve access to consumer directed personal assistance services for eligible people with disabilities. The state commissioned a CFC feasibility study that was released in December 2013. Soon thereafter, the Department of Health Care Policy and Financing (HCPF) released a CFC policy statement indicating its intention to pursue the CFC benefit, albeit cautiously in order to ensure program success.[47] HCPF appointed a CFC council to guide the planning process, and in June 2016, HCPF posted a CFC program assessment draft with cost projections.[48]

The 2013 feasibility study noted that, in order to move forward with the CFC, Colorado would have to make a number of policy decisions, including whether to enact legislation waiving sections of the state's NPA to allow PAS workers to provide health-related services without requiring licensure.[49] Currently, the NPA and Colorado Medical Services Board regulations permit non-medical PAS workers to perform various health maintenance tasks in the In-Home Support Services (IHSS) and Consumer-Directed Attendants Supports (CDASS) programs.[50] Because health maintenance services can be provided by PAS workers under these programs, a body of evidence now exists demonstrating that they can

safely provide health-related services while also supporting the person's capacity to self-direct their care.

The feasibility study noted that, because CFC allows states to provide assistance with health maintenance tasks for eligible consumers, Colorado could take advantage of the funding increase by moving its CDASS and IHSS programs into the State Plan as bundles. Furthermore, preliminary financial modeling provided an early indication that this strategy, along with other CFC-related service changes including adding health maintenance as a separate service, could result in savings for the state while significantly increasing the number of people who can be served.[51]

Colorado commissioned a new CFC concept paper in 2017 that built on the feasibility study. The paper proposed a service package consisting of CDASS and IHSS as the two exclusive consumer directed delivery options for the new CFC State Plan benefit. Although the state continues to deliberate whether or not to move forward with the State Plan CFC amendment, the new study recognizes the person-centered benefits of assigning formerly skilled tasks to PAS workers, through the waiving of NPA delegation requirements. In addition to serving more people, the report notes that benefits also include increased care continuity and the ability to leverage lower labor costs.[52]

Acknowledgment

The contents of this report were developed under a grant from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90RT5026). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this report do not necessarily represent the policy of NIDILRR, ACL, or HHS, and you should not assume endorsement by the Federal Government.

References

[1] Patient Protection and Affordable Care Act of 2010, 42 U.S.C. §2401 (2010); Health Care and Education Reconciliation Act of 2010, §1205 (2010).
[2] Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001 (2010).
[3] H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?" *Health Affairs* 29, no. 1 (2010): 11–21.
[4] Steve Eiken, Kate Sredl, Paul Saucier, and Brian Burwell, *Medicaid Long-Term Services and Supports Beneficiaries in 2011* (Bethesda, MD: Truven Health Analytics, September 2015).
[5] "Users of Long-Term Services and Supports," The Medicaid and CHIP Payment and Access Commission (MACPAC), accessed September 11, 2016, https://www.macpac.gov/subtopic/long-term-services-and-supports-population/.
[6] Eiken et al., *Medicaid Long-Term Services…*
[7] Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier, *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014* (Bethesda, MD: Truven Health Analytics, April 2016).
[8] "Fact Sheet: The White House Conference on Aging," The White House, Office of the Press Secretary, July 13, 2015, https://www.whitehouse.gov/the-press-office/2015/07/13/Fact-sheet-white-house-conference-aging; "ACL 101: Overview of the Administration for Community Living," Administration for Community Living (ACL), July 2015, https://www.disabilitypolicyresearch.org/search?keyword=ACL%20101
[9] Institute of Medicine (IOM), *Future of Nursing: Leading Change, Advancing Health* (Washington, DC: The National Academies Press, 2011).
[10] Susan C. Reinhard, "A Case for Nurse Delegation Explores a New Frontier in Consumer-Directed Patient Care 2010–11," *Generations* 34, no.4 (2010): 75–81.
[11] Heather Young, Jennifer Farnham, and Susan C. Reinhard, "Nurse Delegation in Home Care: Research Guiding Policy Change," *Journal of Gerontological Nursing* 42, no.9 (2016): 7–15, doi: 10.3928/00989134-20160811-04.
[12] Rosalie A. Kane and Lois J. Cutler, "Re-Imagining Long-Term Services and Supports: Toward Livable Environments, Service Capacity, and Enhanced Community Integration, Choice, and Quality of Life for Seniors," *The Gerontologist* 55, no.2 (2015): 286–295.

[13] Reinhard, *Case for Nurse Delegation*; Suzanne Crisp, Pamela Doty, Gary Smith, and Susan Flanagan, *Developing and Implementing Self-Direction Programs and Policies: A Handbook* (Princeton, NJ: Robert Wood Johnson Foundation, 2009).
[14] Olmstead v. L.C. 527 U.S. 581 (1999).
[15] Medicaid Program: Community First Choice Benefit Final Rule, 77 Fed. Reg. 26827 (May 7, 2012): 26827–26903, https://www.federalregister.gov/d/2012-10294.
[16] Medicaid Program.
[17] Medicaid Program.
[18] Medicaid Program.
[19] NY Education Law § 6908(1)(a)(iii)
[20] NY Education Law § 6908(1)(a)
[21] Compare NY Educ L § 6908(1)(a)(iii) with Educ. Law § 6908(1)(a)(i).
[22]NY Soc Serv L § 365-F (2015)
[23] New York Codes, Rules and Regulations, "Consumer Directed Personal Assistance Program (CDPAP) Summary of Express Terms," April 20, 2011, https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/2011-04-20_consumer_directed_personal_assistance_program.pdf**;** Paragraph (b) of subdivision (5) of section 365-f of the Social Services Law, a new section 28 is added to Part 505 of Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR).
[24] Valerie J. Bogart, "Consumer Directed Assistance Program Offers Greater Autonomy to Recipients of Home Care". *New York State Bar Association Journal* 75, no. 1 (January 2003): 8–13.
[25] 18 NYCRR 505.14(a)
[26] Medicaid Consumer Directed Personal Assistance Program (CDPAP) in New York State," New York Health Access, http://www.wnylc.com/health/entry/40/.
[27] "Status of CFC in New York," New York Association on Independent Living, http://www.ilny.org/programs/cfc-tap/status-of-cfc-in-new-york.
[28] Allison Cook, "New York Legislature Passes Advanced Home Health Aide Legislation," *PolicyWorks Blog*, Paraprofessional Healthcare Institute (PHI), June 21, 2016 http://phinational.org/blogs/new-york-legislature-passes-advanced-home-health-aide-legislation; Coalition members include PHI, 1199SEIU, AARP, the Center for Disability Rights, Argentum, Alzheimer's Association New York State Coalition, New York Association on Independent Living, Jews for Racial Economic Justice, LeadingAge New York, and NYS Association of Health Care Providers.
[29] New York State Assembly, "Memorandum in Support of Legislation Submitted in Accordance with Assembly Rule III, sec 1(f)," A10707 Memo, http://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A10707&term=2015&Summary=Y&Actions=Y&Memo=Y; New York State Department of Health, "Advanced Home Health Aides Frequently Asked Questions," https://www.health.ny.gov/facilities/home_care/advanced_home_health_aides/faqs.htm
[30] Cook, "New York Legislature…"
[31] Paraprofessionals Healthcare Institute (PHI), "Wide Array of Organizations Applaud Passage of Advanced Home Health Aide Bill," press release, June 20, 2016, http://phinational.org/press-release/wide-array-organizations-applaud-passage-advanced-home-health-aide-bill.
[32] New York State Assembly, *Memorandum*…
[33] Oregon Department of Human Services, "Oregon Announces CMS Approval of Community First Choice Option (K Plan)," The Lund Report, July 1, 2013, https://www.thelundreport.org/content/oregon-announces-cms-approval-community-first-choice-option-k-plan.
[34] Susan C. Reinhard and Winifred V. Quinn, *State Policy in Practice: Oregon's Nurse Practice Policy for Home and Community Living* (New Brunswick, NJ: Rutgers Center for State Health Policy, 2004).
[35] Office of Licensing and Regulatory Oversight, *RN Delegation in Community Based Care Settings: Self-study Course*, rev. ed. (Salem, Oregon: Oregon Department of Human Services, 2013), https://apps.state.or.us/Forms/Served/de9825.pdf.
[36] Reinhard and Quinn, *State Policy*…
[37] Personal communication with Deborah Cateora, Registered Nurse Consultant, Safety Oversight and Quality Unit, Oregon Department of Human Services, September 28, 2016.
[38] Oregon State Board of Nursing, "Standards for Community-Based Care Registered Nurse Delegation," 851-047-0000, ORS 678.150, http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_047.html.
[39] Oregon Department of Human Services, "Aging and People with Disabilities Oregon Administrative Rules," 411-320-0010, ORS 409.050 & 430.662, Chapter 411, Division 48, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_411/411_320.html.
[40] Oregon Department of Human Services, "Aging and People with Disabilities Temporary Administrative Rules," Amendment to 411-048-0160

and 411-048-0170, https://www.dhs.state.or.us/policy/spd/rules/temp/411_048_temp.pdf; Becky Callicrate and Sarah Hansen, *Long-Term Care Community Nursing: Rule Information and Required Forms* (Oregon Department of Human Services, Aging and People with Disabilities and Medical Assistance Programs, 2016), http://docplayer.net/14608242-Department-of-human-services.html.

[41] Reinhard and Quinn, *State Policy*…

[42] Oregon Department of Human Services, "Aging and People with Disabilities, Long Term Care Community Nursing," 411-048-0150, http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_411/411_048.html.

[43] In the amendment, long-term care community nursing services are referred to with the acronym CNS rather than LTCCN or LTCCNS, which are used elsewhere by the Oregon Department of Human Services.

[44] Oregon Health Authority, "Oregon State Plan Under Title XIX of the Social Security Act, Community First Choice State Plan Option," TN12-14, effective July 01, 2013, http://www.nasuad.org/sites/nasuad/files/K%20Option%20State%20Plan%20Amendment.pdf.

[45] Oregon Health Authority, "Oregon State Plan…"

[46] Personal communication with Mike McCormick, Deputy Director, Aging and People with Disabilities Program, Oregon Department of Human Services, October 4, 2016.

[47] Colorado Department of Health Care Policy and Financing, "Community First Choice Development and Implementation Council, Community First Choice Policy Statement," January 2014, https://www.colorado.gov/pacific/sites/default/files/CFC%20Policy%20Statement%20-%20January%202014%20-%20FINAL_0.pdf.

[48] Colorado Department of Health Care Policy and Financing, "Community First Choice Program Assessment DRAFT," June 30, 2016, https://www.colorado.gov/pacific/sites/default/files/Community%20First%20Choice%20Program%20Assessment%20Report-DRAFT-June%202016.pdf.

[49] Edward Kako, Kira Gunther, Margaret O'Brien-Strain, and Aaron Rosenberger, *Feasibility Analysis of Community First Choice in Colorado* (San Francisco, CA: Mission Analytics Group, Inc., December, 2013), https://www.colorado.gov/pacific/sites/default/files/Final%20CFC%20Feasibility%20Study%2012-30-13.pdf.

[50] 10 CCR 2505-10 8.552.1: Health Maintenance Activities means those routine and repetitive health-related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These Activities include any excluded personal care tasks as defined in 10 CCR 2505-10 Section 8.489, as well as Certified Nursing Assistant (CNA) and nursing services. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the agency, in consultation with the client, shall contact the client's physician and receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's record; CRS 12-38-125; 12-38-1.117;10 CCR 8.552.1; 10 CCR 8.510.3.B.3.

[51] Colorado Department of Health Care Policy and Financing, "Community"; Personal communication with Sarah Hoerle, Community First Choice Manager, Colorado Department of Health Care Policy and Financing, September 29, 2016.

[52] Colorado Department of Health Care Policy and Financing, "Service Package Concept Paper for The State of Colorado Community First Choice," June 30, 2017, https://www.colorado.gov/pacific/sites/default/files/CFC%20Concept%20Paper-June%202017.pdf