Community First Choice (CFC)

Program Overview and Provider Requirements

January 2025

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

CFC/PAS Program Summary and Goals

Community First Choice and Personal Assistance Services are medically necessary, in-home services provided to Medicaid members. These members' health conditions cause them to be functionally limited in performing regular and instrumental activities of daily living.

The goal of the CFC/PAS program is to support a member's choice to live in the community by providing personal care through a person-centered planning framework that enhances the member's quality of life.

CFC/PAS Eligibility

Eligibility requirements for both programs:

1) the member has a health condition that limits his or her ability to perform activities of daily living
2) the member must participate in the screening process
3) the member must be eligible for Medicaid

To qualify for the CFC program a member must also meet level of care for a nursing home facility placement.

Service Scope

Activities of Daily Living (ADLs)

Bathing, dressing, grooming, toileting, transferring, positioning, mobility, meal preparation, eating, exercise, medication assistance. *Medicaid member must have ADL needs to qualify for the program.*

Instrumental Activities of Daily Living (IADLs)

Light housekeeping, laundry, shopping. *IADL services are limited, depending on the ADL needs.*

Medical Escort

For Medicaid members who need assistance enroute or at the destination of medical appointments

Level of Care

Members who meet level of care (LOC) criteria may be eligible for additional services if medically appropriate:

- Personal Emergency Response System (PERS)
- Community integration
- Yard hazard removal
- Correspondence assistance

Everyone approved for PAS is automatically reviewed for CFC.

Currently, CFC members account for 95% of enrollees and PAS accounts for 5%.

CFC Additional Services

- IADL Services:
  - Community Integration
    - Assistance and support to participate in recreational and community activities
  - Yard hazard removal
    - Safe access to the home
  - Correspondence assistance
    - Assistance opening mail, filing records, and completing paperwork- member must direct
- Additional Services:
  - Skill Acquisition Training
  - PERS (Personal Emergency Response System)
  - Mileage (in conjunction with shopping/community integration)

CFC/PAS Services are NOT….

Services to maintain an entire household or family	Supervision or companionship	Habilitation Aide or Specially Trained Attendants
Pet care	Child care/Babysitting	Services to replace parental responsibility

CFC is not available in:

1. Developmental disability group homes
2. Mental health group homes
3. Adult foster homes
4. Assisted living environments

- These settings are explicitly excluded because personal assistance is already included as part of their rate.

Service Options

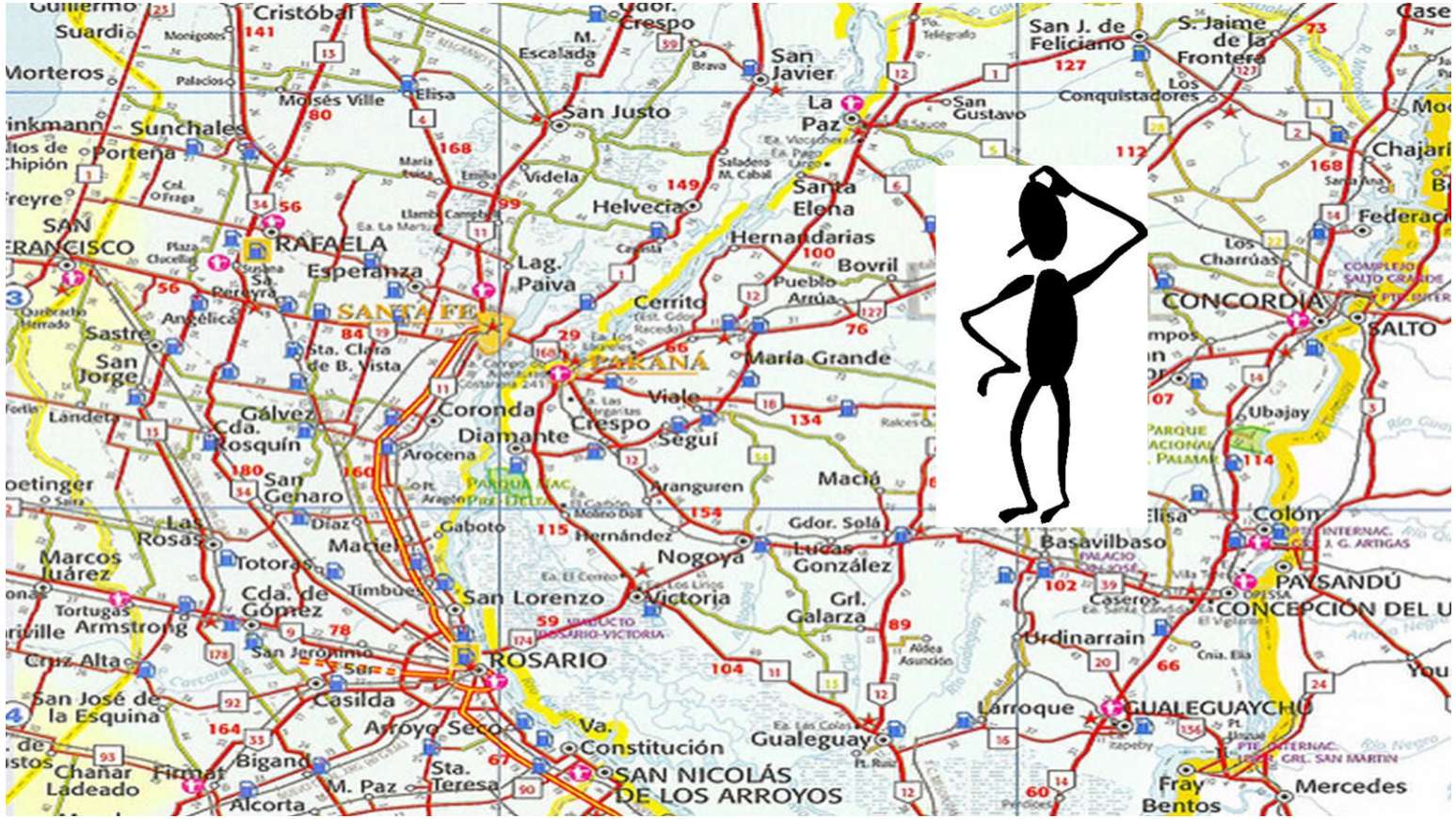
Self Direct (SD)

- Members direct their own care
- Member or PR hires, trains, and manages personal care attendants
- Can direct four skilled services
  - Bowel program, catheter care, medication assistance, wound care
- Member/PR must meet capacity to direct their own care
  - Health Care Professional Form
  - Assume medical and related liability
  - PR = Personal Representative

Agency Based (AB)

- Agency hires, trains, and manages personal care attendants
- Agency provides nurse supervisor to oversee CFC/PAS services
- PCA cannot perform skilled services

What is a State Plan?



State Plan

PAS/CFC is a “State Plan,” entitlement Medicaid Program.

Restrictions

Because it is a state plan program, there are a number of restrictions as to what can be authorized/provided.

PAS/CFC

Hands-On Care

Hands-on care is the focus.

Medicaid Member

Current and Full Medicaid eligibility is required before a referral can be taken.

Medicaid State Plan Services

- Are authorized under Title XIX of the Social Security Act (1965)
- They Initially covered primary and acute health care services, only.
- Home health and personal care were added in the 1980s (through 905(a) of the Social Security Act).
- Montana has a very “rich” state plan which, in addition to Community First Choice, includes services such as Durable Medical Equipment (DME), Hospice, Medicaid Transportation, Pharmacy, Physician Services, Dental, Hospital, Mental Health Services, Case Management, Diabetes Prevention, Women, Infants and Children (WIC), etc.

Basics of Medicaid Services

- Service must be allowed through federal regulations
- Federal regulations found in CFR (generally 42 CFR)
- Every service must be approved by CMS
- Service scope, duration, amount and limits are outlined in the state plan pages or waiver application.
- Reimbursement for service is funded through federal and state funding.
- Medicaid is typically the payer of last resort (third party liability)
- Many services require prior authorization (PA)
- CFC/PAS require a functional assessment from MPQH
- CFC also requires level of care

State and Federal Authority

The PAS program falls under section 1905 of the Social Security Act.

The CFC program falls under section 2401 of the Affordable Care Act.

MCA 53-6-145, ARM 37.40.1001-1030 and ARM 37.40.1110-1135 provide state statute and rules.

Entitlement versus Non-Entitlement Programs

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Community First Choice/Personal Assistance Services

- Community First Choice and Personal Assistance Services (CFC/PAS) are Medicaid entitlement programs that provide long-term, supportive care in the home setting.

- Entitlement programs have set eligibility criteria that, if met, guarantee benefits to the individual.

- Entitlement programs have dedicated funding sources, like payroll taxes for Social Security, which means the government is legally obligated to pay out benefits to eligible individuals and there are no spending caps.

- There are no waiting lists.

Indian Health Services (IHS)

- IHS is a non-entitlement program that is funded federally.
- Non-entitlement programs rely on annual appropriations from Congress, which can fluctuate depending on budget priorities.
- Non-entitlement programs may accumulate waiting lists when appropriations run out.
- IHS is a payer of last resort. When entitlement programs such as CFC/PAS are used first, it can be a savings to IHS.

Roles and Responsibilities

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Primary Role of the Medicaid Provider

- Enroll with Montana Medicaid (Optum/Conduent)
  - Provider Type 12- Personal Assistance Services/Community First Choice
  - Revalidate every five years
- Comply with all Medicaid Administrative rules
- Comply with all policy and procedures
- Comply with all program/provider type specific policy and procedures

Primary Role of the State

01

Ensure state and federal health care funds are not spent improperly

02

Collect and report information necessary for effective program administration and accountability

03

Resolve grievances by applicants, enrollees, and providers

PAS/CFC Referral Process

Make a referral	Member home visit	Nurse sends authorization	Questions?
Call a local agency or call Mountain-Pacific toll-free at 1-800-219-7035. This is a centralized call center.	Mountain-Pacific nurse travels to Medicaid member's home for onsite assessment of member's needs and authorize medically necessary care.	The nurse's authorization is sent to agency of member's choice.	If questions or concerns, please call Mountain-Pacific Medicaid Services Navigator at (406) 457-5825 .

Electronic Visit Verification

EVV is a requirement of the 21st Century Cures Act, 42 U.S.C. 1396(b)(l).

It automates the gathering of service information by capturing time, attendance and care plan information entered by a home care worker.

It is required for live-in caregivers.

Montana fully implemented EVV on July 1, 2024.

The intent of EVV is to reduce fraud, waste and abuse.

Provider Enrollment

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Requirements - ARM 37.40.1013

- Provider must be incorporated under the laws of the state of Montana
- Enroll as a Medicaid Provider
- Service area to cover at least one county or reservation
- Comply with onsite visit requirements before and after enrollment to verify information submitted to the department
- Completion of CFC program training for selected option (Self-Direct or Agency-Based)
- Conflict of Interest Assurances

Required Insurance – ARM 37.40.1013

- Verified yearly in April, Provider-Prepared Standard Reporting
- General Liability Insurance
  - Minimum $1,000,000 per occurrence, $2,000,000 aggregate
- Motor Vehicle Insurance – Non-Owned Autos
  - motor vehicle liability insurance with split limits of $500,000 per person for personal injury, $1,000,000 per accident occurrence for personal injury, and $100,000 per accident occurrence for property damage; or, combined single limits of $1,000,000 per occurrence to cover such claims as may be caused by any act, omission, or negligence of the provider or its agents, officers, representatives, assigns, or subcontractors
- Current Unemployment Insurance
- Current Workers' Compensation Coverage

Quality Assurance

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Provider-Prepared Standards Report

- Policy 610 (AB)
- Internal Review completed annually
- Summary submitted to Program using provided forms
  - Due April 1 (May 1, 2024, during EVV transition)
  - SMART goals are submitted when criteria are unmet
- Internal Chart Reviews
- Provider Prepared Standards Review

Quality Assurance Reviews (QAR)

- Policy 608 (AB)
- Occurs every 1, 2, or 3 years depending on last review or department request
  - Staff changes, failure to submit PPS, complaints, billing errors, etc.
- Verification of Provider Prepared Standards (PPS)
- Member chart reviews
- Agencies prepare charts for review, respond to requests for documentation, and respond to Quality Assurance Communications
- Noncompliance can result in repayment, Quality Assurance Communication (QAC), corrective action plan, or sanctions

Serious Occurrence Report (SOR)

- Policy 709 (AB)
- Appropriate Submission to QAMS is Mandatory
- A significant event which affects the health, welfare, or safety of a member served under the circumstances listed (see policy for further explanation of each type):

Serious Occurrence	
Exploitation, Abuse	APS, CPS, Law Enforcement Reports
Neglect, Self-Neglect	Medicaid Fraud Referrals
Sexual Harassment	Admission for Psychiatric Emergency
Injury resulting in ER or UC treatment	Medication Emergency
Unsafe Environment	Suicide, Suicide Attempt, Suicide Threat

Serious Occurrence Report (SOR)

- Policy 709 (AB)
- Provider has 10 working days from report of incident to enter the SOR into QAMS (Quality Assurance Management System)
- RPO will respond and close the SOR once all corrective action items have been completed.
  - Agencies may have to follow-up after RPO reviews the SOR

Questions?

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