NORC at the UNIVERSITY of CHICAGO

Research Summary

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ACA *SECTION 2401, COMMUNITY FIRST CHOICE OPTION (*Section 1915(k) of the Social Security Act)*;* **MONTANA** STATE PLAN AMENDMENT SUMMARY

OVERVIEW

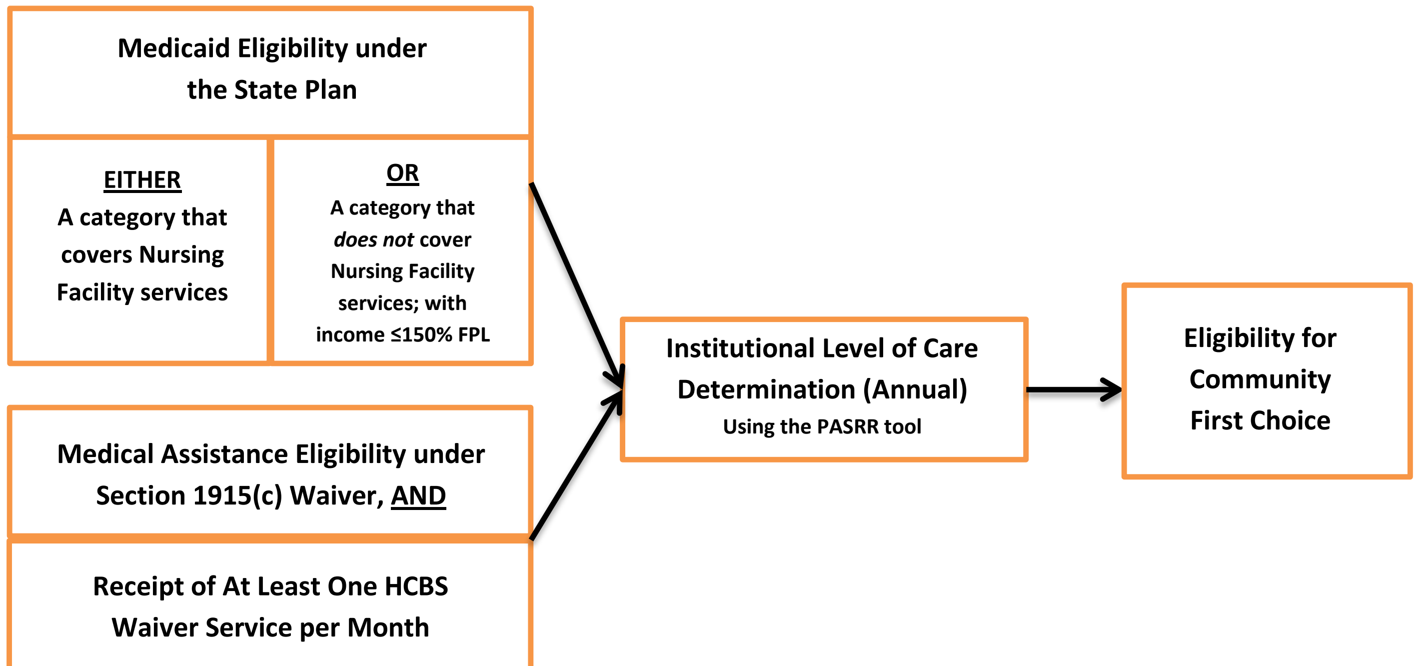
Montana is the fourth state to implement the Community First Choice Option, Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana's Medicaid State Plan Amendment adding Community First Choice services was approved on July 8, 2014, with an effective date of October 1, 2013. Montana's program covers home and community-based attendant services and supports to assist individuals with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health-related related tasks, and related support services, as specified in the ACA and regulations.

By implementing the CFC option, Montana is able to cover a range of home and community-based services under its State Plan, which were previously covered through 1915(c) waivers and State Plan PAS. Montana retained its existing HCBS waivers to cover services that are not permissible for coverage under CFC. The existing agency-based and self-directed State Plan personal assistance services were retained to provide services to individuals who need assistance with activities of daily living but do not meet the institutional level of care.

ELIGIBILITY

Eligibility for Community First Choice services in Montana follows the federal regulations at 42 CFR §441.510. Medicaid beneficiaries must be eligible for medical assistance in one of two ways. Beneficiaries must be within an eligibility group whose benefits include nursing facility services. Those whose eligibility group does not cover nursing facility services must have countable income below 150 percent of the federal poverty level. All individuals must meet an institutional level of care to qualify for CFC services.

Exhibit 1. Montana Community First Choice Eligibility Pathways



Individuals who qualify for Medicaid through a 1915(c) waiver must continue to meet all waiver criteria and must receive at least one waiver service per month. Waiver eligibility remains an important Medicaid eligibility pathway for individuals who need an institutional level of care but would otherwise have too much income to qualify for Medicaid in the community.

The State determines initially, and at least annually, that individuals require the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/ID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. Montana contracts with the Quality Improvement Organization (QIO) to perform level of care determinations, CFC functional assessments, and counseling on LTSS options for CFC.

SERVICE DELIVERY MODELS

Montana is using the agency model of service delivery with two options, the traditional agency model and the agency-with-choice agency model. In the traditional agency model, services and supports are provided by provider agencies directly through their employees. The service includes a registered nurse to assist in staff training and supervision of services. In the agency-with-choice model, provider agencies provide services through co-employment relationships with individuals. Individuals have authority to hire, fire, train, supervise, and schedule their workers, and the agency is the employer of record. Qualified individuals may switch between the two models to allow consumer choice.

SERVICE PACKAGE

The statute and regulations require states to provide community-based attendant services and supports to assist in accomplishing ADLs, IADLs, and health-related tasks, through cueing and supervision, as well as hands-on assistance. In addition, supports must include acquisition, maintenance and enhancement of self-care tasks, back-up systems to

ensure continuity of services and supports, and voluntary training on selecting, managing and dismissing attendants. States also have the option of paying costs associated with transitions from institutions to community living and paying for certain goods and services that increase an individual's independence or substitute for human assistance.

- **Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision and/or cueing.**
  - ADL supports include bathing, personal hygiene, dressing, eating and meal preparation, mobility, positioning and transferring, toileting, assistance with exercise routines, and medication assistance.
  - IADL supports include light housekeeping, laundry, yard hazard removal, assistance with personal finances, and community inclusion services.
  - Health maintenance activities include administration of medications, wound care, and bowel and bladder care.
  - Medical escort service for individuals who need hands-on assistance to attend medical appointments.
  - Mileage for medical escort and community inclusion service travel.

- Acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and **health-related tasks.** This service is available to individuals when there is a reasonable expectation that the individual can acquire self-care skills by the end of three months, and may be re-authorized if medically necessary.

- **Back-up systems or mechanisms to ensure continuity of services and supports.** Personal Emergency Response Systems are available to provide back-up for individuals who live alone or spend significant periods of time alone.

- **Voluntary training on how to select, manage and dismiss attendants.** Training is offered during the initial person-centered planning process and during reassessments. CFC providers provide training in multiple formats, including a handbook and website link.

- **Support System Activities.** Several different entities play a role in providing support system activities.
  - QIO nurses and social workers are responsible for assessment and counseling prior to CFC enrollment, including an initial outline of choices and options. QIO services are provided through a contract with State and claimed at the medical administrative claiming rate, rather than the enhanced CFC service rate.
  - The person-centered planning process is facilitated by CFC Plan Facilitators based on the outline of the range and scope of individual choices and options provided by the QIO. CFC provider agencies are expected to participate in the planning process and support system activities, which include:
    - Identifying goals, strengths, risks and preferences.
    - Incorporating the functional assessment into the plan.
    - Identifying, assessing, and mitigating risks through a process that considers individual choice and independence, as well as health and safety.
    - Developing a personalized back-up plan and a process for changing the person-centered service plan
    - Providing information about rights, responsibilities, advocacy systems, the grievance process, and other consumer protections.

Permissible CFC Services. Montana did not elect to cover the two permissible CFC services: expenditures that substitute for human assistance, related to needs identified in the individual's person-centered plan; and expenditures for transition costs for individuals transitioning from institutions to residence in community settings.

Service Limits. ADL, IADL, and health related services are limited to 84 hours of attendant services per two-week period. IADL tasks may not exceed one-third of total CFC hours, or a maximum of 10 hours per two-week period, whichever is less. Services may only exceed this limit with prior authorization for medical necessity. Medical escort service can exceed this limit without prior authorization. Skills acquisition, maintenance and enhancement may not exceed 25 hours during a three-month period.

Use of Direct Cash Payments. Montana does not make direct cash payments prospectively to CFC participants.

ASSESSMENT AND SERVICE PLAN

Responsibility for assessments and person-centered planning is divided between the QIO, which conducts level-of-care and functional assessments, and the CFC Plan Facilitators, who are responsible for the person-centered planning process. A Plan Facilitator is either a case manager or a CFC provider trained in person-centered planning. To qualify as a case manager, one must be either a licensed nurse, social worker, or have one year's experience in a health care community setting. The criteria for a CFC provider requires both a year in health community settings and training in person-centered planning and functional needs assessment.

- Initial assessments for nursing facility level of care are conducted by a nurse or social worker from the QIO, who completes a preadmission determination and functional assessment using the Preadmission Screening and Resident Review. The same assessment tool is used for HCBS waivers and State Plan services. For individuals with developmental disabilities, state Developmental Services Division staff determines level of care.

- In conjunction with the functional needs assessment, the QIO authorizes CFC services in units; provides information about long-term services and supports options; determines the individual's preference and ability for self-direction, and choice of service delivery model; and determines the individual's choice of service setting and CFC provider.

- The person-centered planning process is facilitated by an individual's CFC Plan Facilitator, who is the existing case manager for individuals receiving HCBS waiver services. Individuals who do not have a case manager are assigned a CFC Plan Facilitator associated with the primary CFC agency provider.

- CFC Plan Facilitators are responsible for development of person-centered plans, including coordinating a planning meeting, defining the individual's strengths, goals, needs, and preferences, and developing a service plan. They are also responsible for development of personalized back-up plans; identifying and assessing services, supports and resources; providing information on individuals' rights and responsibilities.

- CFC provider agencies are expected to participate in the person-centered plan, from the initial planning process, to annual planning, but at a minimum, every 180 days. Plan Facilitators and providers are responsible for incorporating functional assessments into the process, and identifying, assessing, and mitigating risks.

HOME AND COMMUNITY-BASED SETTINGS

Section 2401 of the ACA requires that CFC services be delivered "in the most integrated setting appropriate to the individual's needs." The Montana SPA states that CFC services are provided in residential settings, which include "individual homes, apartment buildings, retirement homes, and group living environments that meet the CFC Residential Criteria." CFC services may not be provided in institutions or in developmental disability or mental health group homes, adult foster homes, or assisted living facilities.

QUALIFICATIONS OF PROVIDERS OF CFCO SERVICES

All CFC providers must enroll as Medicaid CFC providers, and provider qualifications are established through the provider enrollment process. The quality assurance process assures that providers must maintain their qualifications and meet benchmarks to remain enrolled as CFC providers.

QUALITY ASSURANCE AND IMPROVEMENT PLAN

Montana's CFC quality improvement strategy is based on the key components of the CMS framework for HCBS services: design, discovery, remediation, and improvement. The strategy will measure and monitor performance in nine domains: intake, assessment, person-centered planning, independence and choice, service plan and delivery, health and welfare, consumer experience, provider qualifications, and fiscal accountability. The CFC QI strategy consists of six key players responsible for generating data and monitoring the quality assurance (QA) process.

First, the Quality Improvement Organization (QIO) receives referrals for those needing long-term care services (LTCS) and performs a Functional Assessment via a registered nurse. The QIO then assists consumers in navigating available LTCS options to ensure a proper match with service and setting. The Plan Facilitator then ensures the person-centered planning (PCP) process is followed and consumer needs are addressed. The Plan Facilitator operates at the direct consumer level, providing individual-focused information and support.

The CFC provider works directly with consumers, providing day-to-day service delivery, ensuring consumer health, safety, and satisfaction. The provider is responsible for consumers' plan implementation and proper utilization of services. The consumer, family, or representative define quality on an individual basis and ensure both the Plan Facilitator and provider are accountable to quality parameters.

This entire process is managed by state agency QA staff in the field and at the program management level, who are also responsible for quality assurance for HCBS waivers and state plan services. Their role includes collecting and monitoring performance data, reporting outcomes, and overseeing remediation. The CFC program manager compiles QA management reports and presents them to the CFC Steering Committee. The committee, which consists of the CFC program manager and state agency staff representing each of the five HCBS waivers, reviews QA reports and responds with disability-specific remediation plans as needed. Information from these meetings is reported to the CFC Stakeholder Council for input and suggestions. The CFC Council, made up of individuals enrolled in CFC, their representatives, providers, and other stakeholders, also receives QA management reports and provides feedback.

Data sources for the quality assurance process include: functional assessments, critical incident reporting, CFC plan facilitator files, consumer service records, MMIS reports, provider files, CFC Council notes, and consumer interviews. The data will allow the state to measure performance in the nine QA domains listed above, with three or more measures in each domain.

Exhibit 2. Matrix of Montana Community First Choice SPA

Service Delivery Model		
Agency Model	X	Two options are available under the Agency Model: • In the traditional agency model, services and supports are provided directly by employees of the provider agency. • In the agency-with-choice model, the agency provides services through a co-employment relationship with the individual. Individuals have authority to hire, fire, train, supervise, and schedule their workers, and the agency is the employer of record.
Self-Directed Model		
Direct Cash		
Vouchers		
Financial Management Services		
State elects to disburse cash prospectively		

Service Package		
	Claiming Service Match	**Service Type**
ADLs, IADLs, health-related tasks	X	• ADL supports • IADL supports • Health maintenance activities • Medical escort services for individuals who need hands-on assistance to attend medical appointment • Mileage for assisted travel to medical appointments and community activities
Acquisition, maintenance and enhancement of skills	X	Available when there is a reasonable expectation that an individual can acquire a self-care skill within three months
Development of Back-up systems	X	Personal emergency response systems

Service Package		
	Claiming Service Match	**Service Type**
Voluntary training	X	Training on selecting, managing, and dismissing attendants
Support-system activities	X	Assessment & counseling prior to enrollment Development and implementation of service plan through person-centered planning process
Permissible CFC services provided by State:		
Expenditures for services substituting for human assistance		
Expenditures for transition costs		

Assessment and Service Plan		
Participants can appoint a representative to direct services	X	
Uniform assessments	X	The same instrument is used for CFC, HCBS waivers, and State Plan services

CFCO Provider Qualifications	
Service providers	Provider qualifications are established through the provider enrollment process

Quality Assurance and Improvement Plan	
Participating entities	CFC Steering Committee; CFC Council; Quality Improvement Organization (QIO); CFC Plan Facilitators; CFC providers; CFC Consumer, Family, Representative(s); State agency HCBS quality assurance field staff and program managers
Activities	Generating data; Data collection, evaluation, and remediation
Data Sources	Functional assessments, critical incident reporting, CFC plan facilitator files, consumer service records, MMIS reports, provider files, CFC Council notes, and consumer interviews
Performance Measures	Performance measures are collected in the following QA areas: Intake, assessment, person-centered planning, independence and choice, service plan/delivery, services delivered according to CFC service profile Health and Welfare, consumer experience, provider qualifications, and fiscal accountability.

Stakeholder Involvement	
CFC Consumers and Representatives	• Participate in developing service plans, and may direct their own services • Participate in implementation monitoring through the CFC Council
Quality Improvement Organization	• Level of Care determinations and functional assessments • Long-term services and supports options counseling prior to enrollment
CFC Plan Facilitators	• Facilitate the person-centered planning process • Develop service plans, and ensure that they incorporate individuals' choices, goals, preferences, and needs identified through the functional assessment • Assess and monitor risks, health and welfare • Provide information and support to empower consumers
CFC Provider Agencies	• Provide personal assistance services, either directly or as employer of record. • Provide CFC plan facilitation to individuals who do not have a waiver case manager • Provide voluntary training to participants on self-directing PAS
Montana Department of Public Health & Human Services	• Program operation • Provider enrollment • Quality assurance and improvement
CFC Council (consumer majority)	• Provide input to the state on program design • Monitor implementation and provide feedback