

Consumer Directed Community Supports

Lead Agency Operations Manual



Minnesota Department of **Human Services**

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Introduction to Consumer Directed Community Supports (CDCS)

Consumer Directed Community Supports (CDCS) is a service that gives individuals more flexibility in planning, and responsibility for directing, their services and supports, including hiring and managing direct care staff. CDCS may include conventional goods and services, as well as self-designed services that provide needed support to recipients.

Consumer Directed Community Supports (CDCS) is a service that has been available in 37 counties through the Home and Community-Based Waiver for Persons with Mental Retardation and Related Conditions (MR/RC) since 1998. In an effort to make Consumer Directed Community Supports (CDCS) available to individuals in every county and on every Medical Assistance (MA) waiver program, the Department of Human Services (DHS) submitted amendments to all of the home and community-based waiver programs to the Centers for Medicare and Medicaid Services (CMS). The amendment, as approved, changes some aspects of CDCS as previously implemented, and expands the CDCS service. The amendment includes state-level oversight of CDCS and lead agency administration of the service.

The programs affected by the approved amendments are:

- Alternative Care (AC) program (A state-funded non-Medical Assistance program)
- Community Alternative Care (CAC) Waiver
- Community Alternatives for Disabled Individuals (CADI) Waiver
- Elderly Waiver (EW)
- Mental Retardation and Related Conditions (MR/RC) Waiver
- Minnesota Disability Health Options (MnDHO)
- Minnesota Senior Health Options (MSHO)
- Traumatic Brain Injury Waiver (TBIW).

There are slight differences as CDCS applies to some programs. These differences will be indicated in the manual.

Implementation of CDCS Statewide

DHS will implement CDCS, as approved by CMS, across all programs and in all counties by April 1, 2005. There are two phases in the CDCS implementation plan.

Phase I Implementation

CDCS will be implemented across all waivers first in the 37 counties previously authorized to provide CDCS under the MR/RC Waiver, effective **Oct. 1, 2004**. This initial implementation will include transitioning individuals who are currently receiving CDCS under the MR/RC Waiver to services that reflect the new policies, as well as initiating implementation of CDCS across all other programs, and MnDHO and MSHO in those counties.

Phase II Implementation

The second phase of implementation will involve the remaining 50 counties, interested tribal health entities, and participating health plans. These agencies will begin to implement CDCS across all programs, and MnDHO and MSHO by **April 1, 2005**.

Evaluation of CDCS Implementation

An evaluation will occur throughout implementation to determine the effectiveness and appropriateness of CDCS. The resulting recommendations will be incorporated into CDCS policies and procedures as appropriate.

1.1 HCBS Program Eligibility and Access to CDCS

Consumer Directed Community Supports is a new service available under the home and community-based waiver and Alternative Care programs. It is not a new program.

Like other services available under the state statute governing the Alternative Care Program, and the federally approved MA waiver plans, CDCS is available to an individual who is either already receiving services on a waiver or under AC, or who meets all of the following eligibility criteria for each program as determined by the lead agency.

- The person must meet Medical Assistance or AC financial eligibility requirements
- An assessment completed by authorized professionals indicates the person needs the level of care provided by an institution
- The person needs a waiver or AC service to support community alternative living
- There is no alternative payor for the waiver or AC services needed
- The Community Support Plan, when implemented, can reasonably ensure the health and safety of the person
- Some waiver programs have additional criteria such as diagnosis.

Any person who meets all program eligibility criteria, and receives a waiver slot allocation from the lead agency (county, tribe, or health plan) can choose CDCS as a service option, with exceptions noted in the next section.

1.2 Access to CDCS Service Option is Limited for Some People

- ***Living Arrangements:*** CDCS services are not available to waiver or AC recipients living in residential settings licensed by the Department of Human Services (DHS) or licensed or registered with the Minnesota Department of Health (MDH). These include family or corporate foster care, board and lodge facilities, supported living service facilities, and housing with services/assisted living establishments. See Department of Human Services Licensing at http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/DHS_id_008627.hcsp and Department of Health at <http://www.health.state.mn.us>
- ***Fraud or Abuse of Public Funds:*** CDCS services are not available to an individual or their representative who has at any time been restricted by the Primary Care Utilization Review (PCUR) Committee. Information about such restriction will be found in the Recipient Primary Care Utilization Review (RPCR) screen in MMIS. The lead agency should check this information to determine whether the individual has been involved with PCUR before discussing the CDCS option with that individual.
- ***Exits from the Waivers or AC:*** If a CDCS recipient exits the *Waivers or AC* more than once during the recipient's service plan year, the recipient is unable to access CDCS services for the remainder of that service plan year. This does not preclude the individual from using other waiver or AC services for the remainder of the service plan year.
- ***A person who does not meet all program eligibility requirements.*** For example, a person participating in Medical Assistance whose needs can be met sufficiently with state plan home care services is not eligible for a Medical Assistance waiver program because there is no need for a waiver service.

2.1 How Consumer Directed Community Supports Work

This manual will provide more detailed information about the features of CDCS listed below. They are presented here, in loose chronological order, to give lead agency case managers some context for other sections as they are presented. The outline below also represents the major activities the consumer, lead agency case manager and others will perform when CDCS is elected. In addition, it outlines those features of the service that lead agency case managers will have to be most familiar with in order to provide professional support to consumers in decision-making about this service, as well as to carry out lead agency responsibilities under CDCS.

- The person is, or has been, determined to be eligible for a home and community-based waiver program, or for the Alternative Care program. For some programs, a waiver “slot” has to be available to allocate to the client before waiver program participation can begin.
- Personal preferences are combined with assessment information to outline a Community Support Plan.
- The lead agency case manager provides information about different services that can meet the person’s needs and preferences, including CDCS.
- There are consumers who do not have access to CDCS as a service option.
- There are other options that increase flexibility and choice-making in addition to CDCS. This includes PCA Choice and alternative providers of waiver services such as homemaker or adult day care service.
- The lead agency gives the consumer information about budgets for CDCS and non-CDCS options.
- CDCS information given includes written materials that outline the consumer’s role and responsibility under CDCS, the list of allowable and unallowable expenditures, “generic” support plan requirements and criteria for approval of a consumer-developed plan for CDCS.
- The person selects CDCS.
- The lead agency gives the consumer information about options for person-centered planning tools and approaches.
- The lead agency provides a summary of assessment information in order to guide the consumer’s plan development.
- The person develops the support plan, with or without assistance from others. If desired, the person can receive formal assistance from three sources:
 1. If they still live in an institution and are eligible for Medical Assistance, a Relocation Services Coordinator can assist in plan development. If they are eligible for AC, they can access AC conversion case management to assist in plan development.
 2. They can choose to spend some of their CDCS budget to purchase assistance from a qualified Flexible Case Manager. Flexible Case Managers must pass a training course and receive certification from DHS to provide service under CDCS.

3. They can be served under a non-CDCS support plan and receive assistance from their waiver or AC case manager to develop a CDCS plan to move from non-CDCS to CDCS at a point in the future.
- The lead agency provides a list of DHS-certified Fiscal Support Entities under contract with the county. The Fiscal Support Entity is the Medicaid-enrolled provider under CDCS.
 - The consumer is the employer of support staff funded with CDCS.
 - The consumer can purchase support to carry out employer functions.
 - Every CDCS consumer must have an agreement with a Fiscal Support Entity.
 - The Fiscal Support Entity assists the consumer in managing CDCS funding in a variety of ways, including support with employer functions, if the person chooses.
 - The consumer submits the support plan for lead agency approval. The plan can include conventional and self-designed services, paid and unpaid support, and personal risk management plans to meet health and safety needs.
 - CDCS services cannot begin until the support plan is approved by the lead agency.
 - The plan must include emergency and backup plans, and break out planned services into several categories. Some categories have restrictions.
 - The consumer defines provider qualifications for personal assistance. The consumer can add training requirements to meet preferences.
 - The consumer can request background checks of proposed staff. If that person fails this check, they cannot work for the consumer.
 - The person outlines a plan for monitoring service implementation and quality.
 - The plan includes results or outcomes the person wants to achieve by implementing the plan.
 - A spouse or parent can provide personal assistance and be paid for this assistance for up to 40 hours per week when other criteria are met.
 - The lead agency applies stated criteria to approve the plan or outline changes that need to be made to receive approval. The lead agency approves or denies the plan within 30 calendar days of receipt from the consumer.
 - Any support the consumer is purchasing from a Fiscal Support Entity or Flexible Case Manager must be included in the plan, including specific tasks, the schedule of service, and negotiated payment for these tasks.
 - A written denial of the plan, or reduction in services proposed in the plan, must include specific reasons and appeal rights (Fair Hearing) information.
 - The signed, approved support plan is copied to the consumer, legal representative(s) and the selected Fiscal Support Entity.

- The lead agency creates a Service Agreement in MMIS for the person that can include only CDCS, required case management, state plan home care service, background checks, and higher costs for home modifications for certain programs.
- The consumer and Fiscal Support Entity receive copies of the Service Agreement.
- The consumer enters into written agreements with selected support staff for whom the consumer acts as common law and managing employer, and can delegate some employer tasks.
- The consumer can purchase support to carry out employer responsibilities.
- The plan is implemented.
- The Fiscal Support Entity receives invoices for approved expenditures including support staff timesheets. The Fiscal Support Entity submits claims to MMIS that break out CDCS spending into four categories of service:
 1. Personal assistance
 2. Treatment and training
 3. Environmental modifications and provisions, and
 4. Self-directed support
- The Fiscal Support Entity provides monthly reports to the consumer and legal representative, and quarterly summaries to the lead agency.
- The Fiscal Support Entity is required to notify the lead agency when monthly spending significantly exceeds or falls short of projected spending in order to identify potential problems with support plan implementation.
- There are opportunities for lead agency staff to provide interventions to help the person succeed in the community with CDCS and meet program and service requirements.
- There are criteria for involuntary exit from CDCS of an individual.
- The consumer, with or without paid or unpaid support, monitors and evaluates the implementation of the plan, the quality of service, and progress toward or achievement of outcomes.
- The lead agency continues to provide HCBS quality assurances to all waiver or AC program participants as outlined in their HCBS Quality Assurance Plan submitted to the Department.
- Adult and Child Protective Services referrals and services continue to provide protections to vulnerable people in the community.
- Reassessments are performed by lead agency staff at least annually, and when significant changes in need occur.
- The person can make some amendments to their support plan without lead agency approval; other kinds of changes require lead agency participation and agreement.

3.1 Person-Centered Planning Process: The Foundation for Consumer-Directed Services

The philosophy and process of person-centered planning provides the foundation for consumer-directed home and community-based services. Home and community-based services support people in everyday life. These services have an impact on the person's ability to participate as a member within their community, and to fulfill their own life-style choices.

Person-centered planning can organize and direct resources in a manner that will make a difference in a person's quality of life, level of independence, and satisfaction with public services. While person-centered planning should be the foundation for all home and community-based services planning, an explicit person-centered planning process is required when an individual selects CDCS. Understanding person-centered planning processes is a key and necessary lead agency skill.

Consumer Directed Community Supports allows greater flexibility in tailoring services to meet individual needs and preferences. It is through a person-centered planning process that the consumer, along with self-selected friends, family, and providers, determines what, where, when, how, and from whom they will receive the assistance that is needed. The resulting plan reflects goods and services designed by the consumer to meet identified needs and achieve individually identified results or outcomes.

Person-centered planning is an ongoing activity that includes monitoring the effectiveness of the plan and progress toward achieving results, and changing the plan over time to incorporate new types of services or ways of delivering services, or to address changed needs, or support revised personal goals or desired results.

There are various approaches to the person-centered planning process that have been put into public practice, and different approaches will be preferred by individuals. Some people will choose to develop their CDCS plan with little or no assistance, while others may want more support in plan development.

The lead agency must provide resources and information about the person-centered planning process, including the availability of Flexible Case Management service to assist in plan development, and offer choices in planning tools to consumers. The Department offers a "tool box" of person-centered planning information and resources listed in Appendix A.

3.2 Person-Centered Planning Features

All person-centered planning approaches share some features in common. The following list of features can be used to provide basic information about what a person-centered planning process might include, and what opportunity and responsibility the person has under person-centered planning.

- The individual chooses the type and extent of person-centered planning activity they want to participate in to develop their CDCS Community Support Plan.
- The individual selects other individuals they want to participate in providing support and assistance in the planning process.
- The individual can select a person to facilitate planning.
- The person chooses the meeting dates, setting, time, place, and length of any planning meetings.
- The individual chooses how to start, work through, and end any planning meetings, including what he or she wants to get done in a meeting.
- The individual chooses areas of life they want help from other in planning for.
- For some, a life vision, dream, or desire forms the foundation for developing their person-centered plan.
- The person-centered planning process is respectful of the individual, and builds on strengths and talents of the person to design a plan.
- The individual makes choices and decisions about services and goods.
- The person achieves increased opportunity for control over their services under the plan.
- The person makes decisions about their:
 - Living situation
 - Providers
 - Service delivery schedule
 - Daily and vocational activity
 - Level of control and responsibility
 - Level of risk management
 - Back up and emergency plans

These decisions are reflected in the plan.

- The individual describes desired results, develops personal outcome indicators to monitor and evaluate the implementation of the service plan, and the schedule for monitoring.

3.3 Consumer/Representative Role in Person-Centered Planning Process and Plan Management

One of the responsibilities a consumer accepts when selecting CDCS is taking the primary role in support plan development. Each consumer will have personal preferences about the level of control they wish to assume in the overall person-centered planning process. The consumer can select other people to assist with the tasks listed below, as long as the person selected is not otherwise prohibited from performing these tasks.

The following planning tasks will be performed by the consumer (or their representative) under CDCS:

Initial/Annual Activities Performed by the Consumer	Ongoing Activities Performed by the Consumer
<ul style="list-style-type: none"> • Direct the development and revision of the Community Support Plan. • Participate in a formal or informal person-centered planning process that addresses individual strengths, needs, and preferences, including preferences about the nature of the planning process. The planning process can be informal or formal, and can be completed without paying anyone to help develop the plan. • Choose people to assist them in the person-centered planning process if they wish. This assistance can come from friends or family or can be purchased.. • Partner with the lead agency case manager in the plan development, approval, and funding within the CDCS budget amount. • Choose who will provide direct services, goods, or supportive services, and decide how much service will be required to meet identified needs. • Negotiate payment rates for direct services, goods, and supportive services requested under the CDCS budget that are within reasonable range of access to comparable or “like” services within the community, and that do not exceed any State-established rates. • Develop a plan to monitor service delivery and effectiveness. Outline desired results and a plan to measure achievement of results. • Submit a plan for lead agency approval. CDCS services cannot begin until the CDCS plan is approved by the lead agency. 	<ul style="list-style-type: none"> • Monitor plan implementation and effectiveness, and achievement of desired results. • Make revisions to the plan as needed and submit back to the lead agency for approval as needed. This includes revisions to back up or emergency plans. See Section 4 regarding revisions to the plan. • Notify lead agency case manager of significant changes in need, function, or condition.

While others may assist the individual in carrying out activities and tasks listed above, only a Flexible Case Manager can be paid to perform these tasks for the person, and only at their request and agreement.

3.4 Consumer Resources

Additional resources related to the planning process are available to the consumer, are optional and can be selected by the consumer in any combination or level of involvement. The person can:

- Request the use of a particular person-centered planning process, tool or approach.
- If desired, select a qualified Flexible Case Manager (FCM) to provide support and assistance during the person-centered planning process. This assistance must be described in the preliminary CDCS plan, and include projected tasks or functions the FCM will perform, the schedule and length of this service, and the rate approved by the consumer for payment for this service. Costs for this service ARE included in the CDCS service budget, and must be authorized on a Service Agreement in MMIS, and must be billed by a Fiscal Support Entity chosen by the person. The total CDCS authorization in this case could include the estimated costs for Flexible Case Management, Fiscal Support Entity services, and Required Case Management and Background Checks.
- Receive training or education to gain a better understanding of roles and responsibilities in the consumer-directed and person-centered planning processes.
- Establish additional qualification requirements for Flexible Case Managers based on individual needs and preferences. These additional requirements must be defined in the CDCS Community Support Plan along with a process for documenting and monitoring that requirements are met for each person hired to serve in this role.

If the person has not selected CDCS because more assistance is requested for planning, the person may:

- Receive assistance in CDCS plan development PRIOR to a final selection of CDCS service by the waiver or AC case manager, billed as waiver or AC case management, for a person currently supported by (or initially opening to) any of the HCBS programs.
- Receive assistance in CDCS plan development from a certified flexible case manager PRIOR to final selection of CDCS. Provision of this FCM must be approved by the RCM and outlined on a form provided by DHS. Under these circumstance, the flexible case manager will receive payment only when the plan is approved, effective the date CDCS services are authorized by the lead agency. See Appendix A.1. for a copy of the form.
- Receive assistance in CDCS plan development from a Relocation Services Coordinator if they are eligible for Medical Assistance and currently reside in an institution. Persons eligible for AC can access AC conversion case management.
- Receive conventional AC or waiver services, including assistance in developing the CDCS support plan, under an “interim” Community Support Plan implemented while the CDCS plan is developed.

3.5 Lead Agency Role and Tasks in Person-Centered Planning Process

- **Information:** A person needs information in order to decide if CDCS might be a good option for them. The lead agency must:
 - Provide information and consumer education about the combination of allowable goods and services that may be purchased under the consumer-directed community support budget.
 - Provide information that helps the consumer understand their roles and responsibilities under consumer-directed services and person-centered planning processes.
 - Provide information about resources, tools, and technical assistance available.
 - Provide information about Fiscal Support Entity services available, including those that allow the consumer varied levels of autonomy and control as an employer.
 - Provide information about the qualifications for and activities of a Flexible Case Manager.

- **Budget Amounts:** DHS will make individual CDCS budget information available to lead agency case managers as a monthly amount listed on the Long Term Care Screening Document for EW and AC (although proposed expenditures for CDCS are not limited monthly by this amount), and as an annual budget for other waivers including CAC, CADI, TBI, and MR/RC in the Waiver Management System. The person needs to know how much money will be available for goods and services to begin to sketch out a plan. The lead agency must:
 - Inform the consumer of their CDCS and non-CDCS budget(s) available for purchasing services over a one-year period.
 - Prorate the amount of money available under either CDCS or non-CDCS if the service plan will cover less than one year.

- **Facilitate the Person-Centered Planning Process:** The lead agency will also:
 - Help the consumer outline their interests, strengths, desired outcomes, and preferences for services during assessment, as is completed for all HCBS applicants or recipients.
 - Outline planning process options so the consumer can choose the level of direction and control they prefer for the person-centered planning process.
 - Give professional feedback about the level of provider training, standards, and qualifications the consumer should consider given assessed needs.
 - Provide information about the background check process, benefits of the process, and how these background checks will be paid for under CDCS.

3.6 Other Services That Increase Flexibility and Consumer Control

It is important that lead agency staff be thoroughly familiar with other service options that increase consumer direction and flexibility in services planning and delivery. This information must be available to consumers to help them make the most informed choice about not only services available, but the range of consumer direction and control available in the waiver and AC service delivery system.

Consumer Directed Community Supports, when properly implemented, offers the most flexibility and consumer control in service design, selection of supports, and managing individual budgets. However, some consumers may not want to assume the level of responsibility and control expected under CDCS, but still want more flexibility in designing their services, may want to have more authority to direct their care, or may want more choices in who can provide support or service to them.

PCA Choice, for example, can allow a person to recruit, hire, train, and supervise a direct support worker. Under this option, the person receives assistance in developing a service plan, and receives fiscal management support from a PCA Choice provider. See the Disability Services Program Manual for more complete information about this option at <http://www.dhs.state.mn.us>, and click on “CountyLink”. The consumer guidebook for PCA Choice is also available on the web. Look for “Personal Care Assistance Program Consumer Guidebook”, DHS Form 3858. Go to <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3858-ENG>

There has also been an expansion of **caregiver services and respite options for families of persons age 60 or older** that includes new services, new flexibility in the provision of these services, and an ability to tailor these services to meet individual caregiver and recipient needs. See Bulletin 03-25-06 for complete information about these options.

In addition, **quasi-formal and informal support networks** exist in many communities that can offer very individualized service provided by volunteer or paid staff support. These services can be very flexible and include social service and nursing services such as Living At Home Block Nurse Programs and respite. Agencies such as the Area Agency on Aging (AAA) or Centers for Independent Living may link consumers and families with a variety of non-paid help available from volunteers or from faith-based communities, for example. See Bulletin 01-25-09 for information about collaborations between AAAs and the communities they serve designed to increase availability of these kinds of supports. Go to http://www.dhs.state.mn.us/main/groups/publications/documents/pub/DHS_id_003581.pdf

These quasi-formal community based supports can offer individualized service and support from non-traditional “providers”, and can be an important component of a Community Support Plan for CDCS as well as non-CDCS consumers.

3.7 Tools and Resources to Support the Person-Centered Planning Process

Planning tools and resources can assist the person in designing a meaningful person-centered plan. The lead agency will provide information about the availability of these tools and resources.

Refer to *Appendix A: Resources for Person-Centered Planning*.

Resources will be made available through the Department to lead and other agencies free of charge to pass on to consumers free of charge. There are numerous additional resources that people can access without charge. The lead agency will need to become familiar with these resources in order to provide information about person-centered planning options, and to provide assistance with supplemental materials if needed.

If a Flexible Case Manager offers assistance in support plan development and intends to use proprietary tools for which the person will be charged, the person must be told about and agree to these charges prior to completion of the agreement between the person and the vendor.

In some cases, a person may discover a tool that is perfect for them that they must purchase to use. In this case, resource materials for plan development can be paid for under the person's CDCS budget using the "Treatment and Training" CDCS service category for claims.

"Support Plan Components" are outlined in Section 4, as are criteria for lead agency approval of a consumer-designed CDCS support plan.

Appendix A: A Web Resource List on Person-Centered Planning

Web Resources:

http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/DHS_id_029442.pdf is the main web address to the complete tools kit created for person-centered planning under CDCS. The text of and links within the page are recreated here.

Consumer Directed Toolkit:

http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/DHS_id_029442.pdf. The Consumer Directed Toolkit contains a variety of resource materials to assist consumer direct and manage their own supports. Section 5 of the toolkit focuses on person-centered planning.

Minnesota Governor's Council on Developmental Disabilities, click on Publications: <http://www.mncdd.org/>

Two manuals are available through the Research and Training Center on Community Living, a division of the University of Minnesota:

- Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning - A Manual for Person-Centered Planning Facilitators (PDF): [http://www.rtc.umn.edu/pdf/pcpmanual1.pdf](http://www rtc umn edu/pdf/pcpmanual1.pdf)
- Training Person-Centered Planning Facilitators: A Compendium of Ideas (PDF): <http://www.rtc.umn.edu/pdf/pcpmanual2.pdf>

Appendix A.1: CDCS Flexible Case Management Plan Development Notification Tool

Consumer Name: _____

Date of Birth: _____

PMI #: _____

This tool can be used to inform all parties of the use of flexible case management services to develop an initial community support plan for Consumer Directed Community Supports (CDCS).

The estimated cost of the plan development will be added to the consumer's CDCS budget and may be paid to the flexible case manager after the plan has been approved.

Estimated Cost of Plan Development: _____

I understand that a flexible case manager who helps develop the initial community support plan will not be paid if the plan is not approved or if the consumer decides not to pursue CDCS.

Flexible Case Manager: _____

Signature: _____

Date: _____

Consumer: _____

Signature: _____

Date: _____

Legal Representative (if applicable): _____

Signature: _____

Date: _____

***Note: This tool is not a contract; it is an optional tool

4.1 Community Support Plan Requirements for All HCBS Programs

The Community Support Plan developed by a consumer who has chosen CDCS must include certain components required for all HCBS waiver or AC plans. The plan must identify:

- All formal and informal services, goods, and supports that will meet assessed needs
- The frequency and duration of service, the price for that good or service, and who will provide the service or support
- Safeguards to reasonably address and maintain the individual's health and welfare
- Backup services, contingency plans, and emergency service to address potential situations that may arise
- The person's desired outcome or result to be achieved with the plan in place
- Contact information.

4.2 Community Support Plan Formats– (DHS 2925, 4166 or 4556)

The Community Support Plan (*DHS-2925*) form can be used to outline the required CDCS plan components, and can provide a basis for the person-centered planning process. Use of the budget pages and the caregiver support plan can help the consumer outline proposed expenses and ensure caregiver planning occurs. The attached services grid can be used in combination with the “crosswalk” found in Appendix B in this manual to organize conventional waiver or AC services into the appropriate CDCS categories within the plan.

DHS Form 4166 offers an alternative support planning format. Used as an electronic form, detailed assessment information can be merged from the electronic version of DHS Form 3428 (the assessment form) to populate the support plan form. This will allow the consumer to see summary information about assessed needs that must be addressed in the plan, either through paid or informal services, or through a personal risk management proposal.

DHS Form 4556 is the Rule 185 compliant Community Support Plan and meets standards of the MR/RC Waiver. This plan can also be used with the other home and community based waiver programs (CAC, CADI, TBI and EW and AC program).

Any plan format can be used by the consumer that can outline all of the required plan components and that reflects required documentation as listed in the next parts of this Section. The requirements can be listed on a “form” of the consumer’s own creation to guide the planning process and ensure submission of a complete plan, or one can be created by a local agency for OPTIONAL use by consumers.

Forms listed in this manual can be accessed at [http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-\(form number\)-ENG](http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-(form number)-ENG).

4.3 CDCS Requirements of a Person-Centered Community Support Plan

Within the overall plan requirements listed in Section 4.1, a plan developed with CDCS as the choice of service must include the following detail:

- A description of all services and goods that will be purchased under the individual's CDCS budget cap, including payment rates for each service or good, and staff, if known
- Informal or quasiformal supports that are part of an ongoing, predictable, reliable method to meet identified needs
- Schedule of services (how often, for how long)
- Proposed allocation of CDCS dollars between the four categories of CDCS services identified in Section 5.3 and more fully described in Section 6
- Choice of Fiscal Support Entity option, including tasks, schedule, and fees
- Outline of plan to monitor plan implementation and effectiveness of services/supports, including desired results or outcomes, the schedule of monitoring activity, how progress will be measured, and who will perform monitoring activity
- Specific provider qualifications, including training requirements, established by the consumer
- Identification of the person(s) responsible to ensure that provider qualifications and training requirements are met, including whether or not background checks are requested and who will perform the checks
- Individualized Flexible Case Management plan, as proposed by the consumer, including tasks, schedule, and fees
- As noted in 4.1, health and safety needs are addressed, including backup and emergency plans, and personal risk management plans, if applicable.

4.4 CDCS Budget Amount on the Plan

The CDCS budget amounts available to purchase services will be issued annually by the department. Budget amounts will be calculated according to federal waiver authority for each waiver program, based on historical expenditures across the categorical populations.

The lead agency professional conducting the LTCC or DD assessment process will inform the consumer of their available budget amount and non-CDCS service cap amount as part of the information about CDCS services options presented to them when they are determined to be eligible for HCBS, or at reassessment.

This budget amount must be included on the plan in order for the consumer and the lead agency case manager to evaluate cost effectiveness, and the likely success of the proposed plan.

The person-centered Community Support Plan can include costs for services up to the annual CDCS budget amount. Unexpended CDCS budget funds cannot be carried over to subsequent service plan years.

See Section 14 for more information about budgets and authorization processes for people age 65 and older, and Section 16 for information about budgets and authorizations under MnDHO and MSHO. Information about budgets and authorizations for people under 65 is found in Section 15.

Reassessment

Reassessment may change the CDCS budget. If that occurs, the lead agency will inform the person of the new budget amount.

If the budget is increased, the individual should determine whether there are currently unmet needs and if so, revise the Community Support Plan and submit to the lead agency for approval and/or re-authorization.

If the budget decreases, and is less than the amount currently authorized, the individual must determine changes to services or supports within the new budget amount. The Community Support Plan will reflect these changes when re-submitted for lead agency approval.

4.5 Applying Quality Considerations to the CDCS Support Plan

A. Program Requirements: While CDCS allows an individual to design services and goods that are unique and meet the person's needs and preferences, there are criteria for purchasing services under CDCS, as well as specific types of goods and services that are NOT allowed to be purchased with CDCS funding. Goods and services that are NOT allowable are described in Section 8.

The goods and services purchased through CDCS must meet all the basic waiver and AC requirements for authorized services. Proposed services:

- Meet the individual's needs identified in the Community Support Plan AND
- Assure health, safety, and welfare AND
- Goods and services collectively provide an alternative to institutional placement AND
- Are the most cost efficient (least costly alternative that reasonably meets health and safety needs) AND
- Be for the sole benefit of the person.

B. Personal Outcomes: For every person participating in HCBS programs, talking about desired outcomes should be part of the initial discussions about service options. When a person thinks and talks about results they want, it helps them make choices about the types of services, the types of providers, goods, and supports that will best help them achieve those results. If all of the criteria for allowable expenditures in A. are met, goods and services are appropriate purchases under CDCS when they are reasonably necessary to support any or all of these individualized outcomes:

- Maintain community living.
- Enhance or maintain family or community involvement.
- Develop or maintain social, physical or work-related skills.
- Decrease dependence on formal support services.
- Increase independence of the person.
- Increase ability of unpaid family and friends to receive training and education needed to provide support.

A CDCS Support Plan must include the results the person wishes to achieve under the plan.

C. Measuring and Monitoring Plan Implementation and Results: Given the person's stated desired results, does the plan to monitor help the person identify needs for revision to the plan, and help demonstrate achievement of or progress toward desired outcomes or results? Does the plan include a schedule to periodically measure progress? What will be measured (indicators)? Who will do the monitoring? What steps will be taken, by whom, if the plan proves to be ineffective?

Examples:

Desired Result	Measure
Employment	I want to work at least 5 hours a week by summer and 10 hours a week by fall. What will be monitored? By whom? How and how often?
Improved Health	My evaluation of my health is fair now and will be good in 6 months. I will have no emergency room visits for one year. What will be monitored? By whom? How and how often?
Increased Independence	I can create a menu, shop and cook for a week's meals within a year. What will be monitored? By whom? How and how often?

The plan to monitor and periodically evaluate the effectiveness of the plan in helping the person achieve desired results must also include what steps will be taken if the plan does not seem to be effective, cannot be implemented according to the approved service design, or if backup or emergency plans are frequently relied upon.

4.6 Health and Safety: Personal Negotiated Risk Management Plan

People take risks every day as part of life. Our ability to assume and manage risk reflects our competence, our independence, our ability and right to make choices, and our right to assess benefits and consequences of choices we make in life.

A personal negotiated risk management plan is a reflection of the consumer's choices that strike a balance between the recommended level of service coverage (care, supervision, and safety) and the person's desired level of independence. For example, a consumer with quadriplegia may decide that 24 hour care and supervision impinges too much on their feeling of living independently in an apartment, does not allow them enough time to be alone, and interferes with personal privacy, and ability to achieve restful sleep at night. The consumer may choose not to have services during a 10 hour period at nighttime, even though there are personal risks that something may happen. The person is aware of risks or consequences and has proposed a method to manage the risk. For example, an emergency alarm device is used at night, or a neighbor or friend agrees to be available in the event of an emergency. Home modifications may be part of a plan to address environmental hazards or concerns about evacuation. An elderly person agrees to home modifications but does not want to utilize a walker, and has a plan to implement in the event of a fall.

The consumer has weighed the cost-benefit and has decided to assume a level of risk and manage it. The personal negotiated risk management plan should be documented in the Community Support Plan and should be tied to the plans for backup services and community emergencies. A lead agency or flexible case manager can help identify potential risks or consequences as part of the support and risk management planning.

Unless a consumer's plan, including personal risk management, results in unaddressed health and safety issues that are so significant that a referral to Adult Protective Services or Child Protective Services will result, a plan should not be denied for health and safety reasons. In other words, health and safety considerations under CDCS should follow the practice in place for all HCBS service plans and protections.

Liability: According to MN Statute 256B.0916 Subd. 6a (c), MN Statute 256B.49 Subd. 16 (e), and MN Statute 256B.0915 Subd. 8 (c), the state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with mental retardation or a related condition, persons with disabilities, and the elderly waiver:

“shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).” (italics added)

4.7 Backup Plans and Emergency Plans

The backup plan is a contingency plan that can be implemented if the primary services in the Community Support Plan are disrupted. It should be designed to address a variety of circumstances should they occur. A backup plan can reflect a variety of resources and should be feasible and readily implemented. It should be documented in the Community Support Plan along with a plan for maintaining contacts and monitoring feasibility. Activation of the backup plan should be evaluated for responsiveness and effectiveness. If a backup plan has to be implemented frequently, the overall plan should be re-evaluated and revised.

An emergency plan is the plan that goes into effect during community-wide emergencies such as threatening weather, fires, electrical outages and other circumstances that can create safety issues or barriers to care delivery. For example, a threatening storm is approaching and warnings have been issued to move to a basement area. Who will assist in moving the consumer to the basement area? Is the plan feasible at all times? Who will monitor and maintain the plan in case of changing situations? The emergency plan should be documented in the Community Support Plan with responsible persons noted and a schedule for periodic monitoring and revising this portion of the plan.

4.8 Reviewing the Plan

Lead agency case managers will review each plan submitted by a person selecting CDCS for these elements and criteria:

<p>Allowable Goods and Services</p>	<p>Are proposed services and goods allowable under the criteria outlined in 4.5, and according to the definitions of CDCS allowable costs, goods, services, and items as outlined in Section 5 of this manual?</p> <p>Does the plan for personal assistance that includes a spouse or parent who will receive payment for this assistance meet criteria outlined in Section 13 of this manual?</p> <p>Does the plan include items or services that are explicitly excluded as noted in Section 8 of this manual?</p>
<p>Health and Safety: Meeting Assessed Needs, Quality of Care</p>	<p>Do plan components meet identified needs?</p> <p>Will backup and contingency plans, including personal risk management plans, in combination with the proposed plan, reasonably ensure the person’s health and safety in the community?</p> <p>Are proposed backup plans and emergency plans reasonable and likely to be effective?</p> <p>Are training, experience, educational, and licensing requirements outlined in the plan reasonable and adequate given assessed needs and consumer preferences? Do providers meet the qualifications outlined in Section 7 of this manual?</p> <p>Does the plan include adequate and reasonable informal caregiver training and other supports given the assessed needs and consumer preferences?</p>
<p>Quality Plan: Consumer Outcomes</p>	<p>Will services and goods reasonably support the achievement of consumer outcomes listed in the person’s plan?</p> <p>Are the goods and services considered appropriate purchases under CDCS because they are reasonably necessary to support any or all of the outcomes outlined in Section 4.5 of this manual?</p> <p>Will the monitoring schedule, activity, and indicators support achievement of person’s desired results?</p>
<p>Cost Effectiveness and Financial Accountability</p>	<p>Are the proposed costs for goods and services reasonable given the cost of purchasing similar services or goods in the community?</p> <p>Are there alternative payors for proposed services such as Medicare?</p> <p>Does the plan represent a cost-effective way to meet needs?</p> <p>Does the agreement between the Fiscal Support Entity and the consumer outline specific tasks to be performed by the FSE, and fees?</p> <p>Does the description of Flexible Case Management service, if any, include a clear description of what the person wants to buy from the FCM, at what price, for how long?</p> <p>Can the plan be implemented within the person’s CDCS budget?</p>

In general, any plan submitted by a consumer that contains the required documentation and that meets the above criteria, as applicable to an individual consumer, must be approved by the lead agency. See the next sections for information about denial of a proposed CDCS plan or portions of a plan.

4.9 Approval, Denial, or Partial Denial of a Proposed CDCS Plan

The lead agency must make a decision in writing about the proposed CDCS plan submitted by the consumer *within 30 calendar days of receipt of the proposed plan*. The lead agency can:

- **Approve the plan.** Send the consumer and the FSE a copy of the approval letter and a copy of the plan. Enter a Screening Document and Service Agreement into MMIS to authorize CDCS funding to support the plan. Send a copy of the Service Agreement to the consumer and FSE.
- **Recommend changes needed to approve the plan before a final decision.** The lead agency case manager can negotiate with the consumer to change elements of the plan as needed to approve the plan. This negotiation can be informal and will be the most effective method to resolve concerns before the 30 day period for lead agency decision expires.
- **Approve part of the plan.** The plan submitted by the consumer may contain services, costs, outcomes, staffing proposal or other elements that the lead agency determines they cannot approve. In effect, approval of part of a plan represents a decision to reduce proposed service (by denying some portions).

A written decision to deny portions of a proposed plan must be accompanied by an explanation detailing the reason(s) for the denial or reduction of a requested service.

- **Deny or refuse to approve the plan.** A plan may be denied in its entirety. A written decision to deny the requested services must be accompanied by an explanation detailing the reason(s) for the decision to deny.

When the decision is to deny part or all of a proposed plan: The lead agency can use DHS Form 2828 to notify the consumer and their legal representative of this decision. That form includes information about filing an appeal of the agency's decisions; the lead agency must provide assistance to the person who wishes to file an appeal and requests such assistance. The lead agency can also use a similar form if they have developed one, as long as all of the same information is included on the form, and the information is accurate.

The consumer can agree to the partial plan as approved by the agency, or they can ask the lead agency to reconsider any decision made, including whether they agree that the summary of assessed needs accurately reflects their needs. Conciliation conferences can also be scheduled to reconsider issues or concerns that prevented approval of elements of a plan or denial of the plan as a whole.

A consumer who requests a conciliation conference or informal negotiation should be informed that the Fair Hearing (appeal) process includes timelines that must be met. The consumer may wish to file an appeal as well as confer or negotiate. The request for a hearing can be withdrawn if conciliation conferences or negotiation result in resolution of issues or concerns.

4.10 Provision of Technical Assistance: Helping the Consumer Get a CDCS Plan Approved and Implemented

As noted in Section 3.4, a person who wants assistance in CDCS support plan development can access it in a variety of ways, including through assistance from their waiver or AC case manager or a Relocation Services Coordinator. These resources should also be considered available to help a person reshape a CDCS plan that has been submitted and either denied or partially approved.

If a plan is denied or partially approved, a support plan that relies on conventional waiver or AC services can be implemented, with additional waiver or AC case management provided to address CDCS plan components in question. This support plan development activity is currently performed by case managers for any consumer who wishes to change their providers, their services, their schedules, and so on, and represents a well-established role of the case manager in helping develop a support plan that reflects consumer choices, preferences, and participation.

The person could also receive assistance in CDCS plan development from a certified flexible case manager PRIOR to final selection of CDCS. Provision of this FCM must be approved by the RCM and outlined on a form provided by DHS. Under these circumstance, the flexible case manager will receive payment only when the plan is approved, effective the date CDCS services are authorized by the lead agency. See Appendix A.1. for a copy of the form.

The person might also receive approval for a CDCS plan that includes Flexible Case Management *only* to assist in a CDCS support plan revision that results in overall plan approval. An important issue to consider under this option is how and to what extent a person's need for support and assistance will be met during the interim.

4.11 Service Revisions and Plan Changes - Consumer Versus Lead Agency Approval

Consumer Approval Only Required

The recipient or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the lead agency, when the revision does not change or modify the parameters authorized by the lead agency case manager in the Community Support Plan. For example, within the Community Support Plan parameters and budget, the recipient has the flexibility to:

- Change caregivers (with the exception to deciding to pay a spouse or parent if not previously authorized)
- Hire additional caregivers
- Change the days or times of service
- Pay a business instead of staff (e.g. the local laundry instead of personal assistant)
- Grant wage increase to personal assistant up to maximum permitted
- Pay one caregiver who has more experience a higher rate, etc. However, the caregiver(s) must meet the qualifications and training requirements that the county agency approved in the Community Support Plan

Lead Agency and Consumer Approval Required

The person's Community Support Plan will provide the foundation for purchase and delivery of services and achievement of individually desired results. The plan must include certain characteristic elements:

- A summary of assessed needs
- The person's desired service outcomes or results
- How the result or outcome will be achieved/how the need will be met (description of services)
- What training and qualifications are required for staff
- How the service will be monitored, and
- The budget

The individual's budget must be planned for a 12 month period and will include all goods and services to be purchased through the waiver and State plan home care services with the exception of required case management and criminal back ground studies.

Any service plan that is less than a year must be prorated.

These elements or parameters that are defined in the Community Support Plan cannot be altered without agreement from the lead agency. If a requested or proposed revision will result in a change or modification of the approved parameters of a Community Support Plan, the consumer or their legal representative will work with the lead agency to reviewed and approve requested changes.

The lead agency must respond to a request to change the approved plan within 30 days of the request submitted by the consumer. See Section 4.9 for the process required if all or part of a plan, including a request to revise the plan, is denied. A change in the plan that requires approval and/or authorization by the lead agency cannot be implemented nor paid for until lead agency approval has been received by the consumer.

Example:

A homemaker comes to the consumer's home to do laundry, and the consumer decides to send it to the local Laundromat instead. This change does not need lead agency approval since the outcome was laundry, and the laundry is still done. However, if the homemaker was also doing a health and safety check while doing laundry, lead agency approval is needed to ensure the health and safety outcome will still be met.

5.1 Waiver requirements related to all allowable services

While CDCS allows an individual to design unique services and goods to meet the person's needs and preferences, these goods and services must meet all of the basic waiver program requirements for authorized services:

- Meet the individual's needs identified in the Community Support Plan AND
- Assure health, safety, and welfare AND
- Goods and services collectively provide an alternative to institutional placement AND
- Are the most cost efficient (least costly alternative that reasonably meets health and safety needs) AND
- Be for the sole benefit of the person.

5.2 Additional requirements for CDCS services: Consumer Outcomes

If all of the criteria in 5.1 are met, goods and services are appropriate purchases under CDCS when they are reasonably necessary to support any or all of these consumer outcomes:

- Maintain community living
- Enhance family involvement and community inclusion
- Develop or maintain social, physical or work related skills
- Decrease dependence on formal support services
- Increase independence of the person
- Increase ability of unpaid family and friends to receive training and education needed to provide support.

Goods and services that are NOT allowable are described in Section 8.

5.3 Broad CDCS Service Categories

Consumer Directed Community Supports service can represent a variety of goods and services, designed by the consumer, and approved in the plan. Under the single service called CDCS, the waiver and AC programs provide reimbursement for four major types or categories of services:

- *Personal assistance:* Services and supports that typically do not require a professional license, certification or other professional credentialing.
- *Treatment and training:* Primarily services and supports that require the person or entity performing the service to be professionally licensed, credentialed or otherwise certified. Providers of treatment and training must meet all applicable standards. Also included in this category are consumer and paid or unpaid support staff training and education.
- *Environmental modifications and provision:* Home and vehicle modifications, chore, transportation, approved supplies and equipment, prescribed special diets, and adaptive clothing are examples of supports that would be categorized here.
- *Self-direction support activities:* Fiscal Support Entity service, Flexible Case Manager service, and some employer-related costs fall under this category.

These categories are NOT used for Service Agreements. They are used only to classify services and supports under an approved plan, and are used on claims to provide information about the kinds of service and support CDCS funding is used for.

These categories represent broad kinds of support and assistance a person may need to live in the community. Within these categories, consumers are able to define the service that best meets their needs and preferences. More detailed information about use of these categories is presented in Section 6.

5.4 Additional Goods and Services That May Be Included in CDCS Budgets

In addition to the kinds of goods and services listed above, the following goods and services can be included in an individual's plan, under the CDCS budget, as long as they meet the criteria outlined in Section 5.1 and 5.2.

- Goods and services that augment State Plan services (e.g. needed “extended” home care service)
- Goods and services that provide alternatives to “conventional” waiver or State Plan services (e.g. purchasing employment skill training rather than day training and habilitation service, or purchasing assistance with activities of daily living from a neighbor rather than PCA or home health aide service from an agency)
- Therapy, special diets or behavioral supports not otherwise available through Minnesota Health Care Programs (Medical Assistance and Prepaid Medical Assistance) that mitigate a disability and that are prescribed by a physician licensed to practice in Minnesota and enrolled as an MHCP provider
- All currently available waiver and AC goods and services can be purchased as part of a CDCS support plan.

Providers of any service must meet SERVICE qualifications, whether purchased through conventional AC or waiver or CDCS support plans. For example, if the consumer indicates they wish to purchase supported employment service, the provider must meet all required standards and licensing requirements. More information about provider qualifications under CDCS is found in Section 7.

All of the services approved in a plan must be arranged in the categories listed in 5.3 to allow the Fiscal Support Entity to separate and appropriately bill approved services. A “crosswalk” between the conventional waiver and AC services and the CDCS category the service would fall under can be found in Appendix B.

5.5 Additional Services Authorized in Combination with CDCS

In addition to authorization of CDCS services and goods comprised of some combination of the categories of services listed in this Section, a Service Agreement can also include:

- State Plan home care services (not available to AC participants)
- Required Case Management services (Every Service Agreement will include Required Case Management)
- Background checks requested by the consumer. “Background checks” referred to throughout this manual refer to those checks that follow the provisions under MN Statutes, section 245C.
- Certain home modifications for persons under age 65.

Required case management and background checks must be authorized separately because the cost of these activities **cannot be deducted from the individual consumer’s CDCS service budget** under the approved federal waiver plans. For person under age 65, and for persons purchasing CDCS service under the Alternative Care program, the costs of these components of a CDCS plan are covered by aggregate allocation funds.

State Plan home care services can be authorized separately in order to:

- Ensure access to, and “first use” of these benefits
- Allow the consumer to more easily meet spenddown requirements by provider assignment
- Ensure health plan provision of those home care benefits for which capitation payments have been made
- Apply waiver obligation calculations appropriately to only “waiver” and not state plan home care services under the Special Income Standard Elderly Waiver Program (SIS-EW).
- Access Medicare coverage for home care services, which will not be calculated as part of the consumer’s budget (whether CDCS has been chosen or not).

Home Modifications and/or Assistive Technology: For people eligible for the MR/RC, CADI, CAC and TBI waiver programs, home modifications and/or assistive technology whose singular or combined cost will exceed \$5,000.00 and that are approved by the lead agency are also authorized on the Service Agreement separately. See Section 15.

5.6 Using CDCS to Purchase Conventional Waiver Services

All currently available waiver or AC goods and services can be included in a CDCS support plan and purchased with CDCS funding. This includes services such as day training and habilitation, in-home family support, behavior analyst, extended supplies and equipment, extended PCA, adult day care, and transitional services.

If a consumer selects conventional waiver or AC service as part of their support plan:

- The costs are included in the individual's CDCS budget.
- The provider of this service must be certified or licensed according to the Minnesota statute and rule related to the SERVICE.
- The service is authorized as CDCS, and the costs are included in the CDCS authorized total.
- The current waiver or AC service codes ARE NOT entered on the Service Agreement.
- The provider cannot bill MMIS directly. Rather, the Fiscal Support Entity submits a claim for CDCS, using one of four CDCS categories of service on the billing to indicate what type of service was provided, and pays the vendor after service is delivered and according to the agreement between the consumer and the vendor.
- The “crosswalk” for coding between the conventional waiver or AC service and how this service will be categorized if chosen by a person as part of CDCS support plan is shown in Appendix B.

5.7 A Note About State Plan Home Care Services

The consumer who meets waiver eligibility criteria and who has chosen CDCS as their service option can select, as part of their Community Support Plan, state plan home care services. State plan home care services are all those services identified in MN Statutes 256B.0627 and MN Rule 9505.0290. Alternative Care participants are not eligible for Medical Assistance benefits such as state plan home care.

<p>State Plan Home Care Services include:</p> <ul style="list-style-type: none"> • Personal Care Assistance (PCA) • PCA Supervision • Home Health Aide • Skilled Nursing Service • Private Duty Nursing 	<p>The costs of any state plan home care services selected by the consumer must be included under their individual CDCS budget. State plan home care services are provided by a licensed, certified agency.</p> <p>Authorized on the CDCS Service Agreement using state plan home care codes, and the home care agency can bill directly.</p>
<p>“Extended” Home Care Services include:</p> <ul style="list-style-type: none"> • Extended Personal Care Assistance (PCA) • Extended PCA Supervision • Extended Home Health Aide • Extended Skilled Nursing Service • Extended Private Duty Nursing 	<p>The costs of any “extended” home care services selected by the consumer must be included under their individual CDCS budget. These extended home care services are provided by a licensed, certified agency.</p> <p>Authorized under the CDCS service code on the Service Agreement, must be billed by category by the Fiscal Support Entity.</p>
<p>Acute and Primary Care Services include:</p> <ul style="list-style-type: none"> • Physical Therapy • Occupational Therapy • Respiratory Therapy • Speech Therapy • Supplies and Equipment • Medical Transportation • Behavioral and Mental Health Services 	<p>Other services that can be part of a person’s support plan are available under acute and primary coverage through MHCP. The consumer should be encouraged to access therapy and transportation under their acute and primary care benefit set, since the cost of these services IS NOT included under the individual’s CDCS budget.</p> <p>These services do not appear on the CDCS Service Agreement, and they are billed directly by the therapy or supplies and equipment agency.</p>
<p>Extended Acute & Primary Care Services include:</p> <ul style="list-style-type: none"> • Extended Supplies and Equipment • Extended Physical Therapy • Extended Occupational Therapy • Extended Respiratory Therapy • Extended Speech Therapy • Extended Behavioral Therapy 	<p>All of the HCBS waiver programs offer “extended” supplies and equipment. Some HCBS programs also offer services under the waiver that “extend” therapy benefits available under Medicaid acute and primary care coverage. If the person chooses “extended” therapy, or extended supplies and equipment or transportation, the costs of these services is included in the CDCS budget.</p> <p>Authorized under the CDCS service code on the Service Agreement, must be billed by category the Fiscal Support Entity.</p>

Within a Community Support Plan, the consumer may combine state plan home care that will be authorized and billed separately by a home care agency with other CDCS supports. This includes those designed to augment or provide an alternative to state plan home care or conventional waiver services.

Appendix B: “Crosswalk” Between Waiver & Home Care Codes and CDCS Service Categories

CAC WAIVERED SERVICE	CDCS ALTERNATIVE
Case Management (Flexible Case Management Only)	Self-direction support activities
Case Management Aide (Paraprofessional)	Not allowed
Family Counseling	Treatment and training
Family Training	Treatment and training
Foster Care	Not allowed
Home Health Aide, Extended	Treatment and training
Homemaker	Personal assistance
LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
LPN (Complex Home Health, Extended)	Treatment and training
Modifications	Environmental modifications and provisions
Nutritional Therapy, Extended	Treatment and training
Occupational Therapy or Assistant, Extended	Treatment and training
Personal Care Assistant (Extended 1:1; Extended 1:2; Extended 1:3)	Personal assistance
Physical Therapy or Assistant, Extended	Treatment and training
Prescription Drugs, Extended	Treatment and training
RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
RN (Complex Home Health, Extended)	Treatment and training
RN (Supervision of Independent PDN)	Treatment and training
Respiratory Therapy, Extended	Treatment and training
Respite Care (In-home; Out-of-home)	Treatment and training
Speech Therapy, Extended	Treatment and training
Supplies/Equipment	Environmental modifications and provisions
Transportation (One Way Trip)	Environmental modifications and provisions
Transportation-Mileage	Environmental modifications and provisions
Transportation Mileage (Noncommercial Vehicle)	Environmental modifications and provisions
Transportation-Attendant	Personal assistance

Note: Case Management here refers only to Flexible Case Management service selected by the person, and provided by a qualified person. Required Case Management is authorized separately. See Section 10 for a description of Required and Flexible Case Management tasks under CDCS.

CADI WAIVER	CDCS ALTERNATIVE
Adult Day Care	Treatment and training
Adult Day Care Bath	Personal assistance
Case Management (Flexible Case Management only)	Self-direction support activities
Case Management Aide (Paraprofessional)	Not allowed
Family Counseling and Training	Treatment and training
Home Delivered Meal	Environmental modifications and provisions
Home Health Aide, Extended	Treatment and training
Homemaker	Personal assistance
Independent Living Skills	Treatment and training
LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
LPN (Complex Home Health, Extended)	Treatment and training
Modifications	Environmental modifications and provisions
Occupational Therapy or Assistant, Extended Home Health	Treatment and training
Personal Care Assistant (Extended 1:1, Extended 1:2; Extended 1:3)	Personal assistance
Physical Therapy or Assistant, Extended Home Health	Treatment and training
Prevocational Services	Treatment and training
RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
RN (Complex Home Health, Extended)	Treatment and training
Respiratory Therapy, Extended Home Health	Treatment and training
Respite Care (In-home; Out-of-home)	Personal assistance
Speech Therapy, Extended Home Health	Treatment and training
Supplies and Equipment	Environmental modifications and provisions
Supported Employment	Treatment and training
Transportation (One Way Trip)	Environmental modifications and provisions
Transportation-Mileage	Environmental modifications and provisions
Transportation-Mileage (Noncommercial Vehicle)	Environmental modifications and provisions
Transportation-Attendant	Personal assistance

MRRC	CDCS ALTERNATIVE
Adult Day Care	Treatment and training
Assistive Technology	Environmental modifications and provisions
Caregiver Training and Education	Treatment and training
Case Management (Flexible Case Management only)	Self-direction support activities
Chore Service	Environmental modifications and provisions
Crisis Respite	Treatment and training
Consumer Directed Community Supports	Self-direction support activities
Consumer Training and Education	Treatment and training
Day Training and Habilitation	Treatment and training
Environmental Modifications	Environmental modifications and provisions
Homemaker	Personal assistance
Housing Access Coordination	Personal assistance
In-Home Family Support	Treatment and training
Live-in Personal Caregiver Expenses	Personal assistance
Personal Care Assistant Services (PCA)—(Extended 1:1; Extended 1:2; Extended 1:3)	Personal assistance
Personal Support	Personal assistance
Respite Care (In-home; Out-of-home)	Personal assistance
Specialist Service	Treatment and training
Supported Employment	Treatment and training
Supported Living (Adult; Child)	Treatment and training
Transportation, Extended	Environmental modifications and provisions
24-Hour Emergency Assistance	Treatment and training
Transportation, Extended	Environmental modifications and provisions
Transportation, Extended	Environmental modifications and provisions

TBI	CDCS ALTERNATIVE
Adult Day Care	Treatment and training
Adult Day Care Bath	Personal assistance
Behavioral Programming (by Professional; Analyst; Specialist; Aide)	Treatment and training
Case Management (Flexible Case Management only)	Self-direction support activities
Case Management Aide (Paraprofessional)	Not allowed
Chore Services	Environmental modifications and provisions
Cognitive Therapy (by Professional, Extended; by BA/BS Personnel, Extended)	Treatment and training
Companion Services	Personal assistance
Family Counseling and Training	Treatment and training
Foster Care	Not allowed
Home Delivered Meals	Environmental modifications and provisions
Home Health Aide, Extended	Treatment and training
Homemaker Services	Personal assistance
Independent Living Skills (Counseling; Maintenance)	Treatment and training
Independent Living Skills Therapies (ILS: Individual; Group)	Treatment and training
LPN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
LPN (Complex Home Health, Extended)	Treatment and training
Mental Health Explanation of Findings, Extended	Treatment and training
Mental Health Psychological Testing, Extended	Treatment and training
Modifications	Environmental modifications and provisions
Night Supervision	Treatment and training
Occupational Therapy or Assistant, Extended Home Health	Treatment and training
Personal Care Assistant (Extended 1:1; Extended 1:2; Extended 1:3)	Personal assistance
Physical Therapy or Assistant, Extended Home Health	Treatment and training
Prevocational Services	Treatment and training
RN (Regular Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
RN (Complex Home Health, Extended)	Treatment and training
Residential Care	Not allowed
Respiratory Therapy, Extended Home Health	Treatment and training
Respite Care Worker (In-home)	Personal assistance
Respite Care (Out-of-home)	Personal assistance
Speech Therapy, Extended Home Health	Treatment and training
Supported Employment	Treatment and training
Structured Day Program	Treatment and training

Supplies and Equipment	Environmental modifications and provisions
Transportation (One Way Trip)	Environmental modifications and provisions
Transportation-Mileage	Environmental modifications and provisions
Transportation-Mileage (Noncommercial Vehicle)	Environmental modifications and provisions
Transportation-Attendant	Environmental modifications and provisions

EW	CDCS ALTERNATIVE
Adult Day Care	Treatment and training
Adult Day Care Bath	Personal assistance
Assisted Living	Not allowed
Assisted Living Plus	Not allowed
Caregiver Training and Education	Treatment and training
Case Management (Flexible Case Management only)	Self-direction support activities
Chore Services	Environmental modifications and provisions
Companion Services	Personal assistance
Corporate Foster Care	Not allowed
Family Foster Care	Not allowed
Home Delivered Meals	Environmental modifications and provisions
Home Health Aide, Extended	Treatment and training
Homemaker Services	Personal assistance
LPN (Home Health, Extended; Shared Home Health, Extended 1:2)	Treatment and training
Modifications and Adaptations	Environmental modifications and provisions
Personal Care Attendant (Extended 1:1; Ext. Shared 1:2; Ext. Shared 1:3)	Personal assistance
Residential Care	Not allowed
Respite Care (Certified Facility; Hospital; In-Home and Out-of-Home)	Personal assistance
RN (Extended Home Health; Extended Shared Home Health 1:2)	Treatment and training
Supplies and Equipment, Extended	Environmental modifications and provisions
Transportation, Extended	Environmental modifications and provisions
Transitional Supports	Environmental modifications and provisions

AC	CDCS ALTERNATIVE
Adult Day Care	Treatment and training
Adult Day Care Bath	Personal assistance
Assisted Living	Not allowed
Assisted Living Plus	Not allowed
Caregiver Training and Education	Treatment and training
Case Management (Flexible Case Management only)	Self-direction support activities
Case Management (Conversion)	Self-direction support activities
Cash Payment	Self-direction support activities
Chore Services	Environmental modifications and provisions
Companion Services	Personal assistance
Corporate Foster Care	Not allowed
Discretionary Services	Self-direction support activities
Environmental Modifications	Environmental modifications and provisions
Family Foster Care	Not allowed
Home Delivered Meals	Environmental modifications and provisions
Home Health Aide	Personal assistance
Home Health Service (Skilled Nurse)	Treatment and training
Homemaker Services	Personal assistance
Nutrition Service	Treatment and training
Personal Care Assistant (1:1; Shared 1:2; Shared 1:3)	Personal assistance
Private Duty Nursing (LPN regular, shared, or complex; RN regular, shared or complex)	Treatment and training
Residential Care	Not allowed
Respite Care (Certified Facility; Hospital; In-Home and Out-of-Home)	Personal assistance
RN, Supervision of a PCA	Treatment and training
Supplies and Equipment	Environmental modifications and provisions
Transportation	Environmental modifications and provisions

6.1 Customizing Services Under CDCS

Under CDCS, a person is able to design services and supports that are meaningful to and preferred by them. In customizing a support plan, the person can combine self-designed services with AC services, or with federally-approved waiver services and state plan home care services.

When a person selects a service that is ordinarily available as a waiver, AC, or state plan home care service, they are choosing to receive a service that meets all of the provisions of that “ordinary” service, including the service description, provider qualifications, and quality assurance mechanisms inherent to the service (required background check of staff, e.g.).

As noted in Section 5.7, state plan home care services, when selected by the person, can be authorized separately on the Service Agreement and billed directly by the home care agency.

When billing for conventional waiver or AC and self-designed services that augment or provide alternatives to conventional services, all of these services and supports must be fit into one of the four CDCS service categories, and be billed under these categories by the FSE. All services within a plan other than those required to be authorized separately must be categorized into one of the four service categories described in this section.

6.2 Personal assistance

Personal assistance is support or assistance provided by someone hired to help with activities of daily living and instrumental activities of daily living through **hands-on assistance, cueing, prompting and instruction in tasks**. Respite care and homemaker service are included in this category. Typically, this assistance does not require a high level of clinical knowledge or skill.

Examples of personal assistance under CDCS include help with daily activity such as taking a bath, eating, or getting dressed. It can include help with transferring or mobility, or homemaking, laundry and meal preparation. It could be companion services. It could be support in skill building such as meal or restaurant etiquette, assistance with shopping, or behavioral or street safety training.

A person can use CDCS funding to receive personal assistance in a variety of ways, and in combinations from several sources. For example, a person may:

- Hire a neighbor to clean the bathroom and kitchen
- Hire a friend for a weekend of respite care
- Hire a staff to help the consumer get ready for work and while being transported
- Hire someone to provide redirection to prevent acting out behaviors
- Hire someone to provide prompting to help complete certain tasks
- Hire several people who can help each day with all daily activity with hands on assistance
- Hire a PCA from a PCA organization to meet ADL needs. If the person chooses to hire a PCA to provide assistance, the person must meet all PCA requirements.

If a parent of a minor or a spouse is the paid provider of Personal Assistance Service, the rate negotiated between the consumer and the parent or spouse cannot exceed the State-established maximum for Personal Care Attendant (PCA) service for the fiscal year in which the service is authorized, including all benefits. See Section 13 for additional information about payment to a spouse or parent.

6.3 Treatment and training

Treatment and training includes those services that promote the consumer's health and ability to live and participate in the community. Supports and services categorized here are those typically performed or provided by people with specialized skill, certification, or licenses. Examples of services or support that can be covered under this category:

- **Therapy or treatment** provided by nurse, home care and therapy professionals that either augment those available under state plan benefits or are included in the CDCS plan as an alternative to state plan services.
- **Trainer and educational costs for paid or unpaid caregivers:** Payment can be paid for training and education of caregivers to increase their ability to care for the consumer. These costs may include cost of a community CPR training forum, for example, and can include time for paid staff to attend training. This training and education must be directly related to the provision of care or support to the consumer.
- **Trainer and educational costs for recipients** to increase their ability to care for themselves or manage their CDCS plan, employees, or budget. For example, the cost of a nutrition class for a person with diabetes, or transportation and parking costs to attend Dept. of Labor and Industry training on being a domestic employer. The person cannot pay themselves to attend training.

Training and education proposals must be directly related to an identified need resulting from a disability or health condition, must be cost effective, and must be approved as part of the overall plan to meet the person's needs in the community.

Training requested by the consumer and provided by a Flexible Case Manager, or that provided by an FSE must also be outlined and approved in the plan, and be accounted for under the "Self-Directed Support Activity" category of CDCS service.

- **Therapies and behavioral supports** not otherwise defined under state plan or waiver services would be categorized here. If a consumer wants to include a therapy not currently available through the state plan, it must be prescribed by a physician licensed to practice in Minnesota and enrolled in MHCP.
- **Habilitative services:** Habilitative services are required for persons receiving MRRC waiver services. Habilitation includes therapeutic activities, monitoring, supervision, training, or assistance to a person. Whether the habilitation service meets the Personal Assistance Service definition or the Treatment and Training definition, the support plan should identify those services that are part of the required habilitative plan.
- **Life or Employment Skills Development and Community Integration:** CDCS can be used to purchase services or supports that develop or maintain life or employment skills or community integration.
- **Specialized treatment, therapy or training:** CDCS can be used to purchase counseling service, behavioral services, and cognitive or other therapy if the service is part of the approved plan, are prescribed by a physician licensed to practice in Minnesota, and enrolled in MHCP, and are not covered under MHCP elsewhere.

6.4 Environmental Modifications and Provisions

Environmental modifications and provisions include supports, services and goods provided to the recipient to maintain a physical environment that assists the person to live and participate in the community, or that are required to maintain health and well-being.

Examples of services, supports, or goods that would be billed under this CDCS service category include:

- ***Assistive technology***
- ***Home and vehicle modification***
- ***Transportation*** (costs of the person providing the transportation, the driver, or the transportation cost – gasoline or fares) when the need for transportation service is due to a person's functional limitation. CDCS funding cannot be used to meet transportation needs that would be expected to be met by a parent or spouse if the child or spouse did not have a functional limitation (for example, transportation to after school activity or day care, or shopping centers or recreational events).
- ***Environmental supports*** necessary to maintain a clean, sanitary and safe home environment, and when the person cannot perform these necessary tasks due to functional limitation.
- ***Transitional services*** for Elderly Waiver consumers. Expenses related to moving from an institution and establishing a home in the community such as lease or rental deposits, essential furniture, utility set up fees and deposits, and one-time pest treatment of the setting would be categorized here.
- ***Supplies and equipment*** not available under state plan acute and primary care coverage, including durable and non-durable medical supplies and equipments necessary to meet functional limitations.
- ***Supplies and equipment*** could also include devices, controls or appliances *not specifically excluded in Section 8* that increase a person's ability to perform activities of daily living, or instrumental activities of daily living, or to perceive, control or communicate with the environment in order to be more independent or increase community integration. For example, a person may reduce the need for meal preparation with the purchase of a microwave (not considered a "major" appliance) or a modified can opener.
- ***Prescribed special diets*** that are required to address nutritional needs, which are directly related to a disability or health condition, and for which no MHCP coverage is available. See Section 6.4.1 for guidelines related to approving special diets.
- ***Adaptive clothing*** such as those specially designed to increase a person's independence in dressing, grooming, toileting, or bathing, or designed to endure abnormal movement patterns or acting out. It could also include items prescribed by a physician such as orthopedic shoes that are not covered under MHCP.

- *Home delivered meals* provided to a person who is not able to prepare their own meals and for whom there is no other person available to do so, or when the provision of a home-delivered meal is more cost-effective than staff preparation of a nutritionally adequate meal.

Section 6.4.1 Guidelines for Approving Special Diets Under CDCS

Special diets under CDCS must meet the following criteria:

- They are prescribed by a doctor
- They are part of the stated community support plan with identifiable outcomes
- They are approved by the lead agency to meet health and safety needs of the consumer

The following diets are allowable for payment under CDCS if the above criteria are met:

- Anti-dumping diet
- Controlled protein diet (40-60 grams and requires special products)
- Controlled protein diet (less than 40 grams and requires special products)
- Gluten free diet
- High protein diet
- High residue diet
- Hypoglycemic diet
- Ketogenic diet
- Lactose free diet
- Low cholesterol diet
- Pregnancy and lactation diet

Note: Special diets may be covered by an MSA special needs payment or an MFIP special needs payment.

6.5 Self-direction Support Activities

This is the CDCS category of service that is used to bill for *Fiscal Support Entity service and Flexible Case Management service*. Some employer-related expenses such as health benefits, if offered by the consumer to support staff, are also billed under this category.

The consumer may manage their support staff, services and support plan independently, or with assistance from an unpaid informal support. The consumer cannot, however, directly bill MHCP for approved services that have been provided, and will need a Fiscal Support Entity to act as their agent for at least this purpose.

Other consumers may want to purchase assistance with a variety of administrative or management tasks. Self-direction Support Activities include services, supports, and expenses incurred in administering, or in assisting the consumer in administering, CDCS funding.

The consumer cannot reimburse themselves for time spent in developing or administering the support plan, or in hiring, training, or managing employees. However, CDCS funding can be used if the consumer chooses to pay a Flexible Case Manager to perform these functions or assist them in performing them.

Fiscal Support Entity Expenses: The Fiscal Support Entity is the Medicaid-enrolled provider, and is the only entity that can submit claims and receive CDCS payments. These payments are then distributed to the consumer to pay workers, or directly to workers, and to pay for approved goods and other services. As such, every CDCS budget worksheet will include at least some FSE cost for this billing and dispersal of payment activity.

The consumer may also choose to pay the FSE to perform other employer-related activity. See Section 11 for a complete description of the range of services a person can purchase from a certified Fiscal Support Entity.

Flexible Case Management activities are optional, provided by an individual or entity chosen by the recipient, and represent “case management” activities beyond those required to be performed by lead agencies under HCBS requirements. Flexible Case Management service can include, but is not limited to, assistance in support plan development and implementation and in helping the person determine what service options might best meet their needs and preferences. A Flexible Case Manager can provide assistance in brokering services, or in interviewing potential support staff. The person may wish to buy some assistance in designing a quality monitoring plan, and in defining measurable, desired results. See Section 9 for more information about Required and Flexible Case Management.

All Self-directed Support Activity, like other CDCS services and supports, must be elected by the consumer, outlined in the plan, and purchased under agreements between the consumer and the provider that specify tasks to be performed, schedules, and negotiated fees.

7.1 Provider Qualifications: Personal Assistance: The Consumer Decides

Under the CDCS service option, the consumer or their representative determines the qualifications for providers of personal assistance. The person providing assistance does not need a license, certificate or credentialing unless required by the consumer.

For example, a neighbor is hired to provide assistance with ADLs in the morning and at night. The consumer must document desired qualifications in the Community Support Plan and document how the neighbor meets the qualifications. The qualification might be simply that the person can give a bath according to the consumer's instruction, or could include some transfer assistance training. This person does not have to be affiliated with a PCA agency or be certified as a PCA.

On the other hand, the person may elect to use a Personal Care Attendant to meet personal care needs. In this case, the person hired, either as an individual or through an agency, would have to meet all requirements for PCA service provision, including clearance under a criminal background check.

The person can also define additional provider qualifications. For example, knowledge of sign language may be required, or vegetarian meal preparation, or completion of CPR training through the local clinic or recognized community provider of this training. The consumer could hire a person and pay for this training for the individual.

7.2 Provider Qualifications: Treatment & Training:

The following persons can be providers of treatment and training:

- Unlicensed persons who meet the qualifications specified by the consumer in their Community Support Plan. Documentation of completed training and qualifications must be maintained by the consumer.
- Licensed providers who meet all provisions of the “like” waiver or AC service selected, including service description, provider qualifications and quality assurance mechanism of the service.
- Therapists, physicians, nurses, and dieticians acting within their capacity as a provider of the service requested must be licensed.

Providers must meet the certification or licensing requirements in state law related to the *service* the person wishes to include in their plan. If the consumer needs nursing service, the person providing it must be a nurse.

Training and education must be provided a recognized community “expert” in the training topic.

To illustrate the flexibility intended in CDCS, and to highlight the point made above about provider requirements related to the *service*, two examples are offered below. Both of these services would be *billed* as Treatment & Training under CDCS, but the supported employment provider must meet all licensing and other requirements related to supported employment service.

Unlicensed provider of Employment or Life Skills

Development service: The Handy family runs a local hardware store. Mrs. L, who lives next door to the Handys, would like her 17 year old son Mike, a consumer of MR/RC Waiver services, to learn work skills from Mr. Handy. Mr. Handy has agreed to instruct, mentor and coach Mike in a variety of skills as needed. Mike is an employee of Mr. Handy. He is learning appropriate social and work related behaviors—being on time, getting along with other employees and customers, dressing appropriately for the workplace, customer courtesy, etc. and receives wages.

Mrs. L pays Mr. Handy \$200 a month for his services. In the Community Support Plan the provider qualifications are: person must have experience running a small business and supervising staff, patience and teaching ability, understands the needs of persons with a developmental disability in the workplace. Mr. Handy does not need a license to provide supported employment services. He meets the qualifications in the Community Support Plan as determined by Mrs. L.

Licensed provider of Employment or Life Skills

Development services: Mike’s support plan includes the selection of supported employment service. Mike will attend a supported employment work site with his friend three days a week. All waiver service qualifications, rate maximums, and licensing standards must be followed by the provider. The consumer does not have the authority to excuse the provider from state mandated regulations because they selected the CDCS service option.

The supported employment job coach will work with Mike three afternoons a week at Mr. Handy’s, a local hardware store in Mike’s neighborhood. Mr. Handy agreed to provide a work site for Mike, and wages for work performed.

7.3 Provider Qualifications: Environmental Modifications & Provisions

Providers of home and vehicle modifications must have a current license or certificate and must meet all professional standards and/or training requirements required by Minnesota Statutes or administrative rules for the services that they provide.

If state law does not mandate provider licenses, certificates or credentialing, the consumer determines the provider qualifications in their Community Support Plan. All modifications must meet Minnesota code.

- Home modifications must meet building codes and be inspected by the appropriate building authority.
- Vehicle modifications must meet any inspections requirements.
- Transportation falls within the CDCS category of Environmental Modifications and Provisions when the cost applies to the person providing the transportation, the driver, or the cost of the transport – gasoline or fares, for example. A person assisting the consumer during transportation is covered under the CDCS category of personal assistance.
- Private individuals may be designated to provide transportation when they meet the consumer's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage. Drivers can substitute for common carriers if this is a cost-effective option.
- Medical Assistance state plan Medical Transportation should be accessed for trips to medical appointments.
- A person who will perform chore or heavy housekeeping tasks must meet the consumer's qualifications. The consumer may purchase snow removal from the person who does snowplowing in the neighborhood, or heavy housecleaning from a local maid service. (Homemaker service is included in the Personal Assistance Service category). The person may chose to require a person be bonded or insured, for example, as a provider of these services.

7.4 Provider Qualifications for Fiscal Support Entities

A Fiscal Support Entity (FSE) is an umbrella organization that offers a range of financial management services to facilitate consumers' use of Consumer Directed Community Supports services.

Each consumer selecting CDCS must choose an FSE to provide at least fiscal agent service.

The FSE serves as an agent to the consumer for the purposes of:

- Billing DHS for CDCS payment and dispersing payment.
- The person must hire an FSE to process vendor and agency invoices to receive CDCS payment. The consumer may also hire the FSE to pay the staff, vendor and agency invoices for goods and services provided in accordance with an approved Community Support Plan, or the consumer may receive a dispersed payment from the FSE and pay these invoices and wages directly.
- The person can also choose to hire the FSE to manage state and federal payroll taxes and workers' compensation and other insurance either required or offered as a benefit by the consumer to support workers.

The Fiscal Support Entity must be an enrolled MHCP (MA and AC) provider. In order to become enrolled as a provider of FSE service, the agency must:

- Pass the State's "Readiness Review" and receive a certification of such
- Be able to provide, at a minimum, fiscal conduit and payroll services for the consumer
- Have a contract with a local county agency. Counties can agree to shared use of each other's contracts for FSE services in order to ensure choice between FSE providers at the local level.

An FSE may choose to operate as an "Agency with Choice" in which case the agency acts as the common law employer and the consumer is the managing employer. An FSE may also offer qualified Flexible Case Management service, but cannot provide this service to clients who are using them as their Fiscal Support Entity.

See Section 10 for information about the "Consumer as an Employer" under CDCS.

Complete information about the Fiscal Support entity and their qualifications, roles and responsibilities is found in Section 11.

"Readiness Review" requirements are outlined in Section 11.7.

7.5 Provider Qualifications for Flexible Case Management (FCM) Service

A Flexible Case Manager can assist the consumer primarily in:

- Development, implementation, and monitoring of the Community Support Plan
- Employee management functions such as evaluation of employee performance or interviewing for hiring.

This is optional support for the CDCS consumer. Some people may want no Flexible Case Management service at all; others may want to buy some support initially and carry on independently later. Other people may want ongoing support over a longer period of time. The Support Plan must clearly specify the consumer's plan for purchasing FCM, including tasks, schedules and rates.

The consumer may also require the person to meet additional qualifications in order to provide FCM to that individual.

In order to provide paid FCM service to any CDCS consumer, a person must be certified by the State of Minnesota. An online DHS training module is available to certify Flexible Case Managers. (http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/DHS_id_007126.hcsp). Upon satisfactory completion of the training, DHS will issue a certificate to the person completing the training. This certificate must be shown to consumers interested in purchasing FCM.

Experienced lead agency case managers can test out of the training by taking and passing the test. A lead agency can provide Flexible Case Management, but must also offer other choices in providers of this service locally. Lead agency Flexible Case Managers cannot delegate these activities to paraprofessional case managers. However, a paraprofessional case manager at a lead agency may take and pass the training course and test, and directly provide FCM.

A qualified Flexible Case Manager:

- Is certified by DHS
- Cannot be the common law employer (employer of record)
- Must be at least 18
- Cannot be a direct care provider for the consumer (local agency staff and health plan representatives excluded)
- Cannot be an FSE who is also a agency of choice provider for the consumer.

Any person receiving flexible case management services may not provide flexible case management services to another person receiving CDCS services.

A parent, spouse or legal representative can provide many of the same types of support to the consumer that a FCM can provide. However, neither a parent of a minor or a spouse can receive payment for FCM activity, since under the waiver amendments, a parent of a minor child or a spouse can ONLY receive payment under the personal assistance service category. Please see Section 7.6 for more information about prohibitions for payment of guardians and conservators.

Refer to Section 9 which describes possible roles and responsibilities of the Flexible Case Manager in detail, and contrasts optional with Required Case Management tasks.

7.6 Flexible Case Management and Family or Legal Representatives

A parent, spouse or legal representative can provide many of the same types of support to the consumer that a FCM can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for FCM activity.

Prohibitions on Payments to Guardians or Conservators

Minnesota Statutes, Section 524.5-309 states:

“Any individual or agency which provides residence, custodial care, medical care, employment training or other care or services for which they receive a fee may not be appointed as guardian unless related to the respondent by blood, marriage, or adoption.”

Similarly, Minnesota Statutes, Section 524.5-413 applies the same prohibition on conservatorship appointments:

“Any individual or agency which provides residence, custodial care, medical care, employment training, or other care or services for which they receive a fee may not be appointed as conservator unless related to the respondent by blood, marriage, or adoption.”

Under this statute, a person receiving payment for services could NOT be appointed a conservator or guardian. It makes sense then, that a person who has been appointed guardian or conservator cannot receive payment for services. While the guardianship statute exempts relatives, there is another pertinent legal citation that must be applied, as noted below.

Prohibitions on Payments to Parents of Minors or Spouses

Under Minnesota Rules, parts 9525.1850 [Provider Reimbursement], also known as Rule 41: “A provider may receive medical assistance reimbursement for home and community-based services only if the provider meets the criteria in items A to K”.

Item K states: *“The provider is not the person’s guardian or a member of the person’s family. This item does not preclude the county board from providing services if the person is a ward of the commissioner.”*

This prohibition against paying family members was “waived” in the approved CDCS amendments. However, this approval was limited to personal assistance service only and did not extend to other categories of service.

See Section 9.3 for an exemption of these limitations for persons participating in the MR/RC waiver program only. This exemption is part of the overall MR/RC waiver plan and not exclusive to CDCS participation.

8.1 Non-allowable expenses under CDCS

CDCS funding, like all waiver or AC program funding, is NOT to be used for any service:

- Available first through the State Plan (See Section 5.7 for notes about State Plan home care and CDCS.)
- Covered by any other third party payor including Medicare, or state educational or vocational services agencies
- That is diversionary or recreational in nature
- That is for comfort or convenience
- That is an item or support normally furnished by the recipient's parents, family, or spouse
- That does not meet an identified need
- Not approved in the support plan.

Repayment of Goods and Items Returned or Sold

Items are purchased for the recipient and should remain with / be available to the recipient to the extent possible. If an item is returned or sold, the remuneration from that item must be applied to the recipient's service plan. The same applies to any discounts or credits.

8.2 Excluded Services, Support, and Items

Some services, items, and supports are specifically excluded from purchase with CDCS funding. The list below notes services, items, and goods for which CDCS cannot be used to pay for as specifically approved in the amendment submitted by DHS to CMS.

Excluded Services or Supports	Excluded Items
<ul style="list-style-type: none"> ● Family or individual memberships to clubs, recreational centers, museums, etc. ● Vacation expenses other than the cost of direct service including transportation, lodging, meals ● Home-based schooling ● Experimental treatment ● Fees for attorneys, advocates, or others who do not provide a direct service authorized in the service plan ● Room, board, and personal items that are not related to the disability (there may be some exceptions related to transitional services) ● Services provided to people living in licensed foster care settings, settings licensed by DHS or MDH, or registered as housing with services (Assisted Living) establishments ● Available services otherwise covered by the State plan, Medicare or other liable third parties including education and vocational services ● Expenses for travel, lodging, or meals related to training the individuals and his/her representative or paid or unpaid caregiver ● Tickets and related costs to attend sporting or other recreational events ● Services, goods, or supports provided to or benefiting persons other than the consumer 	<ul style="list-style-type: none"> ● Modifications or adaptations to locations other than the recipient's primary residence or, in the event of a minor with parents not living together, the primary residences of the parents ● Home modification that adds any square footage ● Pets and their related costs ● Vehicle maintenance, does not include maintenance or modification related to the disability ● MHCP fees and co-pays ● Insurance for the home, vehicle, etc. ● Internet access or fees <p>While the list above notes specific exclusions, any goods, services or items approved in a CDCS support must meet all criteria outlined in Appendix C. In other words, the absence of a good or service from this excluded list does not mean it can be automatically approved in any plan. Each plan must be reviewed to ensure that all goods and services meet criteria for approval.</p> <p>Experimental Treatment: See Attachment C1 for a form to be used by physicians to indicate whether a proposed treatment is “experimental” as defined on the form itself. If the physician indicates the treatment IS experimental, it cannot be paid for using CDCS funding.</p>

Appendix C: Attachment Submitted and Approved By CMS as Part of Waiver Amendment

Consumer Directed Community Support Service Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:

1. Must be required to meet the identified needs and outcomes in the individual’s community support plan and assures the health, safety and welfare of the individual; AND
2. Goods and services collectively provide a feasible alternative to an institution; AND
3. Be the least costly alternative that reasonably meets the individual’s identified needs; AND
4. Be for the sole benefit of the individual

If all the above criteria are met, goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:

- Maintain the ability of the individual to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services
- Increase independence of the individual
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support

Allowable Expenditures	Unallowable expenditures
<p>Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver as well as alternatives that support recipients. There are four general categories of services which may be billed:</p> <ul style="list-style-type: none"> • Personal Assistance • Treatment and training • Environmental modifications and provisions • Self direction support activities <p>Additionally, the following goods and services that may also be included in the individual’s budgets include as long as they meet the criteria and fit into the above categories:</p> <ul style="list-style-type: none"> • Goods and services that augment State plan services or provide alternatives to waiver or state plan services • Therapies, special diets and behavioral supports not otherwise available through the State plan that mitigate the individual’s disability when prescribed by a physician who is enrolled as a MHCP provider • Expenses related to the development and implementation of the community support plan • Costs incurred to manage the individual’s budget 	<p>Goods and services that shall not be purchased within the individual’s budget are:</p> <ul style="list-style-type: none"> • Services provided to people living in licensed foster care settings, settings licensed by DHS or MDH, or registered as a housing with services establishment • Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services • Services, goods or supports provided to or benefiting persons other than the individual • Any fees incurred by the individual such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies, with the exception of services provided as Flexible Case Management • Insurance except for insurance costs related to employee coverage • Room and board and personal items that are not related to the disability • Home modifications that adds any square footage • Home modifications for a residence other than the primary residence of the recipient or, in the event of a minor with parents not living together, the primary residences of the parents • Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers • Services provided to or by individuals, representatives, providers or caregivers that have at any time been assigned to the Primary Care Utilization and Review Program • Experimental treatments • Membership dues or costs • Vacation expenses other than the cost of direct services • Vehicle maintenance, does not include maintenance to; modifications related the disability • Tickets and related costs to attend sporting or other recreational events • Pets and their related costs • Costs related to internet access.

CDCS Lead Agency Operations Manual

Appendix C1 Experimental/Alternative Treatment Form for Physicians

Consumer Directed Community Supports (CDCS) Alternative Treatment Tool for MHCP-Enrolled Physicians

Consumer's Name: _____

Therapy, special diet or behavioral support being prescribed:

An MHCP enrolled physician is licensed to provide health services within the scope of his/her profession.

According to Minnesota Rule 9525.3015, subpart 16, ***Experimental Treatment means drugs, therapies, or treatments that are unproven, have been confined largely to laboratory use, or have progressed to limited human application and trials, and lack wide recognition from the scientific community as a proven and effective measure of treatment.***

According to the above definition, is this therapy, special diet or behavioral support considered experimental for the condition it is being prescribed to treat?

Yes* No

What are the expected outcomes for the prescribed therapy, special diet or behavioral support for this individual?

Physician's Printed Name:

Physician's Signature:

Date: _____

*If Yes is checked, CDCS funds cannot be used to purchase the alternative treatment.

9.1 Comparison of Required and Flexible (Optional) Case Management Activity

There are some case management functions performed by the lead agency that are not included in the CDCS budget. These functions are required if a person chooses to use CDCS.

The consumer can choose whether they want or need assistance or support to carry out other plan or employee management functions, who will provide that assistance, and whether the consumer wants to purchase it as part of paid services under CDCS.

CDCS consumers must have a plan that is developed through a person-centered process. They must also manage and monitor the CDCS services. If, after choosing CDCS, a consumer wants or needs assistance with these tasks, they may purchase support from a Flexible Case Manager, or the consumer may choose to use unpaid supports.

Required Case Management Functions

In general, case management functions that must be performed by the lead agency address:

- Intake for and access to HCBS
- Provision of information and assistance
- Eligibility determination and re-determination
- Summary of assessment information and outline of required plan elements
- Authorization of service plan and funding, and changes to services and funding
- Monitoring quality and systems performance.

See the table in the next section for a more complete listing of required lead agency activity.

9.2 Required Lead Agency Functions Under CDCS

LEAD AGENCY FUNCTIONS

not included in the consumer's CDCS budget, not optional for the consumer

- ▶ Screen and determine if consumers are MA or AC eligible.
- ▶ Screen and determine if the individual is eligible for waiver or AC services including level of care determination.
- ▶ Provide information regarding HCBS alternatives to make an informed choice, including information about CDCS.
- ▶ If the consumer elects CDCS, provide them with their maximum budget amount & assessment summary.
- ▶ Provide CDCS consumers with resources and informational tool kits to assist them in developing the plan and managing the service.
- ▶ Evaluate whether the consumer's health and safety needs are reasonably expected to be met given the care plan including provider training and standards.
- ▶ Evaluate if the plan is appropriate including whether the goods and services meet the service criteria and provider qualifications, rates appear to be appropriate, etc. Provide feedback to the consumer about plan adjustments needed to approve if any.
- ▶ Authorize CDCS services in MMIS.
- ▶ Review and authorize additional funding for environmental modifications or assistive technology exceeding \$5,000.
- ▶ Manage overall waiver and AC spending within the county's allowable waiver and AC allocation.
- ▶ Monitor and evaluate the implementation of the Community Support Plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions at least annually.
- ▶ At a minimum, review the consumer's budget and spending before the 3rd, 6th, and 12th month of the first year of CDCS services, and at least annually thereafter.
- ▶ Provide technical assistance regarding service implementation, budget and fiscal records management and take corrective action if needed in order to ensure support plan implementation prior to involuntary exit from CDCS.
- ▶ Investigate reports related to vulnerability or misuse of public funds per jurisdiction.
- ▶ Contract with providers and monitor provider's performance including maintenance of fiscal records.
- ▶ Report satisfaction, utilization, budget, and discharge summary information to the state agency.
- ▶ Carry out minimum case manager contacts required under AC or each waiver program.

9.3 Flexible Case Management Functions & Limitations

Flexible, Optional DIRECT SUPPORT

Is included in the consumer's CDCS budget, must be explicitly planned and purchased by the consumer

Not an inclusive list of those direct supports a consumer may design related to planning, implementation, monitoring, evaluating, managing services and employees

- ▶ If the consumer elects CDCS services, provide more detailed information about CDCS and provider options.
- ▶ Facilitate development of a person centered Community Support Plan.
- ▶ Monitor and assist with revisions to the Community Support Plan.
- ▶ Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.
- ▶ Facilitate community access and inclusion. (i.e., locating or developing opportunities, providing information and resources, etc.).
- ▶ Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers.
- ▶ Provide staff training that is specific to the consumer's plan of care.
- ▶ Community Support Plan must include specific tasks to be performed by a paid FCM and payment agreements.

Limitations:

- A Flexible Case Manager cannot have any direct or indirect financial interest in the delivery of services in the plan. In other words, a person helping a consumer develop a plan and receiving payment for this assistance cannot, nor can they employ others chosen by the consumer to, deliver services or supports. (County agencies and health plans are exceptions to this limitation.)
- A Flexible Case Manager, or an agency providing Flexible Case Management service, cannot be the common law employer for any recipient who is receiving Flexible Case Management from them. A Fiscal Support Entity cannot provide both FSE and FCM service to the same client.
- A Flexible Case Manager working independently while employed by a Fiscal Support Entity or any other vendor that is providing services to a CDCS consumer MAY NOT provide FCM to a consumer who is using services from the vendor (FSE or otherwise) that employs the FCM.
- A parent of a minor child or spouse cannot be paid to provide Flexible Case Management.
- A legal guardian or conservator for a person participating in the MR/RC waiver can be paid for either FCM or direct service but never both.
- A Flexible Case Manager cannot receive payment for performing functions that duplicate those required to be performed by the lead agency.

9.4 Excluded Time & CDCS

The election of CDCS service option does not alter any provisions related to the determination of the county of financial responsibility. This determination is the responsibility of financial workers, and is based on a variety of factors, including the receipt of what is referred to as “excluded time service”.

In order to determine whether the services contained in an approved CDCS plan are excluded time services or not, the financial worker must apply the definitions of those services as they exist in law. Financial workers will make these determinations on an individual basis and on an individual plan basis.

For instance, if a plan includes PCA services from a PCA organization, that service clearly is defined as an excluded time service. If, however, the person buys “help in the morning from their neighbor”, this service cannot be adjudged equivalent to PCA.

Similarly, if a person’s plan includes licensed DT&H service, this is clearly defined as an excluded time service. But the person may choose to receive employment support from a local business, and this service cannot be adjudged to be equivalent to DT&H.

10.1 The Consumer As Employer

One of the major differences between CDCS and other community-based service design and delivery is that the consumer is the employer of staff hired to provide services as outlined in the approved plan. It may be helpful to outline the tasks and activities a consumer carries out as an employer. This will help outline the choices a consumer can make about the extent of employer activity they want to perform themselves, and those they may wish to have someone else perform for a fee. It will also serve to highlight some of the differences in the Fiscal Support Entity models described in Section 11.

Managing Employer: The managing employer recruits and advertises for staff. The managing employer interviews and hires staff, and discharges staff. The managing employer supervises, schedules, trains, provides direction in daily tasks, and evaluates employee performance. The managing employer under CDCS negotiates the wage paid to support staff.

A consumer choosing CDCS must minimally act as managing employer. The consumer can perform these functions independently, receive non-paid assistance from friends or family in performing these functions, or can hire a Flexible Case Manager to help perform these roles. When a consumer chooses an “Agency with Choice” as a Fiscal Support Entity, some of the managing employer functions are shared between the consumer and the agency.

Common Law Employer (sometimes referred to as Employer of Record): Other employer duties related to payroll, taxes, and insurance must be performed in addition to the managing employer functions. These activities include collecting time cards, processing payroll, processing checks, calculating, collecting and submitting payroll taxes (state, federal and FICA), making sure workers have the proper insurance coverage under workers’ compensation and unemployment laws, and making sure staff are paid. The common law employer would also manage other optional employee benefits such as health or retirement benefits.

The CDCS consumer may act as the common law employer, or purchase some or all of these tasks from a Fiscal Support Entity (FSE). The extent to which a Fiscal Support Entity performs (or offers to perform) common law and managing employer functions defines the three models of Fiscal Support Entity service described in the next section. These are briefly described below.

10.2 Three Models of Fiscal Support Entity Service

Fiscal Conduit: A consumer who chooses to hire an FSE only to submit claims and disperse payment (either to the consumer to pay for staff and goods or to staff and vendors as directed by the consumer) is electing a “Fiscal Conduit” model of FSE service. Under this model, the consumer is both the managing and the common law employer. The consumer is withholding taxes, submitting tax payments on behalf of workers, has purchased required workers’ compensation insurance for workers, and also performs all managing employer functions. The person could purchase assistance with managing employer functions from a Flexible Case Manager, or could receive non-paid assistance with these tasks.

Payroll or Fiscal Agent: The FSE is the fiscal agent for the person, managing state and federal employment taxes, payroll, and insurances for support workers. The consumer purchases this service from the FSE. The consumer is still considered the common law and managing employer, but in this case is purchasing assistance with common law employer activity. The person could also purchase assistance from a Flexible Case Manager for managing employer tasks.

Agency with Choice: Under this FSE model, the FSE actually hires the support staff, and performs all common law employer functions. The staff is an employee of the agency. The consumer negotiates with the agency about the co-sharing of managing employee duties. The consumer can discharge the staff from service to them but cannot “fire” them from the agency. Minimally, the consumer will select their own worker, and can discharge them as a worker for them. While the consumer is technically considered the managing employer, the range of managing activity will vary.

The Agency with Choice cannot provide Flexible Case Management to a consumer for whom they are providing staff support, nor can the agency participate in the Community Support Plan development.

10.3 Comparison of Consumer Role as Employer Under 3 FSE Models

An FSE must offer Fiscal Conduit and Payroll Agent services. When the FSE also offers Agency with Choice services, it cannot limit consumers’ choice or require the consumer to purchase common law employer service from the agency. Managing employer tasks are shaded.

Tasks	Fiscal Conduit FSE	Payroll or Fiscal Agent FSE	Agency with Choice FSE
Recruit and advertise for staff	Consumer	Consumer	Agency or Consumer + Agency
Hire – Interview staff	Consumer	Consumer	Consumer + Agency
Terminate/Discharge staff	Consumer	Consumer	Consumer + Agency
Supervision of staff	Consumer	Consumer	Consumer + Agency
Schedule	Consumer	Consumer	Consumer + Agency
Train staff	Consumer	Consumer	Consumer + Agency
Ongoing direction of daily tasks	Consumer	Consumer	Consumer + Agency
Employee evaluation	Consumer	Consumer	Consumer + Agency
Collects time cards	Consumer + FSE	Consumer + FSE	Consumer + Agency
Taxes – Payroll (State, Fed., FICA)	Consumer	FSE on behalf of consumer	Agency
Insurance – (workers’ comp.)	Consumer	FSE on behalf of consumer	Agency
Insurance	Consumer	FSE on behalf of consumer	Agency
Submits claims to MMIS	FSE	FSE	Agency
Process checks for the staff	Consumer	FSE	Agency
Pay staff on a consistent basis	Consumer	FSE	Agency
Train or provide support to the consumer to be a common law employer	FSE, or non-paid	FSE, or non-paid	Agency replaces the common law employer function for the consumer
Train or provide support to the consumer to be a managing employer	FCM, or non-paid	FCM, or non-paid	FCM, but not available through the agency, or non-paid

11.1 Fiscal Support Entity

What is a Fiscal Support Entity (FSE)?

- The FSE is the Minnesota Health Care Programs (MHCP) enrolled provider under CDCS, and must meet provider enrollment requirements to participate in Medicaid-funded programs.
- Under the federally-approved amendment to add CDCS as a service options to all HCBS programs in Minnesota, each CDCS consumer must *minimally* purchase FSE service to act as a “conduit” for Medical Assistance payments for CDCS service. That is, a consumer cannot directly bill for approved CDCS services. The state-funded Alternative Care program CDCS service option will adopt the same requirements and restrictions as approved in the federal waiver.
- A Fiscal Support Entity (FSE) is an umbrella organization that must offer a range of financial management services to provide support to consumer using CDCS. Section 11.2 outlines this range of service.
- An FSE must demonstrate the capacity to provide the required range of financial management services to consumers through completion of a “Readiness Review” in order to receive a provider certification from DHS. This certification is required to enroll as a Medicaid provider of FSE service under CDCS. Section 11.7 outlines the readiness review requirements.
- The FSE may not in any way limit or restrict the recipient’s choice of service or support providers.
- The FSE must have a written agreement with the recipient or their representative that identifies the duties and responsibilities to be performed and the related charges.
- An FSE must have a contract with the lead agency to provide FSE services to people receiving Required Case Management from that lead agency.
- A county agency can enroll as an FSE provider.

11.2 Fiscal Support Entity (FSE): Fiscal Conduit & Payroll Agent Services

Every CDCS recipient must at least purchase FSE support to act as the fiscal conduit to pay providers. An FSE must be able to **directly provide, at a minimum**, payroll assistance, and be capable of submitting CDCS claims to MMIS to receive payment for approved CDCS services. Thus, any enrolled FSE must be able to provide those services and options outlined in the shaded columns in the table below.

Fiscal Conduit	Payroll Agent	Agency w/Choice
<p>FSE submits claims to MA for approved, delivered services.</p> <p>FSE pays bills approved by the consumer.</p> <p>FSE returns payment to consumer who directly pays workers or for goods.</p> <p>Consumer is common law and managing employer. Consumer takes responsibility for payroll tax collection, submission, payment of worker' compensation premiums.</p> <p>Consumer recruits, hires, trains, supervises, evaluates, schedules support staff. The consumer may purchase assistance from a Flexible Case Manager to support their role as a common law and managing employer.</p> <p>Most Consumer Control</p>	<p>FSE submits claims to MA for approved, delivered services.</p> <p>The FSE pays the provider, including all paid staff.</p> <p>The FSE is the fiscal agent, managing state and federal employment taxes and payroll for support workers.</p> <p>The FSE pays workers' compensation premiums and annual renewal premiums on behalf of consumer.</p> <p>Consumer is both common law and managing employer, but buys assistance from the FSE for payroll and insurance functions.</p>	<p>The person may also opt to use an agency to act as the common law employer of support staff under CDCS.</p> <p>As common law employer, the agency recruits, hires, trains, manages payroll for, supervises, and evaluates support workers. The agency handles taxes and provides worker's compensation insurance for workers. The consumer can bring individuals for hire to the agency, and can negotiate their management role of support workers with the agency.</p> <p>The FSE acts as payor for services provided through an agency, which is the common law employer of CDCS staff selected by the consumer.</p> <p>The consumer is the managing employer, and, minimally, will select his or her support worker, and can discharge the worker as a support worker for them.</p> <p>FSE submits claims to MA for approved, delivered services.</p> <p>The FSE pays the agency that provides employment management and is the common law employer of staff.</p> <p>Least Consumer Control</p>

11.3 Fiscal Support Entity (FSE): Agency with Choice Services

An FSE that also acts as a common law employer is considered an “Agency with Choice”. That is, the consumer is not the employer of staff hired. Rather, the agency with choice is the employer, and collaborates with the consumer to maximize individual control over staff scheduling, qualifications, activities, wages, expected outcomes, and monitoring strategies. In these arrangements, the consumer is considered to be the “managing” employer but not the common law employer.

An FSE that offers Agency with Choice must also provide fiscal conduit and payroll agent services to CDCS consumers who only wish to purchase this type of financial management service, and cannot insist that any individual use them as their agency with choice, nor that the person employ staff under an agency with choice model.

Furthermore, an FSE that includes agency with choice service under its continuum of service must allow a consumer to elect a different agency with choice if they so choose. In this instance, the FSE would bill MMIS and pay the other agency for provided services authorized in the support plan. The agency with choice would be responsible for all employment management such as payroll taxes and insurance.

For example, an FSE offers Agency with Choice, but a consumer uses a PCA Choice provider along with other self-directed services. The FSE acts as either a fiscal consult or payroll agent for purposes of billing all non-PCA Choice services in the consumer’s plan.

11.4 Other FSE Requirements

Act as Agent of Consumer

In addition to providing payroll support, the FSE must have the capacity to advise consumers about their obligations for workers' compensation, including coverage available through workers' compensation insurance policies. The FSE must have the capacity to broker workers' compensation insurance, assure payment of premiums and annual renewal of premiums, and must attempt to negotiate volume discounts.

In order to provide fiscal agent service, the FSE must obtain an IRS Authorization to act for the person. The consumer must provide this authorization if he or she wants the FSE to provide Fiscal Employer Agent (FEA) services.

Disclosure of Financial Interests

An FSE who has any direct or indirect financial interest in the delivery of:

- Personal assistance
- Treatment and training or
- Environmental modifications and provisions

that is being or will be provided to the recipient must disclose in writing the nature of that relationship, and must not develop nor assist in the development of the recipient's Community Support Plan.

Charges for FSE Services

FSE rates must be established on a fee-for-service basis. Charges to an individual consumer cannot be based on a percentage of the recipient's CDCS or payroll budget, and may not include set up or base rate or other similar charges.

All FSEs must establish and make public the maximum rate(s) for their services.

Individualized Services

The scope of FSE services to be provided to an individual must be determined by the consumer, and documented in the person's support plan.

The rate for these services is negotiated between the recipient or the recipient's representative and the FSE and is included in the Community Support Plan.

11.5 Other FSE Requirements (con't)

Agreements

The FSE must develop and execute written agreements between the FSE and the consumer, the FSE and other support workers and vendors. These agreements should outline roles and responsibilities of the FSE, the consumer, and the support staff or vendor. The agreement should also outline consequences for non-compliance with agreements.

Criminal Background Checks

The FSE must have the capacity to request criminal background checks on behalf of the consumer who is requesting such checks. The type and extent of background checks that the FSE is required to facilitate are those that follow the provisions under Minnesota Statutes, section 245C.

An FSE may not require a consumer to have background checks on support workers, unless the FSE will be the common law employer (Agency with Choice) of staff selected by the consumer. In this case, the agency is responsible to request the check and pay for these checks.

When a licensed service provider is the common law employer, staff hired are still subject to background checks in order to be employed by the licensed service provider. The licensed provider requests and pays for the checks.

Documentation Requirements:

- The FSE must maintain records to track all CDCS expenditures including time records of people paid to provide supports and receipts for any goods purchased, invoices, payroll summaries, and cancelled checks.
- The records must be maintained for a minimum of five years from the claim date and must be available for audit or review upon request.
- The FSE must also receive a copy of the recipient's Community Support Plan approved by the lead agency.
- Claims submitted by the FSE must correspond with services, amounts, time frames, etc. as authorized in the Community Support Plan.

FSE and Flexible Case Management

An FSE may be paid for FCM if the organization does not have a financial interest in the consumer's direct supports. This means that if an FSE is the agency of choice, they CANNOT provide FCM for the same person.

11.6 FSE Reporting Requirements

As the MHCP-enrolled provider, and the entity submitting claims and receiving payment, the FSE is in the most immediate position to provide summary information about spending and balances to both consumers and lead agencies.

An FSE must provide monthly summaries to each consumer about the total CDCS services that were billed, for which services, including charges for the FSE, and balances of authorized budgets.

An FSE must provide quarterly written summaries to the person's lead agency about the total CDCS services that were billed, for which services, including charges for the FSE, and balances of authorized budgets. In addition, the FSE must provide monthly reports when a certain amount of over- or under-spending occurs for an individual.

The following three tables outline the required data elements and schedules for FSE reporting to consumer and families, the lead agencies, and other providers. The frequency of reporting listed represents the minimum standard. The two highlighted items are recommended but not required.

Table 1: FSE Reports to Clients/Families

Data Elements	Frequency of Reporting
Individual total yearly budget	Monthly
Amount budgeted by service category: <ul style="list-style-type: none"> • Personal Assistance • Treatment & Training • Environmental Modifications & Provisions • Self-Directed Support 	Monthly
Budget expenditures by category, and balance remaining in category	Monthly
Total budget expended (used)	Monthly
% of Budget spent YTD	Monthly
Prorated % of budget expended YTD (what 1/12th of budget X number of months YTD would total)	Monthly
Projected staff costs: How much will be spent if YTD staffing expenditures continue	Monthly
Payments made to other vendors in the reporting period (good, units, dollars)	Monthly
Any overtime amounts paid in report period	Monthly

Table 2: FSE Reports to Lead Agency/County of Financial Responsibility

Data Element	Frequency of Reporting
By client, same information as in report to consumer family in Table 1.	Quarterly
Consumers who are spending total budget by more than 15% of what the prorated YTD budget should be	Monthly
Consumer who have spent less than 50% of what the prorated total budget YTD should be	Monthly
Consumers who are spending their staffing budget by more than 15% of what the prorated YTD staffing budget should be	Monthly
Consumer who have spent less than 50% of what the prorated staffing budget YTD should be	Monthly
Consumers paying staff overtime	Monthly
Range of payroll lowest to highest hourly rate paid, average paid (to learn what is usual and customary)	As requested
Summary of number of parents of minors and spouses being paid, and the number of hours/week being paid for Personal Assistance Service	As requested
Number of consumers of the lead agency that the FSE is serving	As requested
Total number of consumers FSE is serving	As requested
Number of consumers served under payroll model, fiscal conduit, agency with choice.	As requested
By consumer, names of support staff and hours submitted	As requested
All consumer notices requesting missing required information such as invoices, timesheets or requests to purchase services or materials not included in the approved CSP.	As occurs

Table 3: Reports to Other Providers

Data Elements	Schedule of Reporting
Initial budgeted amount for their service, by consumer	At start of service
Any changes to the budget amount for the service they provide, by consumer	At any change
YTD expenditures and amount remaining for that service, by consumer	Monthly

11.7 Readiness Review

In order to be certified as qualified to enroll in Minnesota Health Care Programs as an FSE provider, a potential provider will complete a Readiness Review with DHS. This review process will include submission of paper documentation, and can include on-site review by DHS. The review will evaluate whether the provider demonstrates they meet these criteria:

- Be knowledgeable about, and comply with, Internal Revenue Service requirements needed to process employer and employee deductions.
- Provide appropriate and timely submission of employer tax payments.
- Maintain documentation to support MMIS claiming.
- Have current and adequate liability insurance and bonding.
- Have sufficient cash flow.
- Have on staff or under contract a certified public accountant, or an individual with a baccalaureate degree in accounting.

Along with the specific requirement outlined above, an FSE must provide core information to consumers interested in CDCS as a service option. These materials will be provided by DHS to enrolled FSEs.

The FSE must also develop and maintain policies and procedures, as outlined in a policies and procedures manual, that:

- Reflects the philosophy of consumer direction
- Describes policies and procedures used to perform required FSE tasks
- Describes internal controls for tasks performed by FSE. This will be important when an FSE is also an agency with choice, or is also a Flexible Case Management provider.

12.1 Involuntary Exits from CDCS

Under the federally approved waiver amendments, criteria for “involuntary exit” from CDCS were identified. These criteria will also apply to AC participants. Involuntary exit procedures are developed here to address:

- Immediate health and safety concerns
- Maltreatment of consumers
- Suspected fraud or misuse of funds
- Inability to implement the approved support plan or comply with CDCS requirements despite reasonable efforts to provide additional technical assistance and support as described below.

Definition of Terms

In order to ensure equal treatment for people receiving CDCS and provide useful direction to lead agency and other staff, certain terms used in the paragraph above must be defined and applied to carry out the policy decisions related to involuntary exits.

“Involuntary Exit” means only the CDCS service is terminated, not the program. This termination of CDCS service is subject to MHCP Fair Hearing and notice requirements. However, unlike other terminated services under MHCP, CDCS service is NOT available to the person during an appeal process.

“Immediate Concern” is defined as:

- Any matter jeopardizing health and safety
- Evidence of unreported fraud
- Maltreatment of the consumer
- Unapproved expenditures.

“Additional Technical Assistance & Support” means the ongoing involvement of the lead agency to resolve issues surrounding plan implementation or expenditure of funds. This is assistance and support beyond that provided to all consumers through materials and completion of Required Case Manager functions.

“Reasonable Efforts” is defined as three documented events of need for additional technical assistance and support during one plan year. This documentation must include:

- Identification of the problem
- Corrective action needed
- A timeline in which to accomplish the action or change.

12.2 Procedures Related to Involuntary Exits

When health and safety concerns arise, or fraud or misuse of funds are evident, or a fourth occurrence from the date of CDCS authorization requiring corrective action (additional technical assistance) is encountered, consumers may be immediately exited from CDCS and returned to conventional waiver or AC services.

In the event that CDCS alternative services are terminated, a conventional waiver or AC service plan would be implemented as follows:

- Case manager discovers unreported fraud or abuse, or fraud or misuse of funds, or a fourth event requiring corrective action occurs when three previous efforts meet the requirements for “documented” technical assistance.
- Notice is sent informing consumer of termination of CDCS. This notice must include information about the consumer’s right to appeal (Fair Hearing), their right to request assistance in filing an appeal, and must be delivered 10 days prior to the effect date of termination.
- The notice must also include information related to inability to continue CDCS service during the appeal process, and must outline the conventional waiver or AC services to be authorized as replacement for CDCS service.
- A budget amount for the remaining service plan year must be calculated. With the goal of retaining as many aspects of the person centered plan as feasible, the Community Support Plan is updated to reflect any needed changes to backup or emergency plans, or personal risk management plans, as well as services approved and desired consumer outcomes.
- Lead agency case manager reports health, safety or abuse concerns to appropriate agencies such as Adult Protective or Child Protective Services
- Lead agency case manager reports suspected fraud to SIRS.
- Screening Documents and Service Agreements are updated, terminating line items for CDCS service and adding alternative services.
- The FSE is notified by the lead agency case manager of the effective date of the exit from CDCS.

12.3 Additional Technical Assistance and Support

An individual's need for additional technical assistance and support could be reported to a lead agency by an FSE or FCM, or difficulties could be discovered during lead agency monitoring. A person may be the subject of a maltreatment report, or the person might seek assistance to resolve problems encountered in plan implementation or services management.

While not an inclusive list, the matters below would indicate a need for additional technical assistance and support.

- Not spending enough for services needed to support health and safety without a reasonable explanation
- Over-spending at a rate that suggests the plan will not be sustainable over the service plan year
- On-going difficulty in arranging for services needed for health and safety
- Unapproved expenditures
- Failure to respond to notices requesting missing information from the FSE
- Not implementing the Community Support Plan as approved.

Each discovery of non-compliance with the CSP that requires a corrective action could cause a CDCS Notice of Technical Assistance and Support to be sent to the consumer with a copy retained in the lead agency file. See Appendix C for a copy of this notice.

However, the lead agency may choose to provide additional assistance to consumers that does not meet the documentation requirements when successful resolution of the issue(s) seems likely. In order for an involuntary exit to occur, there must be three documented efforts that DO meet the formal definition of Technical Assistance and Support and a fourth occurrence of need for corrective action before CDCS services can be terminated.

Any action which would trigger a fourth notice of qualifying additional technical assistance and support would cause an involuntary exit from the program.

Lead agency activity to assist in a corrective action or provide technical assistance under qualifying, documented occurrence is billed as Required Case Management.

12.4 Immediate Concern

Health and Safety

Any matter arising which jeopardizes the consumer's health and safety may result in involuntary exit. An incidence of substantiated abuse by a paid support staff, for example, could lead to involuntary exit if a backup plan cannot be implemented to assure health and safety.

Referrals to Adult Protective Services for concerns arising about self-neglect rather than maltreatment must occur in the same manner and for the same level of concern for a person receiving supports under CDCS as for those receiving conventional services.

Reported Fraud

Recognizing that some consumers may be vulnerable and may need assistance in the event of threat or coercion from their direct support worker, the process for involuntary exit from CDCS must account for the timely reporting of fraud in the presence of coercion. Direct support workers can wield a great deal of power over people with needs for that support, so policy must allow people to act as needed to avoid negative consequences in the short run.

For example, someone may be asked to sign a fraudulent timesheet, and feels they must wait until the next worker comes on duty to report the matter in a timely fashion to their case manager. A consumer cannot be expected to directly confront someone on whom they are dependent.

Those consumers who report such events and seek appropriate help in a timely manner, and who are not willing participants in fraud or misuse of funds, are considered in compliance with requirements and are not subject to involuntary exit.

Unreported Fraud

If, however, the consumer failed to report an incident as described above in a timely manner, the incident would be considered unreported fraud and would be cause for involuntary exit.

Restrictions Under Primary Care Utilization Committee Decisions

CDCS services are not available to an individual or their representative who has at any time been restricted by the Primary Care Utilization Review (PCUR) Committee for fraud or abuse of public funds. Information about such restriction will be found in the Recipient Primary Care Utilization Review (RPCUR) screen in MMIS. An edit will also post when a screening document is entered or updated that will contain information about past and future restrictions by PCUR.

If a person is placed on such restriction after CDCS is implemented, an involuntary exit from CDCS would also occur.

Appendix D

Consumer Directed Community Supports (CDCS)

Notice of Technical Assistance and/or Support

The Required Case Manager should complete this form to document a need for additional technical assistance and/or support that is beyond reasonable efforts. The consumer or their legal representative should sign the form and be given a copy. The original will be kept in the consumer's file.

Consumer name: _____

Case manager's name: _____

County: _____

Date of this notice of technical assistance and/or support: _____

Number of documented notices in this service plan year and date of each notice:

1 _____ 2 _____ 3 _____ 4* _____

Identification of the problem (describe what caused the need for technical assistance and/or support):

Corrective action needed (describe what action needs to occur to correct the problem):

Timeline to accomplish the corrective action (give a timeline for the CDCS recipient to complete the corrective action):

Consumer or legal representative signature (indicates receipt of this notice):

*On the 4th occurrence of technical assistance and/or support beyond reasonable efforts, the Notice of Action (DHS 2828) will be sent immediately. The CDCS recipient will be exited from CDCS as of the effective date on the form.

13.1 Purchasing Personal Assistance Services (PAS) from a Spouse or Parent

A person can elect to use CDCS funding to purchase personal assistance from a parent or spouse. The intent of this option is to maximize the available personal assistance resources within the home and community-based service system, and to provide consumers with the comfort and assurance of receiving care from familiar and trusted individuals. Generally, consumers rate services from qualified and capable relatives as high quality with a high level of satisfaction. **Personal assistance service is the only support for which a parent of a minor child age 18 years or younger or spouse may be paid using CDCS funding.**

While a parent or spouse may also function in other supportive roles such those performed by a FCM or managing employer, they may NOT receive payment for serving in these other roles or performing other supportive functions.

A parent who is a qualified nurse and who wishes to provide skilled services for payment using CDCS funding must provide this service under the Personal Assistance Service category AND under the payment limitation governing payment to parents and spouses (i.e. the state maximum PCA rate).

13.2 Criteria for Paying Spouse or Parent for PAS

Certain requirements must be met to approve CDCS payment to a spouse or biological or adoptive parent of recipients under 18. For the parent of a minor child or spouse to receive payment for performing Personal Assistance Service, all of the following criteria must be met:

- The type of assistance or support to be provided falls within the description and allowable costs of Personal Assistance Service.
- Personal Assistance Services are specified in the Community Support Plan.
- The care for which a parent or spouse is reimbursed is directly related to functional dependency of the recipient. See the next page for more information about determination of ADL dependencies.
- The parent or spouse meets the qualifications for Personal Assistance Service as outlined in the Community Support Plan.
- The number of hours for which a parent or spouse is to receive payment is addressed in the plan which records the assessed need, such as help with dressing, and includes the frequency of delivery, the payment rate, and units per week.
- The service must NOT be an activity that the parent or spouse would ordinarily perform, or is responsible to perform. These activities would include, but are not limited to, supervision or transportation of children, for example, or household maintenance such as house cleaning, meal preparation, or laundry.

13.3 Determination of ADL Dependency

As noted in the previous section, in order to pay a spouse or parent for Personal Assistance Service, the consumer must be assessed as being dependent in at least one Activity of Daily Living (ADL). This determination will be based on use of the ADL items contained in the LTCC Assessment Form, DHS 3428 or 3428A for adults, and as determined under DHS Form 3428C for minors age 18 or under.

While the MRRC assessment team does not need to complete the entire LTCC assessment, they must also use DHS Form 3428 or 3428C to determine dependencies.

ADULTS: For adults, “dependent” means that the level of need for assistance or supervision is scored for purposes of case mix determination as follows for the 8 case mix ADLs :

Activity of Daily Living Items on 3428 or 3428A	Score(s) Indicating “Dependent”	Notes
Dressing	2-4	
Grooming	2-3	
Bathing	4-5	
Eating	2-4	
Bed Mobility	2-3	
Transferring	2-4	
Walking	2-4	
Toileting	1-6	

CHILDREN: A parent is legally responsible to meet the needs of a minor child, including the need for assistance and supervision typically required for children at various stages of growth and development. A parent can, however, receive payment for Personal Assistance Service when this support goes beyond what would be expected to be performed in the usual course of parenting, and when needed support exceeds what is typically required for a child of the same age.

For persons under age 18, the level of independence expected in activities of daily living increases as children get older. Younger children are typically dependent on parents, and the definitions used to indicate “dependency” represent a level of need that is not typical for children at various ages. DHS Form 3428C identifies those levels of need considered “dependent” relative to the child’s age. See Appendix D for a copy of the items contained in 3428C and the determination of dependency based on age.

13.4 Financial Considerations

There may be financial consequences to consider in a family's decision to receive payment for services:

- If a parent or spouse will be a paid staff, how will the payment affect the employee/family's eligibility for other programs?
- Does the family understand that this is "real income" that is taxable, and that it may affect their eligibility for other programs?
- How will this income affect eligibility for specific programs?

Tax Consequences: Payment made to a spouse or parent of a minor is considered income to the employee, and must be treated as such for purposes of state and federal taxes, including FICA, SUTA, and FUTA.

Consequences for Other Program Eligibility: CDCS income may affect eligibility for programs with income-based eligibility guidelines. The consumer or family should discuss these consequences with other program managers before making a decision about employment through CDCS. CDCS payments made to a spouse or custodial parent of a minor child could affect:

- The family's eligibility for Medicaid: CDCS payments are considered income and deemed as such when determining MA eligibility
- The child's eligibility for SSI
- The spouse's eligibility for other programs or assistance when income is part of eligibility criteria for those programs or services
- The TEFRA parental fee: CDCS income is considered in the TEFRA parental fee calculation
- The family's eligibility for MFIP: CDCS payments can be used to meet MFIP work requirements for the family member-employee
- Food Stamp eligibility is determined by household income. If the total household income increases, this may affect the Food Stamp allotment

13.5 Limitations on Payment to Spouse or Parent

- A spouse or parent may not receive payment for more than 40 hours of Personal Assistance Service in a seven-day period.
- No more than 40 hours per week can be paid to one or both parents, regardless of the number of children in the household receiving CDCS waived services, or the actual number of hours of care being provided by the parent(s).
- The spouse or parent must complete time reports and other required documentation, such as reporting on tasks performed during paid working hours.
- The negotiated payment rate, including wages and payroll-related taxes, may not exceed the public pay fee-for-service rate established by the Department for personal care services (PCA) during the same fiscal year in which services are delivered.
- The Community Support Plan must specify the frequency, duration, units, and payment rate negotiated for the Personal Assistance Service to be provided by the spouse or parent separately from others who may be hired to provide Personal Assistance Services as well.

13.6 Lead Agency Monitoring Requirements When Parent or Spouse is Paid for Personal Assistance Service

In addition to the consumer's or their legal representative's plan to manage and monitor service delivery, including quality and outcome indicators, the lead agency has monitoring requirements when the parent or spouse is serving in the role of a paid employee.

The lead agency case manager must:

- Conduct quarterly reviews of expenditures and services provided, and the health, safety and well-being of the consumer and the caregiver.
- Conduct in-home face-to-face visits twice a year with the consumer.

Appendix E : Determining ADL Dependency in Children Age 18 and Under

Dressing	Assessor's Score	Transfers	Assessor's Score
• Independent	00	• Independent	00
• Intermittent supervision or reminders. May need physical assistance with fasteners, shoes or laying out clothes	01	• Needs intermittent supervision or reminders, i.e. cuing or guidance only.	01
• Constant supervision, but no physical assistance. (N/A 0-48 months)	*02	• Needs physical assistance, but child is able to participate. Excludes carseat, highchair, crib for toddler age child. (N/A 0-30 months)	*02
• Physical assistance or presence of another at all times, but child is able to physically participate. (N/A 0-36 months)	*03	• Needs total assistance of another, and child is physically unable to participate. (N/A 0-18 months)	*03
• Totally dependent on another for all dressing. Child is unable to physically participate. (N/A 0-12 months)	*04	• Must be transferred using a mechanical device, i.e. Hoyer lift.	*04
Grooming		Mobility (walking)	
• Independent	00	• Independent. Ambulatory without device.	00
• Intermittent supervision or reminders	01	• Can mobilize with the assist of a device, but does not need personal assistance.	01
• Help of another to complete task, but child is physically able to participate. (N/A 0-48 months)	*02	• Intermittent physical assistance of another. (N/A 0-24 months) (This does not include supervision for safety of a child under age 5.)	*02
• Totally dependent on another for all grooming needs. Child is physically unable to participate. (N/A 0-24 months)	*03	• Needs constant physical assistance of another. Includes child who remains bedfast. (N/A 0-12 months)	*03
Bathing		Positioning (bed mobility)	
• Independent	00	• Independent. Ambulatory without device.	00
• Intermittent supervision or reminders	01	• Needs occasional assistance from another person or device to change position less than daily.	01
• Needs help in and out of tub	02	• Needs intermittent assistance of another on a daily basis to change position. Child is physically able to participate.	*02
• Constant supervision, but child does not need physical assistance. (N/A 0-60 months)	*03	• Needs total assistance in turning and positioning. Child is unable to participate. (N/A 0-9 months)	*03
• Physical assistance of another, but child is physically able to participate. (N/A 0-48 months)	*04	Toileting	
• Totally dependent on another for all bathing. Child is physically unable to participate. (N/A 0-12 months)	*05	• Independent	00
Eating		• Intermittent supervision, cuing or minor physical assistance such as clothes adjustment or hygiene. No incontinence. (N/A 0-60 months)	*01
• Independent	00	• Usually continent of bowel and bladder, but has occasional accidents requiring physical assistance. (N/A 0-60 months)	*02
• Intermittent supervision or reminders	01	• Usually continent of bowel and bladder, but needs physical assistance or constant supervision for all parts of the task. (N/A 0-60 months)	*03
• Needs constant supervision and/or assistance in setting up meals, i.e. cutting meat, pouring fluids. (N/A 0-60 months)	02	• Incontinent of bowel and bladder. Diapered. (N/A 0-48 months)	*04
• Needs physical assistance. Child can partially feed self. (N/A 0-24 months)	*03	• Needs assistance with bowel and bladder programs, or appliances (i.e. ostomies or urinary catheters).	*05
• Needs and receives total oral feeding from another. Child is physically unable to participate. (N/A 0-12 months)	*04		
• Receives tube feeding.* Child has documented incidents of choking or reflux on a weekly basis or more that is related to diagnosis or disability.	*05		

* **“Dependency”** is signalled by a score asterisked and bolded.

Elderly Waiver and Alternative Care

14.1 CDCS Budget Amount on the Plan

The CDCS budget amounts will be issued annually by the Department. For persons aged 65 and older participating in the Elderly Waiver or Alternative Care Program, budget amounts will follow the community-based case mix structure, and will be calculated according to historical expenditures of each population.

The “caps” contained in Appendix E are the budget maximums for FY05, and will be updated each fiscal year. The amount listed under each case mix category represents the total dollars available to purchase services over one service plan year for all services **except** Required Case Management and background checks requested by the consumer.

The lead agency professional conducting the LTCC assessment or reassessment process will inform the consumer of their available budget amounts for both CDCS and conventional EW or AC services planning as part of the information presented about CDCS and other service options when a person is determined eligible for the program, and at reassessment.

The lead agency has 60 days after the date of assessment/reassessment to implement CDCS. The individual receiving CDCS must be given 30 days to develop their plan. This timeline may require the lead agency to prorate the adjustment depending on when the change occurs in relation to the individual’s plan year.

For the purposes of planning, the lead agency can apply a formula by:

- For EW and AC the budget is based on a case mix

The person-centered Community Support Plan can include costs for allowable services up to the annual CDCS budget amount. The consumer and the lead agency case manager must compare the proposed cost of implementing the CDCS service plan to the total CDCS budget amount available to evaluate cost effectiveness, and the likely success of the proposed plan.

Like any other type of service budget maximum, the “cap” represents an “up to” amount available to purchase service. The amount actually approved for services will be based on projected cost of services needed to address assessed needs, and may be less than the CDCS budget cap.

The Department will calculate the total dollars available for CDCS services as a monthly maximum. While there is not a monthly limit to spending, services plans developed for less than 12 months will have a prorated maximum budget applied to the Service Agreement. For example, if the CDCS monthly maximum amount is \$1,000, and the CDCS service plan is for nine months, the plan budget will be \$9,000 for the nine month period. The amount the consumer plans to spend each month can be more or less than \$1,000 but cannot exceed the total available.

Unexpended CDCS budget amounts cannot be carried over to subsequent service plan years.

14.2 Authorizations and Payments Under CDCS : EW and AC

The process for authorizing and paying for services when CDCS is selected and a plan is approved is the same as that followed for any person receiving AC or EW services.

A Long Term Care Screening Document is entered into MMIS.	Information from the SDOC is reflected on the Service Agreement.	Providers submit claims.
<p>Screening Document edits are applied and the document is approved in MMIS.</p> <p>The Screening Document records assessment information, program selection, and support plan information.</p> <p>It also establishes a “from-through” program eligibility span.</p> <p>This span documents a period of time in which the person will remain eligible for the program that cannot exceed 365 days.</p> <p>Annual reassessment re-establishes eligibility for the program.</p>	<p>There are different Service Agreement types for different programs.</p> <p>Information from the Screening Document (program type, case mix) determines the maximum dollar amount and set of services that can be authorized.</p> <p>Service Agreement edits are applied, and the Service Agreement is approved in MMIS.</p> <p>The Service Agreement identifies approved providers, services, rates, length of approval, and total dollars authorized.</p> <p>Consumers receive copies of their authorizations as a Service Agreement letter generated by MMIS.</p>	<p>Claims edits are applied, including checks against recipient information, authorized providers, and services, dates of service, and rates.</p> <p>Claims are paid or denied.</p> <p>Payments are decreased from total dollars authorized.</p> <p>Providers receive summaries of claims submitted and paid.</p>

Changes were made to each of these support processes and tools to support CDCS implementation in the EW and AC programs as outlined in the next subsections.

14.3 Summary of Changes to the Long Term Care Screening Document: EW & AC

New fields were added to the LTC Screening Document to:

- **Indicate whether CDCS is selected as a service option (Field # 94)**

This field must always be completed when entering a LTC Screening Document for a community assessment. The choice is coded as “Y” or “N”.

- **Show the CDCS monthly budget cap based on case mix classification (Field # 95)**

This amount will always appear on the LTC Screening Document and is based on case mix classification, the program type, and the Assessment Result Date.

New values for existing fields were created to:

- **Record any changes between CDCS and non-CDCS services in a service plan year**, to re-establish budget maximums for that service plan year (New Assessment Result Codes 36= Elderly, elected CDCS from non-CDCS, and 37 = Elderly, elected non-CDCS from CDCS).

Because the CDCS and non-CDCS monthly budget amounts are different, when a person changes between CDCS and non-CDCS in the same service plan year, MMIS will calculate the amount available for the remainder of that service plan year.

- **Record Support Plan information** (New Service Plan Summary codes, 40= CDCS, 41=Parent/Spouse Paid CDCS), if applicable
- **Record reasons for exiting CDCS** using Field 75 “Reasons for Continuing Institutional Stay (Value 02 now reads “Case Mix/CDCS Cap Doesn’t Meet Needs, and new value 11 “Involuntary Exit from CDCS”). Any of the other reasons can also be coded.

New LTC Screening Document edits were created to post when:

- The CDCS = Y or N field is left blank or an invalid code is entered (**Edit # 441**)
- The information coded for changes between CDCS and non-CDCS (Assessment Result Codes) doesn’t match the CDCS = Y or N information (**Edits # 448 and 449**)
- A person leaves CDCS and a Reason Code is not entered in Field 75 (**Edit # 644**). The Department wants to evaluate why people forego the service after election.
- CDCS is elected by a person who cannot access this service because of Primary Care Utilization Review information in the Recipient File (see the RPCR Screen in the Recipient File) in MMIS (**Edit # 442**)

14.4 Service Agreement Changes for CDCS Under EW & AC: Procedure Codes

New Procedure Codes were added to authorize CDCS funding and services under AC and EW.

There are three new procedure codes:

1. T2028 is to be used to authorize *all CDCS services*. It includes the following service categories as defined in Sections 5 and 6 of this manual: Personal Assistance; Treatment and Training; Environmental Modifications and Provisions; and Self-directed Support Activities. It will also be used to authorize all conventional waiver or AC services elected by the person as part of their support plan.
2. T2040 will be used to authorize payment for Background Checks.
3. T2041 includes all activities billed under Required Case Management. If a paraprofessional performs any allowed delegated tasks, the amount billed must reflect the paraprofessional rate.

14.5 Service Agreement Changes for CDCS Under EW and AC: Edits

Goal/Assurance	Edit Number	Edit Text & Notes
CDCS is authorized on the LTC screening document prior to entering the line items on the Service Agreement.	443	("CDCS Not Authorized") will post when the T2028 code is added to a Service Agreement and the LTC Screening Document indicates CDCS=N. If the CDCS field on the last approved LTC screening document was mistakenly valued as an "N", that document will need to be deleted and a new document entered with the correct value.
Only specific services are authorized when CDCS is elected.	445	("Service Not Allowed with CDCS") will post if other services are entered on a line item that are not allowed in combination with CDCS on the Service Agreement. See 14.6 for a list of the procedure codes that ARE allowable in combination with CDCS.
The total amount authorized for CDCS services is kept under the CDCS budget cap.	672	("Total Authorized Amount Exceeded") will post if the total authorized amounts of the combined line items (except for Background Checks) exceed the CDCS budget cap. You must reduce one or more line item units or total amounts.
Required Case Management is included only on a CDCS Service Agreement.	447	"RCM Without CDCS" will post if 1) an approved line item for T2028 is not on the same service agreement as T2041, or 2) T2028 is on the Service Agreement but not T2041, or 3) one of the line items is in a denied status. That is, this case management code is to be used only in combination with CDCS.
The total amount authorized for Required Case Management is kept under a cap amount for Required Case Management.	452	"RCM Cap Exceeded" will post if the total sum of all line items for T2041 exceed the RCM budget cap. Reduce the line item(s) so the total amount does not exceed these maximums. This allowable total is included in Appendix E.
Fiscal Support Entity is the enrolled provider under CDCS. Only the Fiscal Support Entity (FSE) provider number may be used on the line item for T2028. FSE must be recertified periodically to continue to provide service.	412	"The Category of Service Does Not Match the Procedure Requested" There will be an ending date on the category of service for this provider. The provider must re-enroll with DHS Provider Enrollment Unit on a bi-annual basis. If the service agreement line item for T2028 exceeds this ending date, you will receive Edit 412. View the PCOS Screen in the Provider Subsystem for this provider number for the ending date. The line item end date must be changed so it does not exceed this date.

14.6 Other Procedure Codes That Can Be Authorized in Combination with CDCS Services: Elderly Waiver and Alternative Care Programs

For AC and EW:

Other services that can be authorized in combination with T2028 (the CDCS Service code) are:

- T2040 (Background Checks)
- T2041 (Required Case Management)

For EW Only:

The person may have included *state plan home care services* as part of their plan. For this provider type only, the following services can be authorized separately on the Service Agreement, and the agency can bill directly.

- X5609 (PMAP) if the person is enrolled in Managed Care and receiving state plan services
- T1021 (Home Health Aide)
- T1003 with or without modifiers TT or TG (LPN)
- T1002 with or without modifiers TT or TG (RN)
- T1030 (Skilled Nursing)
- T1030 with modifier GT (Telehomecare)
- T1019 (Personal Care Assistant)
- X4037 (RN Supervision of PCA)

For AC Only:

Home care services under an approved AC support plan address only chronic, long term care needs. When authorized in accordance with AC requirements, they are considered to be “extended” home care in nature and, as such, should be authorized under line item costs for T2028.

Note: MA-covered services are not covered services under the AC program.

14.7 Claim Payments: EW and AC

As noted, the Fiscal Support Entity (FSE) will be the enrolled provider and the only entity that can bill for service costs under the CDCS service code T2028. When the FSE submits claims, the charges for services must contain information about which category of CDCS service was provided during the billing period.

Services provided under T2028 will be identified on the claim form by using modifiers. The claim form line items must include one of the following four modifiers:

- ✓ T2028 with modifier U1 for Personal Assistance
- ✓ T2028 with modifier U2 for Treatment and Training
- ✓ T2028 with modifier U3 for Environmental Modifications and Provisions
- ✓ T2028 with modifier U4 for Self-directed Support Activities (includes the FSE and FCM fees, and employer related expenses for benefits such as health insurance, as approved in the plan).
- ✓ T2028 U8 – Flexible Case Management

These modifiers are NOT used on the Service Agreement.

Payments from these line items will decrement against the Service Agreement line item for T2028.

To bill for Background Checks (T2040), use T2040 on the claim form.

To bill for Required Case Management (T2041), use T2041 on the claim form. County or tribal agencies will be allowed to bill MMIS directly (i.e. claims are not submitted by the FSE).

Special Income Standard-Elderly Waiver (SIS-EW): Payments for all three procedure codes (T2028, T2040, and T2041) will be applied toward the SIS/EW waiver obligation. See Section 16.A for more information about spenddown and waiver obligation.

Use of Claim Modifier 76

Claim Modifier 76 was developed to allow payment for multiple services provided on the same date or date span. When completing a claim for CDCS using procedure code T2028 when there will be more than one claim for the same date(s), use modifier U1 - U4 and/or U8 (as needed) in the MOD 1 field of the claim line item along with modifier 76 in the MOD2 field of the claim line item. By using modifier 76, the new claim(s) will not be considered a duplicate of the initial claim.

14.8 Consumer Scenario: Initial Opening – Selects CDCS

The person is not currently on the EW or AC program and selects CDCS at initial opening to the program.

Enter a LTC Screening Document using:	Enter a new Service Agreement using:	Edits You Might Receive:
<ul style="list-style-type: none"> • Activity Type 02 or 04 • Assessment Result 01 or 28 (use 11 only if the same program type was used in the past) • Program Type 03, 04, 09, 10, or 22 • CDCS Field = Y, and • “CDCS” is marked in the Service Plan Summary, and “Paid CDCS Parent/Spouse” if applicable. • The case mix amount for non-CDCS and CDCS will appear on the approved LTC Screening Document based on the person’s case mix, program, and Assessment Result Date (used by MMIS to find the right rate year). • The EW or AC eligibility span is developed. 	<ul style="list-style-type: none"> • The corresponding service agreement type to match the program type. • The header amount will be the CDCS amount listed from the LTC Screening Document, multiplied by the number of months in the header (service plan) period. • One line item for CDCS that represents the total of all CDCS approved services and goods; • For EW, one line item each for any MA state plan service that the person has elected to receive from a conventional home care agency, or one line item for x5609 if the person is enrolled in Managed Care and home care is part of their plan • One line item for Required Case Management, and • One line item for Background Checks (if applicable) • For AC, one line item each for CDCS, Required Case Management, Background Checks • Exception: One line item each for AC home care services if the person is program type 22 – Temp. AC 	<ul style="list-style-type: none"> • New edit 445 “Services Not Allowed with CDCS” will post if any other procedure code is included • Edit 672 “Total Authorized Greater Than Cap” will post if the total authorized amount exceeds the header amount. • New edit 452 “RCM Cap Exceeded” will post if the total amount authorized for T2041 exceeds the maximum limit. • Edit 412 “The Category of Service Does Not Match the Procedure Requested” will post if the line item end date for T2028 exceeds the ending date for the FSE’s provider number.

14.9 Consumer Scenario: Person Who Has Been Using CDCS Wants to Discontinue that Service

If the person elects to end CDCS and switch to non-CDCS services:

- ✓ **Close the Service Agreement** to the last day CDCS will be used and
 - Use **reason code 987** “CDCS services no longer authorized for this person” on the ASA2 Screen of the service agreement to explain to the providers that a funding change was made.
- ✓ **Enter a LTC Screening Document** using:
 - *Activity Type 07* if there are no significant changes in the person’s needs and the change represents a service change only
 - Assessment Result 37 “Elected Elderly Non-CDCS Services From CDCS”
 - Do not change the program type.
 - Change the CDCS field to “N”. Note: Edit 449 “CDCS Field Equals Y” will post if there is a “Y” in this field and the Assessment Result is 37.
 - Enter field 75 “Reason(s) for Continued or Long-term Institution Stay” and
 - Delete the “CDCS” value from the Service Summary Section.

Note: When using Activity Type 07, the eligibility span is not extended, nor can the case mix be changed. The amount of money that will show up on the new Screening Document will represent the non-CDCS monthly amount times the number of months left in the eligibility span.

Reassessment: If there has been a significant change in need, or the decision to opt out of CDCS occurs at or near the time a reassessment would occur, the case manager can complete the reassessment using Activity Type 06 instead of 07. In this case, a new eligibility span will be created, using the Assessment Result Date as the start date for the new span, and the new Service Agreement will reflect a 12 month budget.

- ✓ **Enter a new Service Agreement** using:
 - MA state plan services plus EW extended home care, waiver services, and/or x5609 as applicable, or AC services, depending on the program type.

14.10 Consumer Scenario: A Person Currently Open to EW or AC Decides to Change to CDCS

If the person is currently receiving non-CDCS services and elects to use CDCS:

- ✓ **Close the EW or AC service agreement.** You may add a message to the Provider and Recipient Comment Screens indicating that a new service agreement for CDCS services will be developed.
- ✓ **Complete a LTC Screening Document** using:
 - *Activity Type 07 if the change is in services only*
 - Assessment Result 36 “Elected Elderly CDCS”
 - Do not change the program type.
 - Change the CDCS field to “Y”. Note: edit 448 “CDCS Field Equals N” will post if there is a “N” in this field and the Assessment Result is 36, and
 - Indicate the “CDCS” value from the Service Summary Section, and “Paid CDCS Parent/Spouse” if applicable.
- ✓ **Enter a new Service Agreement** using:
 - The corresponding service agreement type to match the program type
 - One line item for CDCS
 - For EW, one line item each for MA state plan service, or one line item for x5609 if the person is enrolled in Managed Care
 - One line item for Required Case Management and
 - One line item for Background Checks (if applicable)
 - For AC, one line item each for CDCS and Required Case Management, and Background Checks , if applicable
 - Exception: One line item each for AC home care services *if* the person is program type 22 — Temporary AC.

14.11 Consumer Scenario: Renewal of CDCS

The person remains with CDCS services at time of the annual reassessment.

✓ Enter a LTC Screening Document using:

- Activity Type 06
- Assessment Result 13
- Do not change the program type and
- Do not change the CDCS field.

The EW or AC eligibility span is extended.

✓ Enter a new Service Agreement using:

- The corresponding service agreement type to match the program type
- One line item for CDCS
- For EW, one line item each for MA state plan service, or one line item for x5609 if the person is enrolled in Managed Care
- One line item for Required Case Management and
- One line item for Background Checks (if applicable)
- For AC, one line item each for CDCS, Required Case Management, and Background Checks
- Exception: One line item each for AC home care services *if* the person is program type 22
- Temporary AC.

If the Person Lives in an Institution.

For a person who is eligible for Medical Assistance, community services planning that occurs while the person is in the institution, including planning to utilize CDCS as the service option to return to the community, should be billed under Relocation Service Coordination (RSC). See Bulletins 01-56-23 and its replacement, 02-56-08, for complete information about provision and payment for Relocation Services Coordination.

A person determined to be eligible for AC can access AC conversion case management to assist in planning while residing in a nursing facility as well. Use X5476 for diversion-type Service Agreements or T1016 for conversion-type Service Agreements.

Appendix F FY05 CDCS Budgets – EW

The CDCS budgets for FY05, the first year of implementation, for Elderly Waiver participants are based on the average actual expenditures for FY03.¹ In addition, the case mix weights were applied to the FY03 amounts when the FY03 budget amount based on actual FY03 expenditures was lower than the amount expected given the case mix weight. The weight was applied to adjust case mix categories that had very few people in them during the periods analyzed.

The table on the next page shows average CDCS budget amounts per month by case mix cap for Elderly Waiver participants. The annual amount, which also appears on the table, is used for authorization and projected spending caps.

The plan and Service Agreement authorization is not limited by the average monthly amounts shown here, but will reflect proposed services and negotiated rates, and projected use of services over a period of time.

The annual service budget amount cannot be exceeded, and represents an “up to” amount available over the year to purchase needed, approved services, including Fiscal Support Entity service as specified in the plan, and Flexible Case Management service if the person chooses this optional case management service.

Required Case Management amounts are also presented as a monthly average amount and an annual maximum amount. The average amount of case management expenditures during FY03 ranged from between \$121.55 to \$187.89 per person per month.² The annual maximum amount listed cannot be exceeded. Required Case Management billing must reflect the units of service provided in a given billed period, the use of case aide versus case management service, and the lead agency’s usual and customary charge for waiver case management service.

Background checks, which can be requested by a person but not required, can be authorized using up to \$20 per check requested. Billing for this service must be based on actual cost of the check. The cost for background checks is not included in the cap appearing in Column 6 below.

1 Aging and Adult Services Division staff examined authorized and actual Elderly Waiver expenditures for FY02 and FY03 by case mix classification. The analysis included case management and home care (both FFS and PMAP) authorizations and expenditures, and excluded foster care, residential care and assisted living service costs. These costs were excluded because people living in these settings cannot access CDCS as a service option.

2 The division used 8 units per month at the state-wide maximum rate for case management to calculate an annual maximum amount that will support a range of required case management activity, including the provision of additional technical assistance prior to involuntary exit from CDCS service.

Table 1: FY 05 CDCS Budget – EW

1. Case Mix	2. CDCS Monthly Amount	3. Annual Maximum CDCS Service Budget Amount	4. Required Case Management Monthly Amount	5. Required Case Management Annual Maximum Amount	6. Total: CDCS Service Cap + Required Case Management	7. Background Check(s) Maximum Payment
A	\$691	\$8,292	\$181.36	\$2,176.32	\$10,468.32	\$20/check
B	\$1,035	\$12,420	\$181.36	\$2,176.32	\$14,596.32	\$20/check
C	\$1,229	\$14,748	\$181.36	\$2,176.32	\$16,924.32	\$20/check
D	\$1,337	\$16,044	\$181.36	\$2,176.32	\$18,220.32	\$20/check
E	\$1,729	\$20,748	\$181.36	\$2,176.32	\$22,924.32	\$20/check
F	\$1,775	\$21,300	\$181.36	\$2,176.32	\$23,476.32	\$20/check
G	\$1,789	\$21,468	\$181.36	\$2,176.32	\$23,644.32	\$20/check
H	\$2,343	\$28,116	\$181.36	\$2,176.32	\$30,292.32	\$20/check
I	\$2,748	\$32,976	\$181.36	\$2,176.32	\$35,152.32	\$20/check
J	\$2,815	\$33,780	\$181.36	\$2,176.32	\$35,956.32	\$20/check
K	\$2,901	\$34,812	\$181.36	\$2,176.32	\$36,988.32	\$20/check

Lead agencies will receive revised budget maximums information each Fiscal Year.

Table 2. AC Budgets for CDCS FY2005

1. Case Mix	2. CDCS Monthly Amount	3. Annual Maximum CDCS Service Budget Amount	4. Required Case Management: 8 units X \$22.67 average monthly units	5. Required Case Management Annual Maximum Amount	6. Total: CDCS Service Cap + Required Case	7. Background Check(s) Maximum Payment
A	\$683	\$8,196	\$181.36	\$2,176.32	\$10,372.32	\$20/check
B	\$923	\$11,076	\$181.36	\$2,176.32	\$13,252.32	\$20/check
C	\$1,074	\$12,888	\$181.36	\$2,176.32	\$15,064.32	\$20/check
D	\$1,226	\$14,712	\$181.36	\$2,176.32	\$16,888.32	\$20/check
E	\$1,444	\$17,328	\$181.36	\$2,176.32	\$19,504.32	\$20/check
F	\$1,534	\$18,408	\$181.36	\$2,176.32	\$20,584.32	\$20/check
G	\$1,623	\$19,476	\$181.36	\$2,176.32	\$21,652.32	\$20/check
H	\$2,000	\$24,000	\$181.36	\$2,176.32	\$26,176.32	\$20/check
I	\$2,108	\$25,296	\$181.36	\$2,176.32	\$27,472.32	\$20/check
J	\$2,216	\$26,592	\$181.36	\$2,176.32	\$28,768.32	\$20/check
K	\$2,520	\$30,240	\$181.36	\$2,176.32	\$32,416.32	\$20/check

These amounts will be updated annually and republished for lead agency and consumer use.

15.1 CDCS Service Authorizations & MMIS Activity: Persons under Age 65 in CAC, CADI, MR/RC, and TBI Waiver Programs

As of October 1st, 2004, CDCS became available to persons who are enrolled in or eligible for the following programs: CAC waiver (Community Alternative Care), CADI waiver (Community Alternatives for Disabled Individuals), TBI waiver (Traumatic Brain Injury), and MR/RC waiver (Mental Retardation or Related Condition)

The CDCS budget amounts will be issued annually by the Department of Human Services, and calculated according to historical expenditures of each population, except for MR/RC waiver, where budget is based on the individual screening document.

The amount authorized represents the total dollars available to purchase services over one service plan year for all services **except** Required Case Management, background checks requested by the consumer, and the cost of approved modifications or assistive technology that exceeds \$5,000.00.

The lead agency has 60 days after the date of assessment/reassessment to implement CDCS. The individual receiving CDCS must be given 30 days to develop their plan. This timeline may require the lead agency to prorate the adjustment depending on when the change occurs in relation to the individual's plan year.

For the purposes of planning, the lead agency can apply a formula by:

For potential recipients and reassessments for the MR/RC waiver the lead agency can use the MR/RC Waiver CDCS Budget Formula: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_029336.pdf

For current MR/RC, CAC, CADI and TBI waiver recipients, the CDCS budget is located on the Waiver Management Systems

For potential recipients for the CAC/CADI/TBI waivers the lead agency can take the individual's initial waiver resource amount derived from the CCT waiver management system and use this formula: resource amount $-2.9 \times .70$

For reassessments for the CAC/CADI/TBI waivers the lead agency can complete a manual entry on the CCT waiver management system

The lead agency professional (county case manager, tribal entity or health plan representative) conducting the assessment or reassessment process will inform the consumer of services available in the waiver when a person is determined eligible for a waiver program, and at reassessment. This information will include available budget amounts for CDCS.

Like any other type of service budget maximum, the "cap" represents an "up to" amount available to purchase services. The amount actually approved for services will be based on projected cost of services needed to address assessed needs, and may be less than the CDCS budget cap. The person-centered Community Support Plan can only include costs for allowable services up to the annual CDCS budget amount. The consumer and the lead agency must compare the proposed cost of

implementing the CDCS service plan to the total CDCS budget amount available to evaluate cost effectiveness, and the likely success of the proposed plan, taking into consideration the health and safety of the individual.

A person who is currently receiving non-CDCS services can elect to use CDCS. The CDCS budget available would be prorated to reflect remaining months in a waiver year span. The CDCS service agreement date spans could not exceed the waiver span.

If a person enters a full-team screening to begin CDCS, that full team screening extends the waiver span. Also if a reassessment is done and there is a change in services, there would then be a change in the service agreement. **Unexpended CDCS budget amounts cannot be carried over to subsequent service plan years.**

15.2 Consumer Scenarios: Choosing CDCS

Scenario 1: Initial opening – person selects CDCS

The person is not currently on CAC, CADI, or TBI waiver and selects CDCS at the initial opening to the program.

- Enter a LTC screening document using activity type 02, 04, or 07 (if within 60 days of a face to face assessment)
- Use assessment result 01,10,11,28
- Enter a Y in the “CDCS” field

Note: this will create a waiver span for this person.

The person is not currently on the MR/RC waiver and selects CDCS at the initial opening to the program.

- Enter a full team screening document using activity type 01
- Enter a waiver-in screening document, activity type 04 and **enter** the CDCS code, 48 in Field 41 (Current Services)

Scenario 2: At reassessment: a person already on a waiver decides to change to CDCS

If the individual is currently receiving non-CDCS services and elects at his/her reassessment to use CDCS.

For CAC, CADI, or TBI:

- Enter a LTC screening document using activity type 06
- Use assessment result 13
- Enter a Y in the “CDCS” field

Note: This will extend the waiver span for person.

For MR/RC:

- 98 • Enter an Annual Review screening document using activity type 02 and enter the CDCS code, 48 in Field 41 (Current Services)

Scenario 3: A person is already on a waiver and chooses CDCS, but NOT at reassessment.

If this individual is currently receiving non-CDCS services and elects to use CDCS immediately without waiting for his/her reassessment.

- Enter a LTC screening document using activity type 07
- Use assessment result 98
- Enter a Y in the “CDCS” filed.

Note: This will not extend the waiver span for the person.

For MR/RC:

- Enter a service change screening document, using activity type 03 and **enter** the CDCS code 48 in Field 41 (Current Services)

15.3 Consumer Scenarios: Discontinuing CDCS

Scenario 1: A person who has been using CDCS chooses to discontinue that service at the time of his/her reassessment.

If this person wants to discontinue CDCS, and switch to non-CDCS services at the time of his/her reassessment.

For CAC, CADI, TBI:

- Enter a LTC Screening Document using activity type 06
- Use assessment result 13
- Enter an N in the “CDCS” field

Note: This will extend the waiver span for the person.

For MR/RC:

- Enter and Annual Review screening document, activity type 02 and **remove** the CDCS code, 48 from Field 41

Scenario 2: Person who has been using CDCS on a waiver chooses to discontinue that service at any time other than reassessment.

If this person elects to end CDCS anytime before his/her reassessment, and switch to non-CDCS services immediately without having to wait for his/her reassessment.

For CAC, CADI, or TBI:

- Enter a LTC screening document using activity type 07
- Use assessment result 98
- Enter an N in the “CDCS” field

Note: This will not extend the waiver span for the person.

For MR/RC:

- Enter a service change screening document, activity type 03 and remove the CDCS code, 48 from Field 41 (Current Services)

15.4 Service Agreements: CAC, CADI, MR/RC, TBI

In order to authorize CDCS on a Service Agreement:

- The LTCC Screening Document must indicate a “Y” in the CDCS field, OR
- The DD Screening Document Current Service Code is 48

CDCS is authorized as one service agreement line item for CAC, CADI, TBI and MR/RC waivers.

- Enter the dates of the service span
- Use CDCS code T2028 (no modifier)
- Enter the individual’s county authorized budget amount as the requested total amount. (no unit or rate)
- This amount can not exceed the State set resource. This information is also on the Waiver Management System.

Other Services allowed as separate line items on the service agreement.

Not included in the individual’s CDCS service budget

- *T2040 – background checks*
- *X5476 – case management*
- *X5491 – case management aide*
- *X5671 – assistive technology that exceeds \$5000, if the county has chosen to fund the difference within their aggregate pool*
- *S5165 – the cost of approved modifications that exceeds \$5000, if the county has chosen to fund the difference within their aggregate pool*

Included under the CDCS budget

- X5609 – PPHP services (Prepaid health plan services)
- X4037 – supervision of PCA
- T1019 – PCA
- T1030 – skilled nurse visit
- T1020 – home health aide
- T1002 – PDN-RN
- T1003 – PDN-LPN

Extended home care services are authorized as and included in the CDCS budget under the T2028 code.

Home Modifications/Assistive Technology

A note about authorizing home modification and assistive technology that will cost more than \$5000. In addition to state plan home care, CDCS service, background checks, and Required Case Management, home modifications and assistive technology costs of more than \$5000 approved by the lead agency are authorized on the Service Agreement separately if the lead agency decides to fund the cost within their aggregate pool.

Using S5165 procedure code for modifications and 5671 for assistive technology, **authorize the amount exceeding \$5000** approved by the lead agency which will be funded by the lead agency's aggregate pool. Amounts up to \$5000 are included under T2028 (CDCS) and come out of the individual's CDCS budget. Amounts that exceed \$5000 that are paid for out of the individual's CDCS budget would also be included under T2028.

15.5 Screening Document Edits:

Edit 441 – 'CDCS Field is blank or invalid' LTC Screening Document. If the Program Type is CAC, CADI, or TBI, then the CDCS field must be populated.

Edit 442 – 'CDCS not allowed for PCUR (Primary Care Utilization Review)'

If DD screening document has current service 48 (CDCS) or LTC SD has CDCS field "Y" then Recipient cannot have a current or past PCUR begin date.

Service Agreement Edits:

Edit 440 – 'Excluded time field is blank or invalid'. If procedure code T2028 is entered, the Excluded Time must be populated.

Edit 568 – 'Procedure code/current service mismatch'

For procedure code T2028

The DD screening document must include Current Service Code - 48 (CDCS)

Edit 443 – 'CDCS NOT ALLOWED' (CAC, CADI, & TBI)

For procedure code T2028 or T2040

The LTC screening document CDCS field must be "Y".

Edit 363 – 'Procedure/Modifier Conflict'

Procedure code T2028 cannot be entered on an SA with a modifier

Edit 444 – 'CDCS/Other Service Conflict'

Procedure code T2028 conflicts with another service on the SA.

15.6 Billing CDCS Services

CDCS is authorized on the SA using procedure code T2028 (with no modifier)

CDCS is billed on the CMS 1500 using an appropriate modifier.

- T2028 U1 – CDCS – Personal Assistance
- T2028 U2 – CDCS - Treatment and Training
- T2028 U3 – CDCS – Environmental Modifications and Provisions
- T2028 U4 – CDCS – Self Direction Support Activities
- T2028 U8 – Flexible Case Management

Use of these codes for billing will decrement the SA line item T2028.

Use of Claim Modifier 76

Claim Modifier 76 was developed to allow payment for multiple services provided on the same date or date span. When completing a claim for CDCS using procedure code T2028 when there will be more than one claim for the same date(s), use modifier U1 - U4 and/or U8 (as needed) in the MOD 1 field of the claim line item along with modifier 76 in the MOD2 field of the claim line item. By using modifier 76, the new claim(s) will not be considered a duplicate of the initial claim.

16.1 CDCS & Enrollment in Managed Care

MSHO, MnDHO, PMAP, or CBP

When a county or tribe receives a request from a person to receive CDCS, DHS recommends counties call the DHS Eligibility Verification System (EVS) to verify Minnesota Health Programs eligibility.

Minnesota Senior Health Option (MSHO) and Minnesota Disability Health Option (MnDHO) enrollees receiving services on a waiver may be eligible to choose CDCS as a service, and the county or tribe should refer the person to their health plan to access the CDCS service.

The health plan or the health plan's designee (usually the care coordinator) who is responsible for the health coordination or case management functions will establish an individual's waiver budget.

Costs related to required case management and criminal background studies will be excluded from that budget and are paid as a service expense through the health plan.

The cost for MSHO and MnDHO enrollees who choose to have additional flexible case management support beyond that provided by their health plan coordinator for development and implementation of their Community Support Plan will be included in their individual service budget.

Recipients or their representatives have the right to select and work with providers in their health plan's network. To use an out-of-network provider, recipients must follow procedures delineated in the health plan's *Certificate of Coverage*.

If EVS indicates the person is an enrollee of the Prepaid Medical Assistance Program (PMAP) or County-Based Purchasing (CBP), the county or tribe should administer the CDCS waiver service when it administers all other waiver services. The county or tribe must continue to coordinate their activities with the appropriate health plan to insure continuity of care and that efforts and services are not duplicated.

FY05 Note: During the first quarter of 2005, changes will be made to the entity administering the Elderly Waiver in some counties. CBP counties who are also MOU counties (there are five—Freeborn, Steele, Brown, Goodhue and Itasca) will begin to administer all waiver services, including CDCS, through the CBP organization. In addition, some non-CBP MOU counties (unnamed at this time) may be selected to participate in a managed partnership plan in which the managed care provider will manage both state plan and waiver services, including CDCS. Expansion of this delivery system model is expected to occur throughout 2005.

Details of these changes will be shared with counties as they become available.

16A.1 Medical Assistance Spenddowns When Choosing CDCS

The Financial Assistance unit of the lead agency is responsible for determining the financial obligation of a medical assistance participant to contribute toward medical costs. The financial worker informs the consumer if they are responsible for payments under a spenddown.

Also see Minnesota Health Care Manual, http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs_id_018438.hcsp#P109_2243, Chapter 0913, for more detailed information about premiums and spenddowns.

Under CDCS, a spenddown obligation works the same way as it would under conventional HCBS waiver programs. MA spenddown may be met with any combination of expenditures from State Plan services, pharmacy, or waiver services. MA spenddowns are to be met each month.

The information below outlines consumer options for paying determined spenddown amounts.

1. Prepay DHS a Spenddown

Consumers can choose to prepay their spenddown to DHS. This process is “Client Option Spenddown”. The Financial Assistance unit will determine if a person is eligible to use this option. Consumers must sign DHS Form 3081 “*DHS Agreement to Prepay MA Spenddown*”. When this option is chosen, MMIS sends a bill directly to the client.¹

2. No Designated Provider

A spenddown can be met in a “pot luck” order.

- If the first claim that is submitted is from the Fiscal Support Entity (FSE) who is the enrolled CDCS service provider, then the FSE would be responsible for the collection of the spenddown from the client.
- If the first claim that is submitted is from the County or Tribe for Required Case Management and/or background checks then they would be responsible to collect the spenddown from the client.
- If the first claim that is submitted is from any other State Plan service or pharmacy provider, then that provider would be responsible to collect the spenddown from the client.

If the first claim does not satisfy the entire spenddown, then the next claim submitted will determine who would be responsible for the collection of any remaining spenddown. Each claim submitted in the order it is processed in MMIS will be used to decrement the spenddown until the spenddown is satisfied. Each provider submitting the bills would be responsible for collecting the spenddown from the client

¹ Clients who have a Waiver Obligation cannot use this option. See the next section for information about CDCS and waiver obligation under the Special Income Standard Elderly Waiver program.

3. Designate a Provider

It is voluntary for a recipient to use a designated provider. A consumer can designate one provider to whom they will pay their spenddown each month. The recipient with a spenddown can use a designated provider if:

- The recipient has a one month automated spenddown, **and**
- The recipient is the only member of the MA/GAMC household with a spenddown, **and**
- The provider they choose can meet the entire spenddown amount each month.

If the client chooses the designated provider option, the financial worker needs to be notified and the client must sign DHS-3161 – *Agreement to Use a Designated Provider*. The financial worker also will need the provider number of the designated provider to be entered into MMIS.

A note on Designated Providers

Providers cannot refuse to be a designated provider. MMIS sends a notice to the designated provider and the amount to be collected from the client.

The client can choose which provider they want to be the designated provider. The designated provider can be a State Plan home health care provider, (if one is included in the plan), another State Plan provider, the RCM, or the FSE provider. The person determines who the designated provider will be, if any.

Designated Provider Under CDCS

If the FSE is chosen as the designated provider, then the spenddown will be applied against all claims that are submitted through the FSE until spenddown amount is met each month. The FSE would always be responsible to collect the spenddown from the consumer. Payments to the FSE would be decremented against until the spenddown was met, no matter if other claims are submitted, nor in what order all the other claims are submitted.

Any other provider can be chosen as the designated provider, as long as all the criteria outlined above can be met. The designated provider is always responsible to collect the spenddown until it is fully met.

16A.2 Special Income Standard Elderly Waiver and Waiver Obligation

There are two income limits for individuals who are eligible for the Elderly Waiver Program. Under one limit, referred to as the Special Income Standard, or the SIS-EW program, the consumer will be responsible to pay a waiver obligation. **This obligation only applies to their waiver services, not any other medical assistance covered services such as home care.**²

Go to Minnesota Health Care Manual, http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/DHS_id_019053.hcsp#P2661_191589, Chapter 0907, for information about eligibility for Special Income Standard Elderly Waiver, including waiver obligations.

Consumers who have a waiver obligation can also use the designated provider option but must choose a waived service provider as the designated provider.

SIS-EW Waiver Obligation

Since only waiver services claims can be used to meet waiver obligation amounts, no other medical assistance provider claims will be affected by waiver obligation amounts.

1. No Designated Waiver Provider

The waiver obligation would be met in a “pot luck” order.

- If the first claim that is submitted is from the Fiscal Support Entity (FSE) who is the enrolled CDCS service provider, then the FSE would be responsible for the collection of the waiver obligation from the client.
- If the first claim that is submitted is from the County or Tribe for Required Case Management and/or background checks, then they would be responsible to collect the waiver obligation from the client.
- If the first claim does not satisfy the entire waiver obligation, then the next claim submitted will determine who would be responsible for the collection of the remaining waiver obligation. Each claim submitted by a waiver provider, in the order it is processed in MMIS, will be used to decrement against the waiver obligation until the obligation is satisfied.

2. Designated Provider

For a CDCS client, the designated provider can be the FSE or the lead agency for Required Case Management. The waiver obligation would be met with the bills submitted through the FSE or lead agency. The designated provider would be responsible for collecting the waiver obligation from the client.

² For all other EW clients, some may have a medical assistance spenddown, and some will not, depending on their financial and marital situation.

If the FSE is designated, and the county or tribe bills for case management and/or background checks, these claims would not be decremented for the waiver obligation no matter what order they were submitted. The FSE would always be responsible to collect the waiver obligation.

If the client chooses the designated provider option the financial worker needs to be notified and the client must sign DHS-3161 – Agreement to Use a Designated Provider. The financial worker also will need the provider number of the FSE or lead agency to be entered into MMIS.

16A.3 Non payment of Waiver Obligation or Spenddown While Using CDCS

Under the Federal Waiver amendment, one criterion for “involuntary exit” from CDCS is inability to implement the approved support plan or comply with CDCS requirements despite efforts to provide additional technical assistance. Failure to implement the plan would include failure to meet responsibility for Elderly Waiver obligations and Medical Assistance spenddowns.

An unpaid waiver obligation or spenddown after the client receives services is considered to be unpaid debt and the provider is not required to continue to serve recipients with outstanding debt. The provider must give sufficient notice to the client which gives opportunity to repay the debt. If the recipient does not pay, the provider can refuse to provide care and the consumer can seek out services from other providers.

If the client does not pay the designated or “pot luck” provider after receiving services, the provider is to give sufficient notice to the client concerning their obligation and reasonable opportunity to pay the debt. The provider should also inform the lead agency, who needs to provide Additional Assistance and Technical Support. The lead agency will provide some involvement to resolve the non-payment issues. The lead agency should document all reasonable efforts to provide the need for technical assistance.

The documentation must include:

- Identification of the problem
- Corrective action needed
- A timeline to accomplish the action or payment of debt.

Each discovery of non-compliance with the community support plan (non payment of waiver obligation or spenddown for services received) that requires a corrective action would cause a CDCS Notice of Technical Assistance and Support to be sent to the consumer and a copy retained in the lead agency file. When three documented efforts that do meet the formal definition of Technical Assistance and Support are filed and a fourth occurrence of need for corrective action occurs because of non-payment of waiver obligation or spenddown for services that have been delivered, the CDCS option can be terminated and cause an involuntary exit from the CDCS program. The recipient would still be eligible to receive other waiver services.

16A.4 Spenddowns and Waiver Obligations under MnDHO & MSHO

MnDHO collects the spenddown and invoices the enrollees monthly. Designated providers are not used for people in the community. Client Option spenddowns are used for these recipients. The same corrective action and a CDCS notice of TA would be used for this program as well.

MSHO instructions will be added on how the participating plans collect waiver obligations and spenddowns.

17.1 Notes About CDCS Under the Alternative Care Program

(A bulletin will be published outlining AC requirements related to the addition of CDCS as a service option to this program. The bulletin content will also be published and added to this manual at a later date.)

18.1 CDCS and Unpaid Caregiver Supports

Caregiver supports are intended to:

- Build greater capacity for family or other informal caregivers to provide quality care to the person supported under CDCS
- Extend the duration over which informal caregivers can provide support to that person
- Decrease caregiver burden by providing training, coaching, support counseling, and respite.

DHS assessment and support planning forms contain a section for caregiver assessment and support planning. Both DHS Forms used for Community Support Planning, Form 4166 and 2925, contain a section that can be used to outline proposed caregiver support services.

In order to approve proposed caregiver support services under CDCS, the proposed caregiver support services must be intended to accomplish the goals listed above, and meet certain service criteria. For example, training for a caregiver must address specific needs of the person participating in a waiver or AC program.

18.2 Types of Caregiver Support Services

Respite: The primary purpose of respite services is to give relief to the unpaid (typically family) caregiver – allowing a break from or decreasing the intensity of the caregiving responsibilities and routine. Respite services provide “substitute caregiving” at the level of care and supervision necessary to ensure the health and safety of the person. Respite can be an essential service for caregivers provided on an intermittent, occasional or emergency basis. Respite is provided to an informal caregiver whose support or care is an ongoing, dependable, substantial part of the person’s Community Support Plan.

Under CDCS, respite or relief for a primary unpaid caregiver may be an important part of the person’s support plan. Respite is the replacement of care or support provided to the recipient by the caregiver. Respite service would be categorized as Personal Assistance Service if provided by a neighbor or friend or a PCA provider. Respite planned to be delivered in an institution would be categorized as Treatment and Training, as would in-home respite that will be provided by a certified or licensed professional staff.

Family and Caregiver Training and Education is training and education provided to an informal caregiver who provides direct and ongoing services to a recipient. Training can include instruction about treatment regimens, disease management, caregiver roles, or use of equipment as specified in the plan, for examples.

Education can include caregiver counseling, including coaching, guidance or instruction directly related to providing care to the person supported by a waiver or AC program.

Approved costs for training and education should be limited to the cost of the training or counseling (e.g. paying professional or course or conference registration fees). Costs related to transportation, lodging and travel are not covered.

Go to <http://www.dhs.state.mn.us/Agingint/ltc/EWServPS.htm> for information about provider standards for family and caregiver trainers and educators as defined for the Elderly Waiver. While CDCS is intended to allow self-design of provider standards where noted in this manual, approved caregiver training and education proposals should reflect the use of trainers and/or educators who meet community standards and demonstrate competency in the training or education subject matter.

Training must address a specific assessed need of the recipient and be intended to improve the quality of care provided, increase the caregiver’s knowledge about providing care, or assure caregiver health and safety.

19.1 HCBS Quality Framework: Organizing Quality Management Around Seven Quality Focus Areas

All states participating in 1915(c) (Medicaid) waiver programs must provide assurances concerning the quality of care and services provided through these programs as a condition of federal approval of the state waiver plan. The Centers for Medicare/Medicaid Services (CMS) has reformatted the former federal assurances into a Quality Framework that focuses attention on participant-centered desired outcomes along seven dimensions. If you want to review the Quality Focus Areas contained in the federal matrix, please go to: <http://www.cms.hhs.gov/medicaid/waivers/frameworkmatrix.asp>

The outcomes listed below are those desired for all waiver participants, regardless of the type of service selected.

Participant Access: Individuals have access to home and community-based services and supports in their communities.

Participant-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

Provider Capacity and Capabilities: There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.

Participant Safeguards: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

Participant Rights and Responsibilities: Participants receive support to exercise their rights and in accepting personal responsibilities.

Participant Outcomes and Satisfaction: Participants are satisfied with their services and achieve desired outcomes.

System Performance: The system supports participants efficiently and effectively and constantly strives to improve quality.

19.2 The HCBS QA/QI Plan - Local Agency HCBS Quality Assurance & Improvement Responsibilities

Each county or tribal agency or health plan administering home and community waiver services programs, Long Term Care Consultation, or the Alternative Care programs must develop and implement a plan for quality assurance in Home and Community-Based programs (HCBS QA/QI Plan). The plan is forwarded to DHS biannually to demonstrate that the agency:

- Is implementing programs according to statute
- Is carrying out delegated quality assurance, monitoring, and assessment activities necessary to achieve desired program outcomes, and
- Has policies and practices in place to ensure the health and safety and participation and choice-making of consumers participating in these programs.

Under this plan, the lead agency addresses both state and federal quality assurance and improvement requirements for the Long Term Care Consultation and Alternative Care programs, as well as the Elderly Waiver, Community Alternatives for Disabled Individuals Waiver, MR/RC Waiver, Traumatic Brain Injury Waiver, and Community Alternative Care Waiver programs. The most recent plan submitted at the time of the publication of this manual was that for 2005-06, forwarded by the lead agency in fall 2004 via web-based survey. To see a “worksheet” version of the plan, go to http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs_id_028254.pdf

19.3 Applying the Quality Framework to CDCS

Here is a brief list of requirements relevant to CDCS, organized around the quality focus areas or domains. These are requirements in addition to those that are applicable to HCBS in general.

- **Access to CDCS:**

Individuals have complete information about CDCS, including budget amounts

Individuals have access to CDCS in their community

Individuals have access to supports and resources to make CDCS a viable alternative.

- **Participant-Centered CDCS Services Planning and Delivery:**

Services are planned by consumers using person-centered planning tools and approaches

Services are directed by consumers

Lead agencies approve CDCS plans by applying required criteria.

- **Provider Capacity & Capability:**

There are sufficient Fiscal Support Entities and Flexible Case Management providers to ensure choice

CDCS staff possess and demonstrate the capability to effectively serve participants.

- **Participant Safeguards:**

Community support plans include personal risk management, emergency back up, and crisis services plans

Support staff, FCM, and FSE understand their role as mandated reporters of suspected vulnerable adult or child abuse, neglect, or exploitation

County Adult and Child Protection agencies provide appropriate interventions, including support services, to ensure health and safety and an individual's right to manage risk.

- **Participant Rights and Responsibilities:**

Participants understand their role as employer and other responsibilities

Participants have access to support, tools, and other resources to effectively carry out their responsibilities

Participants receive information about their right to appeal lead agency decisions related to their support plan and choices in service delivery, training requirements outlined, or any other condition of their CDCS or waiver approval by the lead agency

Participants receive support to exercise their rights.

- **Participant Outcomes and Satisfaction:**

Participants develop individualized CDCS outcomes or desired results

Participants are satisfied with their services and achieve desired outcomes.

- **System Performance: Reports and Monitoring Requirements**

Approved CDCS plans support participants efficiently and effectively

Approved plans include quality monitoring roles and schedules

The lead agency meets monitoring and reporting requirements.

Appendix G includes a “Self-Assessment” for each lead agency to use to review those practices and policies identified as being necessary to achieve the program and individual outcomes for CDCS listed above.

Appendix G: CDCS Quality Assurance and Improvement Activity: Lead Agency Self-assessment

The lead agency:

- Yes No Provides information about CDCS as a service option to all waiver applicants
- Yes No Provides each person at assessment and reassessment with the consumer CDCS Brochure (DHS-4124)
- Yes No Has a complete CDCS “Tool Kit” available for review and use by potential CDCS users
- Yes No Carries out public education activity related to the availability of CDCS
- Yes No Provides information about budget amounts to help people choose the service options that best meet their needs and preferences
- Yes No Explains Flexible Case Management service as an option to help the person access and continue to use CDCS

Participant-centered CDCS Services Planning and Delivery:

Person-centered planning is central to using CDCS services and supports. All supports are expressly planned and effectively implemented and directed by each participant. The plan will reflect the person’s unique needs, expressed preferences, and decisions concerning his/her life in the community.

The lead agency:

- Yes No Offers the consumer a choice in person-centered planning tools and level of involvement

Ensures that plans submitted for approval by CDCS consumers:

- Yes No Include the frequency, source, rate, and duration of support or service from all sources.
- Yes No Include frequency, payment rate, and description of Flexible Case Management service.
- Yes No Outline training or other requirements for personal assistance, and plans to verify training is completed/adequately.
- Yes No Identify background checks requested by consumer and how findings will be incorporated into or affect plan approval.
- Yes No Appropriately address/include services recommended by other professionals, including physicians, involved in assessment/planning.

- Yes No Include communication plans to accommodate changes in the person's condition, preferred services, or desired outcomes.
- Yes No Incorporate the individual's personally developed outcome and quality indicators and monitoring role and schedule.

Provider Capacity

There are sufficient FSE and FCM providers. CDCS staff possess and demonstrate the capability to effectively serve participants.

The lead agency:

- Yes No Has policies and practices that ensure that FSE providers meets applicable state and federal standards
- Yes No Has policies and practices that ensure that FCM providers meets applicable state and federal standards
- Yes No Provides lists to consumers of all qualified FSE and FCM
- Yes No Reviews provider records on a periodic basis to ensure that the provider is adequately documenting the delivery of services to conform with the individual's support plan. This should include review of individual files and invoices.

The lead agency may carry out activity to increase choice between FSE and FCM providers.

- Yes No Recruits FSE providers
- Yes No Recruits culturally competent providers
- Yes No Assesses the need for service providers with special knowledge, skill or background to provide support to people with dual diagnosis or communication limitations, etc.
- Yes No Provides equal consideration to all providers who meet applicable standards
- Yes No Maintains a directory of all qualified service providers for the CDCS consumer who wants to combine non-CDCS and CDCS.

Participant Safeguards

Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

The lead agency:

- Yes No Has policies and procedures for monitoring the health and safety of the person at least annually
- Yes No Has policies for evaluating unsafe home conditions
- Yes No Has policies for evaluating need for supervision
- Yes No Incorporates personal risk management in support planning
- Yes No Reviews LTCC staff completion of Environmental Safety section of the Community Assessment Form (DHS-3428) or equivalent
- Yes No Required Case Manager has face-to-face contact with the person as indicated in the community support or care plan, and as required under various programs.
- Yes No Has policies in place for the CDCS participant, FCM, or personal assistant to follow if problems arise concerning the person
- Yes No Ensures the person has a contingency plan for emergencies when the lack of immediate care would pose a serious threat to health and welfare. This assurance is directed at community-wide emergencies such as those posed by inclement weather.
- Yes No Ensures the person has a plan for backup assistance when providers aren't available and lack of immediate care would pose a serious threat to health and welfare. This assurance is intended to be in place at the individual client level and to reflect individualized planning.

Vulnerable Adult & Child Protection: The lead agency has policies and practices that address:

- Yes No The prevention of abuse, neglect and exploitation
- Yes No Screening for abuse, neglect, and exploitation
- Yes No Identification of abuse, neglect, and exploitation
- Yes No Investigation of abuse, neglect, and exploitation
- Yes No Reporting abuse, neglect, and exploitation
- Yes No Actions to be taken when the health or safety of a person has not been safeguarded
- Yes No Does the lead agency have policies/procedures that address training directly related to abuse, neglect, and exploitation
- Yes No Has the lead agency developed communication processes that create an appropriate, efficient feedback loop between adult or child protection and case manager.

Participant Rights and Responsibilities

Participants receive support to exercise their rights and in accepting personal responsibilities.

The lead agency ensures:

- Yes No The person receives information about data privacy
- Yes No About their rights to appeal county decisions regarding CDCS services and/or access to programs, including denial of expenditures and failure to approve the support plan
- Yes No The lead agency provides the person with information regarding Ombudsman services.
- Yes No The lead agency ensures the person always receives a copy of service agreements or prior authorizations that includes information about appealing those decisions
- Yes No The lead agency has policies and procedures in place to ensure people have access to guardianship or conservator services.

Participant Outcomes and Satisfaction

Participants are satisfied with their services and achieve desired outcomes.

Does the lead agency conduct consumer satisfaction surveys related to the provision of CDCS?

- Yes No

System Performance: Reports and Monitoring Requirements

The system supports participants efficiently and effectively and constantly strives to improve quality.

A. Consumer Monitoring and Reporting:

- Support plans include monitoring schedules, roles, what inputs and outcomes will be monitored. Consumer has a method and format for monitoring.

B. FSE Monitoring and Reporting

- FSE provides monthly standardized reports to family members and counties as required to maintain certification.
- Reports include monthly expenditure and balances information to consumer.
- Reports include identification of persons with over or underspending.

C. Lead Agency Monitoring and Reporting

- Lead agency submits required reports to DHS.
- Reports include measures of satisfaction
- Reports include utilization, budget and discharge information.
- Conducts additional reviews and monitoring activity required when a spouse or parent is a paid personal assistant.

D. Required Case Management: Reassessment

- Reassessments of waiver eligibility occurs at least annually.
- Support plan is reviewed for continuing adequacy, appropriateness.