Minnesota Elderly Waiver (EW) Amendments

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Respite

1. Appendix C: Participant Services – Service Definition and Provider Specifications

- Expands options for respite provided in unlicensed settings
- Adds camps as a provider type
- Combines provider types that were individually listed under the general provider types of individuals and agencies that meet respite service standards

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition *(Scope):*

Respite care may be provided to enrollees who are unable to care for themselves. The service is furnished on a short-term basis because of the absence or need for relief of the person who normally provides the care and who is not paid or is only paid for a portion of the total time of care or supervision provided. The unpaid caregiver does not need to reside in the same home as the enrollee.

Respite care may be provided in: the enrollee's home or place of residence; a home licensed to provide foster care; a community residential setting (CRS); a Medicare certified hospital or nursing facility; a building registered as a housing with services establishment with services delivered by a licensed home care provider; **unlicensed settings where agency or individual providers must be licensed under Minnesota Statutes, chapter 245D** or another private home that is identified by the enrollee.

Respite care may be provided in a private (unlicensed) home identified by the enrollee, when it is determined by the case manager that the service and setting can safely meet the enrollee's needs. The case manager must take into account the accessibility and condition of the physical plant, ability and skill level of the respite caregiver, and the enrollee's needs and preferences. The unlicensed home and caregiver identified by the enrollee cannot otherwise be in the business or routine practice of providing respite services.

Coverage for respite care provided in licensed facilities will include both services and room and board, as appropriate. Room and board will not be covered for respite care provided in the enrollee's home, enrollee's family home, or in an unlicensed, private home.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. This does not allow the primary caregiver to provide respite services. The commissioner, as necessary, may waive other limitations on this service; in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite care is limited to 30 consecutive days per respite stay in accordance with the care plan. Enrollees who live in settings that are responsible to provide customized living, 24-hour care, supervision, residential care or shift staff foster care or supports are not eligible for this service with the exception of community

emergencies or disasters requiring relocation of waiver participants.

The person or people who provide the care or supervision and for whom the respite service is to provide relief shall not be paid to provide the respite service.

Provider Category	Provider Type Title
Agency	Adult Foster Care Providers
Agency	Housing with services establishments
~~Agency~~	~~Home Health Agencies~~
Agency	Long Term Care Facilities
Individual	~~An~~ Individuals who ~~selected by the enrollee that~~ meet the respite service standards ~~approved by the lead agency~~
~~Agency~~	~~Personal Care Provider Organizations~~
~~Individual~~	~~Licensed Practical Nurse~~
Agency	Hospitals as defined in Minnesota Statutes, section 144.696 sub 3
Agency	Agencies that meet the respite service standards
Agency	Camps

Provider Specifications:

Provider Category:

Agency

Provider Type

Agencies that meet the respite service standards

Provider Qualifications

License (specify):

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 sub 2(1) and (2) must be:
-licensed under Minnesota Statutes, chapter 245D as a provider of Basic Support Services or
-licensed for home care under Minnesota Statutes, section 144A.43 through 144A.483 with a Home and Community Based Services Designation under Minnesota Statutes, section 144A.484

Other Standard (specify):

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D

Agencies excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 (1) and (2) must meet the requirements of: sections245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards if applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota

Statutes, Chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.

For agencies who are excluded under Minnesota Statutes, section 245A.03,subd.2 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

Individual

Provider Type

Individuals that meet the respite service standard ~~an individual selected by the enrollee that meet the service standard approved by the lead agency~~

Provider Qualifications

License (specify):

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 sub 2(1) and (2) must be:
-licensed under Minnesota Statutes, chapter 245D as a provider of Basic Support Services or
-licensed for home care under Minnesota Statutes, section 144A.43 through 144A.483 with a Home and Community Based Services Designation under Minnesota Statutes, section 144A.484

Other Standard (specify):

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D

Individuals providing in-home respite services must demonstrate to the case manager that they are able to provide, on a temporary, short-term basis, the care and services needed by the enrollee. Documentation will be in the person's community support plan. In addition, in-home respite providers who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the enrollee: 1) the provider is physically able to care for the enrollee; 2) the provider has completed training identified as necessary in the care plan; and, 3) the provider complies with monitoring procedures as described in the care plan. The case manager must evaluate and document whether the provider meets the standards to provide respite services

Individuals excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 (1) and (2) must meet the requirements of sections245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards if applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03,subd.2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

~~Agency~~

Provider Type

~~Personal Care Provider Organizations~~

Provider Qualifications

License (specify):

~~Providers must be:~~
~~- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or~~
~~- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services~~
~~Designation under Minnesota Statutes, section 144A.484.~~

~~**Verification of Provider Qualifications**~~

~~**Entity Responsible for Verification**~~:

~~The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.~~

~~The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.~~

~~For providers who are excluded under Minnesota Statutes, section 245A.03, sub 2(1) and (2) the lead agency monitors the provider.~~

~~**Frequency of Verification:**~~

~~Every one to three years~~

Provider Category:

~~Individual~~

Provider Type

~~Licensed Practical Nurses~~

Provider Qualifications

License (specify):

~~Nurses who furnish respite care in the enrollee's home or place of residence must be licensed under Minnesota Statutes, sections 148.171 to 148.2841. Providers must be: licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.~~

Other Standard (specify):

~~Individuals excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards if applicable.~~

Verification of Provider Qualifications

Entity Responsible for Verification:

~~The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.~~

~~The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.~~

~~For individuals who are excluded under Minnesota Statutes, section 245A.03, sub 2(1) and (2) the lead agency monitors the provider.~~

Frequency of Verification:

~~Every one to three years.~~

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License (specify):

Licensed under Minnesota Statutes, Chapter 245D.

Certificate (specify):

Certified by the American Camp Association.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Annually.

Provider Specifications:

Provider Category:

~~Agency~~

Provider Type

~~Home Health Agencies~~

Provider Qualifications

License (specify):

~~In-home respite care providers, including nurses employed by home health agencies, must be licensed under Minnesota Statutes, sections 148.171 to 148.285.~~

~~Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:~~
~~- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or~~
~~- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.~~

Other Standard *(specify):*

~~Home health agencies must have a comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484 and must meet the standards under Minnesota Rules, part 9505.0290, subpart 3(B).~~

Verification of Provider Qualifications

Entity Responsible for Verification:

~~The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.~~

~~The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.~~

~~For providers excluded from licensure under Minnesota Statutes, section 245A.03, subd 2(1) and (2) the lead agency monitors the provider~~

Frequency of Verification:

~~Every one to three years~~

Consumer Directed Community Supports (CDCS)

2. Appendix C: Participant Services – C-1/C-3: Provider Specifications

- Changes Fiscal Support Entity (FE) to Financial Management Services (FMS)
- Clarifies in this section that the community support plan is the CDCS community support plan
- Changes the FMS provider qualifications
- Removes the option for counties to enroll as an FE
- Changes the term 'rate' to 'fee'
- Changes eligibility for enrollment (i.e. successfully complete a readiness review prior to enrollment)
- Changes frequency of qualification verification to a performance review every three years
- Changes the term county to lead agency
- Changes frequency of verification to performance reviews every three years
- Correct language concerning CDCS eligibility and the Minnesota Restricted Recipient Program (MRRP)

Appendix C-1/C-3: Participant Services – Provider Specifications

Service Name:

Consumer-directed community supports (CDCS): personal assistance
Consumer-directed community supports (CDCS): treatment and training
Consumer-directed community supports (CDCS): environmental modifications and provisions
Consumer-directed community supports (CDCS): self-direction support activities=

Provider Category:

Agency

Provider Type

~~Fiscal support entities (FEs)~~ Financial Management Services (FMS) providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the ~~fiscal support entity (FE)~~ financial management services (FMS) provider. ~~The FE must have a written agreement with the person or entity providing goods or services, or the participant may submit an invoice from the person or entity providing goods and services and to the FE for payment.~~

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the CDCS community support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. ~~This does not preclude~~ prevent ~~them from payment for their work in providing~~ CDCS ~~community support plan development services~~. ~~This provision does not apply to: spouses, parents of minors, legally responsible representatives, or case managers employed by county agencies. This provision precludes FEs~~ FMS providers or their representatives cannot ~~from participating~~ participate in the development of a CDCS community support plan for participants who are purchasing ~~FE~~ financial management services from them.

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

Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

FEs FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. ~~Counties may enroll as an FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the participant, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.~~ The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Service (IRS) code, and revenue Procedure Code 2013-39, as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. The ~~FE~~ FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

~~FEs~~ FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The ~~FE~~ FMS provider must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the ~~FE~~ FMS provider.

~~FEs~~ FMS provider must establish and make public the maximum rate(s) for their services. The rate and scope of ~~FE~~ financial management services is negotiated between the participant or the participant's representative and the ~~FE~~ FMS provider, and included in the CDCS community support plan. ~~FE rates~~ FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service

budget, and may not include set up fees or base rates or other similar charges. Maximum ~~FE rates~~ FMS provider fees may be established by the state agency. ~~FEs~~ FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment~~,~~ and training, or environmental modifications and provisions provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's CDCS community support plan.

The ~~FE~~ FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The ~~FE~~ FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an Information Technology Security Officer and certified payroll professional, or a ~~or by contract a~~ certified public accountant or an individual with a ~~baccalaureate~~ bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS under a collective bargaining contract. The FMS provider must have an established customer service system, a HIPAA-compliant system to secure private data, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

~~The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE. FE~~ FMS providers must ~~the pass the~~ successfully complete a readiness review prior to ~~providing services~~ enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years. ~~A certificate is issued to FE providers that successfully complete the readiness review. Recertification reviews are conducted every four years.~~

The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The ~~FE~~ FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The ~~FE~~ FMS provider must also receive a copy of the participants' CDCS community support plan approved by the ~~county~~ lead agency. Claims submitted by the ~~FE~~ FMS provider must correspond with services, amounts, timeframes, etc. as authorized in the CDCS community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

~~The state agency determines whether provider standards are met through a written readiness review submitted by the FE.~~

As established by the state agency, a performance review will include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

~~Recertification reviews are conducted every four years.~~

Enrolled FMS providers will be subject to a performance review every three years.

Service Title:

Consumer Directed Community Supports: Environmental Modifications and Provisions

Service Definition (Scope):

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support enrollees. Environmental modifications and provisions is one of the four categories of CDCS that can be purchased. Enrollees or their representative hire, fire, manage and

direct their support workers.

CDCS: environmental modifications and provisions includes supports, services, and goods provided to the participant to maintain a physical environment that assists the person to live in and participate in the community or are required to maintain health and well-being. The following are typically covered under this category:

Assistive technology
Home and vehicle modifications
Environmental supports (snow removal, lawn care, heavy cleaning)
Supplies and equipment
Special diets
Adaptive clothing
Transportation
For adults, costs related to health clubs and fitness centers

Providers of modifications must have a current license or certificate if required by Minnesota statutes or administrative rules to perform their service. A provider of modification services must meet all professional standards and or training requirements, which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes. Enrollees or their representatives have control over the goods and services to be provided through developing the community support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) enrollees, by the managed care organization or its designee.

A written CDCS Community Support Plan must be developed for each enrollee. The enrollee or their representative will direct the development and revision of the CDCS community support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the enrollee's strengths, needs, and preferences. The plan may include a mix of paid and non-paid services. The plan must define all goods and services that will be paid through CDCS. The enrollee or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The community support plan identifies:

• the goods and services that will be provided to meet the enrollee's needs identified in the assessment and be for the direct benefit of the participant,
• safeguards to reasonably maintain the enrollee's health and safety; and,
• how emergency needs of the enrollee will be met.

The support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur. The waiver shall cover only those goods and services authorized in the community support plan. Goods and services are not covered when they are provided prior to the development of the CDCS community support plan, duplicate other services in the CDCS community support plan supplant natural supports appropriately meeting the participant's needs or are available through other funding sources. Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

The CDCS community support plan will specify CDCS Environmental modifications and provisions provider qualifications including training requirements. The CDCS community support plan will also specify who is responsible to assure that the qualification and training requirements are met. Criminal background study standards as outlined in Minnesota Statutes 245C must be applied to determine whether a person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

The enrollee 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 parameters of

the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the enrollee or their representative will work with the lead agency to have the CDCS community support plan reviewed and re-authorized.). See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care or home care services while residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment.

Criteria for allowable expenditures.
The purchase of goods and service must meet all of the following criteria:

1. An individual written CDCS community support plan must be developed for each participant. Services included in the CDCS community support plan must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's assessed needs. ~~disability and/or condition.~~

2. The waiver shall cover only those goods and services authorized in the CDCS community support plan that collectively represent a feasible alternative to institutional care. Services not included in the CDCS community support plan are not covered. In addition, goods and services are not covered when they:

a) are provided prior to the development of the CDCS community support plan,
b) duplicate other services in the CDCS community support plan,
c) supplant natural supports appropriately meeting the participant's needs,
d) are not the least costly and effective means to meet the participant's needs; or
e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act
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 enrollee 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 enrollee,
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support enrollees. Additionally budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are negotiated and included in the CDCS community support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that mitigate the enrollee's disability when they are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the enrollee's physical condition. The condition must be identified in the enrollee's CDCS community support ~~care~~ plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS community support plan will be included in the budget. Services included in the CDCS community support plan must be necessary to meet a need identified in the participant's assessment. This is referred to as support planner functions. This may include but is not limited to assistance in determining what will best meet the enrollee's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The enrollee chooses who will provide the service and how much will be included in the CDCS community support plan. This support may be provided via care coordination (or case management) through the lead agency or

by another entity.
(6~~) FSE~~ FMS costs incurred to manage the budget; advertise and train staff;
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Costs related to internet access based on criteria established by the state.
(9) Maintenance of vehicle modifications (i.e. wheelchair lift)

Services and supports provided by a spouse – CDCS may be used to pay spouses of enrollees for services. See appendix C-2 section e –State Policies Concerning Payment for Waiver Services furnished by Relatives for more detail.

Enrollee Budgets.
The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees and the health plan. Lead agencies will inform the enrollee prior to the development of the CDCS community support plan of the amount that will be available for implementing the plan over a one-year period. The lead agency is responsible to review and approve final spending decisions in the enrollee's CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the cost of background studies is not included in the individual budget amount. For MSHO and MSC+ enrollees, the cost will be covered as a service expense through the health plan.

In a 12 month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Individual Budget Methodology.
Enrollees' budgets may not exceed the length of their MMIS Service Agreement span (i.e., a maximum of 365 days). If the span is less than 365 days, the budget amount will be prorated. Enrollees shall not carry forward unspent budgeted amounts from one plan year to the next. If an enrollee experiences a significant change in need or condition, that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted. Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's case mix classification amount. These supports must be identified in the CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the enrollee's maximum budget is the published CDCS Case Mix Cap.

Case management is separated into activities that are required and those that are flexible which are provided through the purchase of a support planner. Enrollees select who they want to provide the support planner service. Required case management functions are provided by lead agencies and are not included in the enrollee's budget. Required case management functions are described in Appendix E-1 section J and Appendix E-2 b. section V.

Support planner functions are described in Appendix E-1 section J. The CDCS community support plan must include specific tasks to be performed by a paid support planner.

~~FEs~~ FMSs are the CDCS Medicaid-enrolled provider for all CDCS services. ~~Counties or tribes may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the enrollee, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.~~ See the CDCS Lead Agency Operations Manual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

General Waiver Unallowable expenditures (also applies to CDCS).
CDCS cannot be used to cover goods and services that:

• Are provided prior to the development of the CDCS community support plan
• Duplicate other goods and services in the CDCS community support plan
• Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services

• Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
• Services, goods, supports provided to, or directly benefiting persons other than the individual

Goods and services that shall not be purchased within the enrollees budget are:

• Any fees incurred by the enrollee such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
• Insurance except for insurance costs related to direct support worker employee coverage,
• Room and board and personal items;
• Home modifications that add any square footage with the exception of an accessible bathroom-the lead agency can seek approval to build or modify a
wheelchair accessible bathroom (see Environmental Accessibility Adaptations)
• Home modifications for a residence other than the primary residence of the enrollee
• CDCS Services cannot be provided to any enrollee if he/she or his/her ~~or by enrollees,~~representative, ~~providers or caregivers that~~ have at any time been assigned to the Minnesota Restricted Recipient Program (MRRP)
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS community support plan
• Vacation expenses other than the cost of direct services;
• General vehicle maintenance
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.

Service Title:

Consumer Directed Community Supports: Personal Assistance

Service Definition (Scope):

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support enrollees. Personal Assistance is one of the four categories of CDCS that can be purchased. Enrollees or their representative hire, fire, manage and direct their support workers.

CDCS: personal assistance includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category:

Assistance with activities of daily living and incidental activities of daily living
Respite care
Homemaking

Personal Assistance includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The CDCS community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the enrollee or their designee indicating how the qualifications are met. Enrollees or their representatives have control over the goods and services to be provided through developing the CDCS community support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) enrollees, by the managed care organization or its designee.

A written CDCS Community Support Plan must be developed for each enrollee. The enrollee or their representative will direct the development and revision of the CDCS community support plan and delivery of the CDCS services. The CDCS support plan must be designed through a person-centered process that

reflects the enrollee's strengths, needs, and preferences. The plan may include a mix of paid and non-paid services. The plan must define all goods and services that will be paid through CDCS. The enrollee or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS community support plan identifies:

• the goods and services that will be provided to meet the enrollee's needs identified in the assessment and be for the direct benefit of the participant,
• safeguards to reasonably maintain the enrollee's health and safety; and,
• how emergency needs of the enrollee will be met.

The CDCS support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur. The waiver shall cover only those goods and services authorized in the CDCS community support plan. Goods and services are not covered when they are provided prior to the development of the CDCS community support plan, duplicate other services in the CDCS community support plan, supplant natural supports appropriately meeting the participant's needs or are available through other funding sources. Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

The CDCS community support plan will specify CDCS Personal Assistance provider qualifications including training requirements (if they exceed the provider standards). The CDCS community support plan will also specify who is responsible to assure that the qualification and training requirements are met. Criminal background study standards as outlined in Minnesota Statutes 245C must be applied to determine whether a person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

The enrollee 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 parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the enrollee or their representative will work with the lead agency to have the CDCS community support plan reviewed and re-authorized.). See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care or home care services while residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment.

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

1. An individual written CDCS community support plan must be developed for each participant. Services included in the CDCS community support plan must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's assessed needs ~~disability and/or condition~~.
2. The waiver shall cover only those goods and services authorized in the CDCS community support plan that collectively represent a feasible alternative to institutional care. Services not included in the CDCS community support plan are not covered. In addition, goods and services are not covered when they:
a) are provided prior to the development of the CDCS community support plan,
b) duplicate other services in the CDCS community support plan,
c) supplant natural supports appropriately meeting the participant's needs,
d) are not the least costly and effective means to meet the participant's needs; or
e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act

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 enrollee 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 enrollee,
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures it cannot be authorized and the case manager must provide the enrollee or the enrollee's representative notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support enrollees. Additionally budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are negotiated and included in the CDCS community support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that mitigate the enrollee's disability when they are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the enrollee's physical condition. The condition must be identified in the enrollee's CDCS community support ~~care~~ plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS community support plan will be included in the budget. Services included in the CDCS community support plan must be necessary to meet a need identified in the participant's assessment. This is referred to as support planner functions. This may include but is not limited to assistance in determining what will best meet the enrollee's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The enrollee chooses who will provide the service and how much will be included in the CDCS community support plan. This support may be provided via care coordination (or case management) through the lead agency or by another entity.
(6~~)FSE~~ FMS costs incurred to manage the budget,
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Costs related to internet access based on criteria established by the state.
(9)Maintenance of vehicle modifications (i.e. wheelchair lift)

Services and supports provided by a spouse – CDCS may be used to pay spouses of enrollees for services rendered. See appendix C-2 section e for more detail.

Enrollee Budgets.
The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees and the health plan. Lead agencies will inform the enrollee prior to the development of the CDCS community support plan of the amount that will be available for implementing the plan over a one year period. The lead agency is responsible to review and approve final spending decisions in the enrollee's CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the cost of background studies is not included in the individual budget amount. For MSHO and MSC+ enrollees, the cost will be covered as a service expense through the health plan.

In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Individual Budget Methodology.

Enrollees' budgets may not exceed the length of their MMIS Service Agreement span (i.e., a maximum of 365 days). If the span is less than 365 days, the budget amount will be prorated. Enrollees shall not carry forward unspent budgeted amounts from one plan year to the next. If an enrollee experiences a significant change in need or condition, that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted. Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's case mix classification amount. These supports must be identified in the CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the enrollee's maximum budget is the published CDCS Case Mix Cap. Case management is separated into activities that are required and those that are flexible which are provided through the purchase of a support planner. Enrollees select who they want to provide the support planner service. Required case management functions are provided by lead agencies and are not included in the enrollee's budget. Required case management functions are described in Appendix E-1 section J and Appendix E-2 b. section V. Support planner functions are described in Appendix E-1 section J. The CDCS community support plan must include specific tasks to be performed by a paid support planner.

~~FEs~~ FMS are the CDCS Medicaid-enrolled provider for all CDCS services. ~~Counties or tribes may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the enrollee, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.~~

See the CDCS Lead Agency Operations Manual.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CDCS cannot be used to cover goods and services that:

- Are provided prior to the development of the CDCS community support plan
- Duplicate other goods and services in the CDCS community support plan
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
- Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the individual

Goods and services that shall not be purchased within the enrollees budget are:

- Any fees incurred by the enrollee such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage,
- Room and board and personal items that are not related to the assessed need/ disability;
- Home modifications that add any square footage with the exception of an accessible bathroom-the lead agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations)
- Home modifications for a residence other than the primary residence of the enrollee
- CDCS Services cannot be provided to any enrollee if he/she or his/her by ~~enrollees,~~ representatives, ~~providers or caregivers that~~ have at any time been assigned to the Minnesota Restricted Recipient Program(MRRP)
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS community support plan
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs.

Service Title:

Consumer Directed Community Supports: Self-direction Support Activities

Service Definition (Scope):

CDCS: self-direction support activities includes services, supports and expenses incurred for administering or assisting the enrollee or their representative in administering CDCS. The following are typically covered under this category: liability insurance and workers compensation, payroll expenses including FICA, FUTA, SUTA and wages, processing fees, employer shares of benefits, assistance in securing and maintaining workers, development and implementation of the CDCS community support plan, monitoring and provision of services. Support planner service is covered under this category.

Support Planner services are covered under this CDCS category. Participants may select who they want to provide this service. People reimbursed through CDCS to assist with the development of the participant's person-centered CDCS community support plan must: be 18 years of age or older; pass a certification test developed by the department on person-centered support planning approaches including the Vulnerable Adult Act; provide a copy of their training certificate to the participant; use the CDCS community support plan template or a community support plan format that includes all of the information required to authorize CDCS and, be able to coordinate their services with the ~~county~~ lead agency case manager to assure that there is no duplication between functions. Participants may require additional provider qualifications tailored to their individual needs. These will be defined in the participant's CDCS community support plan. The provider must provide the participant or the participant's representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

Enrollees or their representatives have control over the goods and services to be provided through developing the CDCS community support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) enrollees, by the managed care organization or its designee.

An individual CDCS Community Support Plan (CSP) must be developed for each enrollee. The enrollee or their representative will direct the development and revision of the CDCS community support plan and delivery of the CDCS services. The CDCS CSP must be designed through a person-centered process that reflects the enrollee's strengths, needs, and preferences. The plan may include a mix of paid and non-paid services. The plan must define all goods and services that will be paid through CDCS. The enrollee or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS CSP identifies:

• the goods/services that will be provided to meet the enrollee's needs identified in the assessment and be for the direct benefit of the participant,
• safeguards to reasonably maintain the enrollee's health/safety; and,
• how emergency needs of the enrollee will be met

The CDCS community support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur. The waiver shall cover only those goods/services authorized in the CDCS community support plan. Goods and services are not covered when they are provided prior to the development of the CDCS CSP, duplicate other services in the CDCS CSP, supplant natural supports appropriately meeting the participant's needs or are available through other funding sources. CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

The CDCS CSP will specify CDCS Self direction support provider qualifications including training requirements. Criminal background study standards as outlined in Minnesota Statutes 245C must be applied to determine whether a person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

The enrollee 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 parameters of the CDCS community support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS CSP parameters, the enrollee or their representative will work with the lead agency to have the CDCS community support plan reviewed and re-authorized. See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care or home care services while residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment.

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

1. A written CDCS CSP must be developed for each participant. Services included in the CDCS CSP must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's ~~disability and/or condition.~~ assessed needs
2. The waiver shall cover only those goods and services authorized in the CDCS CSP that collectively represent a feasible alternative to institutional care. Services not included in the CDCS CSP are not covered. In addition, goods and services are not covered when they:
a) are provided prior to the development of the CDCS community support plan,
b) duplicate other services in the CDCS CSP,
c) supplant natural supports appropriately meeting the participant's needs,
d) are not the least costly and effective means to meet the participant's needs; or
e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act

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 enrollee 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 enrollee,
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures it cannot be authorized and the case manager must provide the enrollee or the enrollee's representative notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support enrollees. Additionally budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are negotiated and included in the CDCS community support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that mitigate the enrollee's disability when they are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the enrollee's physical condition. The condition must be identified in the enrollee's CDCS community support ~~care~~ plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS CSP will be included in the budget. Services included in the CDCS CSP must be necessary to meet a need identified in the participant's assessment. This is referred to as support planner functions. This may include but is not

limited to assistance in determining what will best meet the enrollee's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The enrollee chooses who will provide the service and how much will be included in the CDCS CSP. This support may be provided via care coordination (or case management) through the lead agency or by another entity.
(6) ~~FSE~~ FMS Costs incurred to manage the budget,
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Maintenance to vehicle modifications (ie wheelchair lift)
(9) Costs related to internet access based on criteria established by the state.

Services and supports provided by a spouse – CDCS may be used to pay spouses of enrollees for services rendered. See appendix C-2 section e –State Policies Concerning Payment for Waiver Services furnished by Relatives for more detail.

Enrollee Budgets.
The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees and the health plan. Lead agencies will inform the enrollee prior to the development of the CDCS community support plan of the amount that will be available for implementing the plan over a one year period.

The lead agency is responsible to review and approve final spending decisions in the enrollee's CDCS CSP. For recipients who are not enrolled in MSHO or MSC+, the cost of background studies is not included in the individual budget amount. For MSHO and MSC+ enrollees, the cost will be covered as a service expense through the health plan.

In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Individual Budget Methodology.
Enrollees' budgets may not exceed the length of their MMIS Service Agreement span (i.e., a maximum of 365 days). If the span is less than 365 days, the budget amount will be prorated. Enrollees shall not carry forward unspent budgeted amounts from one plan year to the next. If an enrollee experiences a significant change in need or condition that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted.

Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's case mix classification amount. These supports must be identified in the CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the enrollee's maximum budget is the published CDCS Case Mix Cap.

Case management is separated into activities that are required and those that are flexible which are provided through the purchase of a support planner. Enrollees select who they want to provide the support planner service. Required case management functions are provided by lead agencies and are not included in the enrollee's budget. Required case management functions are described in Appendix E-1 section J and Appendix E-2 b. section V.

Support planner functions are described in Appendix E-1 section J. The CDCS community support plan must include specific tasks to be performed by a paid support planner.

~~FEs~~ FMSs are the CDCS Medicaid-enrolled provider for all CDCS services. ~~Counties or tribes may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the enrollee autonomy in employment.~~

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CDCS cannot be used to cover goods and services that:

- Are provided prior to the development of the CDCS community support plan
- Duplicate other goods and services in the CDCS community support plan

• Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
• Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
• Services, goods or supports provided to or directly benefiting persons other than the individual

Goods and services that shall not be purchased within the enrollees' budget are:

• Any fees incurred by the enrollee such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
• Insurance except for insurance costs related to direct support worker employee coverage;
• Room and board and personal items;
• Home modifications that add any square footage with the exception of an accessible bathroom-the lead agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations)
• Home modifications for a residence other than the primary residence of the enrollee
• CDCS Services cannot be provided to any enrollee if he/she or his/her by ~~enrollees,~~ representatives~~, providers or caregivers that~~ have at any time been assigned to the Minnesota Restricted Recipient Program (MRRP)
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS community support plan
• Vacation expenses other than the cost of direct services,
• General vehicle maintenance,
• Tickets and related costs to attend sporting or other recreational events,
• Animals, including service animals, and their related costs.

Service Title:

Consumer Directed Community Supports: Treatment and Training

Service Definition (Scope):

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support enrollees. Treatment and Training is one of the four categories of CDCS that can be purchased. Enrollees or their representative hire, fire, manage and direct their support workers.

CDCS: treatment and training includes a range of services that promote the participant's ability to live in and participate in the community. Providers must meet the certification or licensing requirements in state law related to the service. The following are typically covered under this category:

- Specialized health care – therapists, nurses, dieticians
- Extended therapy treatment
- Habilitative services
- Day services/programs
- Training and education to paid or unpaid caregivers
- Training and education to recipients enrollees to increase their ability to manage CDCS services

Enrollees or their representatives have control over the goods and services to be provided through developing the CDCS community support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) enrollees, by the managed care organization or its designee.

An individual written CDCS Community Support Plan (CSP) must be developed for each enrollee. The enrollee or their representative will direct the development and revision of the CDCS community support plan and delivery of the CDCS services. The CDCS CSP must be designed through a person-centered process that reflects the enrollee's strengths, needs, and preferences. The plan may include a mix of paid

and non-paid services. The plan must define all goods and services that will be paid through CDCS. The enrollee or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS CSP identifies:

• the goods and services that will be provided to meet the enrollee's needs identified in the assessment and be for the direct benefit of the participant,
• safeguards to reasonably maintain the enrollee's health and safety; and,
• how emergency needs of the enrollee will be met.

The CDCS community support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur. The waiver shall cover only those goods and services authorized in the CDCS CSP. Goods and services are not covered when they are provided prior to the development of the CDCS CSP, duplicate other services in the CDCS CSP, supplant natural supports appropriately meeting the participant's needs or are available through other funding sources. Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

The CDCS CSP will specify CDCS Treatment and Training provider qualifications including training requirements. The CDCS CSP will also specify who is responsible to assure that the qualification and training requirements are met. Criminal background study standards as outlined in Minnesota Statutes 245C must be applied to determine whether a person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

The enrollee 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 parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS CSP parameters, the enrollee or their representative will work with the lead agency to have the CDCS CSP reviewed and reauthorized. See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care or home care services while residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment.

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

1.A~~n~~ written CDCS CSP must be developed for each participant. Services included in the CDCS CSP must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's ~~disability and/or condition.~~ assessed need.
2. The waiver shall cover only those goods and services authorized in the CDCS CSP that collectively represent a feasible alternative to institutional care. Services not included in the CDCS community support plan are not covered. In addition, goods and services are not covered when they:
a) are provided prior to the development of the CDCS community support plan,
b) duplicate other services in the CDCS community support plan,
c) supplant natural supports appropriately meeting the participant's needs,
d) are not the least costly and effective means to meet the participant's needs; or
e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act

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 enrollee 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 enrollee,
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures it cannot be authorized and the case manager must provide the enrollee or the enrollee's representative notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support enrollees. Additionally budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are negotiated and included in the CDCS community support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that mitigate the enrollee's disability when they are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the enrollee's physical condition. The condition must be identified in the enrollee's CDCS community support ~~care~~ plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS community support plan will be included in the budget. Services included in the CDCS community support plan must be necessary to meet a need identified in the participant's assessment. This is referred to as support planner functions. This may include but is not limited to assistance in determining what will best meet the enrollee's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The enrollee chooses who will provide the service and how much will be included in the CDCS community support plan. This support may be provided via care coordination (or case management) through the lead agency or by another entity.
(6) ~~FSE~~ FMS costs incurred to manage the budget,
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Costs related to internet access based on criteria established by the state.
(9) Maintenance of vehicle modifications (i.e. wheelchair lift)

Services and supports provided by a spouse – CDCS may be used to pay spouses of enrollees for services rendered. The only service covered is personal assistance services provided as defined above. See appendix C-2 section e –State Policies Concerning Payment for Waiver Services furnished by Relatives for more detail.

Enrollee Budgets.
The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees, .The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees, the health plan or the health plan's design. Lead agencies will inform the enrollee prior to the development of the CDCS community support plan of the amount that will be available for implementing the plan over a one year period. The lead agency is responsible to review and approve final spending decisions as delineated in the enrollee's CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the cost of background studies is not included in the individual budget amount but will be covered as a service expense within the individual's case mix classification amount. For MSHO and MSC+ enrollees, the cost will be covered as a service expense through the health plan.

In a12 month service agreement period, the enrollee's individual budget 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 background studies.

Individual Budget Methodology

Enrollees' budgets may not exceed the length of their MMIS Service Agreement span (i.e., a maximum of 365 days). If the span is less than 365 days, the budget amount will be prorated. Enrollees shall not carry forward unspent budgeted amounts from one plan year to the next. If an enrollee experiences a significant change in need or condition that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted. Assessments shall be conducted by the lead agency case manager.

Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's case mix classification amount. These supports whether included in the individual budget or not, must be identified in the CDCS community support plan. For recipients who are not enrolled in MSHO or MSC+, the enrollee's maximum budget is the published CDCS Case Mix Cap.

Case management is separated into activities that are required and those that are flexible which are provided through the purchase of a support planner. Enrollees select who they want to provide the support planner service. Required case management functions are provided by lead agencies and are not included in the enrollee's budget. Required case management functions are described in Appendix E-1 section J and Appendix E-2 b. section V. Support planner functions are described in Appendix E-1 section J. The CDCS community support plan must include specific tasks to be performed by a paid support planner.

~~FEs~~ FMSs are the CDCS Medicaid-enrolled provider for all CDCS services. ~~Counties or tribes may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the enrollee, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.~~

See the CDCS Lead Agency Operations Manual DHS 4270 for a description of all required lead agency activity.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CDCS cannot be used to cover goods and services that:

• Are provided prior to the development of the CDCS community support plan
• Duplicate other goods and services in the CDCS community support plan
• Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
• Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
• Services, goods or supports provided to or directly benefiting persons other than the individual

Goods and services that shall not be purchased within the enrollees budget are:

• Any fees incurred by the enrollee such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
• Insurance except for insurance costs related to direct support worker employee coverage,
• Room and board and personal items;
• Home modifications that add any square footage with the exception of an accessible bathroom-the lead agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations)
• Home modifications for a residence other than the primary residence of the enrollee
•CDCS Services cannot be provided to any enrollee if he/she or his/her or ~~by enrollees,~~ representatives, ~~providers or caregivers that~~ have at any time been assigned to the Minnesota Restricted Recipient Program (MRRP)
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS

community support plan
• Vacation expenses other than the cost of direct services;
• General vehicle maintenance
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.

3. Appendix C: Participant Services – C-2: General Service Specifications (3 of 3)

- Changes FMS enrollment criteria

Appendix C-2: Participant Services – General Service Specifications

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Fee-for-service providers.

The Department enrolls provider that fulfill state qualifications and complete required state provider training and submit a signed Minnesota Health Care Provider Agreement. Providers access all service information concerning enrollment including enrollment forms on the department's web site: Minnesota Health Care Programs: Enrolled Providers

Every waiver service provider must comply with state requirements. Direct enrollment with the Department is required for most waiver services. Enrolled waiver service providers will be listed in an on-line (MinnesotaHelp.info) directory as of 1/1/14. Enrollment, while available to market and receipt-based waiver service providers, is not required.

Market services are those purchased at a price typically charged on a community market basis. Market services include three basic services directed to a broad community market: Chore, cleaning only component of homemaker, and home construction component of environmental accessibility adaptations.

Lead agencies or the financial management service contractor will assure compliance with non-enrolled market services and maintain payment records in a manner directed by the state.

Receipt-based services are services that involve the purchase of ~~consumer~~ goods and supports from vendors on a retail basis (i.e. public transportation, community classes). Receipt-based service providers have the choice of enrolling as a Medicaid provider, or receiving reimbursement for goods and supports through lead agencies. The state directs lead agencies to authorize the purchase of waiver goods and supports in compliance with federal waiver requirements and to maintain payment records in a manner directed by the state.

On an annual basis, the state agency will review qualifications of applicants for Financial Management Services (FMS) providers through a Request for Proposal process.

Providers must have an agreement with the Department of Human Services and be enrolled as an MHCP provider. ~~Communication and training of local lead agencies and providers, and waiver provider qualification review process of providers statewide has begun.~~ A web based provider directory, found at MinnesotaHelpInfo Waiver Provider Services Guide,(DHS-6933) has been designed and is available. New MHCP providers will be required to take training that ~~has been~~ is developed by the department. All lead agencies will utilize any qualified provider in Provider Enrollment. For MCOs, which can use non-enrolled providers under the contract with DHS, the MCO is responsible to ensure the provider meets qualifications, and must submit this information to DHS.

Federally recognized tribes may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7,item (c). A tribe that intends to implement standards for credentialing health professionals must submit the standards to the department, along with

evidence of meeting, exceeding, or being exempt from corresponding state standards. The department maintains a copy of the standards and supporting evidence to enroll health professionals approved by tribes. If the tribe elects to become a provider under the alternative licensing standards, they must establish separation of authority from the tribal licensing agency and the provider agency to mitigate potential conflicts of interests.

Managed care providers.
The provider network may be limited by the MCO in accordance with §1915(b)(1) for MSC+ or in accordance with §1915(a) for MSHO and the MCO's contract with the department. For services that are not market services or receipt-based services, the MCO's will have three options for developing their networks:

1. Contracted model MCO may develop contracts and negotiate rates with Tier 1 MHCP enrolled providers. The MCO must provide notice in writing to the contracted provider who will be utilized in the MCO's network and provide written information needed for the provider to deliver and bill for EW services at the State established rate or at a negotiated rate.
2. Open access model: MCO may use the entire network of providers that are directly enrolled with the department and pay these providers on a nonparticipating basis. If paying on a non-participating basis, the MCO must pay at least the FFS rates published by the state.
3. Mixed model: MCO may use a contracted network for some provider types and open access for other provider types. In such a model, MCO must clearly indicated to enrollees how to gain access to providers through a provider directory; for provider types available through open access, MCO must indicate that there are no restrictions other than State enrollment.

4. Appendix C: Participant Services – Qualified Providers

- Changes certification to include Support Planners only

Appendix C: Participant Services – Qualified Providers

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

To participate as a Minnesota Health Care Programs (MHCP) provider and provide waiver services, providers must meet professional, certification and/or licensure requirements (including waiver requirements) according to state and federal laws and regulations. The Department's Provider Enrollment Unit verifies that these requirements are met before a provider is enrolled. All waiver providers must be enrolled through the Provider Enrollment Unit. Before they can provide services, bill and be reimbursed for providing waiver services, fee-for-service provider must: (1) enroll as a MHCP provider, (2) receive prior authorization to deliver services to an individual waiver participant and (3) bill for services appropriately. The Department maintains a list of active MHCP providers in the MMIS provider subsystem. Edits in MMIS ensure that payment is made only to providers that (1) are enrolled as a MHCP provider, and (2) have been authorized to provide the service for which they are claiming. If a provider's license or certification expires or is revoked and it does not respond in a timely manner to the Department's request for information related to the expiration or revocation, the provider is removed from active enrollment status. Payment claims submitted for services delivered after removal from active enrollment status are rejected.

In analyzing MCO encounter claims, while MCOs can utilize non-enrolled providers, the analysis indicates that MCOs use DHS-enrolled providers for waiver services.

Non-licensed providers have had qualifications reviewed and monitored through the lead agency. The department monitors the practices of lead agencies through the annual Quality Assurance Plan that lead

agencies submit to the department. The department provides direction and oversees all operational activities carried out by counties, managed care organizations, and tribes. Counties, managed care organization, and tribes that carry out delegated waiver operations are referred to as lead agencies. Unless otherwise noted, references to lead agencies in this document include these entities.

Case Managers -As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers. ~~County/tribe contracting will be eliminated as of 1/1/2014, and~~ Providers must be reviewed by the department to remain enrolled as an MHCP provider.

~~Communication plans have been developed and have commenced. Training of local lead agencies and providers is being rolled out. Review and renewal of provider agreements with the department has begun statewide.~~

Enrolled waiver service providers are ~~will be~~ listed in an on-line (MinnesotaHelp.info) directory as of 1/1/14.

Licensing -Certain waiver service providers as indicated in Appendix C-1/C-3 are required to be licensed by either the Department, local lead agencies under delegation from the Department, or the Minnesota Department of Health. In addition to periodic compliance reviews (annual or biennial), these agencies provide ongoing monitoring via complaint and maltreatment investigations involving the providers they license. Corrective actions and other sanctions may be imposed when deficiencies are identified. Requisite provider and staff training is reviewed and verified as a condition of licensure for certain waiver service provider types.

New MHCP providers will be required to take training that has been developed by the department.

Disability or Aging Services Division - The Disability or Aging Services Division receives complaints from lead agency case managers of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The division may independently, through the department's enrollment area, or with the affected lead agency(ies) seek to remedy the situation with the provider.

Certification - The Department certifies Support Planners ~~and Fiscal Support Entities (FE)~~ for Consumer Directed Community Supports service. Initial ~~FE~~ certification requires ~~verification of provider standards being met and~~ successful completion of ~~initial review~~ test requirements prior to providing services. ~~FE recertification reviews are conducted as determined by the department.~~ Support planners must verify training requirements are met (if applicable) and pass the Department's recertification test every two years.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

MMIS edits ensure that only enrolled providers can be authorized to provide services, and must remain actively enrolled throughout any authorization and claiming dates. The enhanced waiver provider qualification review process underway statewide for all waiver providers will augment current MMIS editing at the service authorization and claims payment level. The enhanced review provides additional assurances at the provider enrollment level.

When enrolled Financial Management Services (FMS) providers are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The FMS provider must submit evidence of remediation depending on the nature, severity, and/or chronicity of the violation, the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;
- Limiting a provider's ability to receive payment;
- Suspending or terminating the provider's enrollment; or
- Terminating the contract with the State.

When a participant's Support Planner is found to be out of compliance with applicable requirements, the Department may deny recertification unless/until remediation is made. Depending on the nature, severity, and/or chronicity of the violation, certification may be revoked.

5. Appendix E: Participant Direction of Services – E-1: Overview (1 of 13)

- Changes the scope of fiscal services an FMS provider will offer
- Clarifies that the agreement between the FMS provider and the participant does not determine who the employer of record and managing employer are. FMS providers will not offer an agency model
- Changes Flexible Case Manager to Support Planner to align with the rest of the waiver plan

Appendix E: Participant Direction of Services – E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Enrollees have had the option to self-direct their waiver services through the Consumer "Directed Community Supports (CDCS) service since 2004. Approximately 362 enrollees in state FY12, including those who receive waiver services through managed care, elected this option for their waiver services.

CDCS allows enrollees to design an individualized set of supports to meet their needs. The service includes four categories of supports: personal assistance; treatment and training; environmental modifications and provisions; and, self-direction support activities. Enrollees choose the level of support they want to assist them in developing care plans, monitoring services, and managing budgets and payments. This model provides more opportunity to individually tailor and arrange staffing compared to allowing an enrollee to self-direct a specific waiver service. The participants or their representatives ~~may~~ purchase assistance with these functions through a financial management services (FMS) provider ~~fiscal support entity (FE).~~ FMS providers ~~FEs~~ offer ~~a range of~~ supports as defined in the agreement between the FMS and the participant; the contract with the State; and provider enrollment standards. ~~The agreement between the FE and the participant determines who the employer of record and managing employer are.~~ The employer of record must be identified and documented in the participant's CDCS community support plan. ~~Certified~~ Support planners may also provide assistance with employee-related functions as defined in the service ~~provider~~ standards. ~~Certified~~ Support planners shall not be the employer of record ~~with the exception of those operating within section 305 of the Internal Revenue Code under revenue procedure 80-4 and IRS notice 2003-70 related to government entities~~.

Participants or their representatives have control over the goods and services to be provided through development of the community support plan, selection of vendors, verification of service delivery, evaluation of the provision of the service, and management of the CDCS budget. The individual budget maximum amount is set by the state by case mix cap and is published annually. The participant or their representative will direct the development and revision of the CDCS community support plan and delivery of the CDCS services. The CDCS support plan must be developed through a person-centered process that reflects the participant's strengths, needs and preferences. The plan may include a mix of paid and non-paid services. The plan must define all allowable goods and services that will be paid through CDCS. In a

12-month service agreement period, the participant's individual budget 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 background studies. Case management is separated into lead agency activities that are required to be performed by a lead agency for all waiver participants and other activities that individuals can elect to be performed by ~~Certified~~ Support Planner to assist them with self-direction of their services and those that are flexible. Required case management functions are provided by lead agencies and are not included in the participant's budget. Required case management activities cannot be completed by the ~~Certified~~ Support Planner. ~~Certified~~ Support planner service is included in the budget. Services to be provided by a ~~Certified~~ Support Planner must be specified in the CDCS community support plan as designed by the consumer.

~~Certified~~ Support Planner Direct Support Functions (included in the participant's CDCS budget):

1. If the consumer elects waiver services, provide information about CDCS and provider options.
2. Facilitate the development of a person-centered community support plan.
3. Monitor and assist with revisions to the CDCS community support plan.
4. Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.
5. Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.).
6. Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers.
7. Provide staff training that is specific to the consumer's CDCS community support plan.

There is no difference between managed care and FFS for the CDCS care plan development, plan approval, lead agency or ~~Certified~~ Support Planner assistance and support provided or the ~~FE~~ FMS function.

6. Appendix E: Participant Direction of Services – E-1: Overview (3 of 13)

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan

Appendix E: Participant Direction of Services – E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy ***(select one):***

_Waiver is designed to support only individuals who want to direct their services.
_The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
X The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria:

Participants are not eligible for CDCS if they or their representative have at any time been assigned to the Minnesota Restricted Recipient program. ~~CDCS services are not available to waiver participants~~ People receiving licensed foster care or home care services while residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment with MDH are not eligible for CDCS.

7. Appendix E: Participant Direction of Services – E-1: Overview (4 of 13)

- Deletes certified FE's and adds enrolled FMS providers

Appendix E: Participant Direction of Services – E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Waiver participants are given information about participant-directed options at assessment and during care planning regarding their choice of CDCS services. ~~There is a brochure entitled "You Decide. Your Help." that is available for case managers to provide to consumers, as well as a video of the same name that is used for both case managers and consumers. The video is available on the DHS website. Both the brochure and the video provide information about the benefits, responsibilities and liabilities of self-direction.~~ The lead agency case manager provides the participant with information regarding benefits, responsibilities and liabilities of self-direction so the participant can make an informed choice.

The lead agency is charged with providing information and consumer education about the goods and services that may be purchased under CDCS; information that helps consumers understand their roles and responsibilities; information about resources, tools and technical assistance; information about ~~certified FEs~~ enrolled financial management services (FMS) providers that are available to the participant; and information about the qualifications and activities of a support planner. This is all done before and/or during community support plan development

8. Appendix E: Participant Direction of Services – E-1: Overview (7 of 13)

- Clarifies that governmental entities will not be used as a third party entity

Appendix E: Participant Direction of Services – E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant.

***Select one*:**

● **Yes. Financial Management Services are furnished through a third party entity**. *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ Governmental entities
☑ Private entities

9. Appendix E: Participant Direction of Services – E-1: Overview (8 of 13)

- Updates FMS oversight

Appendix E: Participant Direction of Services – E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity**. *Select one*:**

● **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Consumer-directed community-supports: self-direction support activities

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

See Appendix C, Consumer Directed Community Supports: self-direction support activities.

The fees are negotiated between the participant and the ~~FE~~ FMS Provider and documented in the CDCS community support plan. The ~~FE~~ FMS Provider must have a written agreement with the recipient that identifies the duties ~~and~~ responsibilities, ~~to be performed~~ and the related charges. ~~FE~~ FMS 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 FMS Providers ~~FEs~~ must establish and make public the maximum rate(s) for their services. The scope of ~~FSE~~ FMS services to be provided to an individual must be determined by the consumer, and documented in the person's CDCS community support plan. The rate for these services is negotiated between the recipient or the recipient's representative and the FMS provider ~~FSE~~ and is included in the CDCS Community Support Plan.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

These services are included in the global CDCS budget, under the category of consumer-directed community supports: self-direction support activities

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ Assist participant in verifying support worker citizenship status
☑ Collect and process timesheets of support workers
☑ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
☐ Other

Supports furnished when the participant exercises budget authority:

☑ Maintain a separate account for each participant's participant-directed budget
☑ Track and report participant funds, disbursements and the balance of participant funds
☑ Process and pay invoices for goods and services approved in the service plan
☑ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
☐ Other services and supports

Additional functions/activities:

☑ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
☑ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
☑ Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐ Other

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Oversight is achieved through ~~the~~ a readiness review ~~and certification process, the community support~~

~~planning process, and the FE recertification~~ process prior to enrollment and a performance review every three years. Entities completing the readiness and performance reviews have previously performed a VF/EA readiness review for a vendor that has an agreement (including subcontract) with a government entity to provide services under a Medicaid or another federally funded health care program. ~~Initially the State required FE recertification every 2 years, but it now occurs between 3 and 4 years, unless an earlier review is indicated.~~

10. Appendix E: Participant Direction of Services – E-1: Overview (9 of 13)

- Removes flexible case manager and adds CDCS support planner

Appendix E: Participant Direction of Services – E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested ***(check each that applies)*:**

☑ Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

This section delineates and distinguishes those mandatory functions of the lead agency (required case management), and those optional functions that are covered under CDCS: self-direction support activities, under the subcategory of ~~flexible case management~~ support planning.

Required lead agency functions that are not included within the CDCS budget:

- Determine if individuals are MA eligible (financial assistance unit)
- Assess to determine if the individual is eligible for waiver services including level of care requirements
- Provide the participant with information regarding HCBS alternatives to make an informed choice
- If the consumer elects CDCS, provide them with their maximum case mix budget amount
- Provide CDCS participants with resources and informational tool kits to assist them in managing the service
- Determine whether the participant's CDCS community support plan and the ~~CDCS support plan~~ will reasonably ensure health and safety needs are expected to be met. - Determine if the plan is appropriate, including that the goods and services meet the service description and provider qualifications, rates are appropriate, etc.
- Review the service plan and MMIS service agreement, review rates, and set limits by service category
- Authorize waiver services (prior authorize the MMIS agreement) for FFS participants. MCOs perform authorizations in their own systems
- 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. This includes taking action as a mandated reporter when required to address exploitation of a participant according to the Vulnerable Adult and Maltreatment of Minors Acts.
- At a minimum, review the consumer's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter (monitoring requirements are increased when the provider is the parent of a minor participant or spouse of a participant).
- Monitor the maintenance of financial records, and the management of the budget and services
- Provide technical assistance regarding budget and fiscal records management and take corrective action if needed
- Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction
- Assist the state agency in completing satisfaction measurements as requested
- Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested

Optional, direct support functions (~~flexible case management~~) support planner) that are included in the CDCS budget:

- If the consumer elects waiver services, provide information about CDCS and provider options
- Facilitate development of a person centered CDCS community support plan
- Monitor and assist with revisions to the CDCS 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.)
- Provide staff training that is specific to the participant's CDCS community support plan.

People who are paid through CDCS to assist with the development of the enrollees person centered community support plan must:

-be 18 years of age or older
-pass a ~~certification~~ test developed by the department on person-centered support planning approaches, including the Vulnerable Adult Act
~~-Provide a copy of their training certificate to the enrollee~~
-use the community support plan template or community support plan format that includes all the required information to authorize CDCS

11. Appendix E: Participant Direction of Services – E-1: Overview (12 of 13)

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan

Appendix E: Participant Direction of Services – E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The case manager will initiate a revision of the community support plan in order to provide waiver services other than CDCS. CDCS services are not available to an individual or representative who has at any time been restricted by the Minnesota Restricted Recipient Program (MRRP). Also, if a CDCS participant exits with the waiver more than once during a service plan year, the participant is ineligible for CDCS services for the remainder of that service plan year. Finally, a participant can become ineligible for CDCS services ~~by moving to~~ if they move to and receive licensed foster care or home care services in a residential setting licensed by DHS or MDH, ~~because CDCS services are not available to residents at these sites.~~ or a registered housing with services establishment. In these situations, the full array of traditional waiver services is available to the participant, and the lead agency case manager is responsible for revision of the ~~care~~ community support plan and arranging for waiver services. There are no gaps in service availability during the transition.

12. Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (1 of 6)

- Removes co-employment as an option since the FMS providers will not offer agency services

Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

~~☑~~ ☐ Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

~~The Fiscal Entity serves as the co-employer.~~

☑ Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer

Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ Recruit staff
~~☑~~ ☐ Refer staff to agency for hiring (co-employer)
☑ Select staff from worker registry
☑ Hire staff common law employer
☑ Verify staff qualifications
☑ Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Background checks are paid outside of the participant's CDCS budget.

☑ Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.
☑ Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
☑ Determine staff wages and benefits subject to State limits
☑ Schedule staff
☑ Orient and instruct staff in duties
☑ Supervise staff
☑ Evaluate staff performance
☑ Verify time worked by staff and approve time sheets
☑ Discharge staff (common law employer)
~~☑~~ ☐ Discharge staff from providing services (co-employer)
☐ Other

13. Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction

- Changes flexible case management to CDCS support planning services

Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of

the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participant Budgets. The individual budget maximum amount is set by the state based on the participant's case mix budget cap. Required case management and mandatory background studies are outside of the CDCS budgets. CDCS support planning services are included in the budget. ~~These~~ Limits may be adjusted annually based on adjustments authorized by the legislature. The case mix budget limits are published annually. The lead agency is responsible to review and approve final spending decisions as delineated in the participant's community support plan. The individual budget caps can be found at Long-Term Services and Supports Service Rate Limits.DHS-3945. The individual CDCS budget caps can be found at Long-Term Services and Supports Service Rate Limits.DHS-3945

An individual's budget is based on the assessed need for services in the community support plan. Goods and services are priced within the maximum budget amounts. Enrollees are given choice of goods and services that are assessed within their budget limits. When a CDCS participant experiences a significant change in need, the lead agency may authorize a budget change for that CDCS participant based on the results of the assessment.

Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant directed budget and the procedures by which the amount of the participant directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The lead agency case manager/care coordinator informs each participant of their budget amount based on their assessed need and resulting case mix budget cap.

Individuals in both CDCS and traditional waiver services can always contact their case manager/care coordinator to discuss changes in needs or concerns about their service plan. For CDCS individuals, ~~flexible case managers~~ support planners can also review the adequacy of the CDCS support plan with the individual. If an individual has remaining resources under their current budget cap, the service plan can be amended. If the change in need warrants a change in case mix classification, the budget amount would be changed and a revised service plan would be developed, with approval by the lead agency of the participant's revisions. An individual can change their plan under circumstances without lead agency approval as described in Appendix E.

14. Appendix D: Participant-Centered Planning and Service Delivery– D-1: Service Plan Development (4 of 8)

- Corrects language

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

Case managers must monitor each enrollee's community support plan and service provision at least annually. Person-centered planning requirements include that the case manager specify the frequency of monitoring and evaluation activities in the enrollee's community support plan. The amount and frequency is based on the enrollee's assessed needs, and other factors that may affect the type, amount and frequency of monitoring e.g., the availability of caregivers who are not paid, unstable medical conditions, etc. Under the consumer-directed community supports service option, enrollees determine their own quality management and monitoring plan, and individuals, such as ~~a flexible~~ case managers, are responsible to carry out those monitoring activities. If a provider fails to carry out their responsibilities as identified in the participant's community support plan or develop an individual service plan when needed, the case manager shall notify the provider and, as necessary, the

interdisciplinary team. If the concerns are not resolved by the provider or interdisciplinary team, the case manager shall notify the participant, the appropriate licensing and certification agencies, and the Disability or Aging and Adult Services division for persistent performance concerns and patterns with non-licensed waiver service providers. The case manager shall identify other steps needed to assure that the participant receives the needed services and protections.

15. Appendix G: Participant Safeguards – G-1: Response to Critical Events or Incidents

- Removes obsolete form and inserts replacement

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Providers who furnish home care services are required to provide their clients with a copy of the Home Care Bill of Rights and information about how to report maltreatment concerns. The Bill of Rights is provided to waiver enrollees who receive services through a home health care agency. This includes enrollees who receive customized living services. Routine licensing reviews of providers include monitoring that enrollees are informed of their rights as required. The Home Care Bill of Rights, including copies in other languages, can be accessed http://www.health.state.mn.us/divs/fpc/consumerinfo/index.html- http://www.health.state.mn.us/divs/fpc/consumerinfo/mn_hcbor_eng_reg.pdf

The department provides training to counties, tribes and MCOs regarding vulnerable adult reporting, triage, and follow-up, including training for waiver case managers. The department offers an online training course on Vulnerable Adult Mandated Reporting, at http://registrations.dhs.state.mn.us/WebManRpt and publishes a vulnerable adult brochure ~~"Help protect people who are frail or vulnerable" (DHS-2754).~~ "Minnesota Adult Abuse Reporting Center" (DHS 6778E). The brochure includes information about what may be considered abuse, neglect, and exploitation, and how to report concerns. The department publishes a handbook for enrollees and families, "Older Minnesotans, Know Your Rights About Services," DHS form 4134. The handbook includes information about enrollees' rights to "be safe and free from harm," including how to report a concern and information about advocacy assistance. The brochures and more information regarding vulnerable adult protections are available on the department's web site and the DHS Adult Protection Resource Page – https://mn.gov/dhs/people-we-serve/seniors/services/adult-protection/resources/. The brochures are also available through lead agencies, who provide copies during waiver screenings. All DHS forms, including consumer products, can be found at http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

The Long Term Care Consultation tool assessment used to determine waiver eligibility (DHS 3428) contains assessment questions intended to help discover any risk for maltreatment the applicant maybe experiencing. An assessor is required to forward to the CEP reports of any alleged maltreatment by an informal caregiver or by a service provider. Actions taken would follow those outlined above related to the CEP and next steps related to investigation and the provision of protective services.

The Senior and Disability Linkage Lines (SLL and DLL) are widely publicized public resources that include information on vulnerable adults and how to report maltreatment. These resources are operated by the department and other partners and include toll free phone numbers and a searchable web database. Information about this resource is also provided during assessment. Information about the SLL and DLL can be seen at: - http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_00545; and- http://www.dhs.state.mn.us/main/id_056508 respectively, the SLL website and MinnesotaHelp.info website on services for people with disabilities.

16. Appendix B: Participant Access and Eligibility – B-7: Freedom of Choice

- Removes obsolete form and inserts replacement

a. Procedures Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The department publishes a pamphlet titled "Older Minnesotans- Know Your Rights About Services" (DHS form 4134). The pamphlet includes information about eligibility screening, service options, fair hearing rights, vulnerable adult protections, etc. For managed care enrollees, similar information is included in the MCO's certificate of coverage (COC). Managed care enrollees receive a COC each year. The department's website also provides information about service options and rights. See DHS website on services for seniors.

~~http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=Aging~~

Lead agency staff who conduct LTCC assessments and case managers are required to provide enrollees choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. To acknowledge that choice was offered, enrollees sign Long Term Care Consultation Community Support Plan, DHS form ~~2925~~ 6791 and the Community Support Plan, DHS form 4166.

There is also a field on the MMIS screening document that asks the case manager if the individual was given choice between waiver services and the institutional placement and choice of providers for waiver services. MMIS edits prohibit a screening document from being authorized when a case manager indicates in this field that choice was not provided or if the field is left unanswered. In addition, the enrollee's care plan form includes a signature section that asks whether the enrollee was provided choice between institutional and community-based services and among waiver services and service providers. Refer to DHS form ~~2925~~ 6791 and 4166. All forms are available at Searchable document library (eDocs) ~~http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp~~

17. Appendix B: Participant Access and Eligibility – B-8: Access to Services by Limited English Proficiency Persons

- Removes obsolete form and inserts replacement

Community Support Plan forms (DHS ~~2925~~ 6791 or 4166) also provide information in ten languages about how to obtain assistance with translation. All forms now state, "if you need ~~want~~ free help in interpreting ~~translating~~ this information ask your worker or call the above number for your language." This statement is provided in ten languages

18. Appendix D: Participant-Centered Planning and Service Delivery– D-1: Service Plan Development

- Removes obsolete form and inserts replacement

The care plan format published by the department and used by long term care consultant/case managers reflects person-centered planning components. Enrollees are asked to verify, by signature, if they participated in the development of and agree with the care plan, were offered choices between services, and between providers. See more detailed care plan requirements at Minnesota Statutes, section 245B.0915, subdivisions 6 and 8 at https://www.revisor.mn.gov/statutes/?id=256B.0915. See also care plan forms DHS 6791 ~~2925 (an open-ended care planning format~~) and DHS 4166 (a format that can be populated with the LTCC assessment data) at Searchable document library (eDocs) ~~http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp~~