February 9, 2004

Consumer Directed Community Supports

This document includes the proposed CDCS service description and provider standards that have been incorporated into each of Minnesota's home and community-based waiver plans. Each waiver plan has nuances and formatting differences. There are also slight differences in the amendment as it applies to each waiver (e.g., habilitation is used in MR/RC but not the other waivers, MnDHO references only apply to TBI and CADI). The EW amendment will be essentially the same as the DSD waivers. References to MnDHO will be shifted to MSHO and references to paying parents and county allocations will not be included, etc. Other differences between the waiver plans are noted in this document.

Service Description, Appendix B1

[applicable to ALL waivers -- CAC and MR/RC will not include the MnDHO references] Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver including alternatives that support recipients. Four categories of CDCS are covered: personal assistance; treatment and training; environmental modifications and provisions; and, self direction support activities. Refer to Attachment A of this Appendix for definitions and service examples. Recipients or their representative hire, fire, manage and direct their support workers. The recipients or their representative may purchase assistance with these functions through a fiscal sector support entity (FE).

FEs offer a range of supports as defined in the provider standards. The agreement between the FE and the recipient determines who is the employer of record and managing employer. The employer of record must be identified and documented in the recipient's community support plan. Flexible case managers may also provide assistance with employee related functions as defined in the provider standards. Flexible case managers cannot be the employer of record.

Recipients 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 Disability Health Options (MnDHO) enrollees, by the health plan or health plan's designee.

CDCS may be used to pay parents of minor recipients or spouses of recipients for personal assistance services provided as defined in Attachment A of this Appendix. Parents of minors and spouses must meet the provider qualifications in Appendix B2.

Individuals are not eligible for CDCS if they or their representative have at any time been assigned to the Health Care Designated Providers program.

People living in licensed foster care settings, settings licensed by DHS or MDH, or registered as a housing with services establishment with MDH are not eligible for CDCS.

Community Support Plan. The recipient or their representative will direct the development and revision of their community support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the individuals 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 recipient or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

[MR/RC only]
The community support plan must include a habilitative component as defined in the waiver plan.

[ALL]
The community support plan identifies: the goods and services that will be provided to meet the recipient's needs; safeguards to reasonably maintain the recipient's health and welfare; and, how emergency needs of the recipient 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 community support plan will specify provider qualifications including training requirements (if they exceed the provider standards in Appendix B2). The community support plan will also specify who is responsible to assure that the qualification and training requirements are met and whether or not a criminal background study will be required for each service. If a criminal background study is required, the standards outlined in Minnesota Statutes 245C, Department of Human Services Licensing Act must be applied to determine if the person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

[CADI, MR/RC, TBI, CAC -- CAC and MR/RC will not include the MnDHO references]
The cost of background studies is not included in the individual budget amount but will be covered as a service expense through the counties' waiver allocations. For MnDHO recipients, the cost will be covered as a service expense through the health plan.

[EW only]
For recipients who are not enrolled in MSHO, 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 recipients, the cost will be covered as a service expense through the health plan.

[ALL -- CAC and MR/RC will not include the MnDHO references]
The recipient or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the local agency or for MnDHO enrollees, the health plan or health plan's designee when the revision does not change or modify what was

authorized by the case manager, or for MnDHO enrollees, the health plan or the health plan designee. If a revision results in a change or modification of the approved community support plan, the recipient or their representative will work with the local county agency or for MnDHO enrollees, the health plan or health plan's designee to have the community support plan reviewed and re-authorized.

[ALL, CAC and MR/RC will not include the MnDHO references]
Recipient Budgets. The individual budget maximum amount is set by the state or for MnDHO enrollees, the health plan or the health plan's designee. For recipients who are not enrolled in MnDHO, the local county agency is responsible to review and approve final spending decisions as delineated in the recipient's community support plan. For MnDHO enrollees, the health plan or the health plan's designee develops the enrollee's individual budget maximum amount and reviews and approves the final spending decisions as delineated in the recipient's community support plan.

[ALL]
In a 12 month service agreement period, the recipient'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 activities that are required and those that are flexible. Refer to Attachment B for examples of each. Required case management functions are provided by county agencies and are not included in recipient's budgets. Flexible case management supports are included in the budget.

[CADI, CAC, TBI, – MR/RC will be slightly different because it includes assistive technology as a distinct service category]
If the combined costs of environmental modifications and assistive technology (as defined within supplies and equipment), during a 12 month service agreement period, exceed $5000 and cannot be covered within a recipient's individual budget, the recipient may request additional funding from the county or, for MnDHO enrollees, from the health plan to pay for these items.

[ALL -- CAC and MR/RC will not include the MnDHO references]
Case managers must apply the criteria for allowable expenditures (Attachment C) to all CDCS services, supports, and items to determine if the service, support, or item can be authorized in the community support plan. If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures (listed in Attachment C), it cannot be authorized and the case manager must provide the recipient or the recipient's representative notice of appeal rights. For MnDHO enrollees, these functions are the responsibility of the care coordinator or health plan representative.

Budgets may include: (1) Goods or services that augment State plan services, provide alternatives to waiver or State plan services. The rates for these goods and services are

negotiated and included in the 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 and behavioral supports that mitigate the recipient's disability when they are not covered by the State plan and are prescribed by a physician that is. (4) Expenses related to the development and implementation of the community support plan will be included in the budget. This is referred to as flexible case management functions in Attachment B of this Appendix. This may include but is not limited to assistance in determining what will best meet the recipient's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The recipient chooses who will provide the service and how much will be included in the community support plan. This support may be provided via care coordination (or case management) through the local county agency or by another entity. For MnDHO enrollees who choose to have additional support beyond the health coordinator for development and implementation of the community support plan, this expense will be included in the individual budget. (5) Costs incurred to manage the budget; advertise and train staff; pay employer fees (FICA, FUTA, SUTA, and workers compensation, unemployment and liability insurance) as well as employer share of employee benefits, and retention incentives (i.e., bonus, health insurance, paid time off).

[EW]
(6) Environmental modifications up to the amount allowed in the waiver plan per service agreement year. This amount includes all environmental modifications to be paid for by the waiver per service agreement year. This amount is $4634.00 for state fiscal year 2004.

Individual Budgeting.

[ALL -- CAC and MR/RC will not include MnDHO]
Local agencies, or for MnDHO enrollees the health plan or the health plan's designee, will inform the recipient prior to the development of the community support plan of the amount that will be available to the recipient for implementing the support plan over a one year period.

[ALL but is in the budget description for EW]
The recipients' CDCS service authorization cannot exceed three month periods. The recipient may not carry forward unspent budgeted amounts from one plan year to the next.

[CADI, CAC, TBI, MR/RC – not applicable to MnDHO]
For recipients who are not enrolled in MnDHO, the individual budget limit (i.e., maximum spending amount) established for CDCS recipients shall not exceed 70% or the statewide average cost of non-CDCS recipients with comparable conditions and service needs as determined by the commissioner, using state fiscal year 2002 service payment information, minus 50% of the case management payments for recipients with comparable conditions and service needs. For subsequent years, the budget shall be adjusted based on rate or other

adjustments authorized by the legislature. The individual budget limit includes the costs of waiver and State plan home care services.

[CADI, TBI, CAC, MR/RC (EW is managed through case mix)]
When a CDCS recipient experiences a significant change in need, the commissioner may authorized a budget change for that CDCS recipient based on the results of the assessment. For MnDHO enrollees, the health plan or the health plan's designee may authorize a budget change.

[CADI, CAC, TBI, MR/RC]
If a CDCS recipient exits the waiver more than once during the recipient's service plan year, the recipient is ineligible for CDCS for the remainder of their service plan year. For MnDHO, enrollees, if a CDCS recipient exits the waiver during the recipient's service plan year, the health plan or the health plan's designee may prorate the individual budget based on the remainder of the recipient's service plan year.

[MR/RC]
Recipients, who have CDCS services authorized at the time this amendment is approved and whose service spending exceeds the individual budget limits established by this amendment, shall have up to twelve months from the date of their next annual review to comply with the individual budget limits in this amendment. If they do not comply with the individual budget limits, they cannot continue to receive CDCS services but may elect to use other home and community-based waiver services. The compliance date for this provision is not affected by any extension of the date of the annual review. In no case shall the time period exceed 24 months. A CDCS recipient whose spending exceeds the limit established by this amendment is not eligible for any increase in their CDCS budget.

[TBI and CADI]
For MnDHO enrollees, the individual budget is developed by the health plan or the health plan's designee based on the enrollee's historical, current home and community-based service needs, and available resources. Costs related to required case management and criminal background studies are excluded from the budget. The health plan or the health plan's designee (usually the health coordinator) is responsible for the health coordination / case management functions and establishing a payment level. This includes working with the recipient to establish a budget. Recipients or their representatives have the right to select and work with providers in their health plan's network. To use an out of network provider, recipients must follow procedures delineated in the health plan's *Certificate of Coverage.*

[CADI and TBI, MnDHO and EW, MSHO]
The individual limits for MnDHO enrollees shall not exceed the individual budget limits for

recipients who are not enrolled in MnDHO, unless authorized by the health plan or the health plan's designee.

[CADI, MR/RC, TBI, CAC]

For recipients who are not enrolled in MnDHO, expenses covered outside of the individual budget, must be managed within the local agency's allowable waiver budget. These supports whether included in the individual budget or not must be identified on the community support plan.

[EW]
Individual budgets may not exceed the length of the recipient's 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. The recipient's CDCS service authorization cannot exceed three month periods and the recipient shall not carry forward unspent budget amounts from one plan year to the next. If a recipient 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 county case manager or for MSHO enrollees, the health plan or the health plan designee.

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 on the community support plan.

For recipients who are not enrolled in MSHO, the recipient's individual maximum budget amount for CDCS will be the average value of State plan home care and waiver services provided to non-CDCS recipients during the calendar year prior to the beginning of the state fiscal year in which the budget will be applied. When establishing the budgets, the total waiver and home care costs for people who are not eligible for CDCS will be excluded from the budget methodology. Budgets will be adjusted by case mix and may be adjusted by the department based on inflationary increases or other cost changes authorized in law.

For MSHO enrollees, the individual budget is developed by the health plan or the health plan's designee based on the enrollee's historical costs, current home and community-based service needs, and available resources. When establishing the budgets, the total waiver and home care costs for people who are not eligible for CDCS will be excluded from the budget methodology. The health plan or the health plan's designee (usually the health coordinator) is responsible for the health coordination or case management functions and establishing a payment level. This includes working with the waiver recipient to establish a budget. Waiver recipients or their representatives have the right to select and work with providers in their health plan's network. To use an out of network provider, recipients must follow procedures delineated in the health plan's *Certificate of Coverage*.

[ALL, unless otherwise noted -- CAC and MR/RC will not include MnDHO]
Required Case Management. The local agency, or for MnDHO enrollees, the health plan or the health plan's designee are responsible to: (1) Review and approve the community support plan if it meets the criteria in Attachment C. All goods and services to be covered by CDCS must be

specified in the community support plan and prior authorized by the county case manager. There must be a clear audit trail. (2) **[CADI, CAC, MR/RC, and TBI – not EW]** Evaluate requests for environmental modification and assistive technology that in combination exceed $5000 and cannot be otherwise covered within the recipient's individual budget. The county of financial responsibility may authorize additional funding if the county determines that the cost can be managed within the county's overall budget allocation. For MnDHO enrollees, the health plan or their designee determine if additional funds will be made available. (3) Monitor and evaluate the implementation of the community support plan. This includes reviewing that health and safety needs are being adequately met, the recipient's level of satisfaction, the adequacy of the current plan and the possible need for revisions, the maintenance of financial records, and the management of the budget and services. (4) Review each recipient's CDCS expenditures, at a minimum, within three months, six months, and twelve months of the community support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved community support plan. (5) Review expenditures and the recipient's health, safety, and welfare at least once per quarter when a parent of a minor recipient or spouse of a recipient is being paid through CDCS. (6) Provide additional technical assistance and support to the recipient or their representative, or authorized representative if it is determined that the recipient or their representative has not followed the authorized community support plan. This may include a corrective action plan. If efforts to resolve problems in using CDCS are unsuccessful, the CDCS authorization will be discontinued after providing the required notification. The recipient's community support plan will return to traditional waiver or State plan services. (7) Provide notice, and suspend CDCS services if there are immediate concerns regarding the recipients' health and safety or misuse or abuse of public funds and report the concern to the appropriate local or state agency for investigation. The notice will include fair hearing rights and inform recipients that their CDCS services are being suspended pending the outcome of the hearing. The recipients' community support plan will return to traditional waiver or State plan services pending the outcome of the hearing. (8) Provide or arrange for the provision of information and/or tools for recipients or their representatives to direct and manage goods and services provided through CDCS. This will include information or assistance in locating, selecting, training, and managing workers as well as completing, retaining, and submitting paperwork associated with billing, payment and taxes and monitoring on-going budget expenditures. (9) Obtain and make available on a semiannual basis the following information to the state agency: Results of annual CDCS recipient satisfaction surveys conducted during that quarter (a standardized form will be provided by the state agency); the number of waiver recipients who exited CDCS and the reason why; and, results of random sampling of plan and budget reviews.

[ALL, health plan will not be included in CAC or MR/RC]
State Agency Responsibilities. Annually, the state agency will review and analyze the following aggregate information: Results of CDCS reports submitted by the local agency or health plan or the health plan's designee; data showing access and utilization of CDCS by waiver type; number and outcomes of filed and heard CDCS appeals; results of random reviews completed by the state agency.

Provider Standards, Appendix B2

[ALL, CAC and MR/RC will not include MnDHO]
CDCS are divided into four categories: personal assistance; treatment and training; environmental modifications and provisions; and self direction support activities. These categories are used for data and monitoring purposes. Refer to Appendix B1, Attachment A for examples of services and supports included in each category.

CDCS direct care workers and other people or entities providing supports are selected by the recipient. People or entities providing goods or services covered by CDCS must have a written agreement with and bill through the financial sector support entity (FE).

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

People or organizations paid to assist in developing the community support plan (e.g., flexible case managers) must not have any direct or indirect financial interest in the delivery of services in that plan. This does not preclude them from payment for their work in providing 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 or for MnDHO enrollees, health plan representatives. This provision precludes Fiscal Entities (FEs) or their representatives from participating in the development of a community support plan for recipients who are purchasing FE services from them.

1) Personal Assistance
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 recipient or their designee indicating how the qualifications are met.

2) Treatment and Training
For services and supports that require the person or entity providing the service or support to be professionally licensed, credentialed, or otherwise certified to perform the service under state law, the provider must meet all applicable standards. The following service providers are typically covered in this category: therapists, physicians, nurses, and dieticians. The community support plan may identify additional qualifications that the person must meet to provide the service. For services and supports that do not require professional licensing, credentialing, or certification, the community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the recipient or their designee indicating how the qualifications are met.

[MR/RC] For waiver services defined in Appendix B1 and B2 that require licensing under Minnesota Statutes 245.A. 01 to .17 and 245.B, the same standard applies if the service is provided through CDCS. Minnesota Statutes 245.A. 01 to .17 and 245.B do not apply to CDCS services that do not otherwise require licensing.

[CAC, CADI, TBI, and EW] For waiver services defined in Appendix B1 and B2 that require licensing under Minnesota Statutes 245.A.01 to 17, the same standard applies if the service is provided through CDCS. Minnesota Statutes 245.A.01 to 17 do not apply to CDCS services that do not otherwise require licensing.

[ALL]

3) Environmental Modifications and Provisions

The following items are typically covered in this category: home and vehicle modifications and adaptations, supplies and equipment, assistive technology, transportation, chore services, special diets, and adaptive clothing.

Home and Vehicle Modifications. 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 and be inspected by the appropriate building authority.

Transportation. Standards for common carrier transportation are bus, taxicab, other commercial carrier, private automobile; county owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the consumer's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

4) Self Direction Support Activities

This category of service includes two main functions: financial sector support entity (FE) services and flexible case management. Each has defined provider standards. Refer to Appendix B1, Attachment B for examples of flexible case management.

A) Financial Sector Support Entities (FEs)

FEs are the CDCS Medicaid enrolled provider. Counties may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the recipient to select how much autonomy they want in employing, managing, and paying for services, supports, and goods. The FE may not in any way limit or restrict the recipient's choice of service or support providers.

FEs must have a written agreement with the recipient or their representative that identifies the duties and responsibilities to be performed and the related charges. The FE must provide the recipient and county of financial responsibility with a

monthly written summary of what CDCS services were billed including charges from the FE.

FEs must establish and make public the maximum rate(s) for their services. The rate for and scope of FE services is negotiated between the recipient or the recipient's representative and the FE and included in the community support plan. FE rates must be on a fee-for-service basis other than a percentage of the recipients service budget and may not include set up or base rate or other similar charges. Maximum FE rates may be established by the state agency. FEs 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 recipient must disclose in writing the nature of that relationship, and must not develop the recipient's community support plan.

The FE 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 must have current and adequate liability insurance and bonding, sufficient cash flow, and have on staff or by contract a certified public accountant or an individual with a baccalaureate degree in accounting. The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE.

The FE 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 must also receive a copy of the recipients' community support plan approved by the county. Claims submitted by the FE must correspond with services, amounts, time frames, etc. as authorized in the community support plan.

B) Care Plan Support

Flexible case management supports are covered under this CDCS category. Refer to Appendix B1, Attachment B for examples of flexible case management supports. Recipients select who they want to provide this service. People who are paid through CDCS to assist with the development of the recipient's person-centered community support plan must: be 18 years of age or older; successfully pass a training module approved or developed by DHS on person-centered planning approaches including the vulnerable adult or maltreatment of minors act; provide a copy of their training certificate to the recipient; use the 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 case manager to assure that there is no duplication between

functions. Recipients may require additional provider qualifications tailored to their individual needs. These will be defined in the recipient's community support plan. The provider must provide the recipient or their representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

Services and supports provided by a legally responsible individual including biological and adoptive parents of recipients under 18. For a recipient's spouse or parent of a minor recipient to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

- meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;
- be a service/support that is specified in the individual plan of care (community support plan);
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the individual's community support plan;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care attendant (PCA) services;
- NOT be an activity that the family would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation Screening Document*

* The LTC Consultation Screening Document will be used to provide a means to identify activities in which the recipient is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- the family member providing the service must meet the qualification or training standards necessary to perform the service or support which must be described in the individual's community support plan;
- rates paid cannot exceed the amount allowed by the department for personal care attendant (PCA) services;
- a parent/parents in combination or a spouse may not provide more than 40 hours of services in a seven day period. For parents, 40 hours is the total amount regardless of the number of children who receive services under CDCS;
- the family member must maintain and submit time sheets and other required documentation for hours paid;
- married individuals must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.

Monitoring Requirements:

In addition to the already specified requirements for reporting and monitoring when selecting CDCS as an option including the required case management activities outlined in Appendix B1, Attachment B, these additional requirements will apply to consumers electing to use legally responsible family members as paid service providers:

- monthly reviews by the fiscal agent of hours billed for family provided care and the total amounts billed for all goods and services during the month;
- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal agent when billing;
- at least quarterly reviews by the county on the expenditures and the health, safety, and welfare status of the individual recipient;
- face-to-face visits with the recipient by the county on at least a semi annual basis.

Appendix B1
ATTACHMENT A
Minnesota Department of Human Services

CONSUMER DIRECTED COMMUNITY SUPPORTS (CDCS) SERVICE CATEGORIES

Four categories of services and supports may be covered under CDCS: Personal Assistance, Treatment, Environmental Modifications and Provisions, and Self Direction Support Activities. This attachment provides examples of supports and items in each category. The examples are not exclusionary. All categories of service must comply with the CDCS waiver service description and provider standards.

PERSONAL ASSISTANCE

Personal assistance includes a range of direct assistance provided in the consumer's home or community. Consumers determine the provider's 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
Extended transportation

TREATMENT and TRAINING

Treatment includes a range of services that promote the consumer'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
Extended therapy treatment
Habilitative services
Day services/programs
Training and education to paid or unpaid caregivers
Training and education to recipients to increase their ability to manage CDCS services

ENVIRONMENTAL MODIFICATIONS AND PROVISIONS

Environmental modifications and provisions include supports, services, and goods provided to the recipient to maintain a physical environment that assists the person to live

in and participate in the community or are required to maintain health and wellbeing. 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

* Costs exceeding $5,000 may be negotiated with the county of financial responsibility and provided outside of the consumer's individual budget. The county of financial responsibility may authorize additional funding for assistive technology and home and vehicle modifications within the counties overall waiver allocation. This exception does not apply to the Elderly Waiver.

SELF DIRECTION SUPPORT ACTIVITIES

Self-direction support activities include services, supports, and expenses incurred for administering or assisting the consumer 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 community support plan
Monitoring the provision of services

Appendix B1
ATTACHMENT B
Minnesota Department of Human Services

CASE MANAGEMENT FUNCTIONS

The term case management is being used for purposes of common understanding in this document. Case management or other direct support functions provided as a CDCS service are flexible and may be provided by traditional or nontraditional providers.

Direct support functions are **flexible** in terms of who provides them and whether they are covered as a paid service. CDCS consumers must have a care plan that is developed through a person-centered process. Consumers must also manage and monitor their CDCS services. If consumers need assistance with these tasks, support may be purchased through traditional county case management, or provided by private providers, or someone else the consumer may make arrangements with and not pay. If the service is paid for, the cost related to flexible case management tasks are included in the consumer's budget. A nonexclusive list of flexible direct support functions is included in the following table.

There are some case management functions performed by the county that are *not* included in the consumer's CDCS budget. These functions are **required** if a person chooses to use CDCS. A list of many of the required county functions is included in the following table.

REQUIRED	**FLEXIBLE**
COUNTY FUNCTIONS *not included in the consumer's CDCS budget*	**DIRECT SUPPORT FUNCTIONS** *included in the consumer's CDCS budget*
Screen and determine if individuals are MA eligible	If the consumer elects waiver services, provide information about CDCS and provider options
Screen and assess to determine if the individual is eligible for waiver services including level of care requirements	Facilitate development of a person centered community support plan
Provide the consumer with information regarding HCBS alternatives to make an informed choice	Monitor and assist with revisions to the community support plan
If the consumer elects CDCS, provide them with their maximum budget amount	Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers
Provide CDCS consumers with resources and informational tool kits to assist them in managing the service	Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.)
Evaluate that the consumer's health and safety needs are expected to be met given the care plan including provider training and standards	Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers
Evaluate if the plan is appropriate including that the goods and services meet the service description and provider qualifications, rates appear to be appropriate, etc.	Provide staff training that is specific to the consumer's plan of care

Review the service plan and MMIS service agreement, review rates, and set limits by service category	
Authorize waiver services (prior authorized the MMIS service agreement)	
Review and authorized additional funding for environmental modifications or assistive technology exceeding $5,000 and additional quality assurance if it is manageable within the county's overall waiver allocation	
Manage waiver spending within the county's allowable waiver allocation	
Monitor and evaluate the implementation of the community support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions (this includes taking action, when required to address suspected or alleged abuse, neglect, or exploitation of a consumer as a mandated reporter according to the maltreatment of minors or vulnerable adult 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*	
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 vulnerability or misuse of public funds per jurisdiction	
Contract with providers and monitor provider's performance	
Complete satisfaction measurements	
Report satisfaction, utilization, budget, and discharge summary information to the state agency	
Have a system for consumers to contact the local agency on a 24 hour basis in the case of a service emergency or crisis.	

** monitoring requirements are increased when the provider is the parent of a minor or spouse of a consumer.*

Consumer Directed Community Support Service
Criteria for allowable expenditures

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

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

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

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

Allowable Expenditures	**Unallowable expenditures**
Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver as well as alternatives that support recipients. There are four general categories of services which may be billed: • Personal Assistance • Treatment and training • Environmental modifications and provisions • Self direction support activities Additionally, the following goods and services that may also be included in the individual's budgets include as long as they meet the criteria and fit into the above categories: • Goods and services that augment State plan services or provide alternatives to waiver or state plan services • Therapies, special diets and behavioral supports not otherwise available through the State plan that mitigate the individual's disability when prescribed by a physician who is enrolled as a MHCP provider • Expenses related to the development and implementation of the community support plan • Costs incurred to manage the individual's budget	Goods and services that shall not be purchased within the individual's budget are: • Services provided to people living in licensed foster care settings, settings licensed by DHS or MDH, or registered as a housing with services establishment; • Services covered by the State plan, medicare, or other liable third parties including education, home based schooling, and vocational services; • Services, goods or supports provided to or benefiting persons other than the individual; • Any fees incurred by the individual such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies, with the exception of services provided as flexible case management; • Insurance except for insurance costs related to employee coverage; • Room and board and personal items that are not related to the disability; • Home modifications that adds any square footage; • Home modifications for a residence other than the primary residence of the recipient or, in the event of a minor with parents not living together, the primary residences of the parents; • Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers.; • Services provided to or by individuals, representatives, providers or caregivers that have at any time been assigned to the Primary Care Utilization and Review Program • Experimental treatments; • Membership dues or costs; • Vacation expenses other than the cost of direct services; • Vehicle maintenance, does not include maintenance to; modifications related the disability; • Tickets and related costs to attend sporting or other recreational events; • Pets and their related costs; • Costs related to internet access.