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Introduction to CDCS

Consumer directed community supports (CDCS) is a service option available to people on the home and community-based services (HCBS) waiver and Alternative Care (AC) programs. CDCS gives a person flexibility in service planning and responsibility for self-directing his or her services, including hiring and managing support workers. CDCS may include traditional services and goods, and self-designed services.
Section 1: Eligibility for CDCS

This information moved to Eligibility for CDCS in the CDCS Policy Manual.

1.1 Access to CDCS service option is limited for some people

This information moved to Eligibility for CDCS in the CDCS Policy Manual.
Section 2: How CDCS works

This information moved to CDCS process and procedure in the CDCS Policy Manual.
Section 3: Person-centered planning process: The foundation for consumer-directed services

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

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

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

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

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

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

3.1 Person-centered planning features

All person-centered planning approaches share some features in common. The following list of features can be used to provide basic information about what a person-centered planning process might include, and what opportunity and responsibility the person has under person-centered planning:
- The individual chooses the type and extent of person-centered planning activity they want to participate in to develop their CDCS Community Support Plan.
- The individual selects other individuals they want to participate in providing support and assistance in the planning process.
- The individual can select a person to facilitate planning.
- The person chooses the meeting dates, setting, time, place and length of any planning meetings.
- The individual chooses how to start, work through and end any planning meetings, including what he or she wants to get done in a meeting.
- The individual chooses areas of life they want help from other in planning for.
- For some, a life vision, dream or desire forms the foundation for developing their person-centered plan.
- The person-centered planning process is respectful of the individual and builds on strengths and talents of the person to design a plan.
- The individual makes choices and decisions about services and goods.
- The person achieves increased opportunity for control over his or her services under the plan.
- The person makes decisions about his or her living situation, providers, service delivery schedule, daily and vocational activity, level of control and responsibility, level of risk management and back up and emergency plans.

These decisions are reflected in the plan. The individual describes desired results, develops personal outcome indicators to monitor and evaluate the implementation of the service plan and develops the schedule for monitoring.

3.2 Consumer/representative role in person-centered planning process and plan management

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

Initial/annual activities

The following are initial/annual activities performed by the consumer (or their representative) under
CDCS:

- Direct the development and revision of the Community Support Plan.
- Participate in a formal or informal person-centered planning process that addresses individual strengths, needs and preferences, including preferences about the nature of the planning process. The planning process can be informal or formal and can be completed without paying anyone to help develop the plan.
- Choose people to assist them in the person-centered planning process if they wish. This assistance can come from friends or family or can be purchased.
- Partner with the lead agency case manager in the plan development, approval and funding within the CDCS budget amount.
- Choose who will provide direct services, goods or supportive services, and decide how much service will be required to meet identified needs.
- Negotiate payment rates for direct services, goods and supportive services requested under the CDCS budget that are within reasonable range of access to comparable or “like” services within the community, and that do not exceed any state-established rates.
- Develop a plan to monitor service delivery and effectiveness. Outline desired results and a plan to measure achievement of results.
- Submit a plan for lead agency approval. CDCS services cannot begin until the CDCS plan is approved by the lead agency.

**Ongoing activities**

The following are ongoing activities performed by the consumer (or representative) under CDCS:

- Monitor plan implementation and effectiveness, and achievement of desired results.
- Make revisions to the plan as needed and submit back to the lead agency for approval as needed. This includes revisions to back up or emergency plans. See Section 4 regarding revisions to the plan.
- Notify lead agency case manager of significant changes in need, function or condition.

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

**3.3 Consumer resources**

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

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

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

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

3.4 Lead agency role and tasks in person-centered planning process

Information
A person needs information in order to decide if CDCS might be a good option for them. The lead agency must:

- Provide information and consumer education about the combination of allowable goods and services that may be purchased under the consumer-directed community support budget.
- Provide information that helps the consumer understand their roles and responsibilities under consumer-directed services and person-centered planning processes.
- Provide information about resources, tools and technical assistance available.
- Provide information about FMS services available, including those that allow the consumer varied levels of autonomy and control as an employer.
- Provide information about the qualifications for and activities of a flexible case manager.

**Budget amounts**

DHS will make individual CDCS budget information available to lead agency case managers as a monthly amount listed on the Long-Term Care Screening Document for EW and AC (proposed expenditures for CDCS are limited by this monthly amount multiplied by number of months the Service Agreement covers), and as an annual budget for other waivers including CAC, CADI, TBI and DD in the Waiver Management System. The person needs to know how much money will be available for goods and services to begin to sketch out a plan. The lead agency must:

- Inform the consumer of their CDCS and non-CDCS budget(s) available for purchasing services over a one-year period.
- Prorate the amount of money available under either CDCS or non-CDCS if the service plan will cover less than one year.

**Facilitate the person-centered planning process**

The lead agency will also:

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

3.5 Other services that increase flexibility and consumer control

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

Consumer Directed Community Supports, when properly implemented, offers the most flexibility and consumer control in service design, selection of supports and management of individual budgets.

However, some consumers may not want to assume the level of responsibility and control expected under CDCS, but still want more flexibility in designing their services, may want to have more authority to direct their care, or may want more choices in who can provide support or service to them.

PCA Choice, for example, can allow a person to recruit, hire, train and supervise a direct support worker. Under this option, the person receives assistance in developing a service plan and receives fiscal management support from a PCA Choice provider.

Caregiver services and respite options for families of persons age 65 or older include services and flexibility in the provision of these services, and an ability to tailor these services to meet individual caregiver and recipient needs.

In addition, quasi-formal and informal support networks exist in many communities that can offer very individualized service provided by volunteer or paid staff support. These services can be very flexible and include social service and nursing services such as Living At Home Block Nurse Programs and respite. Agencies such as the Area Agency on Aging (AAA) or Centers for Independent Living may link consumers and families with a variety of non-paid help available from volunteers or from faith-based communities, for example. For more information about collaborations between AAAs and the communities they serve designed to increase availability of these kinds of supports contact the local AAA. The Senior LinkAge Line® is also available to answer questions and provide links to resources to families and their caregivers.

These quasi-formal community based supports can offer individualized service and support from non-traditional “providers” and can be an important component of a Community Support Plan for CDCS as well as non-CDCS consumers.
3.6 Tools and resources to support the person-centered planning process

Planning tools and resources can assist the person in designing a meaningful person-centered plan. The lead agency will provide information about the availability of these tools and resources. Refer to Appendix A: Resources for Person-Centered Planning.

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

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

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

“Support Plan Components” are outlined in Section 4, as are criteria for lead agency approval of a consumer-designed CDCS support plan.
Appendix A: CDCS Flexible Case Management Plan Development Notification Tool

Consumer Name:
Date of Birth:
PMI #:

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

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

Estimated cost of plan development: _________________________________

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

Flexible Case Manager: _________________________________
Signature: _________________________________
Date: _________________________________

Consumer: _________________________________
Signature: _________________________________
Date: _________________________________

Legal representative (if applicable): _________________________________
Signature: _________________________________
Date: _________________________________

Note: This tool is not a contract; it is an optional tool.
Section 4: CDCS community support plan (CSP) requirements

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

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

4.1 Community support plan formats – (DHS 2925, 4166 or 4556)

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

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

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

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

4.2 CDCS requirements of a person-centered community support plan

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

- A description of all services and goods that will be purchased under the individual’s CDCS budget cap, including payment rates for each service or good, and staff, if known
- Informal or quasi-formal supports that are part of an ongoing, predictable, reliable method to meet identified needs
- Schedule of services (how often, for how long)
- Proposed allocation of CDCS dollars between the four categories of CDCS services identified in Section 5.3 and more fully described in Section 6
- Choice of FMS provider option, including tasks, schedule, and fees
- Outline of plan to monitor plan implementation and effectiveness of services/supports, including desired results or outcomes, the schedule of monitoring activity, how progress will be measured, and who will perform monitoring activity
- Specific provider qualifications, including training requirements, established by the consumer
- Identification of the person(s) responsible to ensure that provider qualifications and training requirements are met, including who will perform background studies
- Individualized Flexible Case Management plan, as proposed by the consumer, including tasks, schedule and fees
- As noted in 4.1, health and safety needs are addressed, including backup and emergency plans, and personal risk management plans, if applicable.

4.3 CDCS budget amount on the plan

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

The lead agency professional conducting the LTCC or DD assessment process will inform the consumer of their available budget amount and non-CDCS service cap amount as part of the information about CDCS services options presented to them when they are determined to be eligible for Home and Community-Based Services (HCBS), or at reassessment.
This budget amount must be included on the plan in order for the consumer and the lead agency case manager to evaluate cost effectiveness, and the likely success of the proposed plan.

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

See Section 13 for more information about budgets and authorization processes for people age 65 and older, and Section 15 for information about budgets and authorizations under MSHO. Information about budgets and authorizations for people under 65 is found in Section 14.

**Reassessment**

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

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

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

### 4.4 Applying quality considerations to the CDCS community support plan

**Program requirements**

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

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

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

**Personal outcomes**

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

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

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

**Measuring and monitoring plan implementation and results**

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

Here are some examples:

**Desired result:** Employment  
**Measure:** I want to work at least 5 hours a week by summer and 10 hours a week by fall. What will be monitored? By whom? How and how often?

**Desired result:** Improved health  
**Measure:** My evaluation of my health is fair now and will be good in 6 months. I will have no emergency room visits for one year. What will be monitored? By whom? How and how often?
**Desired result:** Increased independence

**Measure:** I can create a menu, shop and cook for a week’s meals within a year. What will be monitored? By whom? How and how often?

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

### 4.5 Health and safety: Personal negotiated risk management plan

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

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

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

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

**Liability**
According to Minn. Stat. §256B.0916 subd. 6a (c), Minn. Stat. §256B.49 subd. 16(e), and Minn. Stat. §256B.0915 subd. 8(c), the state of Minnesota, county agencies, tribal governments or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for people with developmental disabilities or related conditions, people with disabilities and the elderly waiver:

“Shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual’s family, legal representative, or the authorized representative with funds received through the consumer-directed community support service” under this section.

Liabilities include but are not limited to: workers’ compensation liability, the Federal Insurance Contributions Act (FICA) or the Federal Unemployment Tax Act (FUTA).” (italics added)

4.6 Backup plans and emergency plans

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

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

4.7 Reviewing the plan

Lead agency case managers will review each plan submitted by a person selecting CDCS for the following elements and criteria.

In general, any plan submitted by a consumer that contains the required documentation and meets the above criteria, as applicable to an individual consumer, must be approved by the lead agency. If consumer’s health and safety needs change, the case manager will reevaluate the Community Support Plan for any necessary changes. See the next sections for information about denial of a proposed CDCS
plan or portions of a plan.

**Allowable goods and services**

- Are proposed services and goods allowable under the criteria outlined in 4.5, and according to the definitions of CDCS allowable costs, goods, services, and items as outlined in Section 5 of this manual?
- Does the plan for personal assistance that includes a spouse or parent who will receive payment for this assistance meet criteria outlined in Section 12 of this manual?
- Does the plan include items or services that are explicitly excluded as noted in Section 8 of this manual?

**Health and safety: Meeting assessed needs, quality of care**

- Do plan components meet identified needs?
- Will backup and contingency plans, including personal risk management plans, in combination with the proposed plan, reasonably ensure the person’s health and safety in the community?
- Are proposed backup plans and emergency plans reasonable and likely to be effective?
- Are training, experience, educational and licensing requirements outlined in the plan reasonable and adequate given assessed needs and consumer preferences? Do providers meet the qualifications outlined in Section 7 of this manual?
- Does the plan include adequate and reasonable informal caregiver training and other supports given the assessed needs and consumer preferences?

**Quality plan: Consumer outcomes**

- Will services and goods reasonably support the achievement of consumer outcomes listed in the person’s plan?
- Are the goods and services considered appropriate purchases under CDCS because they are reasonably necessary to support any or all of the outcomes outlined in Section 4.5 of this manual?
- Will the monitoring schedule, activity and indicators support achievement of person’s desired results?

**Cost effectiveness and financial accountability**

- Are the proposed costs for goods and services reasonable given the cost of purchasing similar services or goods in the community?
• Are there alternative payers for proposed services such as Medicare? Does the plan represent a cost-effective way to meet needs?
• Does the agreement between the financial management services (FMS) provider and the consumer outline specific tasks to be performed by the FMS provider, and fees?
• Does the description of Flexible Case Management service, if any, include a clear description of what the person wants to buy from the FCM, at what price, for how long?
• Can the plan be implemented within the person’s CDCS budget?

4.8 Approval, denial, or partial denial of a proposed CDCS plan

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

• Approve the plan
• Recommend changes needed to approve the plan before a final decision
• Approve part of the plan
• Deny or refuse to approve the plan.

Approve the plan

Send the consumer and the FMS provider a copy of the approval letter and a copy of the plan. Enter a Screening Document and Service Agreement into MMIS to authorize CDCS funding to support the plan. Send a copy of the Service Agreement to the consumer and FMS provider.

Recommend changes needed to approve the plan before a final decision

The lead agency case manager can negotiate with the consumer to change elements of the plan as needed to approve the plan. This negotiation can be informal and will be the most effective method to resolve concerns before the 30-day period for lead agency decision expires.

Approve part of the plan

The plan submitted by the consumer may contain services, costs, outcomes, staffing proposal or other elements that the lead agency determines they cannot approve. In effect, approval of part of a plan represents a decision to reduce proposed service (by denying some portions).

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

**Deny or refuse to approve the plan**

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

**When the decision is to deny part or all of a proposed plan**

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

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

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

**4.9 Help the consumer get a CDCS plan approved and implemented**

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

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

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

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

4.10 Service revisions and plan changes – Consumer versus lead agency approval

**Consumer-approval only required**

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

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

**Lead agency and consumer approval required**

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

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

The individual’s budget must be planned for a 12-month period and will include all goods and services to be purchased through the waiver and state plan home care services, with the exception of required case management and criminal background studies.

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

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

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

**Example:** A homemaker comes to the consumer’s home to do laundry, and the consumer decides to send it to the local laundromat instead. This change does not need lead agency approval since the outcome was laundry, and the laundry is still done. However, if the homemaker was also doing a health and safety check while doing laundry, lead agency approval is needed to ensure the health and safety outcome will still be met.
Section 5: Waiver requirements related to all allowable services

This information moved to Allowable and unallowable goods and services in the CDCS Policy Manual.

5.1 Additional requirements for CDCS services: Consumer outcomes

This information moved to Allowable and unallowable goods and services in the CDCS Policy Manual.

5.2 Broad CDCS service categories

This information moved to CDCS service categories in the CDCS Policy Manual.

5.3 Additional goods and services that may be included in CDCS budgets

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

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

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

All of the services approved in a plan must be arranged in the categories listed in 5.3 to allow the FMS provider to separate and appropriately bill approved services. A “crosswalk” between the conventional waiver and AC services and the CDCS category the service would fall under can be found in Appendix B.
5.4 Additional services authorized in combination with CDCS

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

- State plan home care services (not available to AC participants)
- Required case management services (Every Service Agreement will include Required Case Management)
- Background checks (“background checks” referred to throughout this manual refer to those checks that follow the provisions under Minnesota Statutes, Chapter 245C)
- Certain home modifications for people under age 65.

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

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

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

Home modifications and/or assistive technology: For people eligible for the BI, CAC, CADI and DD waiver programs, home modifications and/or assistive technology whose singular or combined cost will exceed $5,000.00 and that are approved by the lead agency are also authorized on the Service Agreement separately. See Section 14.

5.5 Using CDCS to purchase conventional waiver services

This information moved to Purchasing traditional AC/waiver goods and services in the CDCS Policy
5.6 A note about state plan home care services

This information moved to **Purchasing home care services** in the CDCS Policy Manual.

Appendix B: “Crosswalk” between waiver and home care codes and CDCS service categories

This information moved to **Service categories for traditional AC/waiver services** in the CDCS Policy Manual.
Section 6: Customizing services under CDCS

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

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

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

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

6.1 Personal assistance

This information moved to Personal assistance in the CDCS Policy Manual.

6.2 Treatment and training

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

- Therapy or treatment provided by nurse, home care and therapy professionals that either augment those available under state plan benefits or are included in the CDCS plan as an alternative to state plan services.

- Trainer and educational costs for paid or unpaid caregivers: Payment can be paid for training and education of caregivers to increase their ability to care for the consumer. These costs may include cost of a community CPR training forum, for example, and can include time for paid staff to attend training. This training and education must be directly related to the provision of care or support to the consumer.
• Trainer and educational costs for recipients to increase their ability to care for themselves or manage their CDCS plan, employees or budget. For example, the cost of a nutrition class for a person with diabetes, or transportation and parking costs to attend Dept. of Labor and Industry training on being a domestic employer. The person cannot pay themselves to attend training.

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

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

**Therapies and behavioral supports not otherwise defined under state plan or waiver services**

Therapies and behavioral supports not otherwise defined under state plan or waiver services would be categorized here. If a consumer wants to include a therapy not currently available through the state plan, it must be prescribed by a physician licensed to practice in Minnesota and enrolled in MHCP.

**Habilitative services**

Habilitative services are required for persons receiving MRRC waiver services. Habilitation includes therapeutic activities, monitoring, supervision, training or assistance to a person. Whether the habilitation service meets the Personal Assistance Service definition or the Treatment and Training definition, the support plan should identify those services that are part of the required habilitative plan.

**Life or employment skills development and community integration**

CDCS can be used to purchase services or supports that develop or maintain life or employment skills or community integration.

**Specialized treatment, therapy or training**

CDCS can be used to purchase counseling service, behavioral services and cognitive or other therapy if the service is part of the approved plan, prescribed by a physician licensed to practice in Minnesota and enrolled in MHCP, and is not covered under MHCP elsewhere.

**6.3 Environmental modifications and provisions**

This information moved to [Environmental modifications and provisions](#) in the CDCS Policy Manual.
6.4 Self-direction support activities

This information moved to [Self-direction support activities](#) in the CDCS Policy Manual.
Section 7: Provider qualifications

7.1 Provider qualifications for personal assistance: the consumer decides

This information moved to Personal assistance in the CDCS Policy Manual.

7.2 Provider qualifications for treatment and training

The following people can be providers of treatment and training:

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

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

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

Examples

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

Unlicensed provider of employment or life skills development service

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

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

**Licensed provider of employment or life skills development services**

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

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

**7.3 Provider qualifications for environmental modifications and provisions**

This information moved to [Environmental modifications and provisions](#) in the CDCS Policy Manual.

**7.4 Provider qualifications for financial management services (FMS) providers**

This information moved to [FMS providers](#) in the CDCS Policy Manual.

**7.5 Provider qualifications for flexible case management (FCM) service**

A Flexible Case Manager can assist the consumer primarily in:

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

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

The consumer may also require the person to meet additional qualifications in order to provide FCM to that individual.
In order to provide paid FCM service to any CDCS consumer, a person must be certified by the state of Minnesota. An online DHS training module is available to certify Flexible Case Managers. Upon satisfactory completion of the training, DHS will issue a certificate to the person completing the training. This certificate must be shown to consumers interested in purchasing FCM.

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

A qualified Flexible Case Manager:

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

Any person receiving service planner services may not provide service planner services to another person receiving CDCS services.

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

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

### 7.6 Flexible case management and family or legal representatives

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

**Prohibitions on payments to guardians or conservators**
Minnesota Statutes, Section 524.5-309 states:

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

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

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

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

**Prohibitions on payments to parents of minors or spouses**

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

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

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

See Section 9.3 for an exemption of these limitations for people participating in the DD Waiver program only. This exemption is part of the overall DD Waiver plan and not exclusive to CDCS participation.
Section 8: Non-allowable expenses under CDCS

This information moved to Allowable and unallowable goods and services in the CDCS Policy Manual.

8.1 Excluded services, supports and Items

This information moved to Allowable and unallowable goods and services in the CDCS Policy Manual.

Appendix C: Attachment submitted and approved by CMS as part of waiver amendment

This information moved to Allowable and unallowable goods and services in the CDCS Policy Manual.

8.2 Fitness and exercise programs

Health clubs and fitness centers that provide fitness and exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the individual’s physical condition. The condition must be identified in the individual’s plan of care and monitored by an MHCP-enrolled physician. Because children have other resources available to meet these needs, fitness and exercise programs are limited to adults. If authorized by the county, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the individual’s actual and projected use of the health club or fitness center. Individuals must periodically provide verification to the county that they using the health club or fitness center.
Section 9: Comparison of required and flexible (optional) case management activity

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

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

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

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

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

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

9.1 Required lead agency functions under CDCS

The following are lead agency functions are not included in the consumer’s CDCS budget and not optional for the consumer.

Administrative activities: Not billable under waivers

- Screen and determine if consumers are MA or AC eligible
- Screen and determine if the individual is eligible for waiver or AC services including level of care determination
• Authorize CDCS services in MMIS
• Manage overall waiver and AC spending within the county’s allowable waiver and AC allocation
• Investigate reports related to vulnerability or misuse of public funds per jurisdiction
• Offer choice of providers, contract with providers and monitor provider’s performance including maintenance of fiscal records
• Assist state agency in completing satisfaction measurements as requested
• Have a system for consumers to contact the local agency on a 24-hour basis in the case of a service emergency or crisis.

Service coordination activities: Billable under waivers

• Provide information regarding HCBS alternatives to make an informed choice, including information about CDCS
• If the consumer elects CDCS, provide them with their maximum budget amount and assessment summary
• Provide CDCS consumers with resources and informational tool kits to assist them in developing the plan and managing the service
• Evaluate whether the consumer’s health and safety needs are reasonably expected to be met given the care plan including provider training and standards
• Evaluate if the plan is appropriate, including whether the goods and services meet the service criteria and provider qualifications, rates appear to be appropriate, etc. Provide feedback to the consumer about plan adjustments needed to approve if any
• Review and authorize additional funding for environmental modifications or assistive technology exceeding $5,000 for the disability waivers
• Review and authorize funding for environmental modifications up to $20,000 per waiver year for EW and AC
• Monitor and evaluate the implementation of the Community Support Plan, including health and safety, satisfaction and the adequacy of the current plan and the possible need for revisions at least annually
• At a minimum, review the consumer’s budget and spending before the 3rd, 6th and 12th month of the first year of CDCS services, and at least annually thereafter
• Provide technical assistance regarding service implementation, budget and fiscal records management and take corrective action if needed in order to ensure support plan implementation
prior to involuntary exit from CDCS

- Carry out minimum case manager contacts required under AC or each waiver program.

9.2 Flexible case management functions and limitations

Flexible, Optional DIRECT SUPPORT is included in the consumer’s CDCS budget, must be explicitly planned and purchased by the consumer. Not an inclusive list of those direct supports a consumer may design related to planning, implementation, monitoring, evaluating and managing services and employees:

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

Limitations

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

• A Flexible Case Manager cannot receive payment for performing functions that duplicate those required to be performed by the lead agency.

9.3 Excluded time and CDCS

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

In order to determine whether the services contained in an approved CDCS plan are excluded time services, the financial worker must apply the definitions of those services as they exist in law. Financial workers will make these determinations on an individual basis and on an individual plan basis.

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

Similarly, if a person’s plan includes licensed DT&H service, this is clearly defined as an excluded time service. However, the person may choose to receive employment support from a local business, and this service cannot be adjudged to be equivalent to DT&H.
Section 10: Financial management services (FMS) providers

This information moved to FMS providers in the CDCS Policy Manual.

10.1 FMS provider reporting requirements

This information moved to FMS provider documentation and reporting requirements in the CDCS Policy Manual.
Tables 1, 2 and 3: FMS provider reporting frequency to lead agencies and people/families

This information moved to FMS provider reporting frequency to lead agencies and people/families in the CDCS Policy Manual.
Section 11: Involuntary exits from CDCS

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

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

11.1 Definition of terms

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

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

“Immediate concern” is defined as:

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

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

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

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

### 11.2 Procedures related to involuntary exits

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

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

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

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

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

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

Each discovery of non-compliance with the CSP that requires a corrective action could cause a CDCS Notice of Technical Assistance and Additional Oversight Form to be sent.

However, the lead agency may choose to provide additional assistance to consumers that does not meet the documentation requirements without the completing the form when successful resolution of the issue(s) seems likely.

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

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

11.4 Immediate concern

Health and safety

Any matter arising which jeopardizes the consumer’s health and safety may result in involuntary exit. An incidence of substantiated abuse by a paid support staff, for example, could lead to involuntary exit if a backup plan cannot be implemented to assure health and safety.
Referrals to Adult Protective Services for concerns arising about self-neglect rather than maltreatment must occur in the same manner and for the same level of concern for a person receiving supports under CDCS as for those receiving conventional services.

**Reported fraud**

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

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

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

**Unreported fraud**

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

**Restrictions under primary care utilization committee decisions**

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

If a person is placed on such restriction after CDCS is implemented, an involuntary exit from CDCS would also occur.
Appendix D: Consumer directed community supports (CDCS) notice of technical assistance and additional oversight

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

Consumer name: ________________________________
Case manager’s name: ____________________________
County: ________________________________
Date of notice of technical assistance and/or additional oversight ____________

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

1 ________ 2 ________ 3 ________ 4* ________

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

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

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

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

______________________________________________

*On the 4th occurrence of the technical assistance and/or additional oversight beyond reasonable efforts, the Notice of Action (DHS 2828) will be sent immediately. The CDCS recipient will be exited from CDCS as of the effective date on the form.
Section 12: Purchasing personal assistance services (PAS) from a spouse or parent

This information moved to Paying a spouse or parent of a minor for personal assistance in the CDCS Policy Manual.
Section 13: CDCS budget amounts under the AC program and EW

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

Appendix F outlines how budget and maximum required case management amounts for EW and AC were calculated. These amounts are updated and published in the Aging Initiatives bulletin outlining budget and rates changes each fiscal year, as applicable. The amount listed under each case mix category represents the total dollars available to purchase services over one service plan year for all services except Required Case Management and background checks.

The amount available for a participant for both CDCS and non-CDCS service plans is posted on the Long Term Care Screening Document. The lead agency professional conducting the LTCC assessment or reassessment process will inform the consumer of their available budget amounts for both CDCS and conventional EW or AC services planning as part of the information presented about CDCS and other service options when a person is determined eligible for the program, and at reassessment.

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

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

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

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

13. 1 Authorizations and payments under CDCS: EW and AC

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

A long-term care screening document is entered into MMIS:

- Screening document edits are applied and the document is approved in MMIS
- The screening document records assessment information, program selection and support plan information
- It also establishes a “from-through” program eligibility span
- This span documents a period of time in which the person will remain eligible for the program that cannot exceed 365 days
- Annual reassessment re-establishes eligibility for the program.

Information from the SDOC is reflected on the service agreement:

- There are different service agreement types for different programs
- Information from the screening document (program type, case mix) determines the maximum dollar amount and set of services that can be authorized
- Service agreement edits are applied, and the Service Agreement is approved in MMIS
- The service agreement identifies approved providers, services, rates, length of approval and total dollars authorized
- Consumers receive copies of their authorizations as a service agreement letter generated by MMIS.

Providers submit claims:

- Claims edits are applied, including checks against recipient information, authorized providers, and services, dates of service, and rates
- Claims are paid or denied
- Payments are decreased from total dollars authorized
- Providers receive summaries of claims submitted and paid.
Changes were made to each of these support processes and tools to support CDCS implementation in the EW and AC programs as outlined in the next subsections.

13.2 Summary of changes to the long-term care screening document: EW and AC

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.3 Service agreement changes for CDCS under EW and AC: Procedure codes

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.4 Service agreement changes for CDCS under EW and AC: Edits

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.5 Other procedure codes that can be authorized in combination with CDCS services: Elderly Waiver and Alternative Care programs

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+
13.6 Claim payments: EW and AC

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.7 Consumer scenario: initial opening – selects CDCS

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.8 Consumer scenario: person who has been using CDCS wants to discontinue that service

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)

13.9 Consumer scenario: a person currently open to EW or AC decides to change to CDCS

This information moved to:

- Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS, DHS-4625 (PDF) (CDCS information begins in section 201.09 on Page 165)
- Instructions for Completing and Entering the LTCC Screening Document for the MSHO and MSC+ Program, DHS-4669 (PDF) (CDCS information begins in section 201.08 on Page 65)
13.10 Consumer scenario: renewal of EW or AC CDCS

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

Enter a LTC Screening Document using:

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

The EW or AC eligibility span is extended.

Enter a new service agreement using:

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

If the person lives in an institution

For a person who is eligible for Medical Assistance, community services planning that occurs while the person is in the institution, including planning to utilize CDCS as the service option to return to the community, should be billed under Relocation Service Coordination (RSC).

A person determined to be eligible for AC can access AC conversion case management up to 100 days to assist in planning while residing in a nursing facility as well. Use X5476 for diversion-type Service Agreements or T1016 for conversion-type Service Agreements.

Appendix F: EW and AC CDCS budget amounts

The CDCS budgets for Elderly Waiver participants were calculated based on the average actual expenditures for services received in FY03 excluding expenditures for services for recipients not eligible to
use the CDCS service such as those in foster care, residential care and customized living. Aging and Adult Services Division staff analyzed the data by case mix classification and established the CDCS budget amounts per month by case mix cap for Elderly Waiver participants. The CDCS budget amounts per month for Alternative Care participants were established at 75% of the CDCS budget amounts per month for Elderly Waiver participants. The annual CDCS budget amount is used for authorization and projected spending caps.

The plan and service agreement (SA) authorization are not limited by the average monthly amounts, but will reflect proposed services and negotiated rates, and projected use of services over the period of time that the SA covers. Elderly Waiver participants enrolled in a health plan will receive their CDCS budget amounts from their health plan or health plan’s designee (usually the care coordinator) who is responsible for their health coordination or case management functions.

The service budget amount cannot be exceeded, and represents an “up to” amount available over the SA period to purchase needed, approved services, including FMS service as specified in the plan, and Flexible Case Management service if the person chooses this optional case management service. This budget amount will increase if the SA period is increased and decrease when the period is shortened e.g., when the participant exits Elderly Waiver.

**Required case management** is limited to the average of 8 units per month projected over the period of time that the SA covers. The rate is up to the state-wide maximum rate for case management in the months service will be provided. This unit limit for case management will support a range of case management activity, including the provision of additional technical assistance prior to involuntary exit from CDCS service. Required Case Management billing must reflect the units of service provided in a given billed period, the use of case aide versus case management service, and the lead agency’s usual and customary charge for waiver case management service.

**Background checks** can be authorized using up to $25 per check requested beginning 7-1-2009. Billing for this service must be based on actual cost of the check. The cost for background checks is not included in the cap.
Section 14: CDCS service authorizations and MMIS activity: People under age 65 in BI, CAC, CADI and DD waiver programs

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

14.1 Consumer scenarios: choosing CDCS

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

14.2 Consumer scenarios: discontinuing CDCS

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

14.3 Service agreements: BI, CAC, CADI, DD

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

14.4 Screening document edits:

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

14.5. Billing CDCS services

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.

Use of claim modifier 76

This information moved to Chapter 2 of Instructions for Completing and Entering the LTCC Screening Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.
Document and Service Agreement Into MMIS, DHS-4625 (PDF). CDCS information begins in section 201.09.
Section 15: CDCS and enrollment in managed care

MSHO or MSC+

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

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

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

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

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

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

15.1 Medical Assistance spenddowns when choosing CDCS

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

Also see MHCP Eligibility Policy Manual for more detailed information about premiums and spenddowns.

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

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

Prepay DHS a spenddown
Consumers can choose to prepay their spenddown to DHS. This process is “Client Option Spenddown.” The Financial Assistance unit will determine if a person is eligible to use this option. Consumers must sign DHS Form 3081 “DHS Agreement to Prepay MA Spenddown.” When this option is chosen, MMIS sends a bill directly to the client. (Clients who have a Waiver Obligation cannot use this option. See the next section for information about CDCS and waiver obligation under the Special Income Standard Elderly Waiver program.)

**No designated provider**

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

- If the first claim that is submitted is from the FMS provider who is the enrolled CDCS service provider, then the FMS provider would be responsible for the collection of the spenddown from the client
- If the first claim that is submitted is from the county or tribe for Required Case Management and/or background checks, then they would be responsible to collect the spenddown from the client
- If the first claim that is submitted is from any other state plan service or pharmacy provider, then that provider would be responsible to collect the spenddown from the client.

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

**Designate a provider**

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

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

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

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

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

Designated provider under CDCS

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

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

15.2 Special Income Standard Elderly Waiver and waiver obligation

There are two income limits for individuals who are eligible for the Elderly Waiver Program. Under one limit, referred to as the Special Income Standard, or the SIS-EW program, the consumer will be responsible to pay a waiver obligation. This obligation only applies to their waiver services, not any other medical assistance covered services such as home care. (For all other EW clients, some may have a medical assistance spenddown, and some will not, depending on their financial and marital situation.)

Go to the [MHCP Eligibility Policy Manual](#) for information about eligibility for Special Income Standard Elderly Waiver, including waiver obligations.

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

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

No designated waiver provider

The waiver obligation would be met in a “pot luck” order:
• If the first claim that is submitted is from the FMS provider who is the enrolled CDCS service provider, then the FMS provider would be responsible for the collection of the waiver obligation from the client.

• If the first claim that is submitted is from the County or Tribe for Required Case Management and/or background checks, then they would be responsible to collect the waiver obligation from the client.

• If the first claim does not satisfy the entire waiver obligation, then the next claim submitted will determine who would be responsible for the collection of the remaining waiver obligation. Each claim submitted by a waiver provider, in the order it is processed in MMIS, will be used to decrement against the waiver obligation until the obligation is satisfied.

**Designated provider**

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

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

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

**15.3 Non-payment of waiver obligation or spenddown while using CDCS**

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

An unpaid waiver obligation or spenddown after the client receives services is considered to be unpaid debt and the provider is not required to continue to serve recipients with outstanding debt. The provider must give sufficient notice to the client which gives opportunity to repay the debt. If the recipient does not pay, the provider can refuse to provide care and the consumer can seek out services from other providers.
If the client does not pay the designated or “pot luck” provider after receiving services, the provider is to give sufficient notice to the client concerning their obligation and reasonable opportunity to pay the debt. The provider should also inform the lead agency, who needs to provide Additional Assistance and Technical Support. The lead agency will provide some involvement to resolve the non-payment issues. The lead agency should document all reasonable efforts to provide the need for technical assistance.

The documentation must include:

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

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

15.4 Spenddowns and waiver obligations under MSC+ and MSHO/Elderly Waiver

The provider collects the spenddown or waiver obligation and invoices the enrollees monthly. Designated providers are not used for people in managed care programs. Client Option spenddowns may be able to be used for these recipients. The same corrective action and a CDCS notice of TA would be used for this program as well.
Section 16: CDCS and unpaid caregiver supports

Caregiver supports are intended to:

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

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

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

16.1 Types of caregiver support services

**Respite**

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

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

**Family and caregiver training and education**

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

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

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

While CDCS is intended to allow self-design of provider standards where noted in this manual, approved caregiver training and education proposals should reflect the use of trainers and/or educators who meet community standards and demonstrate competency in the training or education subject matter.

Training must address a specific assessed need of the recipient and be intended to improve the quality of care provided, increase the caregiver’s knowledge about providing care or ensure caregiver health and safety.
Section 17: HCBS quality framework: Organizing quality management around seven quality focus areas

All states participating in 1915(c) (Medicaid) waiver programs must provide assurances concerning the quality of care and services provided through these programs as a condition of federal approval of the state waiver plan. The Centers for Medicare/Medicaid Services (CMS) works with states to assure and improve quality across the Medicaid authorities that support long-term services and supports, including the Medicaid 1915(c) HCBS waiver programs. For more information, see Medicaid.gov – Authorities.

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

- **Participant access**: Individuals have access to home and community-based services and supports in their communities.
- **Participant-centered service planning and delivery**: Services and supports are planned and effectively implemented in accordance with each participant’s unique needs, expressed preferences, and decisions concerning his/her life in the community.
- **Provider capacity and capabilities**: There are sufficient HCBS providers and they possess and demonstrate the capability to serve participants effectively.
- **Participant safeguards**: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
- **Participant rights and responsibilities**: Participants receive support to exercise their rights and in accepting personal responsibilities.
- **Participant outcomes and satisfaction**: Participants are satisfied with their services and achieve desired outcomes.
- **System performance**: The system supports participants efficiently and effectively and constantly strives to improve quality.

17.1 The HCBS QA/QI Plan - Local agency HCBS quality assurance and improvement responsibilities

Each county, tribal agency, or health plan administering home and community-based waiver services programs, long-term care consultation, or the Alternative Care program develops and implements a plan for quality assurance (Biannual Quality Assurance Plan for Home & Community-Based Service Programs). The plan is forwarded to DHS biannually to demonstrate that the agency:
• Is implementing programs according to statute
• Is carrying out delegated quality assurance, monitoring, and assessment activities necessary to achieve desired program outcomes
• Has policies and practices in place to ensure the health and safety and participation and choice-making of consumers participating in these programs.

Under this plan, the lead agency addresses both state and federal quality assurance and improvement requirements for long-term care consultation and the Alternative Care program, as well as the Elderly Waiver, Community Access for Disability Inclusion (CADI) Waiver, Developmental Disabilities (DD) Waiver, Brain Injury (BI) Waiver, and Community Alternative Care (CAC) Waiver. The most recent plan submitted at the time of the publication of this manual was that for 2010-2011, submitted by lead agencies in fall 2009 via web-based survey.

17.2 Applying the quality framework to CDCS

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

Access to CDCS

• Individuals have complete information about CDCS, including budget amounts Individuals have access to CDCS in their community.
• Individuals have access to supports and resources to make CDCS a viable alternative.

Participant-centered CDCS services planning and delivery

• Services are planned by consumers using person-centered planning tools and approaches Services are directed by consumers.
• Lead agencies approve CDCS plans by applying required criteria.

Provider capacity and capability

• There are sufficient financial management services and Flexible Case Management providers to ensure choice.
• CDCS staff possess and demonstrate the capability to effectively serve participants.

Participant safeguards

• Community support plans include personal risk management, emergency back up, and crisis services plans.
• Support staff, FCM and FMS providers understand their role as mandated reporters of suspected vulnerable adult or child abuse, neglect, or exploitation.

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

Participant rights and responsibilities

• Participants understand their role as employer and other responsibilities

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

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

• Participants receive support to exercise their rights.

Participant outcomes and satisfaction

• Participants develop individualized CDCS outcomes or desired results

• Participants are satisfied with their services and achieve desired outcomes.

System performance: reports and monitoring requirements

• Approved CDCS plans support participants efficiently and effectively.

• Approved plans include quality monitoring roles and schedules

• The lead agency meets monitoring and reporting requirements.

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

Appendix G: CDCS quality assurance and improvement activity: lead agency self-assessment

The lead agency should review the following statements, answering “yes” or “no” to each.

Access to CDCS

The lead agency:

• Provides information about CDCS as a service option to all waiver applicants
• Provides each person at assessment and reassessment with the consumer CDCS Brochure (DHS-4124)
• Has a complete CDCS “Tool Kit” available for review and use by potential CDCS users
• Carries out public education activity related to the availability of CDCS
• Provides information about budget amounts to help people choose the service options that best meet their needs and preferences
• Explains Flexible Case Management service as an option to help the person access and continue to use CDCS.

Participant-centered CDCS services planning and delivery

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

The lead agency offers the consumer a choice in person-centered planning tools and level of involvement.

The lead agency ensures that plans submitted for approval by CDCS consumers:
• Include the frequency, source, rate and duration of support or service from all sources
• Include frequency, payment rate and description of Flexible Case Management service
• Outline training or other requirements for personal assistance and plans to verify training is completed/adequately
• Identify background and how findings will be incorporated into or affect plan approval
• Appropriately address/include services recommended by other professionals, including physicians, involved in assessment/planning
• Include communication plans to accommodate changes in the person’s condition, preferred services or desired outcomes
• Incorporate the individual’s personally developed outcome and quality indicators and monitoring role and schedule.

Provider capacity

There are sufficient FMS and FCM providers. CDCS staff possess and demonstrate the capability to effectively serve participants.
The lead agency:

- Has policies and practices that ensure FMS providers meets applicable state and federal standards
- Has policies and practices that ensure FCM providers meets applicable state and federal standards
- Provides lists to consumers of all qualified FMS and FCM providers
- Reviews provider records on a periodic basis to ensure that the provider is adequately documenting the delivery of services to conform with the individual’s support plan. This should include review of individual files and invoices.

The lead agency may carry out activity to increase choice between FMS and FCM providers:

- Recruits FMS providers
- Recruits culturally competent providers
- Assesses the need for service providers with special knowledge, skill or background to provide support to people with dual diagnosis or communication limitations, etc.
- Provides equal consideration to all providers who meet applicable standards
- Maintains a directory of all qualified service providers for the CDCS consumer who wants to combine non-CDCS and CDCS.

**Participant safeguards**

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

The lead agency:

- Has policies and procedures for monitoring the health and safety of the person at least annually
- Has policies for evaluating unsafe home conditions
- Has policies for evaluating need for supervision
- Incorporates personal risk management in support planning
- Reviews LTCC staff completion of Environmental Safety section of the Community Assessment Form (DHS-3428) or equivalent
- Required Case Manager has face-to-face contact with the person as indicated in the community support or care plan, and as required under various programs
• Has policies in place for the CDCS participant, FCM or personal assistant to follow if problems arise concerning the person

• Ensures the person has a contingency plan for emergencies when the lack of immediate care would pose a serious threat to health and welfare. This assurance is directed at community-wide emergencies such as those posed by inclement weather

• Ensures the person has a plan for backup assistance when providers are not available and lack of immediate care would pose a serious threat to health and welfare. This assurance is intended to be in place at the individual client level and to reflect individualized planning.

**Vulnerable adult and child protection**

The lead agency has policies and practices that address:

• The prevention of abuse, neglect and exploitation
• Screening for abuse, neglect and exploitation
• Identification of abuse, neglect and exploitation
• Investigation of abuse, neglect and exploitation
• Reporting abuse, neglect and exploitation
• Actions to be taken when the health or safety of a person has not been safeguarded
• Training directly related to abuse, neglect and exploitation.

Has the lead agency developed communication processes that create an appropriate, efficient feedback loop between adult or child protection and case manager?

**Participant rights and responsibilities**

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

The lead agency ensures the person receives information about:

• Data privacy
• Their rights to appeal lead agency decisions regarding CDCS services and/or access to programs, including denial of expenditures and failure to approve the support plan
• Ombudsman services.

The lead agency ensures the person always receives a copy of service agreements or prior authorizations
that includes information about appealing those decisions

The lead agency has policies and procedures in place to ensure people have access to guardianship or conservator services.

**Participant outcomes and satisfaction**

Participants are satisfied with their services and achieve desired outcomes.

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

**System performance: reports and monitoring requirements**

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

**A. Consumer monitoring and reporting**

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

**B. FMS provider monitoring and reporting**

This information moved to [FMS provider documentation and reporting](#) in the CDCS Policy Manual

**C. Lead agency monitoring and reporting**

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

**D. Required case management: reassessment**

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