Care Coordination CFSS Guidelines

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DEFINITIONS

Activities of Daily Living (ADL): Tasks essential to perform routine self-care functions (e.g., dressing, combing hair, brushing teeth, bathing, eating, transfers, mobility, positioning, toileting).

Certified Assessor**:** MnCHOICES lead agency/MCO staff who complete assessments for people requesting long-term services and supports (LTSS).

Community First Services and Supports (CFSS): A new self-directed home and community-based service that replaces PCA and CSG services beginning October 1, 2024. CFSS allows people greater independence in their homes and communities.

CFSS Individual Service Delivery Plan (DHS-6893P): Refers to the member's written plan, which includes detailed descriptions of the individual supports, goods and services, and/or PERS requested within the CFSS budget.

Community-Based Services Manual (CBSM): A resource for care coordinators who administer home and community-based services that support older adults.

Consultation Services Provider: A provider that educates members about CFSS and member choices and supports the member in writing their service delivery plan and reviews the plan.

DHS: Minnesota Department of Human Services

Financial Management Services (FMS): An FMS provider is an MA-enrolled provider that supports the member using the budget model with payroll tasks and members in both models with the purchase of goods and services.

Goods and Services: Items or services the member chooses to purchase if they are related to an assessed need for the direct benefit of the person and either increase the person's independence or decrease their need for human assistance.

Insurance: Refers to Medical Assistance, Medicare, Managed Care, MSC+, MSHO and private insurance.

Member: Refers to the UCare enrollee.

MnCHOICES Assessment: The required assessment tool to determine eligibility for Elderly Waiver and CFSS eligibility.

Participant Representative: An individual who directs care on behalf of a member who cannot direct their own care. In PCA, this was known as the "responsible party".

PCA/CFSS Communication Form: The UCare form used by care coordinators to submit CFSS-authorized supports and services. This form is also used to DTR CFSS.

Support Plan - MCO MnCHOICES Assessment: A written summary is completed after a member's MnCHOICES assessment. The certified assessor/care coordinator completes the support plan and provides it to the member, regardless of whether the person is eligible for Minnesota Health Care Programs (MHCP) or chooses to receive publicly funded Home and Community-Based Services (HCBS) or state plan services. This document provides a summary of the person's choice of supports and/or services and the person's preferences for the delivery of supports/services.

Worker Training and Development Budget: Budget that the agency (Agency Model) or the member (Budget Model) can use flexibly for training their worker on their specific needs. Replaces Qualified Professional Units in PCA.

COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS) OVERVIEW

The following is information and updates regarding the Community First Services and Supports program option. This material **may change** as the Minnesota Home and Community Based Services (HCBS) policy is subject to State and Federal approval and interpretation. The CFSS Policy Manual is the primary source of truth to guide care coordinators authorizing CFSS.

Community First Services and Supports (CFSS) is a Minnesota healthcare program that offers flexible options to meet the unique needs of members. CFSS allows people greater independence in their homes and in the community. CFSS will replace Personal Care Assistance (PCA) and the Consumer Support Grant (CSG).

The rollout of CFSS begins on October 1, 2024. Members will transition from PCA to CFSS at their next reassessment and initial assessment for new members on or after October 1, 2024. Eligibility for CFSS is the same as it is for PCA. People currently eligible for PCA, will remain eligible for CFSS unless there has been a change in condition. CFSS covers

all the services PCA does and offers more choices for who can serve as the CFSS worker, such as a spouse or minor child. Members who use CFSS can also serve as the CFSS worker for others. Members have a worker training and development budget, the ability to purchase goods, services and PERS and the ability to choose between two service models: agency or budget.

It is important that members who utilize the CFSS option understand what their rights and responsibilities are when using these services. People who are well-informed may more easily exercise the increased freedom, authority, and control of resources through CFSS. UCare provides information about CFSS through assigned care coordinators and relies on DHS training and resources to inform of policy and regulations.

RESOURCES

CFSS Policy Manual
CFSS Manual – PCA/CFSS covered services
CFSS Frequently Asked Questions (FAQ)
CFSS Budget Calculator
DHS 6893P Individual Service Delivery Plan
DHS 6893H CFSS Home Care Rating/Units Tool
DHS CFSS Consultation Services Provider List
Financial Management Service Provider Information
Financial Management Services (FMS) for CFSS
MinnesotaHelp.info
DHS CFSS Forms and Documents
UCare PCA/CFSS Communication Form
UCare MSC+/MSHO Requirement Grids

AGENCY AND BUDGET MODELS

CFSS funds using the Agency or Budget service option do not equate to a cash allowance. Services and/or goods are authorized by the UCare care coordinator and may be purchased as part of an approved person-centered plan. All CFSS expenditures must be prior approved and traceable back to an authorized service or good approved in the member's DHS-6893P CFSS Individual Service Delivery Plan.

Agency Model: CFSS model where a member has approved units, and a chosen provider agency that is the employer of the member's workers and will complete the required employer tasks. This model is similar to traditional PCA. The agency is responsible for recruiting, hiring, training, supervising, scheduling, and setting workers' wages. The member still has a say in who their workers are, has a say in their worker schedules and participates in training and supervising of their workers.

- Members may NOT choose the Agency Model if only using goods, services and/or PERS
- Agency Model MUST be used for a 45-day temporary start of CFSS
- The agency pays workers
- The member must select an FMS provider to assist with purchasing goods and services
- Provider agency requests reassessment 60 days prior to current authorization

Budget Model: CFSS model where a member has a budget with dollars and is the employer of their workers. The member selects an FMS to assist with the required employer-related tasks in the Budget Model. The member is responsible for recruiting and hiring, training, supervising, scheduling workers, setting wages, and arranging for back-up staffing when needed.

- Members MUST choose the Budget Model when CFSS is being used to only purchase goods, services and/or PERS without personal care services.
- Members on the Minnesota Restricted Recipient Program (RRP) are NOT allowed to use the Budget Model

    - CCs can confirm participation in the MN RRP program in MN-ITS
- The member recruits, hires, trains, monitors, sets workers' wages and manages support workers
- Neither the members nor the participant representatives may use the worker training and development budget to meet employer responsibilities
- The member arranges for backup staffing
- The member must select an FMS Provider to assist with payroll tasks and the purchase of goods and services
- The member reviews and submits support workers' timesheets to the FMS provider
- The FMS Provider requests reassessment 60 days prior to the current authorization

Reference: CFSS Service Models

ROLES AND RESPONSIBILITIES

The member, Consultation Services Provider, FMS provider and care coordinator each have responsibilities.

MEMBER

The member is responsible to:

- Select Consultation Services Provider and complete outreach to establish services. If the member needs assistance, the member may utilize the CC for support and to complete the referral/authorization.
- Work with a Consultation Services provider to choose between CFSS Agency or Budget Model to receive CFSS services
- Collaborate with Consultation Services Provider to create DHS-6893P Individual Service Delivery Plan
- Communicate on an ongoing basis with the care coordinator, CS provider and FMS provider (as applicable)
- Revise the CFSS Plan as needed (some revisions will require care coordinator approval)

Reference: Person's Rights and Responsibilities in CFSS

CONSULTATION SERVICES (CS) PROVIDER

The Consultation Services Provider is responsible to:

- Educate the member about CFSS including the Agency and Budget Models
- Help the member write their DHS-6893P Individual Service Delivery Plan. Assistance is optional based on member preference.
- Provide the member Financial Management Services (FMS) options when using Goods and Services
- Review member's Service Delivery Plan and offer guidance. The CS provider ensures the plan is complete, meets the member's assessed needs, and includes only covered services.
- Upload the DHS-6893P Individual Service Delivery Plan to MnCHOICES as an attachment
- Notify the CC to review the DHS-6893P and for CC approval
- Provide ongoing support throughout the year, including answering questions and helping the members to make changes to their service delivery plan when using the budget model
- Notify the CC if greater than six (6) sessions of consultation services are needed along with justification

NOTE: If a member or CC has a concern regarding a specific Consultation Services provider, the member and/or CC may contact DHS.cfss@state.mn.us.

Reference: CFSS consultation services overview (state.mn.us)

FMS PROVIDER

An FMS provider is needed when a member is purchasing goods and services as part of the member's DHS-6893P Individual Service Delivery Plan in the agency model or when the member selects the budget model.
Administrative tasks the provider agency or FMS takes care of in either model: filing employer taxes, ensuring compliance with labor laws, billing UCare. In the Agency Model, the agency completes these tasks. In the Budget Model, the member chooses an FMS to complete these tasks.

In both models, an FMS provider is responsible for helping the member purchase goods and services and is responsible to:

- Keep a copy of the service delivery plan on file
- Only bill for covered goods and services listed in the service delivery plan

The FMS provider performs vendor fiscal/employer agent (VF/EA) tasks. This means the FMS provider's role is to:

- Support members using the CFSS budget model to fulfill their responsibilities in being the employer of their workers
- Facilitate the purchase of goods/services for members in both the CFSS agency and budget models

In this role, the FMS provider performs tasks that include, but are not limited to:

- Bill UCare and pay vendors or the member's individual workers for authorized goods and services
- Ensure the member's CFSS spending follows the rules of CFSS and the approved service delivery plan (refer to CFSS Manual – PCA/CFSS covered services)
- Help the member obtain workers' compensation
- Educate the member on how to employ workers
- Document and report all spending of CFSS funds
- Initiate background studies for workers.
- File federal and state payroll taxes for workers on the member's behalf

Reference: Financial Management Services (FMS) for CFSS

CARE COORDINATOR

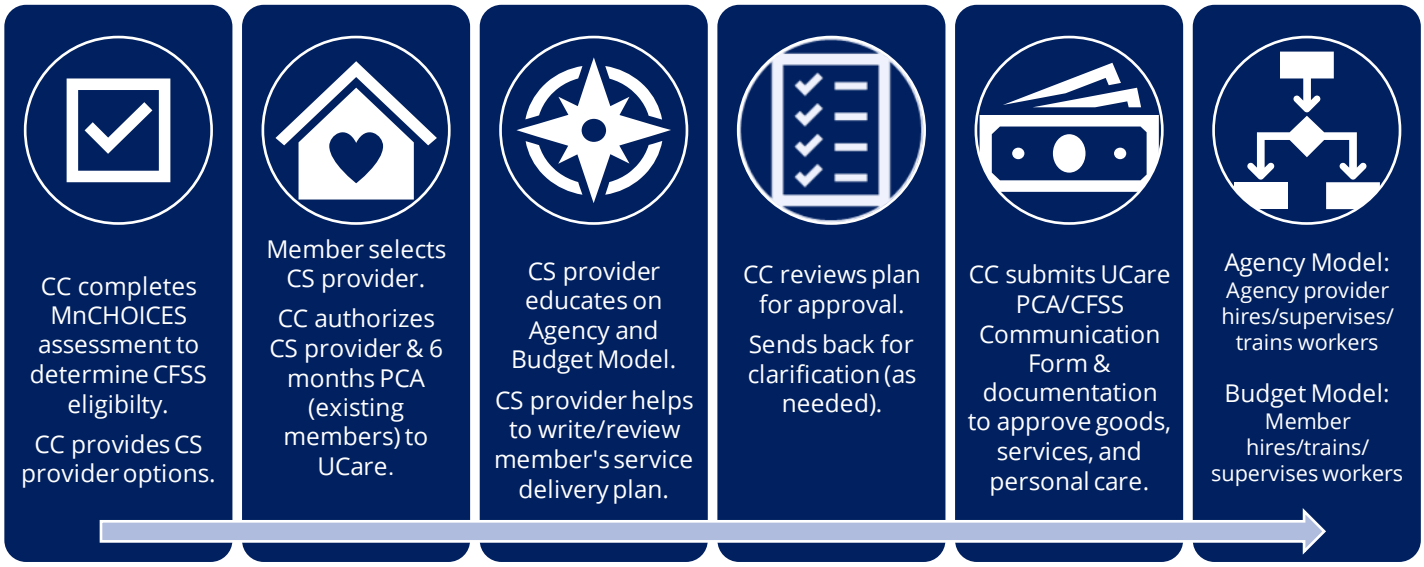
The care coordinator is responsible for the following:

COMPLETE DHS ON-LINE TRAINING

Complete Overview of CFSS for Lead Agencies (CFSS_LA) TrainLink training course before the initial CFSS implementation and keep updated on changes in DHS rules and requirements related to CFSS.

- Utilize the CFSS Policy Manual and the DHS CFSS FAQ to reference current DHS policy and guidance.

CFSS Process Flow:



Reference: Overview of the PCA and CFSS processes (state.mn.us)

MNCHOICES ASSESSMENT AND SUPPORT PLAN

UCare care coordinators utilize the MCO MnCHOICES-Assessment tool and Support Plan-MCO MnCHOICES Assessment to determine whether a member meets eligibility requirements for the Home and Community-Based Services (HCBS) and CFSS. Members do NOT need to meet the Nursing Facility Level of Care to be eligible for CFSS.

Reference: Assessment Checklist

PROVIDE EDUCATION

When the care coordinator determines a person is eligible for CFSS via the MnCHOICES assessment, the care coordinator provides information to the member so the member can make an informed choice about services. This information may include:

- Starting the conversation about services that could meet the person's needs (e.g., CFSS Agency and Budget models)
- Explanation of self-direction and its roles and responsibilities for CFSS
- Using DHS enrolled and UCare in-network PCA/CFSS provider agencies
    - The care coordinator will work with the member to identify a UCare in-network CFSS agency using the UCare Provider Search Tool. Use the Places tab and search by name: "Community First Services" and add location. Expand your filter to greater than 60 miles to see all options available.
- Goods, services, and supports the person can purchase within a CFSS budget

Care coordinators provide the member/representative with the following **within 10 business days of the assessment**:

1. MNCHOICES Assessment Summary to the member and/or representative
2. A list of DHS-enrolled Consultation Service Providers to select their provider
    - DHS CFSS Consultation Services Provider List
3. The DHS-8477A CFSS Fact Sheet (available in e-Docs in five languages)

*See Six-Month PCA Transition section for additional 10 business day requirements

Assessment & Eligibility Reminders:

- All CFSS Assessments must be completed in person
- The CC is responsible for documenting the reported abilities for activities of daily living in the assessment
    - Best Practice: Observe the member walking, using arms/hands, sitting/standing
- The CC uses critical thinking to ensure the member is using services that are the most cost-effective
- If a member qualifies for CFSS and all needs can be met by CFSS, including personal care, goods and services, and PERS, the member will not need to be opened to an Elderly Waiver
- If a member is eligible for EW and has needs beyond EW coverage, the member may choose to use some or all of the state plan CFSS benefits
- CFSS could be used for only goods and services if the person has support for any other assessed needs and the plan addresses health and safety
- A person can utilize both CFSS and CDCS, if desired. CFSS is foundationally a personal care service. Members can decide to use some of their CFSS funds to purchase things that are allowable. If they choose to use only personal care in CFSS, people on a waiver can use waiver funds to receive other items/services that are coverable on a waiver.
    - If a person chooses to use CDCS and CFSS, CFSS funds come from within the CDCS budget
- The member must be able to direct their own care or designate a participant representative to act on the member's behalf. If a guardian is a CFSS worker, they cannot also be the participant representative for the member.
- CCs ensure services are not duplicative – i.e. ICLS vs CFSS
- Members must maintain Medical Assistance (MA) eligibility to continue with CFSS

Reference: Assessment for PCA/CFSS services (state.mn.us) | DHS 6893H CFSS Home Care Rating/Units Tool

BUDGET & AGENCY MODEL CALCULATIONS

The MnCHOICES Assessment will determine the member's CFSS eligibility and hours. Members can choose to convert some or all units to dollars depending on the CFSS model the member selects. Members will utilize the DHS-6893P Individual Service Delivery Plan to provide details on model selection, direct care, goods and services, and/or PERS selected. CFSS BUDGET and AGENCY model budget calculation is determined using the DHS CFSS Budget Calculator.

Budget Model:

Agency Model:

Reference: PCA/CFSS unit determination (state.mn.us) | DHS CFSS Budget Calculator

AUTHORIZATION: PCA/CFSS COMMUNICATION FORM

Upon the first submission of a PCA/CFSS Communication Form to UCare Intake (pca_cfss@ucare.org), the CC includes:

1. Supplemental Summary Chart
2. Assessment Results

45-DAY TEMPORARY START OF CFSS (MEMBER WITHOUT MNCHOICES ASSESSMENT)

STOP: If a MnCHOICES assessment has been completed, a member is not eligible for a 45-day temporary start of CFSS.

When a member is new to PCA/CFSS and has emergent needs to access services prior to the MnCHOICES assessment being completed, the CC may use clinical judgment to temporarily authorize CFSS for up to 45 days. The CC gathers information needed over the phone to determine the need and clearly documents justification in the member record. The DHS-6893A may be utilized as a tool to assist in determining hours. A 45-day temporary start of CFSS cannot be extended. An in-person MnCHOICES assessment is needed to authorize ongoing CFSS. Unused units from the 45-day temporary start do not carry over to the CFSS service authorization.

In CFSS, a member can only use the CFSS agency model during the 45-day temporary start. The care coordinator will work with the member to identify a UCare in-network CFSS agency using the UCare Provider Search Tool. The CC uses the PCA/CFSS Communication Form to authorize a 45-day Temporary CFSS. At the end of this authorization, a DTR is not needed.

Reference: 45-day temporary start for PCA/CFSS services (state.mn.us)

SIX-MONTH PCA TRANSITION (EXISTING MEMBER)

For members currently utilizing PCA: **Within 10 business days of the assessment**, CCs authorize the temporary continuance of PCA for 6 months into the new span to avoid a gap in services based on the new MnCHOICES assessment. The 6 months of transition PCA is for existing PCA-eligible members who had an authorization within the previous 60 days. UCare PCA/CFSS Intake will continue to provide the PCA/CFSS provider with a copy of the Supplemental Summary Chart

Example:

- Current PCA Authorization, the member is eligible for 5 hours/day
- New MnCHOICES Assessment determines member is now eligible for 6 hours/day
- Authorize 6 months of PCA at 6 hours/day

The CC uses the PCA/CFSS Communication Form to authorize PCA Services – 6 month transition. A DTR is not needed to discontinue 6 month transitional PCA when the member's DHS-6893P Service Delivery Plan is approved.

IMPORTANT: If the member completes the DHS-6893P Service Delivery Plan prior to the completion of the PCA 6 month transition authorization, the member may elect to move to CFSS between months 4-6. A member cannot transition to CFSS during months 1-3 of the 6 month transitional PCA.

See AUTHORIZING APPROVED CFSS SERVICE DELIVERY PLAN section for additional details on Service Delivery Plan approval and start dates.

CONSULTATION SERVICES

Once the member selects a CS provider, authorize Consultation Provider Services using the UCare PCA/CFSS Communication Form to initiate services

- CC authorizes an initial 6 sessions/units of consultation services starting no sooner than the start of the new authorization period through the end of the new span.
    - If the CS provider is selected after the start of the new span, use a start date of when the CS provider was selected through the end of the new span.
- If more than 6 units/sessions are needed, the CC must receive a request from the CS provider with justification/documentation. The CC must provide approval and submit a new PCA/CFSS Communication form with a justification noted in the description on the form.

NOTE: Consultation Services are not included in the Elderly Waiver budget.

DHS-6893P INDIVIDUAL SERVICE DELIVERY PLAN REVIEW

The Consultation Service Provider is responsible for uploading the member's DHS-6893P Individual Service Delivery Plan to MnCHOICES as an attachment and notifying the CC it is ready for review. Care coordinators review the member's DHS-6893P Service Delivery Plan to ensure it meets all requirements (refer to CFSS Manual – PCA/CFSS service delivery plan) and does not include services or goods that are not covered (refer to CFSS Manual – PCA/CFSS covered services). A care coordination aide or support staff cannot approve a service delivery plan, and it must be the care coordinator or other staff member who has training and/or experience with the assessment and care coordination.

- Review the plan to understand if the member chooses Agency or Budget Models and if using goods and services. This will determine what is needed for authorizations.
- CC ensures DHS-6893P goods and services are not covered by other sources (i.e., MA, Supplemental Benefits, 3rd party payors) and are not duplicative of other supports and services
    - CFSS allows for the purchase of goods and services to aid in independence

        - CFSS allows for the purchase of a Personal Emergency Response System (PERS) to support the member when they do not have staff
- CC ensures the personal care hours/units are appropriately represented in the DHS-6893P based on the assessment outcome
    - CFSS allows for spouses and individuals receiving CFSS to provide services to members using CFSS

Reference: CFSS service delivery plan development and approval process (state.mn.us)

AUTHORIZING APPROVED CFSS SERVICE DELIVERY PLAN

Pending Approvals: If a service delivery plan does not meet CFSS requirements, the care coordinator should work with the member directly to update the service delivery plan or refer the member back to their consultation service provider to make adjustments to the plan. Members must receive final approval with signature from the care coordinator before the service delivery plan is implemented.

Final Approval: The CC approves the Service Delivery Plan by signing the DHS-6893P. A care coordinator must approve or deny the plan within **30 calendar days** of receipt. If the CC denies part or all of the plan, the CC must submit the UCare PCA/CFSS Communication Form to DTR the item(s) or plan. The CC must send the final copy of the approved DHS-6893P to the member, CS provider, and CFSS provider agency and/or FMS provider.

Start date of CFSS Service Delivery Plan: The start date of the CFSS service lines is the date the CC approved the service delivery plan or the date providers are chosen, whichever is later. A member cannot transition to CFSS during months 1-3 of their 6 month transitional PCA.

To authorize payment of CFSS, the CC completes the UCare PCA/CFSS Communication Form including applicable service items:

1. Agency Model:
    a. CFSS Provider Agency: personal care services in units
    b. CFSS Provider Agency: Worker training and development
    c. FMS: Goods/services in dollars (as applicable)
2. Budget Model:
    a. FMS: monthly fees
    b. FMS: personal care services in dollars
    c. FMS: Worker training and development
    d. FMS: Goods/services in dollars (as applicable)
3. PERS: Authorize using DHS enrolled PERS provider
    a. PERS installation and testing
    b. PERS monthly fee
    c. PERS purchase (as applicable)

Reference: DHS CFSS Codes & Rates | CFSS service delivery plan development and approval process (state.mn.us)

45-DAY TEMPORARY INCREASE OF PCA/CFSS (CURRENTLY AUTHORIZED FOR SERVICES)

Process to increase PCA/CFSS services for up to 45 days when the member has had either of the following:

- Significant change in condition
- Change in their need for services and support.

Once notified of the need for increased services, the CC gathers information over the phone to determine the need for increased time and clearly documents the justification for increased time in the member record. Revise the member's Support Plan—MCO MnCHOICES to reflect the increase in services.

The increase cannot exceed 45 days. If the member requires an increase of PCA/CFSS services for more than 45 days, an in-person MnCHOICES assessment is needed. Unused units from the 45-day temporary increase do not carry over.

The CC uses the PCA/CFSS Communication Form to authorize a 45-day increase in PCA/CFSS. At the end of this authorization, a DTR is not needed.

Reference: 45-day temporary increase of PCA/CFSS services (state.mn.us) | DHS CFSS Codes & Rates

DAILY AUTHORIZATION REPORT

UCare informs the CC of the completed authorization approval/denial via the Daily Authorizations Report (DAR). UCare also notifies the member, Consultation Services Provider, FMS provider or PERS provider via a Service Authorization Letter (SAL). Providers begin providing services after receiving the SAL.

ONGOING MONITORING OF DHS-6893P

Care coordinators monitor and evaluate the plan's implementation, including the member's health, safety and satisfaction, the plan's effectiveness, and the possible need for revision at least every six months. The FMS provides a spending summary. CCs document a review of the spending summary. If concerns are present, the CC follows up with the member/consultation services provider to review and provide guidance. Care coordinators may not conduct early assessments due to a member exhausting their budget prior to the completion of their current CFSS authorization.

REVISIONS TO THE DHS-6893P

Members may not exhaust their care needs budget or payment for goods/services and may request more within the current authorization span. Members may amend their service delivery plan at any time, provided sufficient funds/units are available in the current authorization span.

Reference: PCA/CFSS service delivery plan changes (state.mn.us)

CHANGE IN SERVICE PROVIDERS

It's important to notify UCare of changes in service providers using the UCare PCA/CFSS Communication Form to ensure proper and timely payment of services including:

- Agency Providers
- FMS Providers
- Responsible Party
- Consultation Service Provider
- PERS Provider
- Change in the selected model – Agency to Budget or vice versa

Reference: PCA/CFSS Communication Form Instructions

Reassessments

Agencies and/or FMS Providers request a reassessment 60 days prior to the expiration of the current service delivery plan. The care coordinator must perform a reassessment annually (within 30 days of enrollment and before 365 days of the previous assessment) and when the member's condition warrants an early assessment. An assessment is valid for 60 days from the date of assessment.

Reference: Reassessment for PCA/CFSS services (state.mn.us).

DENIAL TERMINATION OR REDUCTION OF CFSS

Care coordinators review the submitted DHS-6893P to ensure items are appropriate for CFSS authorization. If education or clarification is needed, the CC may return the DHS-6893P to the member/CS Provider for requested updates. Once the DHS-6893P is agreed upon, the plan can be approved.

DTR needed:	Yes	No
Member requests early reassessment: If the CC determines there has not been a significant change in condition and early assessment is not warranted	x	
If a CC is denying, reducing or terminating a member's eligibility for CFSS	x	
A member does not choose a CS provider w/in 90 days of the assessment	x	
Upon the 30th day of admission to Skilled Nursing Facility (if EW/CFSS)	x	
A MnCHOICES assessment determines CFSS eligibility, but the member did not request CFSS		x
DHS-6893P is in process/pending status while waiting for clarifications		x
A MnCHOICES assessment after 45-day temp start results in a reduction of CFSS hours		x

ADMISSION TO HOSPITAL OR SNF

CFSS services may not be billed while the member is in the hospital. If such an admission occurs, the member must notify the care coordinator, who must then let the FMS know not to pay for services provided or purchased during this time. The CC should ensure providers are aware of the member's admission and to temporarily suspend providing services until the member returns to the community.

CFSS ANNUAL BUDGET

Care coordinators notify eligible members of the CFSS budget by sharing the Assessment Summary. CFSS monthly budget limits are allocated based on the assessed needs and determined by the MnCHOICES Assessment.

CFSS Only and Case Management Fees: Unlike EW budgets, when a member is CFSS only (non-EW) CCs do not subtract UCare case management fees, and they are not accounted for in the member's MnCHOICES support plan budget.

UNUSED FUNDS

The DHS-6893P is approved for up to 12 months. Unused funds cannot be carried over to the next year. A member's annual budget amount will not be reduced the following year due to unused funds.

MEMBERS NEW TO UCARE WITH CFSS

From another MCO or from Fee for Service with existing PCA/CFSS authorization

Upon enrollment, care coordinators complete a THRA (MCO to MCO transfer) or a MnCHOICES FNU (FFS to UCare) within the required timelines. Ensure the member's PCA/CFSS provider is in-network and (if needed) provide the PCA/CFSS Transfer Form to the existing PCA/CFSS agency. The provider completes and returns the PCA/CFSS Transfer form as indicated on the form. All provider facing forms will be located on the Provider Authorization Page, PCA/CFSS Forms drawer.

- Assessment refused or unable to reach: UCare will honor the existing authorization using in-network providers through its current end date. CC completes reassessment prior to the current authorization end date.
- Continuity of Care: Members may continue to receive PCA/CFSS services for up to 120 days after enrollment through an out-of-network provider. CCs work with members to establish care with an in-network UCare PCA/CFSS agency.

NOTE: County case managers are responsible for completing the MnCHOICES PCA/CFSS assessment for members on other disability waivers (CADI, BI, DD, CAC). Disability waiver case managers submit the DHS-5841 to UCare to authorize any/all CFSS services. Care coordinators ensure collaboration with the disability waiver case manager to ensure there is no gap in services.

EXTENDED CFSS REQUESTS FOR MEMBERS ON EW

Services that follow Medical Assistance (MA) state plan PCA/CFSS policies but are allowed to exceed the state plan limits on amount, duration and frequency based on a person's assessed need. A person's dependencies determined in the state plan assessment do not change by adding extended PCA/CFSS services. The member can only use extended CFSS units for personal care services from the CFSS personal care worker. In the CFSS budget model, extended CFSS units convert into dollars at the same rate as state plan units. The member cannot use extended CFSS hours/dollars to purchase goods, services, or PERS. Extended CFSS must be included in the member's EW budget.

Care coordinators may only authorize extended PCA services when all the following conditions are met:

- The member meets basic PCA/CFSS service access criteria on CFSS Manual – Eligibility for PCA services;
- The member has a need for PCA/CFSS services identified during the assessment;
- The member is open to Elderly Waiver;
- The member's need for PCA/CFSS services is of greater frequency or duration than the state plan PCA/CFSS allows; and
- PCA/CFSS services do not duplicate other services on the person's service plan or support plan

The CC authorizes extended CFSS utilizing the UCare PCA/CFSS Communication Form.

Reference: Extended PCA/CFSS services (state.mn.us)

ENHANCED CFSS RATE

Members may be eligible for an enhanced reimbursement rate or budget for work based on the DHS-approved amount when:

- The member is eligible for 10 or more hours per day of state plan PCA/CFSS and/or has the home care rating EN.
- The member's worker has completed qualifying training

The CC completes the UCare PCA/CFSS Communication Form per normal practice. The provider bills the enhanced PCA/CFSS rate using the T1019 TG modifier. UCare verifies eligibility and pays the enhanced rate when the worker is eligible.

Reference: PCA, CFSS and CSG enhanced rate/budget (state.mn.us)

CFSS COVERED SUPPORTS

CFSS is foundationally a personal care service that may include services, supports, and/or items that supplement state plan services or provide alternatives to waiver or state plan services.

PERSONAL CARE SERVICES

Activities of daily living (ADLs): Activities a person needs to carry out on a daily basis to remain healthy and safe. Covered ADLs: dressing, grooming, bathing, eating, positioning, transfers, and mobility.

Instrumental activities of daily living (IADLs): Activities a person needs to carry out on a regular basis to remain independent. Examples include accompanying to medical appointments, shopping, paying bills and meal preparation.

Health-related procedures and tasks: Tasks such as supporting a person with self-administered medications, providing immediate attention to health and hygiene, or helping with range-of-motion exercises.

Observation and redirection of behaviors: Monitoring a person's behaviors and redirecting them to more positive behaviors when needed.

Worker Training and Development: Budget that the agency (Agency Model) or the member (Budget Model) can use flexibly for training their worker on their specific needs. Replaces Qualified Professional Units in PCA.

Worker Information

CFSS expands on who may be a member's personal care worker.

- Agency staff, friend, neighbor or family member (including spouse)
  - Maximum hours paid for a spouse is 60 hours per week
- Workers who are also receiving CFSS may be another recipient worker
- Pass background study
- Enroll with the state as a worker

Not Covered:

CFSS workers are NOT allowed to provide injection services or tasks typically completed by another person.

GOODS AND SERVICES

Goods and services are items or services purchased through CFSS that either increase the person's independence or decrease the person's need for assistance from another person. All people who use CFSS may purchase covered goods and services. Members who only purchase goods and services (I.e., not using personal care services) must use the CFSS budget model. People on a waiver cannot use extended CFSS units/dollars to purchase goods and services. Goods and services should not duplicate a good or service the member is receiving through their waiver, if applicable.

Covered goods and services purchased through CFSS must meet all of the following criteria:

- Related to an assessed need
- For the direct benefit of the member
- Increase the member's independence or decrease their need for assistance from another person
- Included in the member's service delivery plan

Examples:

Covered **goods** could include, but are not limited to:

- Grab bars (could replace transfers or mobility)
- Wheelchair ramps (could replace mobility)
- Assistive technology (communication device not covered by MA could replace IADL)
- Specialized devices for dressing or grooming (grabber tool could replace assistance with dressing)

Covered **services** could include, but are not limited to:

- Meal delivery (could replace eating or IADL)
- Laundry service (could replace time a worker needs doing laundry)

Not Covered Goods and Services:

A member cannot use CFSS funds to purchase:

1. A good or service that is:
   - Not related to an assessed need
   - A replacement for human assistance that is not a covered CFSS service listed on the CFSS Manual – PCA/CFSS covered services
   - Not for the direct benefit of the person
   - Not the most cost-effective option to meet the person's need(s)
     - If the person prefers a version of an item that is more expensive than the least costly alternative, they can purchase that item and pay for the difference in cost.
   - Covered under any other state plan service
   - The responsibility of another entity (e.g., a person's school, Medicare or private insurance)

2. Medical supplies or equipment covered by Medical Assistance (MA)
3. Insurance premiums and copays
4. Room and board costs
5. Vacation expenses
6. Vehicle maintenance, except for maintenance of disability-related modifications
7. Tickets to recreational events
8. Camps and classes
9. Legal or advocacy-related fees
10. Experimental treatments
11. Membership fees or costs, except when the service is necessary for the person's health condition and monitored by a Minnesota Health Care Programs (MHCP)-enrolled physician, advanced practice registered nurse or physician's assistant

Reference: Goods and services through CFSS (state.mn.us)

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

In CFSS, members can use some of their units/dollars to purchase a personal emergency response system (PERS) as an electronic backup system. A member is not required to purchase PERS as part of their CFSS service delivery plan. A member may choose to utilize their CFSS units/budget for personal care and/or goods and services and receive their PERS device through Elderly Waiver, if eligible.

To be eligible, a member must meet at least one of the following criteria:

- Lives alone or is alone for significant parts of the day.
- Does not have a regular caregiver for extended periods of time and requires support and supervision.
- Has not identified anyone as their back-up support.

CFSS covers the following services for PERS:

- Purchase of the PERS equipment, including necessary training or instruction on use of the equipment ($1,500 maximum).
- Installation, setup and testing of the PERS equipment ($500 maximum).
- Monthly monitoring fees ($110 monthly maximum).

If a member is choosing to utilize PERS, the member must select a PERS provider that is enrolled with DHS as an MHCP PERS provider and located on MinnesotaHelp.info. The member must include the type of services they need (purchase, install, monitoring) and the provider they have selected in the PERS section of their service delivery plan.

Not Covered:

A member cannot use extended CFSS units/dollars to purchase PERS.

A replacement PERS is covered if the equipment is being replaced for the member. In other words, UCare will cover a lost or stolen pendant while the member is using the service. A replacement PERS is not covered if the pendant is lost or stolen and the member is no longer using the device/service as that is a provider's responsibility to cover lost or stolen equipment for a service the member is no longer receiving. If the provider is pursuing financial recoupment, they can submit a benefit exception required to UCare utilizing the UCare prior authorization form.

CC role:

Members work with the CS Provider to develop the service delivery plan. The member chooses their PERS service provider, which will be indicated on the service delivery plan. The care coordinator is responsible for PERS referrals and authorization through the UCare PCA/CFSS Communication Form. CFSS PERS is authorized

as a separate line item with the selected provider at the negotiated rate. Do not authorize CFSS PERS utilizing the Waiver Service Authorization Form as the procedure codes/modifiers vary for EW PERS compared to CFSS PERS services.

Reference: CFSS personal emergency response systems (PERS) (state.mn.us)