Care Coordination CDCS Guidelines

Table of Contents

The following is information and updates regarding the Consumer-Directed Community Supports (CDCS) program option. This material **may change** as the Minnesota Home and Community Based Services (HCBS) waiver policy is subject to State and Federal approval and interpretation.

Consumer Directed Community Supports (CDCS) Overview

Consumer Directed Community Supports (CDCS) is a program option for Home and Community-Based Services (HCBS) waivers. This option offers members a person-centered approach, allowing more flexibility and responsibility for directing their own services and supports, including hiring and managing direct care staff. It may include services, supports, and/or goods currently available through licensed waivers and additional services/goods that provide needed "unlicensed" support to the member. There are specific requirements for all services, supports and/or goods available through HCBC waivers and AC grants, including CDCS.

Services under the CDCS option offer members support, care and assistance to prevent institutionalization and allow them to live an inclusive life in their community. Supports are designed to build, strengthen, or maintain the informal community support networks for the member. It allows members to purchase services that will best meet their needs from people they have selected themselves and trust, such as family and friends. The member identifies staff qualifications and training requirements. The members can direct their own assigned resource allocation within the established state, federal, and UCare-approved parameters and guidelines. All services must be paid for within the member's CDCS resource allocation. Approval of certain services or goods may be denied if health, safety and/or welfare concerns are not met, or if funds are misused or certain criteria are not met. (For example, a behavioral issue or respite need is identified in the MnCHOICES assessment, and these are not addressed or utilized during a developed plan year).

It is important that waiver members who utilize the CDCS 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 CDCS. UCare provides information about the CDCS option through assigned care coordinators and written information to educate members on available service options, their responsibilities and the service limitations.

Waiver funds using the CDCS 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 using a preset individualized resource allocation. A signed member agreement must be obtained prior to submission of a CDCS plan.

All CDCS waiver fund expenditures must be prior approved and traceable back to an authorized service or good approved in the member's DHS-6532 Community Support plan (CSP).

Definitions

Allowable Expenditure: A good or service that is covered under CDCS and can be purchased using waiver funds.

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).

Alternative Treatment Form (ATF): The DHS-5788 Alternative treatment form is used to request non-experimental therapies, treatments or supports outside the scope of Medical Assistance State Plan or other waiver services. The form is completed by the participant's MN healthcare provider and forwarded to the care coordinator.

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

CDCS Community Support Plan (DHS-6532): Refers to the member/Support Planner created written plan which includes detailed descriptions of the individual supports and services requested within the CDCS budget.

DHS: Minnesota Department of Human Services

Financial Management Services (FMS): An FMS provider is an MA-enrolled provider for CDCS who reimburses service providers for authorized CDCS services, supports and/or items. Also referred to as Fiscal Support Entity (FSE).

Insurance: Refers to Medical Assistance, Medicare, managed care, MSHO, MSC+, and private insurance.

Member: Refers to the UCare enrollee.

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

Notice of Technical Assistance (NTA): A formal notification to members who require additional assistance and oversight with their CDCS plan. The NTA indicates the member does not comply with CDCS requirements.

Support Plan - MCO MnCHOICES Assessment: A written summary of the person's 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 HCBS or state plan services. This document provides a summary of discoveries made through the assessment process and identifies the person's needs. The support plan also includes the elderly waiver budget based on the member's case mix capitation.

Support Planner: An individual selected by the person and reimbursed through the person's CDCS budget to help develop and implement the person's person-centered CDCS Community Support Plan (CSP). The support planner may work independently or be employed by an agency. See: CDCS support planner / Minnesota Department of Human Services (mn.gov)

Waiver Service Authorization (WSAF): The UCare form used by CCs to submit EW and CDCS authorized services.

Roles and Responsibilities

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

MEMBER

The member is responsible to:

- Develop a DHS-6532 CDCS Community Support Plan
- Provide a written Health and Safety Plan (optional when more detail is required than what can be written in the Health and Safety Plan section on the DHS-6532 CDCS CSP form)
- Provide the DHS-5788 Alternative Treatment Plan to care coordinator (as applicable)
- Select the FMS provider
- Communicate on an ongoing basis with a care coordinator and FMS provider
- Select a certified support planner (optional)
    - If using a support planner, a DHS support planner certificate must be attached to the CDCS Plan for consumer protection
- Hire, train, monitor and manage support workers
    - If using Shared Staffing, the member provides the CC the DHS-6633D CDCS Shared Services Agreement
- Review and submit support workers' timesheets to the FMS provider
- Revise the CDCS Community Support Plan as needed (some revisions will require care coordinator approval)
- Review and monitor spending summaries

FMS PROVIDER

The FMS provider is responsible to:

- Bill DHS or the managed care organization (MCO)/UCare
- Provide monthly spending summaries to the member
- Provide quarterly spending summaries to the care coordinator
- Provide monthly reports to the care coordinator when over or under-spending occurs
- Receive and process invoices for approved expenditures

- Review and process support workers' timesheets

CARE COORDINATOR

The care coordinator is responsible for the following:

COMPLETE DHS ON-LINE TRAINING

Complete CDCS training TrainLink DHS CDCS 400 course before the initial CDCS plan implementation and keep updated on changes in DHS rules and requirements related to CDCS.

- Utilize the DHS CDCS Manual as a reference to current DHS policy and guidance

MNCHOICES ASSESSMENT AND SUPPORT PLAN

UCare care coordinators utilize the MCO MnCHOICES - Assessment tool and Support Plan - MCO MnCHOICES Assessment to determine member's eligibility requirements for the Home and Community-Based Service (HCBS) Elderly Waiver. Members who meet Nursing Facility Level of Care and are eligible for the Elderly Waiver may elect CDCS. The care coordinator is responsible for determining the appropriateness of participation in CDCS and discretion regarding methods for disbursement of funds. In addition:

- The member must maintain Medical Assistance (MA) eligibility for waivers and receive Home and Community-Based waivered services
- The member must be able to manage their support, budget, and services within DHS guidelines
    - Or have a "managing party" designated to manage their support, budget and services

CDCS Ineligible:

The following individuals are **NOT** eligible for CDCS:

- Member who exits the waiver more than once during the service plan year. This does not preclude the individual from using other waiver services for the remainder of the service plan year.
- Member is on the Minnesota Restricted Recipient Program
- Member receives services in a licensed or registered setting:
    - Example: Adult foster care settings
- Notice of Technical Assistance: Members may become ineligible for CDCS when the CC has issued four NTAs within the waiver span year. A Denial/Termination/Reduction for CDCS is issued when being terminated from CDCS.

PROVIDE EDUCATION

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

- Services that could meet the person's needs (including CDCS)
- Member education online training: DHS CDCS Member Training (required for initial eligibility authorization)
- Explanation of self-direction and its roles and responsibilities for CDCS
- Budget information for CDCS
    - DHS-3945 LTSS Rate Limits
- Services, supports and goods the person can purchase within a CDCS budget
    - Member Guide to CDCS Allowed Expenditures
- Provide members the DHS-4124 CDCS Overview (annually)
- DHS 4317 CDCS Consumer Handbook (Initial start of CDCS)

CDCS ELECTION

When a member elects CDCS, the care coordinator:

- Authorizes non-CDCS waiver services, if necessary, while the member develops the DHS-6532 CSP

- Pro-rate WSAF accordingly to avoid a gap in services
- Gives the member a list of certified Support Planners (if applicable)
  - MinnesotaHelp.info Tip: Search Consumer Directed Community Supports (CDCS), Support Planner, to locate Support Planner options
- Gives the member a list of DHS-certified financial management services (FMS) providers
  - Financial Management Service Provider Information
- Gives the person options for person-centered planning
  - DHS Person-Centered Planner Information
- Provide the MnCHOICES Assessment Summary information to help guide the member's plan development
- Obtains member signature on the DHS-6532 CSP, UCare's CDCS Member Agreement and Checklist and the MnCHOICES Support Plan annually

COMMUNITY SUPPORT PLAN REVIEW

Care coordinators review the member's DHS-6532 Community Support Plan (CSP) to ensure/approve requested supports and services are within the allowable services and budget.

- **DO NOT provide verbal approval to the member/authorized representative.**
- **Initial and annual DHS-6532 CSPs are to be reviewed/acknowledged by a supervisor prior to submitting WSAF.**
- CC ensures DHS-6532 CSP expenditures are not covered by other sources (i.e., MA, Supplemental Benefits, 3rd party payors)
- Pending Approvals: Care coordinators provide communication to the member/support planner of any discrepancies noted in the review of the DHS-6532 CSP. Members update the DHS-6532 CSP and return it to the CC for final approval. Members must have final approval before the start day of the DHS-6532 CSP.
- Final Approval: Care coordinator sends the DHS-6532 CSP to the FMS, member/support planner to acknowledge final approval.

AUTHORIZING CDCS

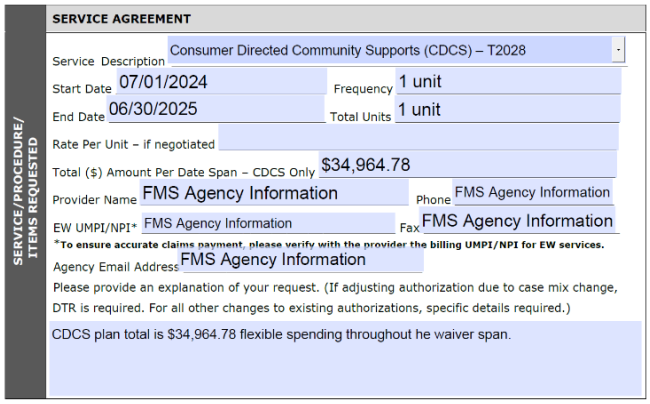
Care coordinators submit the UCare Waiver Service Approval Form to authorize CDCS supports. The WSAF includes two (2) line items:

1. The services within the plan (CDCS T2028) with frequency of 1 unit per year and Rate Per Unit: Annual Budget Grand Total from DHS-6532 CSP
   a. An updated WSAF is submitted each time the "Annual Budget Grand Total" changes throughout the wavier span year
2. The CDCS background checks (CDCS T2040) with frequency of "5" and Rate Per Unit: Check DHS-3945 LTSS Rate Limits for current rates
   a. Frequency of "5" is the maximum allowed background checks per waiver span

NOTE: Case Management fees are not authorized on WSAFs.

Examples:

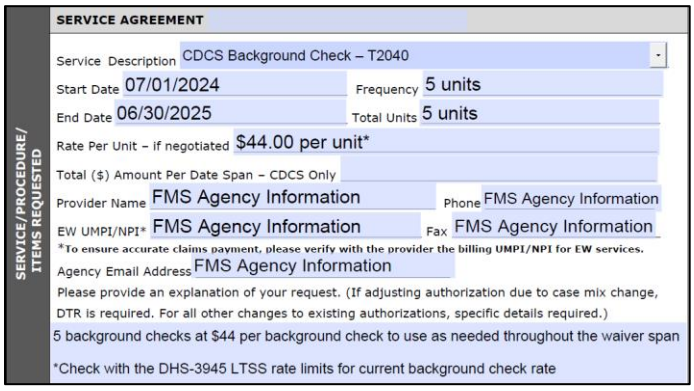
Annual Budget	**$49,889.00**
Total Personal Assistance	$28,315.68
Total Treatment and Training	
Total Environmental Modifications	
Total Self-Directed Support Activities	$6,649.10
Total MA Home Care Services	
Grand Total	**$34,964.78**
Unused Budget Amount	**$14,924.22**



SERVICE/PROCEDURE/ ITEMS REQUESTED

SERVICE AGREEMENT

Service Description: Consumer Directed Community Supports (CDCS) – T2028
Start Date: 07/01/2024 Frequency: 1 unit
End Date: 06/30/2025 Total Units: 1 unit
Rate Per Unit – if negotiated:
Total ($) Amount Per Date Span – CDCS Only: $34,964.78
Provider Name: FMS Agency Information Phone: FMS Agency Information
EW UMPI/NPI*: FMS Agency Information Fax: FMS Agency Information
*To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.
Agency Email Address: FMS Agency Information
Please provide an explanation of your request. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.)
CDCS plan total is $34,964.78 flexible spending throughout he waiver span.



SERVICE/PROCEDURE/ ITEMS REQUESTED

SERVICE AGREEMENT

Service Description: CDCS Background Check – T2040
Start Date: 07/01/2024 Frequency: 5 units
End Date: 06/30/2025 Total Units: 5 units
Rate Per Unit – if negotiated: $44.00 per unit*
Total ($) Amount Per Date Span – CDCS Only:
Provider Name: FMS Agency Information Phone: FMS Agency Information
EW UMPI/NPI*: FMS Agency Information Fax: FMS Agency Information
*To ensure accurate claims payment, please verify with the provider the billing UMPI/NPI for EW services.
Agency Email Address: FMS Agency Information
Please provide an explanation of your request. (If adjusting authorization due to case mix change, DTR is required. For all other changes to existing authorizations, specific details required.)
5 background checks at $44 per background check to use as needed throughout the waiver span
*Check with the DHS-3945 LTSS rate limits for current background check rate

Communication

UCare informs the CC of the completed authorization approval and entry via the Daily Authorizations Report (DAR). UCare also provides the member and FMS a Service Authorization Letter.

ONGOING MONITORING OF DHS-6532 CSP

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 monthly spending summary. CCs document a review of the spending summary. If concerns are present, the CC follows up with the member/support planner to review and guide.

Notification of Technical Assistance (NTA): NTA may be issued when a member is not following their plan. Reasons for NTA's may include:

- Failure to respond to notices from FMS requesting missing information.
- Not following the member's CDCS plan as approved / unapproved expenditures.
- Overspending at a rate that suggests the plan will not be sustainable over the service plan year.
- Not receiving services, supports and/or items identified as critical for health and safety.
- Not spending enough dollars for services/supports and/or items needed without a reasonable explanation.
- Ongoing difficulty in arranging for services, support and/or items needed for health and safety.

NOTE: The care coordinator has additional monitoring requirements when a spouse serves as a paid worker. For more information, refer to CDCS – Paying a spouse or parent of a minor for personal assistance.

REVISIONS TO THE DHS-6532 CSP

New services, supports, or goods are not allowed to be added to the DHS-6532 CSP 30 days prior to the end of the member's annual service plan date unless approved by the assigned care coordinator for reasons of critical health and safety.

To revise the current DHS-6532 CSP, the member/Support Planner can either select the "revision" radio button and update the current plan in the text box or complete the UCare CDCS Plan Change Form. The member/support planner sends revisions to the CC for review and approval. The CC forwards the approved changes to the member's FMS for payment. If needed, CC will submit an updated WSAF reflecting the budget increase to the plan.

PARTICIPANT CONSENT FOR USE OF MONITORING TECHNOLOGY

Monitoring technology includes the use of equipment to oversee, monitor and supervise someone who receives EW services. It can help keep people safe and support independence. The equipment used may include alarms, sensors, cameras and other devices. For more information, see CBSM-Monitoring technology usage.

If a member will be utilizing monitoring technology covered in their DHS-6532 CSP, the DHS-6789B Participant Consent for use of Monitoring Technology is required to be completed.

The care coordinator:

- Assists member/legal representative in completing the form.
- Retains a signed copy of the DHS-6532 in the member's file.
- Gives a copy of the signed DHS-6532 to the member or member's legal representative.
- Gives a copy of the signed DHS 6532 to the FMS provider.

REASSESSMENTS

The care coordinator must perform a reassessment annually and when the member's condition warrants an early assessment. For more information, refer to CBSM – Assessment applicability and timelines.

DENIAL TERMINATION OR REDUCTION OF CDCS

Care coordinators review the submitted DHS-6532 CSP to ensure items are appropriate for CDCS authorization. If education or clarification is needed, the CC may return the DHS-6532 CSP to the member for requested updates. Once the DHS-6532 CSP is agreed upon, the plan can be approved. A DTR is not needed while the CSP is in process/pending status.

If a CC is denying or terminating a person's eligibility for CDCS, for example, in the event of the 4th Notice of Action, the CC issues a DTR for the entire CDCS plan. The member may remain on EW. In the event a member requests items/services that are not allowed under CDCS and the member would like appeal rights, the CC issues a DTR.

Example: Member is requesting regular elastic waist pants for $200 (two pairs) to help improve independence with dressing. The CC explains clothing/apparel is not covered by MA/EW/CDCS. It is a personal expense. If a member disagrees with the care coordinator's decision that the clothing is not an allowable item, a DTR is issued to deny the request. The DTR form in this example includes using the Service Description of T2028 and Reason Code 0714 with additional comments to explain the item/service being denied, reduced or terminated. Add the language "CDCS sub service" under Reason Code and, as applicable, "Do NOT discontinue all CDCS" if no intending to terminate entire CDCS plan.

SERVICE/ITEM REQUESTED:

☒ Denial ☐ Termination ☐ Reduction ☐ Terminating EW Eligibility — select as applicable	Use DTR code that best fits member situation. Common codes may include: 0714, 1610, 1611.	Reason code: 0714 CDCS sub-service — Add to provide clarity
Service Description: Consumer Directed Community Supports (CDCS) – T2028 — Use T2028 for Service Description		
Frequency: NA		Rate per unit (*if negotiated*): $200
Provider: NA		
EW UMPI or NPI: NA		
Phone: NA		Fax: NA

DTR Comments *(e.g., date of Nursing Home admission/out of country date/services reduced via CL Tool)*:

Do NOT discontinue all CDCS - only Deny clothing/elastic pant because clothing is member responsibility per CDCS guidelines.

Ensure to clarify when not intending to terminate CDCS entire plan.

ADMISSION TO HOSPITAL

CDCS 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 waiver must be closed if the hospital stay is over 30 days.

ADMISSION TO NURSING HOME

- CDCS services are immediately suspended once the member is admitted into a nursing home. Members are to notify the care coordinator when entering a nursing home.
- Follow the EW Nursing Home admission DTR process

CDCS Annual Resource Allocation (Case Mix Cap)

Care coordinators notify eligible members of the CDCS allowed resource allocation. The annual MnCHOICES assessment is used to determine the member's resource allocation/case mix capitation. Services and goods will not be authorized without a signed and completed MnCHOICES Support Plan, Signature Page.

CDCS monthly budget limits are allocated based on the assessed case mix. The monthly and yearly CDCS budget limits can be found on DHS-3945 LTSS Rate Limits for Elderly Waiver.

Case Management Fees: Unlike regular EW budgets, CCs do not subtract UCare case management fees, and they are not accounted for in the member's MnCHOICES support plan budget. Additionally, UCare does not use the CDCS Mandatory Case Management fee code T2041. Do not authorize T2041 case management fees and do not include in the member's budget.

EW LEGISLATIVE RATE CHANGES

Legislative increases to EW CDCS budgets are available to members as of the DHS effective date. The care coordinator reviews the new service rate and EW budget caps, which are found in the Long-Term Services and Supports Service Rate Limits DHS-3945. Increases can be applied when there is an assessed need for increased services and support.

CDCS Rate Change Process

- CC completes the DHS-6633A CDCS CSP Addendum following all directions in the form – including supervisor review signatures
- Provide the DHS-6633A CDCS CSP Addendum to the member
- Upon return from member: Update member record and upload DHS-6633A to member file
- Review and update the MNCHOICES Support Plan
- CC sends completed DHS 6633A to FMS
- If the member will be utilizing the increased funds, the care coordinator must complete a new WSAF

CDCS Enhanced Budget

Members may be eligible for a CDCS enhanced budget when the results of the person's MnCHOICES Assessment indicate they are eligible for ten or more hours per day of state plan PCA. The purpose of an enhanced budget is to help people with high needs and attract and retain qualified workers.

A 7.5% CDCS enhanced budget is available for work that is both:

- Provided by a worker who has completed qualifying training.
- Provided to a member who is eligible for ten or more hours per day of state plan personal care assistance (PCA) and/or has the home care rating EN.

Regardless of the number of workers who have completed the qualifying training, the member's budget can be enhanced by 7.5% only once during the service plan year.

PROCESS TO AUTHORIZE CDCS BUDGET ENHANCEMENT

Care Coordinator:

- Identifies and informs members of eligibility for the enhanced budget (see the eligibility section of the CBSM page on the CDCS enhanced budget process)
- Provide the DHS-6633B CDCS Enhanced Budget Request and Community Support Plan Addendum to the member to inform them of the enhanced budget amount and ask the member to complete the bottom portion of the form
- Verifies the member has a qualifying worker by reviewing the DSW training administrator's confirmation letter the member provided to the care coordinator
- Performs a final verification that the member is eligible and the worker completed the qualifying training
- Review and approve the member returned DHS-6633B
- Calculates the 7.5% enhancement to the member's CDCS budget
- Completes the top portion of DHS-6633B CDCS Enhanced Budget Request & Community Support Plan Addendum and DSW training administrator's confirmation letter, then submit it to the Clinical Liaisons at MSC_MSHO_ClinicalLiaison@ucare.org
- Waits for approval from the Clinical Liaisons that UCare has approved the enhanced budget
- Directs the member to revise their CDCS Community Support Plan, DHS-6532, to reflect the budget modification (as applicable)
- Completes the Waiver Service Approval Form and submits to UCare
- Adds a Y (Yes) to the PCA complex field on the LTC screening document, but DO NOT add the enhanced budget amount in the CDCS amount field
- Retains the completed DHS-6633B in the member's file
- Provide the approved DHS-6633B and revised CDCS Community Support Plan to the FMS provider to implement the budget

Members' Worker:

- The eligible member's worker completes qualifying training and submits documentation to the Minnesota Direct Support Worker (DSW) training website for validation
- The DSW training administrator confirms the worker met requirements and emails a confirmation letter to the worker
- The worker gives the administrator's confirmation letter to the member

Member Responsibility:

- The member completes the bottom portion of DHS-6633B, signs it and submits it to the care coordinator
- The member provides the CC with the worker's confirmation letter

The enhanced budget is effective through the end of the member's service plan year. At the end of that year, the care coordinator must follow the process and procedure in the reassessment section of the CBSM page for the CDCS enhanced budget process.

Unused Funds

The DHS-6532 CSP is approved for up to 12 months. Unused funds cannot be carried over to the next year. A member's annual resource amount will not be reduced the following year due to unused funds. A member's resource allocation will be pro-rated based on the monthly CDCS amount.

Supervisor Approval

UCare requires annual DHS-6532 CS and CSP revisions over $500 to be thoroughly reviewed and approved by the care coordinator's supervisor.

The supervisor should review supporting documentation based on approval of the criteria for allowable expenses. Prior approval is required for new services/goods or changes to a paid spouse throughout the plan year. UCare Clinical Liaisons are available to provide consultation and direction to care coordinators regarding CDCS guidelines.

Overview of CDCS Expenditures

CDCS expenditures may include services, supports, and/or items that supplement state plan services or provide alternatives to waiver or state plan services. All expenses MUST fit into one of five categories:

- Personal Assistance
- Treatment and Training
- Environmental Modifications and Provisions
- Self-Direction Support Activities
- MA Home Care Services

See the Member Guide to CDCS Allowed Expenditures for goods and services that may be included in the member's DHS-6532 CDCS CSP if they meet the criteria below and fit into one of the five categories:

- Therapies, special diets and behavioral supports not otherwise available through Minnesota Health Care Programs or private insurance that directly benefits the individual's needs based on their disability/condition and are prescribed by a physician/nurse practitioner who is enrolled as a MHCP provider
- Expenses related to the development and implementation of the DHS-6532 CSP
- Costs related to managing the member's resource allocation

IMPORTANT!

All services and items should be the most cost effective or may have suggested limits. Limits are included as a guide to what is considered "customary" and "fiscally responsible". Requested amounts beyond what is suggested will require additional written explanation in the DHS-6532 CDCS CSP and/or evaluation.