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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: 22-0005

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

February 27, 2024

Patrick Hultman, Deputy Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
PO Box 64983
Saint Paul, MN 55164-0983

RE: MN 22-0005 new §1915(k) Community First Choice State Plan Benefit

Dear Deputy Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its state plan to add a new 1915(k) Community First Choice (CFC) benefit, transmittal number MN 22-0005.

CMS conducted the review of the state's submittal according to statutory requirements in Title XIX of the Social Security Act and relevant federal regulations. The effective date for this 1915(k) benefit is June 1, 2024. Enclosed is a copy of the approved state plan amendment (SPA).

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS' approval of this new 1915(k) CFC state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, §504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Shawn Zimmerman at Shawn.Zimmerman@cms.hhs.gov or (410) 786-8291.

Sincerely,

[redacted] igitally signed by George . Failla Jr -S ate: 2024.02.27 13:52:17 -05'00'

George P. Failla Jr., Director
Division of HCBS Operations and Oversight

cc: Annese Abdullah-Mclaughlin, CMS
Kenya Cantwell, CMS
Cynthia Nanes, CMS
Wendy Hill Petras, CMS
Shante Shaw, CMS
Debi Benson, CMS
Mark Siegel, MN DHS
Michelle Long, MN DHS

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0005

2. STATE: MN

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
1915(k) of the Social Security Act 42 CFR §§441.500 – 441.590

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 42,854,000
b. FFY 2025 $ 850,541,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-k, pages 1 – 55 NEW
Attachment 4.19-B, Supplement 6, pages 1 - 4 NEW

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

9. SUBJECT OF AMENDMENT
Adopting Community First Choice benefits under 1915(k)

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Patrick Hultman

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
November 30, 2023

15. RETURN TO
Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

FOR CMS USE ONLY

16. DATE RECEIVED
March 13, 2022

17. DATE APPROVED
February 27, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
June 1, 2024

19. SIGNATURE OF APPROVI[redacted]
Digitally signed by George P. Failla Jr -S
Date: 2024.02.27 13:52:44 -05'00'

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director of DHCBSO

22. REMARKS

MINNESOTA
MEDICAL ASSISTANCE
Federal Budget Impact of **TN 22-0005**

Effective June 1, 2024, Minnesota will provide Community First Services and Supports (CFSS) as described in 1915(k) of the Act. CFSS is a participant-controlled method of selecting and providing community-based services and supports.

Fee for service		FFY '24	FFY '25
	Total cost (thousands)	$52,664	$1,073,210
	FFP	59.6%	59.6%
	State Share (thousands)	$ 21,262	$433,285
	Federal Share (thousands)	**$31,402**	**$639,925**

Managed Care		FFY '24	FFY '25
	Total cost (thousands)	$22,333	$408,313
	FFP	51.3%	51.6%
	State Share (thousands)	$10,881	$197,697
	Federal Share (thousands)	**$11,452**	**$210,616**

Total		FFY '24	FFY '25
	Total cost (thousands)	$74,997	$1,481,523
	FFP	57.1%	57.4%
	State Share (thousands)	$ 32,142	$630,982
	Federal Share (thousands)	**$42,854**	**$850,541**

1915(k) State Plan HCBS

Benefit Summary

Please provide a brief general overview of the state's proposed Community First Choice (CFC) benefit, including but not limited to an overview of services, delivery method, impact on other long-term services and supports (LTSS) programs, and how services will be coordinated between the CFC program and other state services provided:

The Minnesota Department of Human Services (DHS) is redesigning its state plan PCA services to expand self-directed options under a program called Community First Services and Supports (CFSS). The Minnesota Legislature authorized DHS to implement CFSS in state statute.

CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of services and supports. The participant chooses the level of direction and management of supports by choosing to have a significant and meaningful role in management of services and supports, including directly employing support workers with the necessary supports to perform that function. This would include services available under both fee for service and managed care. CFSS provides supports to participants to help them remain independent in the community.

CFSS will cover the following services and supports:

Assistance with activities of daily living (ADLs) (e.g., eating, bathing, grooming, and transferring);

- Assistance with health-related tasks;
- Assistance with instrumental activities of daily living (IADLs) (e.g., shopping, cooking, laundry, and assistance with medications);
- In accordance with 42 CFR 441.520, assistance is provided through hand-on assistance, supervision, and /or cueing;
- Support with acquisition, maintenance, and enhancement of skills necessary to accomplish ADL, IADL and health related tasks;
- Purchase of individual backup systems to ensure continuity of services and supports (back-up support and personal emergency response system);
- Purchase of goods and services to replace human assistance and increase independence;
- Payment to the participant's spouse, parents, stepparents, or unpaid legal guardians to serve as the participant's direct support worker providing personal care;
- Participant-specific worker training and development budget for direct support workers providing personal care; and
- Consultation service to provide the participant with support for: voluntary training/education, assisting the participant with writing the participant's service delivery plan and managing services available through the CFC benefit.

CFSS has two service delivery models: the provider agency model and the budget model. In both models, the participant:

- Directs their own care;
- Selects their worker, including their spouse or parent of a minor;

- Writes their plan with assistance from the consultation services provider, as desired; and
- Purchases goods; and

back-up systems

In the provider agency model, the participant selects an agency that serves as the support worker's employer. This means the agency recruits, hires (including workers selected by the participant, if the worker meets qualifications), trains, supervises, and pays the CFSS worker.

In the budget model, the participant is the employer of their own support workers. The participant recruits, hires, trains and supervises their CFSS worker. The person selects a financial management services (FMS) provider to help the person comply with applicable employment-related laws.

Participants who currently receive state plan PCA services will not experience any loss or interruption of services.

Coordination with other services:
The CFSS program is comprised of the §1915(k) benefit and the §1915(i) benefit to provide Personal attendant services and supports to people who meet an institutional level of care (via the §1915(k) benefit) and people who do not meet an institutional level of care (via the §1915(i) benefit). These two components of CFSS are designed to work together seamlessly to provide appropriate services to people who have a functional need.

Consultation services will be authorized and available while the participant is receiving state plan PCA services. PCA services will continue to be authorized until the participant has been served by the consultation services provider, decisions for CFSS services have been made, and CFSS services have been authorized.

Current Personal Care Agency (PCA) providers are given the opportunity to transition to be CFSS agencies. All PCA agencies will make an independent business decision as to whether they wish to be a CFSS agency. Beneficiaries of PCA services will continue to have a choice in PCA providers during the transition to CFSS. At the time of transition to CFSS, beneficiaries will be able to choose from available providers who chose to transition to CFSS agencies. DHS will accept applications for CFSS agencies on a rolling basis.

Community First Choice Development and Implementation Council

Name of State Development and Implementation Council:

Community First Services and Supports Development and Implementation Council

Frequency of Meetings:

The Community First Services and Supports Development and Implementation Council has met at varied intervals over the years but currently meets quarterly throughout the year.

Date of first Council meeting:

Nov. 19, 2012

Date of all council meetings held to date:
2012:
October 17th
November 19th

December 13th

2013:
January 17th
February 21st
April 4th
June 6th
July 30th
August 21st
October 24th
November 13th
December 16th

2014:
January 16th
March 12th
June 16th
September 15th
October 14th
November 19th

2015:
January 12th
May 19th
September 14th
December 7th

2016:
February 8th
June 6th
December 9th

2017:
April 3rd
September 29th
December 4th

2018:
February 6th
June 18th
July 19th
September 17th

2019:
January 14th
June 24th
September 17th

December 9th

2020:
March 16th
June 15th
September 12th

2021:
January 7th
February 4th
June 17th
December 7th

2022:
March 8th
June 8th
September 14th
December 14th

2023
March 8th
June 14th

☒ Box Checked: The state has consulted with its Development and Implementation Council before submitting its CFC State Plan amendment.

☒ Box Checked: The state has consulted with its Development and Implementation Council on its assessment of compliance with home and community-based settings requirements, including on the settings the state believes overcome the presumption of having institutional qualities.

☒ Box Checked: The state has sought public input on home and community-based settings compliance beyond the Development and Implementation Council. If yes, please describe.

DHS sought public input on HCBS settings compliance through the Statewide Transition Plan for HCBS waivers (PDF).

A significant component of Minnesota's public engagement efforts included collaboration with the HCBS rule advisory group through:

- Providing input on the development of DHS' HCBS settings rule statewide transition plan;
- Developing policy expectations and practice considerations;
- Testing the provider-attestation process and providing technical assistance throughout the attestation process;
- Providing input on the desk audit and site visit processes and protocols; and
- Providing technical assistance to providers about the desk audit follow-up and site visits

DHS also seeks public input prior to submitting any settings to CMS for heightened scrutiny review.

Community First Choice Eligibility

☒ Box Checked: Individuals are eligible for medical assistance under an eligibility group identified in

the state

☒Box checked: Categorically Needy Individuals

☒ Box Checked: Medically Needy Individuals

☒ Box Checked: Medically Needy individuals receive the same services that are provided to Categorically Needy individuals

☐ Box unchecked: Different services than those provided to Categorically Needy individuals are provided to Medically Needy individuals. (If this box is checked, a separate template must be submitted to describe the CFC benefits provided to Medically Needy individuals)

The state assures the following:

☒ Box Checked: Individuals are in eligibility groups in which they are entitled to nursing facility services, or

☐ Box Unchecked: If individuals are in an eligibility group under the state plan that does not include nursing facility services, and to which the state has elected to make CFC services available (if not otherwise required), such individuals have an income that is at or below 150 percent of the Federal poverty level (FPL)

Level of Care

☒ Box Checked: The state assures that absent the provision of home and community-based attendant services and supports provided under CFC, individuals would require the level of care furnished in a long term care hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing inpatient psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over.

Recertification

☐ Box Unchecked: The state has chosen to permanently waive the annual recertification of level of care requirement for individuals in accordance with 441.510(c)(1) & (2).

Please indicate the levels of care that are being waived:

☐ Box Unchecked: Long-term care hospital

☐ Box Unchecked: Nursing facility

☐ Box Unchecked: Intermediate care facility for individuals with intellectual disabilities

☐ Box Unchecked: Institution providing psychiatric services for individuals under age 21

☐ Box Unchecked: Institution for mental diseases for individuals age 65 or over

Describe the state process for determining an individual's level of care:

Long Term Hospital LOC

A certified assessor or public health nurse completes an in-person initial assessment. Redetermination

of level of care through reassessment must be performed at least annually. The results of the level of care assessment are summarized on the Long-Term Care Screening Document (PDF), Developmental Disabilities Screening Document (PDF) or a type B service agreement, which is an authorization document for persons who are not on a waiver program.

The person must:

- have both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes because of the person's health condition;
- require professional nursing assessments and intervention multiple times during a 24-hour period to maintain and prevent deterioration of health status;
- require a 24-hour plan of care, including a back-up plan, to reasonably ensure health and safety in the community; and
- require frequent or continuous care in a hospital without services.

Nursing Facility LOC and Individual with Intellectual Disabilities

A certified assessor or public health nurse completes an in-person initial assessment. Redetermination of level of care through reassessment must be performed at least annually. The results of the level of care assessment are summarized on the Long-Term Care Screening Document (PDF), Developmental Disabilities Screening Document (PDF) or a type B service agreement, which is an authorization document for persons who are not on a waiver program.

Younger than age 21 psychiatric institution level of care

For younger than age 21 psychiatric institution level of care, the participant must meet the criteria defined under eligibility categories for children with disabilities in accordance with Minnesota state law. Level of care eligibility is determined by the State Medical Review Team (SMRT).

Institution for mental disease (IMD) level of care for individuals age 65 and older

For IMD level of care, the participant must meet one of the five categories of need below.

1. Does/would live alone or be homeless without current housing type and meets one of the following criteria:
    a. Has had a fall resulting in a fracture within the last 12 months
    b. Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence
    c. Is at risk of maltreatment or neglect by another person, or is at risk of self-neglect
2. Has a dependency in four or more activities of daily living (ADLs)
3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention
4. Needs the assistance of another person or constant supervision to complete toileting, transferring or positioning, and this assistance cannot be scheduled
5. Needs formal clinical monitoring at least once a day

Tools and policies

The following tools and related polices are used to determine a participant's level of care:

- MnCHOICES assessment or Minnesota Long-Term Care Consultation Services Assessment Form (PDF)
- Nursing Facility level of care:
  - Nursing Facility Level of Care Criteria Guide (PDF)
- ICF/DD level of care:
  - Case Manager's Guide to Determining ICF/DD Level of Care for ICF/DD (PDF)

Informing Individuals Potentially Eligible for the Community First Choice Option

Indicate how the state ensures that individuals potentially eligible for CFC services and supports are informed of the program's availability and services:

☒ Box checked: Letter

☒ Box checked: Email

☒ Box checked: Other – Describe:

Please describe the process used for informing beneficiaries:

Prior to implementation, DHS will send a direct mailing to all participants receiving PCA services that explains CFSS and how it will affect them. DHS will use other communication methods as appropriate, which may include email distribution lists, statewide webinars, Facebook live events and informational resources through Disability HUB MN to inform both existing and new beneficiaries of the CFSS benefit.

All individuals seeking Long Term Services and Supports will undergo a comprehensive assessment. Once the assessment is completed, they will be told about all services for which they may be eligible, including CFSS.

Assurances (All assurances must be checked).

☒ Box checked: Services are provided on a statewide basis.

☒ Box checked: Individuals make an affirmative choice to receive services through the CFC option.
☒ Box checked: Services are provided without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual needs to lead an independent life.

☒ Box checked: Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid state plan, waiver, grant or demonstration authorities.

☒ Box checked: During the period that begins January 1, 2014 and extends through September 30, 2023 (or other date as required by law), spousal impoverishment rules are used to determine the eligibility of individuals with a community spouse who seek eligibility for home and community-based services provided under §1915(k).

CFC Service Models

Indicate which service models are used in the state's CFC program to provide consumer-directed home and community-based attendant services and supports (Select all that apply):

☒ Box checked: Agency-Provider Model

☐ Box unchecked: Self-Directed Model with Service Budget

☒ Box checked: Other Service Model. Describe:

Minnesota will use a variation of the self-directed model with service budget as described in the code of federal regulations under 42 CFR §441.545(c), heretofore referred to as the "budget model."

Under the budget model, participants have budget and employer authority and accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan.

County human services agencies (hereinafter "county" or "counties") , tribal human services organizations, managed care organizations, or Consultation Service Providers (the provider type providing voluntary support as required under CFC benefit) may identify that a person is unable to fulfill their obligations under the budget model. The consultation service provider may recommend to the county, tribal human services organization, or managed care organization that a person may benefit from a participant representative. The county, tribal human services organization, or managed care organization may require the participant to identify a representative to act on their behalf.

The budget model is similar to the self-directed model with service budget, but with the following differences:

- State established minimum qualifications for personal care attendants as outlined in the SPA
- A minimum wage floor that is governed by a collective bargaining agreement that outlines what personal care attendants must be paid

Please complete the following section if the state is using the Self-Directed Model with Service Budget or the Other Service Model if it includes a Service Budget.

Financial Management Services (FMS)

The state must make available financial management services to all individuals with a service budget.

The state will claim costs associated with financial management services as:

☒ Box checked: A Medicaid Service

☐ Box unchecked: An Administrative Activity

☒Box checked: The state assures that financial management service activities will be provided in accordance with the code of federal regulations under 42 CFR 441.545(B)(1).

If applicable, please describe the types of activities that the financial management service entity will be providing, in addition to the regulatory requirements at 42 CFR 441.545(B)(1).

Participants using the budget model must select an FMS provider. The role of the FMS provider is to support the participant to fulfill their responsibilities in being the employer of their workers. The FMS provider is responsible to:

- Collect and process timesheets of the participant's support workers;

- Process payroll, withholding, filing, and payment of applicable federal, state and local employment-related taxes and insurance;
- Separately manage budget funds and expenditures for each participant;
- Track and report disbursements and balances of each participant's funds;
- Process and pay invoices for services in the person-centered service delivery plan;
- Provide individual periodic reports of expenditures and the status of the approved service budget to the participant or their representative and DHS, as well as the consultation services provider and the county, tribal human services organization, or managed care organization as applicable;
- Initiate background studies for CFSS support workers;
- Help the participant obtain workers' compensation insurance;
- Educate the participant on how to employ workers;
- Ensure what the participant spends their funds on follows the rules of the program and the approved plan; and
- Process the purchase of goods and services if the provider of goods or services is not a Minnesota Health Care Programs (MHCP) enrolled provider.

Specify the type of entity that provides financial management services:

☐Box unchecked: State Medicaid Agency

☐ Box unchecked: Another State Agency – Specify:

☒ Box checked: Vendor Organization Describe:

FMS provider means a qualified organization required for participants using the budget model that is an enrolled provider with DHS to provide vendor fiscal/employer agent FMS services. DHS contracts with all FMS providers to provide FMS services. DHS determines if FMS providers meet the qualifications through a request for proposal (RFP) process every 5 years in order to continue to offer participants a choice in qualified providers of Financial Management Services. This timeline enables DHS to have increased scrutiny as required under federal law to ensure the providers have a readiness review completed by a certified national organization specializing in, and qualified to, maintain compliance with Federal, State and Local tax rules, specifically as they pertain to participant-directed services. This interval further enables DHS to ensure quality assurance and program integrity through careful monitoring and quality assurance activities occurring throughout the contract period. While this process exists, the state allows for continuous provider enrollment for any qualified Medicaid provider in accordance with the free choice of provider statute and implementing regulations, including 42 CFR 431.51 for all provider types. Any provider reaching out to DHS who meets the criteria outlined in the last posted RFP as well as other state and federal provider qualifications would be permitted to begin the contracting and enrollment process.

All FMS providers must:

- Enroll as a Medical Assistance Minnesota Health Care Programs (MHCP) provider and meet all applicable provider standards and requirements;

- Comply with background study requirements in accordance with state statute and maintain documentation of background study requests and results;
- Successfully complete a readiness review before enrollment, conducted by an individual or organization that meets the qualifications required by the state;
- Have knowledge of and compliance with Internal Revenue Service (IRS) requirements;
- Provide services statewide;
- Meet the requirements under a collective bargaining contract; and
- Process the purchase of goods and services if the provider of goods or services is not a Minnesota Health Care Programs (MHCP) enrolled provider.

Other Payment Methods

☐ Box unchecked: The state also provides for the payment of CFC services through the following methods:

☐ Box unchecked: **Use of Direct Cash Payments** - The state elects to disburse cash prospectively to CFC participants. The state assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing

functions themselves. Describe:

☐ Box unchecked: Vouchers - Describe:

Service Budget Methodology

Describe the budget methodology the state uses to determine the individual's service budget amount. Also describe how the state assures that the individual's budget allocation is objective and evidence based utilizing valid, reliable cost data and can be applied consistently to individuals:

The CFSS service budget amount is based on an assessment of the participant's personal care needs as defined in state statute. The service budget amount is based on an objective assessment of the participant's needs. The assessment must be conducted by a trained and certified assessor as defined in state statute. All components of this process adhere to 42 CFR 441.560. DHS acknowledges that the assessment process is an administrative function.

Using a statistical model, the county, tribal human services organization, or managed care organization arrives at a total dollar and service amount, based on a needs assessment.

After the needs assessment is completed, the assessor provides (by mail or in person) the participant with a written summary outlining their needs for care and options for services and supports, including their service authorization amount for CFSS (units of service or dollar amount). The participant works with their consultation services provider to receive voluntary support to the extent desired, to understand the amount of their individual CFSS services and supports, to determine how the funds will be used and provides assistance to the participant as needed to finalize the service plan. If the participant is enrolled in a §1915(c) HCBS waiver or if the participant is age 65 or older and enrolled in managed care, the participant works with the 1915(c) case manager or Managed Care coordinator to finalize the plan for use of CFSS services, as well as additional services under the expanded service menu of one of DHS' five §1915(c) HCBS waivers to meet their needs. Participants use their service budget to:

- Directly employ and pay qualified support workers;
- Obtain covered goods as defined under the optional services and supports;
- Select and pay for FMS services based on the DHS published rates; and
- Purchase back-up systems

The consultation services provider is responsible to review the CFSS service delivery plan written by the participant or their representative. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider then submits the plan for approval to the State Medicaid agency or its delegated county, tribal human services organization, or managed care organization. If the participant is enrolled in a 1915(c) waiver or managed care, the case manager or care coordinator will provide a final review of the plan of care on behalf of the state. The state Medicaid agency oversees final approval of all plans of care.

Consultation services and worker training and development are authorized on a per-diem basis and do not count against a participant's CFSS service budget.

Six consultation service sessions are initially allocated for each participant and additional sessions approved by DHS as requested.

The CFSS service delivery plan must include a detailed plan for worker training and development. In the agency model the CFSS provider agency arranges for worker training and development. In the budget model the participant, as the employer, arranges for worker training and development. The plan must include what components of worker training and development will be used, when the components will be used, how they will be provided and how these relate to the participant's individual needs. Components include, but are not limited to:

- Support worker training on the participant's individual assessed needs;
- Tuition for professional classes for the support workers related to the participant's assessed needs;
- Direct observation, monitoring and documentation of support worker skills and tasks; and
- Activities to evaluate CFSS services and ensure worker competency

A separate budget for worker training and development is available to employers of CFSS workers (i.e., CFSS agency or person/representative) to pay for documentation, training, observation, monitoring and coaching of CFSS workers. These activities help CFSS workers expand their skills to support the participant's specific needs.

When a participant is eligible for and chooses to receive CFSS services:

- The participant includes a worker training and development plan in the individual service delivery plan, with support from the consultation services provider as desired;
- The county, tribal human services organization, or managed care organization authorizes worker training and development for the person; and

The CFSS agency (agency model) or FMS provider (budget model) bills for classes (either model) or employer training (agency model only).To request additional funds for the participant's worker training and development budget, the CFSS provider agency or FMS provider must request an increase from DHS, the waiver case manager or the managed care organization. The entity that approves additional funds for worker training and development depends on the type of program and/or if the participant is

receiving services via fee-for- service or managed care.

The CFSS provider agency or FMS provider must submit the following documentation to the appropriate entity (DHS, waiver case manager, MCO) for authorization of additional funds:

- Request for the specific dollar amount for the increase to the worker training and development budget;
- Reason for increasing the worker training and development budget; and
- Documentation of completed worker training and development tasks and related spending for the current service delivery plan.

The state recognizes that worker training and development for support workers is considered an administrative service.

Describe how the state informs the individual of the specific dollar amount they may use for CFC services and supports before the person-centered service plan is finalized:

After the assessment is completed, the assessor will provide (by mail or in person) the participant with a written summary outlining their needs for care and options for services and supports, including the specific budget allocation amount. The participant or their representative is responsible to write the CFSS service delivery plan. DHS has provided a standardized service delivery plan template to use. Consultation services are available to the participant and/or their representative to provide assistance and support in writing the CFSS service delivery plan, to the extent desired by the participant and this service does not come out of the service budget. The plan will include how the participant will use funds for staff and goods/services.

The consultation services provider is responsible to review the CFSS service delivery plan written by the participant or their representative. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider then submits the plan for approval to the State Medicaid agency or its delegated county, tribal human services organization, or managed care organization. If the participant is enrolled in a 1915(c) waiver or managed care, the case manager or care coordinator will provide a final review of the plan of care on behalf of the state. The state Medicaid state agency oversees final approval of all plans of care.

Plan approval includes ensuring the plan meets requirements and does not include services or goods that are not covered.

The State Medicaid Agency or their delegate sends copies of the approved plan to the participant and the CFSS provider agency and/or FMS provider, depending on the service model the person has chosen.

For participants who are using the provider agency model, the CFSS provider agency is responsible to work with the participant to fill in any additional service delivery details not included in the plan approved by the consultation services provider.

Describe how the individual may adjust the budget, including how he or she may freely change the budget and the circumstances, if any, which may require prior approval of the budget change from the state:

A participant might experience a change in condition or health status that results in an increased need for CFSS services.

A participant with a temporary change in condition (45 days or less) may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human services organization, managed care organization, or FMS provider of the change in condition so the 45-day telephonic reassessment can be completed and the total number of units/dollars can be adjusted.

A participant with a change in condition expected to last longer than 45 days requires a full in-person reassessment to determine their eligibility and a new service authorization before the temporary service increase expires.

Adding goods and/or services to the budget mid-year requires prior approval.

Describe the circumstances that may require a change in the person-centered service plan:

A participant's CFSS service delivery plan (person-centered service plan) must be updated in the following situations:

- When there is a change in the participant's condition, tasks, procedures, living arrangements, representative or planned monthly use of units; or
- Annually at the time of the reassessment.

Describe how the individual requests a fair hearing if his or her request for a budget adjustment is denied or the amount of the budget is reduced:

When a budget is reduced, denied or terminated, the county or tribal human services organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action;
- The timeline associated with the action;
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

MCOs must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking;
- The reason the MCO is taking this action;
- The state and federal laws or MCO policies that support the MCO's action; and
- The process the member must follow to file an appeal with the MCO or the state

Describe the procedures used to safeguard individuals when the budgeted service amount is insufficient to meet the individual's needs:

The county, tribal human services organizations, or managed care organization provides an assessment

summary to the participant in writing. The summary identifies appropriate CFSS supports and services that would meet the participant's assessed needs. The participant works with the consultation services provider to understand any limits to the individual services and supports.

Additionally, the following safeguards are in place:

- The participant may be eligible for additional services offered through both Medicaid and non-Medicaid programs in addition to state plan CFSS services.
- All CFSS participants may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human organization, or managed care organization or FMS provider of the change in condition so the total number of units/dollars can be adjusted. A participant with a change in condition longer than 45 days requires a reassessment to determine their eligibility and a new service authorization.

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action;
- Timeline associated with the action; and
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal.

MCOs must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking;
- The reason the MCO is taking this action;
- The state and federal laws or MCO policies that support the MCO's action; and
- The process the member must follow to file an appeal with the MCO or the state

Describe how the state notifies individuals of the amount of any limit to the individual's CFC services and supports:

After the assessment is completed, the assessor will provide (by mail or in person) the participant with a written summary outlining the needs for care and options for services and supports to meet the assessed needs, including the service unit amount. The participant works with the consultation services provider to understand the dollar and unit amount determined in the assessment process, as well as any limits to the individual services and supports, including how the funds for staff and goods will be used. If the participant is enrolled in a §1915(c) HCBS waiver, or if the participant is age 65 or older and enrolled in managed care, the participant works with the case manager or care coordinator to finalize the plan (after working with the consultation services provider) for use of CFSS services, as well as additional services under the expanded service menu of one of DHS' five §1915(c) HCBS

waivers to meet the needs.

Describe the process for making adjustments to the individual's budget when a reassessment indicates there has been a change in his or her medical condition, functional status, or living situation:

A participant might experience a change in condition or health status that results in an increased need for CFSS services, including during the time of reassessment.

A participant with a temporary change in condition (45 days or less) may be eligible for a 45-day temporary increase. The CFSS provider (agency model) or the participant (budget model) must notify the county, tribal human services organization, managed care organization, or FMS provider of the change in condition so the total number of units/dollars can be adjusted.

A participant with a change in condition longer than 45 days requires a reassessment to determine the budget amount and create a new service authorization.

Mandatory Services and Supports

1. Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hand-on assistance, supervision, and/or cueing.

Identify the activities to be provided by applicable provider type and describe any service limitations related to such activities.

☒ **Box checked: Personal Attendant Services. Describe:**

Personal attendant services include assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task. Personal care attendant services may also include observation and redirection to the participant for episodes of behavior impacting ADLs and IADLs as well as preventing harm to self and others that need redirection, as identified in the CFSS service delivery plan.

ADLs include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting.

IADLs include activities related to living independently in the community, such as attending medical appointments, providing or assisting with transportation, paying bills, communicating by telephone or other media, completing household tasks necessary to support the participant with an assessed need, such as planning and preparing meals or shopping for food, clothing and other essential items.

Health-related procedures and tasks are procedures and tasks performed by a support worker that can be delegated or assigned by a health care professional licensed in accordance with Minnesota state law. Health-related procedures and tasks may include assistance with self-administered medications, interventions for seizure disorders, range-of-motion and passive exercise, clean tracheostomy suctioning and services to a participant who uses ventilator support or other activities within the scope of CFSS that meet the definition of health-related procedures or tasks.

Personal attendant services may be delivered individually (1:1) or as shared care (1:2 or 1:3).

The participant's spouse or parents, stepparents or unpaid legal guardians may be direct support workers providing personal care.

Personal attendant services do not include:

- CFSS provided by a participant's representative or paid legal guardian
- Services that are used solely as a childcare or babysitting service
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules
- Sterile procedures
- Injections into veins, muscles or skin
- Homemaker services that are not an integral part of the assessed CFSS service
- Home maintenance or chore services
- Home care services, including hospice services if chosen by the participant, covered by Medicare or any other insurance held by the participant
- Services to other members of the participant's household
- Services not specified as covered under Medical Assistance as CFSS
- Application of restraints or implementation of deprivation procedures
- Independent determination of the medication dose or time for medications for the participant

The amount of personal care attendant service units is determined based on the person-center assessment using the MnCHOICES tool. Units are authorized in 15-minute increments. The maximum number of units is 112 per day based on the individual's needs. Services units are permitted to be used flexibly within the individual's service authorization period.

As outlined in our assurances and the service budget methodology sections of this SPA, individuals whose needs exceed the personal care benefit allowance under the state plan are eligible for a temporary 45 day increase in services. A participant with a change in condition that is expected to last longer than 45 days must have a reassessment to determine their eligibility and receive a new service authorization. The participant may then be eligible for additional services offered through both Medicaid and non-Medicaid programs in addition to state plan CFSS services. This includes extended personal care attendant services that are authorized under a 1915(c) waiver that may exceed the state plan limits.

Those meeting criteria for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit will not have limitations on the amount of personal attendant units authorized.

Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Standardized certification training

Education-Based Standard. No Describe:

Other Qualifications Required for this Provider Type. Yes Describe:

All CFSS support workers, regardless of service delivery model must:

- Complete the standardized certification training and pass the "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test"
- Pass a background study initiated by the CFSS provider agency/FMS provider as required

under the state's background study law
- Enroll with Minnesota Health Care Program as a PCA/CFSS support worker
- Be able to communicate effectively with the participant and the provider agency/FMS provider
- Have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs.

The participant may establish additional CFSS support worker qualifications.

Under the provider agency model, the provider agency must verify and maintain evidence of support worker competency, including documentation of the support worker's:

- Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
- Relevant training received from sources other than the provider agency
- Orientation and instruction to implement services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
- Periodic performance reviews completed by the supervising professional(s) at the provider agency at least annually

Under the budget model, the participant or their representative is responsible to:

- Hire the support worker(s)
- Ensure that support workers are competent to meet the participant's assessed needs and additional requirements identified in the CFSS service delivery plan
- Verify and maintain evidence of support worker competency, including documentation of the support worker's:
    - Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
    - Training received from sources other than the participant
    - Orientation and instruction to implement defined services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
    - Periodic written performance reviews completed by the participant at least annually

Limitations:
CFSS support workers are limited to providing 310 hours of care per calendar month, regardless of the number of participants they serve or the number of agencies or participants that employ the support worker.

The participant's spouse or the parents, stepparents or unpaid legal guardians of a person under age 18 may be direct support workers providing personal care. These support workers cannot provide any Medical Assistance home and community-based services (HCBS) in excess of the following:

- If multiple parents are support workers providing CFSS services to their minor child or children, each parent may provide up to 40 hours of medical assistance home and community-based services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.
- If only one parent is a support worker providing CFSS services to the parent's minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

- If a participant's spouse is a support worker providing CFSS services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.
- For parents of minor children and spouses, the limitations set forth above apply to the total amount of hours per family regardless of the:
    - Number of parents
    - Combination of parent(s) and spouse
    - Number of children who receive 1915(i) benefits.
- Paid legal guardians are not allowed to be the support worker, whether the participant is a minor or an adult.

☐ Box unchecked: Companion Services. Describe:

Provider Type:

License Required

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

☐ Box unchecked: Homemaker/Chore Service. Describe:

Provider Type:

License Required:

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

☐ Box unchecked Other Services. Describe:

Provider Type:

License Required:

Certification Required. Describe:

Education-Based Standard. Describe:

Other Qualifications Required for this Provider Type. Describe:

2. The acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Identify the activities to be provided by applicable provider type and any describe any service limitations related to such activities:

Personal attendant services as described above may include functional skills training through hands-on assistance, supervision and cueing to accomplish the ADL, IADL and health-related tasks. Participants who are assessed to need training or assistance to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs and health-related tasks will receive this support concurrently with hands-on assistance or constant supervision/and or cueing to accomplish the task as described under the personal attendant services.

Assistance to acquire, maintain and/or enhance skills will be tied specifically to the assessment and CFSS service delivery plan. This assistance is a means to maximize the participant's independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. These services are limited to supports necessary for the participant to acquire, maintain or enhance skills to independently accomplish (to the extent possible) ADLs, IADLs and health-related tasks as described under personal attendant (personal care assistance) services.

Support workers may provide assistance under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the CFSS service delivery plan
- The activities provided are concurrent with the performance of ADLs, IADLs and health-related tasks as described in the previous section
- The activities are for the sole benefit of the participant and are only provided to the participant
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence
- The activities provided are consistent with the stated preferences and outcomes in the CFSS service delivery plan
- The support worker is competent to perform these services for the participant

Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Complete the standardized certification training and pass the "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test"

Education-Based Standard. Describe: No

Other Qualifications Required for this Provider Type. Yes. Describe:

All CFSS support workers, regardless of service delivery model must:

- Pass a background study initiated by the provider agency/FMS provider as required under state background study law
- Enroll with Minnesota Health Care Programs as a PCA/CFSS worker
- Be able to communicate effectively with the participant and the provider agency/FMS provider
- Have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs

The participant may establish additional CFSS support worker qualifications.

Under the provider agency model, the provider agency must verify and maintain evidence of support worker competency, including documentation of the support worker's:

- Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
- Relevant training received from sources other than the provider agency
- Orientation and instruction to implement services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan.

Under the budget model, the participant or their representative is responsible to:

- Hire the support worker(s)
- Ensure that support workers are competent to meet the participant's assessed needs and additional requirements identified in the CFSS service delivery plan
- Determine the competency of the support worker through evaluation within 30 days of any support worker beginning to provide services and with any change in the participant's condition or modification to the CFSS service delivery plan
- Verify and maintain evidence of support worker competency, including documentation of the support worker's:
    - Education and experience relevant to the job responsibilities assigned to the support worker and the participant's needs
    - Training received from sources other than the participant
    - Orientation and instruction to implement defined services and supports to meet the participant's needs and preferences identified in the CFSS service delivery plan
    - Periodic written performance reviews completed by the participant at least annually

3. Individual back-up systems or mechanisms to ensure continuity of services and supports.

Identify the systems or mechanisms to be provided and limitations for:

☒ Box checked: Personal Emergency Response Systems

☐ Box unchecked: Pagers

☐ Box unchecked: Other Mobile Electronic Devices

☒ Box checked: Other. Describe: Persons identified by an individual to be included as backup

Describe any limitations for the systems or mechanisms provided:

Personal emergency response systems (PERS) covers:

- Purchase of the PERS equipment, including necessary training or instruction on the use of the equipment; and
- Installation (set up, testing) and monitoring of the device

PERS does not cover:

- Equipment used to deliver Medical Assistance or other waiver services;
- Sensing and/or monitoring systems that do not require activation by the person;
- Supervision or monitoring of ADLs provided to meet the requirements of another service;
- Telehealth and biometric monitoring devices; or
- Video equipment

The following information must be documented in the person's CFSS service delivery plan:

- The participant's assessed need for PERS;
- The type of PERS equipment the participant will use;
- How the PERS equipment will meet the participant's assessed need;
- Back-up system for PERS equipment during electrical outages or other equipment malfunctions; and
- Fees for equipment purchase, installation and monthly monitoring
- Provider Type: Personal emergency response equipment vendor

Certification Required. No

Education-Based Standard. No

Other Qualifications Required for this Provider Type: Yes Describe:

Minnesota Health Care Programs (MHCP) enrolled vendors or providers enrolled in MCO network(s) that meet one of the following qualifications:

- State medical equipment provider
- Pharmacy licensed by the Minnesota Board of Pharmacy
- Medicare-certified home health agency

Individual back-up supports:
The participant can identify individual(s) to provide back-up supports. The individual(s) chosen to provide back-up supports must be identified in the person's CFSS service delivery plan. The participant's CFSS service delivery plan must also include a description of how the participant will communicate with or summon the designated back-up supports.

- Provider Type: Support worker

License Required: No

Certification Required. Yes Describe: Complete the standardized certification training and pass the "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test"

Education-Based Standard. Describe: No

Other Qualifications Required for this Provider Type. Yes. Describe:

All CFSS support workers, regardless of service delivery model must:

- Pass a background study initiated by the provider agency/FMS provider as required under state background study law;
- Enroll with Minnesota Health Care Programs as a PCA/CFSS worker;
- Be able to communicate effectively with the participant and the provider agency/FMS provider; and
- Have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs

The participant may establish additional qualifications for individual back-up supports.

The participant or their representative is responsible to verify provider qualifications under the budget model, and DHS Provider Enrollment or the county, tribal human services organization, or managed care organization is responsible to verify provider qualifications under the agency model.

4. Voluntary training on how to select, manage and dismiss attendants.

The state will claim costs associated with voluntary training as (check one):

☐ **Box unchecked: A Medicaid Service**

☒**Box checked: An Administrative Activity**

Describe the voluntary training program the state will provide to individuals on selecting, managing and dismissing attendants:

CFSS includes consultation services, which supports participants to select, manage and dismiss support workers. This includes:

- Training the participant to interview, select, manage interactions with and dismiss support workers;
- Responding to the participant's questions related to self-directed tasks or other concerns throughout the CFSS service delivery plan year; and
- Revising the person-centered CFSS service delivery plan to achieve quality service outcomes

The consultation services provider will maintain and document routine communication with the participant to review services and plan implementation. The participant has the option to request additional ongoing support from the consultation services provider throughout the course of receiving CFSS. This may occur when the participant chooses to change their plan or when they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also need support from the consultation services provider to help understand the role as the employer.

Provider Type: Consultation Services Provider

License Required: No

Certification Required. No Describe:

Education-Based Standard. Yes Describe:

Consultation services is available to participants for training on the skills needed to select, manage and dismiss qualified support workers. The consultation services provider offers this training when the participant starts the service. It is available to the participant throughout their service eligibility.

Consultation services providers are required to employ a lead professional staff member that meets certain education criteria. The lead employee must meet at least one of the following education requirements:

- Be a doctor of medicine or osteopathy;
- Be a registered nurse;
- Have a bachelor's degree or higher, or a certification as appropriate, in one of the following fields:
    - Occupational therapist
    - Physical therapist
    - Psychologist
    - Social worker
    - Speech-language pathologist or audiologist

- Professional recreation staff
- Professional dietitian
- Designation as a human services professional; and

- Have at least one year of experience working directly with people with disabilities or people older than age 65 and have a degree in a discipline associated with at least one of the following fields of study:
  - Human behavior (e.g., psychology, sociology, speech communication, gerontology)
  - Human skill development (e.g., education, counseling, human development)
  - Humans and their cultural behavior (e.g., anthropology)
  - Human condition (e.g., literature, art)
  - Any other study of services related to basic human care needs (e.g., rehabilitation counseling)

Staff members working directly with participants (but not as the lead employee of a consultation services provider) must meet the education requirements listed in the lead employee education section above or meet the education substitution. These staff members can substitute one of the following for a bachelor's degree:

- Experience coordinating or directing services for people with disabilities or people older than age 65, including self-directed services; or
- Experience coordinating their own services

Other Qualifications Required for this Provider Type. Yes. Describe:

The consultation services provider must meet all of the following qualifications:

- Enroll with Minnesota Health Care Programs (MHCP);
- Employ at least one lead staff member who meets the qualifications for the lead employee;
- Have the ability to provide services statewide (either in person or remotely);
- Have an office located in Minnesota;
- Have a toll-free phone number and secure fax number;
- Have never had a county, tribal human services organization, or managed care organization contract or provider agreement discontinued due to fraud;
- Have never had any owners, managers or board members who have been disqualified under the criminal background check system; and
- Ensure employees complete all DHS-mandated training applicable to their roles

The lead employee must:

- Be age 18 or older;
- Clear a background study as required in accordance with state statute; and
- Have a minimum of two years of full-time experience in the field of self-direction

All staff members working directly with participants (but not as the lead employee) must:

- Be age 18 or older;
- Clear a background study as required in accordance with state statute

Optional Services and Supports:

Indicate which of the following optional services and supports the state provides and provide a

detailed description of these benefits and any limitations applicable to them.

No Transition Costs (Provided to individuals transitioning from a nursing facility, Institution for Mental Disease, Intermediate care facility for Individuals with Intellectual Disabilities to a community based home setting) – Check all of the following costs that apply:

☐ Box unchecked: Rental and Security Deposits Description and Limitations:

☐ Box unchecked: Utility Security Deposits Description and Limitations:

☐ Box unchecked: First Month's Rent Description and Limitations:

☐ Box unchecked: First month Utilities Description and Limitations:

☐ Box unchecked: Basic Kitchen Supplies Description and Limitations:

☐ Box unchecked: Bedding and Furniture Description and Limitations:

☐ Box unchecked: Other Household Items Description and Limitations:

☐ Box unchecked: Other coverable necessities linked to an assessed need to enable transition from an institution to the community

☒ **Box checked: Goods and Services** - Services or supports for a need identified in the individual's person centered plan of services that increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance. Include a service description including provider type and any limitations for each service provided.

CFSS may cover the costs of goods that either:

- Increase a participant's independence; or
- Decrease a participant's need for assistance with an assessed need from another person

Expenditures for goods and services must:

- Relate to a need identified in the participant's service delivery plan;
- Be priced at fair market value;
- Increase the participant's independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance for the participant's assessed need; and

Fit within the annual limit of the participant's approved service allocation or budget Goods that are covered under the Medicaid Home health medical supplies, equipment and appliances benefit would not be covered by CFSS.

When the participant uses CFSS funds to purchase goods and services, the consultation services provider must review the CFSS service delivery plan with the person. In supporting the person, they will review whether the good or service meets an assessed need outlined in the needs assessment and is a covered CFSS service. The consultation services provider then submits the plan to the State Medicaid agency or the delegate of the State Medicaid Agency for approval. All goods must be purchased through either a MHCP enrolled provider or an FMS provider.

When the participant uses the provider agency model and chooses to purchase goods through CFSS, the personal care units are adjusted to account for the purchase of goods and services that substitute

for human assistance. When the participant uses the budget model and chooses to purchase goods through CFSS, the cost for the goods is covered using the participant's service budget as described earlier in this document.

Provider qualifications:

Entities providing goods or services covered by CFSS must bill for them through a MHCP enrolled provider or an FMS provider. All individuals or vendors of goods and services must have both of the following:

- The capability to perform the requested work and the ability to successfully communicate with the participant; and
- The necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable

Home and Community Based Settings

☒Each individual receiving CFC services and supports must reside in a home or community-based setting and receive CFC services in community settings that meet the requirements of the code of federal regulations 42 CFR 441.530.

Setting Types (check all that apply):

☐ Box unchecked: CFC services are only provided in private residences and are not provided in provider - owned or controlled settings.

☒ Box checked: CFC services may be provided in private residences and in provider owned or controlled settings.

☒ Box checked: The CFC benefit includes settings that have been determined home and community-based through the heightened scrutiny process.

1. Please identify all residential setting types in which an individual may receive services under the CFC benefit.

1. Participants may receive CFSS in their own home or family home.

A participant's own home is defined as a single-family home or a unit in a multi-family home (e.g., apartment) where a participant lives, and the participant or their family owns/rents and maintains control over the individual unit, demonstrated by a lease agreement (if applicable).

2. Participants may receive services in settings registered by the Minnesota Department of Health (MDH) as a board and lodge establishment.

This includes hotel, vacation rental or other locations where a participant may be visiting or residing on a temporary basis.

3. Participants may receive CFSS in residential settings that are not owned or controlled by the provider of CFC services.

a. Participants may receive CFSS services in residential settings that are owned/controlled by the residential §1915(c) HCBS waiver service provider in the following settings:

a. Customized living settings
b. Integrated community supports settings

2. Please identify all non-residential setting types in which a person may receive services under the CFC benefit.

CFSS will not be provided in any non-residential waiver provider-controlled settings.

Setting Assurances– The state assures the following:

☒ Box checked: CFC services will be furnished to individuals who reside in a home or community setting, which does not include a nursing facility, institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, or a hospital providing long-term care services.

☒ Box checked: Any permissible modifications of rights within a provider owned and controlled setting is incorporated into an individual's person-centered service plan and meets the requirements of 42 CFR 441.530(a)(vi)(F).

Additional state assurances:

Community First Choice Support System, Assessment and Service Plan Support System

☒ Box checked: The support system is provided in accordance with the requirements of §441.555.

Provide a description of how the support system is implemented and identify the entity or entities responsible for performing support activities:

Consultation services

Consultation services are an integral part of the CFSS program. Consultation services include services that support the participant in the person-centered planning process. The service also provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. Components of this service include providing required voluntary training on how to select, manage and dismiss attendants among other things. This service is available to all individuals receiving the CFSS benefit regardless of the service delivery models selected.

All participants using CFSS, regardless of service delivery method, must select a consultation services provider. Once the participant has selected a provider, the provider is responsible for delivering the supports set forth below and in accordance with the participant's needs and wishes. The participant determines the degree of support and information that is needed from the provider. Regardless of the amount of support that the participant elects to receive, the provider is responsible for submitting the completed service plan for approval to the state Medicaid agency or its delegated county, tribal human services organization, or managed care organization.

Consultation service providers assist the participant with understanding CFSS, planning for services, choosing a model, creating and implementing the CFSS service delivery plan to the extent desired by the participant. Consultation Service providers may:

- Educate about service options
- Educate about choices in providers
- Educate about rights and responsibilities (including appeal rights)
- Educate the participant about CFSS
- Educate the participant about the agency model and budget model
- Assure a person-centered planning process
- Help the participant or the participant's representative write, implement and evaluate their CFSS service delivery plan (to the extent the participant desires)
- Assist participants who have chosen the budget model with outlining a budget
- Provide the participant with a list of CFSS agency providers (if the participant chooses the agency model) or financial management services (FMS) providers (if the participant chooses the budget model).
- Training the participant to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers
- Responding to participant's questions related to self-directed tasks or other concerns throughout the CFSS service delivery plan year
- Completing a semi-annual review if the participant does not have a case manager/care coordinator and the spouse or parent (if a minor) serves as the support worker
- Revise a person-centered CFSS service delivery plan to achieve quality service outcomes

When a participant uses the budget model, the consultation services provider may provide these additional functions:

- Monitor the participant's success in using the budget model and re-educate and/or recommend involuntary exit, if needed
- Work with the FMS provider to provide the participant with ongoing support to serve as the employer of their support workers
- Answering the participant's questions related to being a participant employer during check-ins (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).
- Check in with the participant to ask if they are completing employer tasks, such as:
    - Ensuring the support workers are competent to meet the participant's needs
    - Orienting and training support workers
    - Evaluating support workers within 30 days of hire, the start of a new plan year or after a change in condition
    - Verifying and maintaining evidence of support worker competency, including documentation
    - Completing support worker performance reviews at least once per year (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).
    - Answering the participant's questions during check-ins (frequency based on an individuals needs as identified in consultation services provider agreement with the participant).

The consultation service provider will maintain and document routine communication with the

participant to review services and plan implementation. The participant has the option to request additional ongoing support from the consultation service provider when needed. This may occur when the participant chooses to change their plan or they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also request support from the consultation service provider to assist with understanding their role as the employer.

Consultation service providers provide additional support if a CFSS participant is not carrying out their duties under the budget model. The consultation service provider will develop an individualized plan to provide additional training, check-ins or other assistance to ensure the participant is completing employer tasks. The consultation service provider will document outcomes of the additional supports and training, and may recommend involuntary exit to DHS/county, tribal human services organization, or managed care organization, if needed.

Additional responsibilities and expectations of consultation service providers:

- Help DHS/county, tribal human services organization, or managed care organization with surveys and data collection, at request
- Document complaints received for possible audit
- Have policies and procedures to meet the needs of culturally diverse participants receiving services
- Review their grievance policy annually
- Pass on information from DHS/county, tribal human services organization, or managed care organization (e.g., policy clarifications or changes) to participants using CFSS when requested by DHS
- Comply with all requirements, as applicable.

Provider qualifications

See the provider qualifications for consultation services providers under the "voluntary training on how to select, manage and dismiss attendants" section of the mandatory services and supports.

Authorization of consultation services

Consultation service providers provide support services (such as: orientation/annual, ongoing support, remediation) as sessions. Only one session can be billed by a Consultation services provider in a single day. Consultation service sessions are initially allocated for each participant and additional sessions approved by DHS as requested. See the budget methodology section for additional information.

Additional supports

Worker training and development

Worker training and development is a function of CFSS that pays for the training, observation, monitoring and coaching of CFSS support workers as required under 42 CFR 441.565. Participants have the right to access other training provided by or through the State so their attendant care provider can meet any additional qualifications required or desired by the participant. These activities help CFSS support workers gain the skills to support the participant's specific needs. Under the provider agency model, the CFSS agency is the employer of the support worker. Under the budget model, the participant (or their representative) is the employer of the support worker. The support worker's employer is responsible to train, supervise and evaluate the support worker's competency. The employer must orient each support worker to the participant's needs and train them on the tasks the participant needs.

All participants must have a worker training and development plan included in their CFSS service delivery plan. The plan must describe:

- What training the participant's support workers need
- Who provides the training and the license, education, training or work experience the trainer needs
- Who determines the support worker is competent to provide the service the participant needs
- A plan to supervise and evaluate the support workers
- A plan to evaluate whether the overall service delivery is meeting the participant's needs

The employer must update the worker training and development plan in all of the following situations:

- At reassessment
- When a new support worker begins providing services to the participant
- When there are significant changes to the participant's service delivery plan
- When a performance review indicates a support worker needs additional training.

In the CFSS agency model, a CFSS provider agency staff member with a background relevant to the needed task trains and ensures the support worker is competent.

In the CFSS budget model, the participant is responsible to train and ensure the support worker is competent to perform the needed task. The participant or their representative cannot use the worker training and development budget to pay themselves to meet their employer responsibilities. The participant or their representative also cannot hire another individual to supervise their support workers.

In both the CFSS agency and budget models, the support worker's employer can use the CFSS worker training and development budget to pay the fees for a support worker attending a class or workshop on topics related to the participant's assessed needs. A class can take place in a variety of settings and have varying numbers of learners (e.g., one-on-one training, traditional classroom course, online class).

Worker training and development has a minimum annual allocation of $1,272.96 credited to each participant and is separate from the participant's service delivery budget. Additional funds for the participant's worker training and development may be requested and are subject to DHS approval. DHS understands that worker training and development for the support worker is considered an administrative service.

Specify any tools or instruments used as part of the risk management system to identify and mitigate potential risks to the individual receiving CFC services:

Assessment and service/support planning

The comprehensive assessment tool is used to determine eligibility for CFSS. It contains assessment questions intended to help discover any potential risks to document in the CFSS service delivery plan. Assessors are responsible to identify issues that may affect the participant's health and safety.

The support plan, informed by the assessment, provides information to the participant, provider agency, support worker and consultation services provider. The support plan includes:

- Documentation of dependencies in ADLs and IADLs, presence of health-related needs and presence of level-one behaviors

- Determination of institutional level of care
- Determination of the participant's representative, if needed
- Identification of appropriate paid, unpaid and natural supports and services
- Referrals to appropriate payers and community resources
- Documentation of the plan to mitigate any identified risks

An assessor is a mandated reporter and is required to report any suspected maltreatment of a vulnerable adult to the Minnesota Adult Abuse Reporting Center (MAARC) and to report any suspected maltreatment of a child to the local social services agency or law enforcement.

Incident reporting

CFSS provider agencies must establish policies and procedures for responding to incidents that occur while services are being provided. When the participant has a legal representative or a participant's representative, the agency must report incidents to these representatives. When the participant self-directs under the budget model, the participant or the participant's representative must report any adverse incidents to the consultation services provider, FMS provider, case manager or care coordinator, if applicable. Providers of consultation services educates participants and, if applicable, their representatives about how to report adverse incidents and concerns to the appropriate persons. An incident is an occurrence that involves a participant and requires a response that is not a part of the ordinary provision of the services to that participant. Incidents include:

- Serious injury of a participant as defined by state statute
- A participant's death
- Medical emergencies, unexpected serious illness or significant unexpected change in a participant's illness or medical condition that requires a call to 911, physician treatment or hospitalization
- Mental health crises that require a call to 911 or a mental health crisis intervention team
- Acts or situations involving a participant that requires a call to 911, law enforcement or the fire department
- A participant's unexplained absence
- Behavior that creates an imminent risk of harm to the participant or another person
- Reports of alleged or suspected vulnerable adult maltreatment as defined in state statute
- Reports of alleged or suspected maltreatment of minors as defined in state statute

Background study and training requirements

CFSS provider agencies, FMS providers and consultation service providers must comply with background study requirements in accordance with state statute and maintain documentation of background study requests and results. CFSS provider agencies and FMS provider are also required to comply with background study requirements in accordance with state statute.

All CFSS support workers, regardless of service delivery model, must complete a background study requirement in accordance with state statute before enrolling with DHS as a support worker.

All CFSS support workers are mandated reporters and are required to complete state-provided minimum training components related to identifying and mitigating potential risks to CFSS participants including, but not limited to:

- Basic first aid

- Vulnerable adult and child maltreatment
- Positive behavioral practices
- Responding to a mental health crisis

Provide a description of the conflict of interest standards that apply to all individuals and entities, public or private to ensure that a single entity doesn't provide the assessments of functional need and/or the person-centered service plan development process along with direct CFC service provision to the same individual:

CFSS provides the participant with different types of support from various entities. These entities include the county, tribal human services organization, or managed care organization conducting assessments, CFSS provider agency, consultation services provider, and the FMS provider. While an entity may provide more than one of these supports, a single entity may only provide one type of support to the same CFSS participant. This complies with 42 CFR 441.555.

The participant's representative must not have a financial interest in the provision of any services included in the participant's CFSS service delivery plan. Additional conflict of interest standards for a participant's representative are included in the following section.

☐ Box unchecked: Conflict of Interest Exception: The only willing and qualified entity performing assessments of functional need and or developing the person-centered service plan also provide home and community-based services.

Provide a description, including firewalls, to be implemented within the entity to protect against conflict of interest, such as separation of assessment and/or planning functions from direct service provision functions, and a description of the alternative dispute resolution process:

Standards for assessors (county, tribal human services organization , or managed care organization):

Minnesota law requires all counties and the tribal human services organizations that have elected to administer and manage HCBS program through a DHS contract to provide assessment for eligibility for long-term services and supports. The state contracts with MCOs that serve enrollees age 65 and older to manage home and community-based services and supports for those enrollees.

These entities perform assessments and develop support plans that reflect participant preferences in services and supports for self-direction and include risk management, back-up and emergency planning.

Counties, tribal human services organizations and MCOs are not allowed to enroll as consultation services providers.

A participant's representative may not also be assigned as their county, tribal human services organization, or managed care organization assessor or case manager/care coordinator.

Standards for provider agencies:

The CFSS provider agency supports the participant with many things, including supervising the support worker(s). The CFSS agency model sets conflict of interest standards. The agency staff member providing supervisory duties under the CFSS agency model cannot also be the participant's:

- Family foster care provider
- Direct care (support) worker
- Legal guardian, parent or step-parent when the participant is a minor
- Responsible party
- Spouse

A participant's representative cannot be part of the provider agency's staff unless related to the participant by blood, marriage or adoption.

Standards for consultation services providers:

Consultation services providers assist the participant with planning, developing and implementing the service delivery plan by providing information about service options, choices in providers and rights and responsibilities, including appeal rights.

Consultation services providers can only provide services within the scope of their service. Examples of activities outside of the scope of consultation services include:

- Determining the person's program eligibility
- Supporting the person's appeal of the assessment results
- Performing employer functions for a participant using the budget model or for a CFSS provider agency
- Performing the tasks of a medical provider (e.g., registered nurse, home health aide).

Consultation services providers cannot be the person's FMS provider, county, tribal human services organization, or managed care organization or the CFSS or HCBS waiver vendor or provider agency.

Counties, tribal human services organizations and MCOs are not allowed to enroll as consultation services providers.

A participant's representative may be an employee of the consultation provider, but they cannot be an agency owner or a staff member who delivers consultation services to the participant.

The individual must be informed by the consultation services provider when the provider has any direct or indirect financial interest in the delivery of other services. The consultation services provider must disclose the information to the person in writing. This permits the individual to make an informed choice of whether they wish to select the provider for consultation because it precludes the participant from selecting the provider for other services. The other services the consultation services provide may offer include, but are not limited to:

- CFSS worker training
- Goods
- Any services provided as an MHCP-enrolled provider

The consultation services provider must obtain a document signed by the participant and the consultation services provider stating that:

- The participant acknowledges they understand the information disclosed about the direct or indirect financial interest the provider has in the delivery of other services
- The person identifies they had an informed choice of services, service models and providers and understood the options they had to meet their needs
- The person acknowledges they understand they cannot utilize any other services provided

by the Consultation Services provider they have selected
- The consultation services provider offered the participant informed choice of service delivery

Standards for FMS providers:

CFSS provider agency services cannot be provided by the FMS provider.

A participant's representative cannot be the:
- FMS staff, unless related to the participant by blood, marriage or adoption
- FMS owner or manager

Standards for worker training and development:

A participant's representative cannot be the worker training and development service provider.

Assessment of Need

Describe the assessment process or processes the state will use to obtain information concerning the individual's needs, strengths, preferences and goals.

A person interested in receiving CFSS services must receive an assessment of need from a certified assessor. Initial assessments for CFSS are completed when the person requests an assessment from the county, tribal human services organization, or managed care organization that has jurisdiction to complete the assessment, or when another individual requests the assessment on their behalf. The county, tribal human services organization, or managed care organization schedules and conducts the assessment in-person.

The assessment tool is a comprehensive, conversation-based, person-centered assessment. The assessment includes the health, psychological, functional, environmental and social needs of the individual necessary to develop a person-centered support plan that meets the person's needs and preferences.

The assessment tool includes an assessment of ADLs, IADLs, medical service needs, safety and supervision needs and informal caregiver support. The certified assessor also uses information from medical histories, physician records and reports from providers to further evaluate and understand the person’s needs. For children, the assessment also includes identifying needs that are beyond what is typical for a parent. For example, a parent of a minor typically is responsible for grocery shopping, meal preparation, supervision, etc.

Counties, tribal human services organizations, or managed care organizations enter key summary information from the assessment (including information related to the level of care) into MMIS screening documents.

After completion of the assessment, the participant or the participant’s representative develops and evaluates the CFSS service delivery plan through a person-centered planning process, with assistance from the consultation services provider as desired.

☐Box checked: The state will allow the use of telemedicine or other information technology medium in lieu of a face-to-face assessment in accordance with the federal code of regulations under §441.535. The individual is provided with the opportunity for an in-person assessment in lieu of one performed via telemedicine. Include a description about how an individual receives appropriate support including access to on-site support staff during the assessment:

The state will claim costs associated with CFC assessment activities as:

☐ Box unchecked: A Medicaid Service

☒ Box checked: An Administrative Activity

Indicate who is responsible for completing the assessment prior to developing the CFC person-centered service plan. Also specify their qualifications:

☐ Box unchecked: Social Worker (specify qualifications)

☐ Box unchecked: Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.

☐ Box unchecked: Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law

☐ Box unchecked: Licensed Physician (M.D. or O.D.), acting within scope of practice under state law

☐ Box unchecked: Case Manager (specify qualifications)

☒ Box checked: Other (specify what type of individual and their qualifications)

Assessments are completed by the county, tribal human services organization, or managed care organization that has jurisdiction to complete the assessment for the person. Each county, tribal human services organization, or managed care organization must use assessors who have completed the assessor training and the certification process. Assessors are required to be recertified every three years.

Assessors must meet one of the following requirements:

- Minimum of a bachelor's degree in social work, nursing with a public health nursing certificate or other closely related field with at least one year of home and community-based experience
- Registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

☒ Box checked: The reassessment process is conducted every: 12 months

☐ Box unchecked: Other (must be in increments of time less than 12 months)

Describe the reassessment process the state will use when there is a significant change in the individual's needs or the individual requests a reassessment. Indicate if this process is conducted in the same manner and by the same entity as the initial assessment process or if different procedures are followed:

Reassessments are conducted by the county, tribal human services organization, or managed care organization. Reassessments are completed using the same assessment tool that is used for the initial assessment, in the same manner and many times by the same entity as the initial assessment.

A different county, tribal human services organization, or managed care organization may complete the

reassessment if, during the service plan year, the participant moved to a different region of the state or enrolled in managed care.

Reassessments must be completed at least every 12 months and whenever a significant change in the participant's condition warrants a comprehensive review. Annually, the CFSS provider agency (agency model) or FMS provider (CFSS budget model) requests a reassessment at least 60 days before the end of the service agreement. For participants enrolled in a §1915(c) HCBS waiver or is age 65 or older and enrolled in managed care, the CFSS provider agency or the FMS provider would collaborate the request for reassessment with the participant's case manager or care coordinator.

When a participant has a significant change in condition, the participant, CFSS provider agency (agency model) or FMS provider (budget model) can request a reassessment using the Referral for Reassessment form (PDF). The request for assessment goes to the county, tribal human services organization, or managed care organization who conducts the assessment. After receiving the request, the county, tribal human services organization, or managed care organization will determine if it should complete:

- A 45-day temporary increase in CFSS services
- A full reassessment

Person-Centered Service Plan

The CFC service plan must be developed using a person-centered and person- directed planning process. This process is driven by the individual and includes people chosen by the individual to participate.

The state will claim costs associated with CFC person-centered planning process as:

☒ Box checked: A Medicaid Service

☐ Box unchecked: An Administrative Activity

Indicate who is responsible for completing the Community First Choice person-centered service plan.

☐ Box unchecked: Case Manager. Specify qualifications:

☐ Box unchecked: Social Worker. Specify qualifications:

☐ Box unchecked: Registered Nurse, licensed to practice in the state, acting within scope of practice under state law.

☐ Box unchecked: Licensed Practical Nurse or Vocational Nurse, acting within scope of practice under state law.

☐ Box unchecked: Licensed Physician (M.D. or O.D.), acting within scope of practice under state law.

☒ Box checked: Other. Specify provider type and qualifications: The participant or their representative, with assistance of Consultation Services as requested.

The CFSS service delivery plan is written by the participant and others chosen by the participant, which may include their representative (when applicable) and other people important to support being active in the community and/or meeting the needs described in the plan.

The consultation services provider is a neutral third party who ensures the participant is able to choose who is involved in the development of the CFSS service delivery plan. See provider qualifications under "other" below.

Provider type: Consultation services provider

Qualifications: See the provider qualifications for consultation services providers under the "voluntary training on how to select, manage and dismiss attendants" section of the mandatory services and supports of this document.

Person-Centered Service Plan Development Process: Use the section below to describe the process that is used to develop the person-centered service plan.

Specify the supports and information that are made available to the individual (and/or family or authorized representative, as appropriate) to direct and be actively engaged in the person-centered service plan development process and the individual's authority to determine who is included in the process:

The CFSS service delivery plan is based on the comprehensive assessment, which includes the health, psychological, functional, environmental and social needs of the participant necessary to develop a plan that meets the participant's needs and preferences. The comprehensive assessment is completed by a certified assessor, as described under the assessment section. The participant may choose who is present for the assessment, including their representative, family members and other important people. Service providers may be present to provide care during the assessment and service planning activities, but providers are not included in the assessment process.

The assessor (as defined in Minnesota statute) must determine and communicate the results of the assessment and any recommendations and authorizations for CFSS within 10 business days to the participant or their representative and CFSS providers of choice. After the assessment, the participant chooses a consultation services provider who provides information about CFSS service models, rights and responsibilities (including appeal rights), choice in providers and CFSS policies. The consultation services provider also provides the participant with the CFSS service delivery plan template.

The participant or the representative is responsible to write the CFSS service delivery plan. Consultation services are available to the participant and/or the representative to provide assistance and support in writing the CFSS service delivery plan, to the extent desired by the participant. The participant may choose others to participate in the CFSS service delivery plan development process who are important in supporting them to be active in community and/or meeting the assessed needs. This could include the representative, family members, friends, natural supports or others.

Indicate who develops the person-centered service plan. Identify what individuals, other than the individual receiving services or their authorized representative, are expected to participate in the person-centered service plan development process. Please explain how the state assures that the individual has the opportunity to include participants of their choice:

The CFSS service delivery plan is written by the participant and others chosen by the participant, which may include their representative (when applicable) and other people important to supporting the participant to be active in the community and/or meeting needs described in the plan.

The consultation services provider is a neutral third party who ensures the participant is able to choose who is involved in the development of the service delivery plan.

The CFSS service delivery plan must be developed and evaluated through a person-centered planning process by the participant or the participant's representative. The consultation services provider can help the participant plan, develop, and implement the service delivery plan by providing information about service options, choice in providers and rights and responsibilities, including appeal rights. The consultation services provider must support the participant in developing the service delivery plan, to the extent the participant desires.

The participant submits the completed service delivery plan to the consultation services provider. The consultation services provider will review the CFSS service delivery plan with the person. In supporting the person, they will review whether the plan meets assessed needs outlined in the needs assessment and contains covered CFSS services. The consultation services provider submits the plan to the State Medicaid agency or the delegate of the State Medicaid Agency for approval. If the participant uses CFSS services on a waiver, the county, tribal human services organization or managed care organization case manager must approve the plan. If the participant is age 65 or older and receives CFSS services through an MCO, the MCO care coordinator must approve the plan. Plan approval includes ensuring the plan meets requirements and does not include services or goods that are not covered.

The approved plan will then be sent by the State Medicaid Agency or delegate to the participant and the CFSS provider agency and/or FMS provider, depending on the service model the person has chosen.

For participants who are using the provider agency model, the CFSS provider agency is responsible to work with the participant to fill in any additional service delivery details not included in the plan.

Describe the timing of the person-centered service plan development to assure the individual has access to services as quickly as possible; describe how and when it is updated, including mechanisms to address changing circumstances and needs or at the request of the individual:

The county, tribal human services organization, or managed care organization's assessor must determine and communicate (in writing) the results of the assessment and any recommendations and authorizations for CFSS within 10 business days to the participant or the representative and chosen CFSS providers. The written communication from the county, tribal human services organization, or managed care organization allows the participant to begin developing the CFSS service delivery plan as soon as possible.

The written communication must include the participant's right to appeal the assessment in accordance with state law. The participant or the representative will complete the CFSS service delivery plan based on the information provided by the county, tribal human services organization, or managed care organization’s assessor, with assistance from the consultation service provider, if requested. The consultation services provider supports the participant in the person-centered planning process.

The participant/representative and consultation services provider review the CFSS service delivery plan at least annually upon reassessment, or more frequently when there is a significant change in the participant's condition, a change in the participant’s need for services and supports or if the participant requests a person-centered assessment. When the participant has an assessment that results in a

change of the participant's need for services, the consultation services provider will help the participant change the service delivery plan so it aligns with the change in service need.

The county, tribal human services organization, or managed care organization must conduct an assessment within 20 business days of receiving a request when there is a significant change in the participant's condition, a change in the participant's need for services and supports or if the participant requests a person-centered assessment. If the participant has a temporary change in condition that requires more support, the county, tribal human services organization, or managed care organization can conduct a telephone assessment for a temporary increase.

If the participant has an immediate need to begin services, the county, tribal human services organization , or managed care organization can conduct a telephone assessment for a temporary start of services. A participant authorized for a 45-day temporary start does not need to meet with a consultation services provider before they start services. A temporary start is limited to the agency model and direct care services. To continue using CFSS services beyond the 45-day temporary start, the participant must select a consultation services provider, complete an orientation with that provider, select a model and write an approved CFSS service delivery plan before the temporary authorization ends.

Describe the state's expectations regarding the scheduling and location of meetings to accommodate individuals receiving services and how cultural considerations of the individual are reflected in the development of the person-centered service plan:

The person-centered planning process must occur at times and locations convenient to the participant and must reflect the participant's cultural considerations.

All CFSS providers (consultation services, provider agency, etc.) are expected to offer a variety of modes to meet and communicate with the participant or the representative. The modes can include communication via email, text, phone, in-person, video phone or any other mode preferred by the participant. Meetings should be at a location chosen by the participant, with consideration for the participant's preferences for privacy. Meetings must be scheduled flexibly to meet the participant's needs.

DHS requires CFSS providers to develop and implement policies and procedures that emphasize the application and philosophy of participant direction, including being culturally competent in all business practices to communicate effectively with participants of all ages, needs, disabilities and chronic conditions. These expectations also include meeting and communicating with the participant's representative. These expectations are addressed in the planning process.

Describe how the service plan development process ensures that the person-centered service plan addresses the individual's goals, needs (including health care needs), and preferences and offers choices regarding the services and supports they receive and from whom. Please include a description of how the state records in the person-centered service plan the alternative home and community based settings that were considered by the individual:

After the assessment and completion of a county, tribal human services organization nation, or managed care organization developed support plan that identifies the participant's needs (including health care needs), preferences and goals, the participant chooses a consultation services provider. The consultation services provider:

- Provides orientation regarding the provider agency model and the budget model, including information on roles, responsibilities, processes, policies, options available for services and supports and appeals
- Helps the participant create a plan for the budget under the budget model and, prior to completing the CFSS service delivery plan:
    - Calculates the specific dollar amount
    - Compares the costs of the agency and budget models
    - Describes any limitations associated with the models
- Provides support to the participant (to the extent the participant desires) to develop the plan and ensure the services and supports in the plan match the participant's needs, goals and preferences
- Offers choices to the participant regarding the services and supports to receive and from whom
- Records the alternative HCBS settings the participant considered.

The participant or their representative creates the CFSS service delivery plan using a template developed by DHS or collaborative care plan used by MCOs, which documents:

- People chosen by the participant for support in the planning process and in the provision of services and supports
- The participant's chosen service model and their corresponding choice of provider agency or FMS provider
- HCBS setting options the participant considered and chose
- The participant's strengths, preferences, goals and preferred outcomes
- How the participant's areas of assessed needs will be met, including assistance with ADLs, IADLs, observation and redirection of behavior, health-related needs, or assistance with maintenance, acquisition or enhancement of skills
- Instructions on what support the worker will provide and how the worker will provide it in response to the participant's assessed needs and to achieve the participant's goals and outcomes
- Plans for worker training and development, as applicable
- Risk factors and measures in place to minimize them, including individualized back-up plans
- Individuals or entities responsible for monitoring the service delivery plan

For the budget model, the CFSS service delivery plan must include a detailed spending budget that identifies support worker related expenses and other purchases.

The CFSS service delivery plan must be understandable to the participant and the individuals providing support. When the CFSS service delivery plan is finalized and agreed to in writing by the participant or their representative, the consultation services provider forwards the plan to the State Medicaid agency or their delegate (also referred to as county, tribal human services organization, or managed care organization) for plan approval. After approval the county, tribal human services organization, or managed care organization then distributes it to the participant and others involved in the CFSS service delivery plan.

Describe the strategies used for resolving conflict or disagreements within the process:

Consultation Services will provide support as desired to the participant to include only covered services in

the person-centered service delivery plan. In the event that a participant wishes to include non-covered services in the plan consultation services will provide support to explore alternative solutions to meet the participant's needs with covered goods and services only. In the event that the participant insists on including non-covered goods and services in the person-centered delivery plan and no alternative solutions can be reached the plan will be forwarded to the county, tribal human services organization, or managed care organization for review at which time the county, tribal human services organization, or managed care organization would need to inform the participant of the non-covered items through a formal notice of action. The notice of action will outline the participants appeal rights. This process is described below:

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action
- Timeline associated with the action
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

Managed care organizations (MCOs) must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking
- The reason the MCO is taking this action
- The state and federal laws or MCO policies that support the MCO's action
- The process the member must follow to file an appeal with the MCO or the state

Participants may also submit fair hearing requests if they feel that they have not been offered free choice of service provider.

DHS also tracks patterns in eligibility, service/budget allocation, service delivery plan and termination.

Please describe how the person-centered service plan development process provides for the assignment of responsibilities for the development of the plan and to implement and monitor the plan.

The participant or their representative is responsible to develop the CFSS service delivery plan, with support from the consultation services provider, as desired by the participant. The CFSS service delivery plan reflects the services and supports the participant chooses to meet their assessed needs and identifies the individual or entity responsible for monitoring the CFSS service delivery plan.

When the participant has chosen the provider agency model, the provider agency, participant, and the representative (when applicable) are responsible for implementing and monitoring the CFSS service delivery plan. The individual(s) or entities responsible for monitoring the plan will be identified on the service delivery plan. The provider agency is responsible for completing an evaluation of CFSS services with 90 days of service initiation and at least quarterly thereafter.

When the participant has chosen the budget model, the participant, the representative (when

applicable) and the FMS provider are responsible for implementing and monitoring the CFSS service delivery plan and expenditures. The individual(s) or entities responsible for monitoring the plan will be identified on the service delivery plan.

All service delivery plans are subject to the monitoring of the State Medicaid Agency. For all participants the State Medicaid Agency will audit service delivery plans at the consultation service provider level, review satisfaction surveys and track appeals related to service reduction, termination or denial to identify programmatic deficits. For those who have an assigned case manager or care coordinator, the individual at the County, tribal human services organization, or managed care organization assigned is responsible to ensure the service delivery plan is implemented as outlined. Oversight of service delivery plans is conducted by the state Medicaid agency through the County, tribal human services organization, or managed care organization review process. The county, tribal human services organization, or managed care organization review process is described here:

The State Medicaid Agency conducts on-site county, tribal human services organization, or managed care organization reviews on an ongoing basis. Counties and tribes are randomly selected for review. The purpose of the review is to monitor compliance with program requirements, performance of delegated administrative functions, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Reviews are continuous and ongoing, and all agencies are reviewed at least once every three years. Reviews include a case file review of a randomly selected representative sample of cases.

☒ Box checked: The state assures that assessment and service planning will be conducted according to 441.540(B) 1-12.

The person-centered service plan is reviewed and updated every:

☐ Box unchecked: 3 months

☐ Box unchecked: 6 months

☒ Box checked: 12 months

☐ Box unchecked: Other must be less than 12 months)

AND

☒ Box checked: When an individual's circumstances or needs change significantly or at the individual's request.

Describe the person-centered service plan review process the state will use. In the description please indicate if this process is conducted in the same manner and by the same entity as the initial service plan review process or if different procedures are followed:

The participant and others chosen by the participant are responsible to review the CFSS service delivery plan. The participant may choose to include the representative, when applicable, as well as any other people important in supporting the participant to be active in the community and/or meeting needs. Other entities that review the CFSS service delivery plan include the case manager or care coordinator (when applicable), consultation service provider and, depending on the service model chosen by the participant, the provider agency or FMS provider.

The CFSS service delivery plan review is conducted in the same manner and by the same entity as the

initial CFSS service delivery plan. Different entities may review the CFSS service delivery plan in certain circumstances, including if the participant has chosen a different consultation service provider during the year, changed service models, changed the county of residence or changed the MCO. The CFSS service delivery plan must be reviewed at least annually and whenever the participant has a change in condition.

The consultation services provider will assist the participant with the service delivery plan review and implementing any changes by providing information about how to change the service delivery plan based on the needs identified.

Community First Choice Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving CFC services:

☒ Box checked: Traditional State-Managed Fee-for-Service (4.19(b) page is required)

☒ Box checked: Managed Care Organization; only those serving enrollees age 65 and older

☐ Box unchecked: Other, describe:

Quality Assurance System

Please describe the state's quality improvement strategy:

DHS will review and analyze performance and remediation data ("monitoring data") according to the following process. Problems or concerns that require intervention beyond the existing remediation processes (i.e., system improvement) will undergo more advanced analysis and new/improved policy and/or procedure development, testing and implementation.

Data sources:

- Input (all identified CFSS program indicator data sources)
- Performance measure and remediation (monitoring) data

Data analysis:

1. Is there a problem (single instance or trend) indicated by the monitoring data?
    - If yes, test data (step 2).
    - If no, return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
    - If yes, identify what type of problem is indicated (i.e., policy, process and/or "bad actor").
    - If no, return to monitoring.
3. Do existing remediation processes address the identified problem?
    - If yes, remediate and return to monitoring.
    - If no, enter the appropriate system improvement realm (i.e., policy or process analysis).

System improvement:

Policy analysis realm

1. Can the problem's cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven policy alternatives.
- If no, develop theory-driven policy alternatives.

2. Test policy alternative(s).

3. Select the "best" policy alternative.

4. Enact the new policy and return to monitoring.

Process analysis realm

1. Is the problem an internal (i.e., DHS) or external process issue?

2a. If it is an internal process issue, can the cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven internal process alternatives.
- If no, develop theory-driven internal process alternatives.

2b. If it is an external process issue, can the cause(s) be identified from analysis of the monitoring data?

- If yes, develop data-driven external process alternatives.
- If no, develop theory-driven external process alternatives.

3. Test process alternative(s).

4. Select the "best" process alternative.

5. Enact the new process or processes and return to monitoring.

Per the same process outlined above, DHS will monitor and analyze the effects of system design changes and undertake additional system redesign/improvement, as needed. DHS will communicate high-level monitoring and trending data to stakeholders and the public via multiple communication channels.

Describe the methods the state will use to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports:

DHS seeks to prevent maltreatment through a variety of processes, including:

- CFSS provider background studies
- Support worker certification and background check requirements
- Foundational and participant-centered provider training requirements
- Identification and management of participant health and safety risks through the assessment and support planning process.

The support and CFSS service planning process directs the identification and alignment of services to meet the participant's health and safety needs. An emergency back-up plan ensures a concrete approach to managing unanticipated situations that might otherwise result in maltreatment. An emergency back-up plan is required as a part of the development of the service delivery plan. It provides specific direction on how to manage general and unplanned staffing emergencies. The consultation services provider is responsible to support the participant or the representative to develop an emergency back-up plan that will ensure the participant's health and safety. Case managers/care coordinators also have an ongoing responsibility to monitor the implementation of

CFSS service delivery plans to ensure the participant's health and safety.

The consultation services provider works with the CFSS employer (e.g., CFSS provider agency or participant under the budget model) to ensure the CFSS service delivery plan adequately addresses the health and safety issues and risks identified in the participant's assessment. For participants who use the agency model, CFSS provider agencies monitor service delivery, including the health and safety of participants, on a quarterly basis. If the quarterly monitoring indicates a need for refinement of the participant's CFSS service delivery plan or a need for reassessment, the CFSS agency and/or participant work with the consultation services providers or the county, tribal human services organization, or managed care organization.

The consultation services provider is responsible to ensure support worker training is addressed and support worker performance is documented as required. For participants who use the budget model, the consultation services provider also is responsible to review how the participant's health and safety is managed as a part of their service delivery plan. The consultation services provider supports participants using the budget model in modifying the CFSS service delivery plan and seeking reassessment, as needed.

The consultation services provider is responsible to monitor services on a semi-annual basis for CFSS budget model participants who use a parent of a minor or a spouse as a personal care support worker and do not have a case manager or care coordinator. This monitoring includes ensuring services and/or supports and the service delivery plan are meeting the participant's health and safety needs. The consultation services provider helps the participant make changes to the service delivery plan, as needed.

When a CFSS participant is enrolled in a §1915(c) HCBS waiver or is age 65 or older and enrolled in managed care, the case manager/care coordination has comprehensive monitoring responsibilities. The case manager/care coordinator responds to changes in the participant's health and safety needs, which involves coordinating with the consultation services provider to modify the participant's CFSS service delivery plan, assessing whether other services (e.g., waiver) might help meet the participant's needs or referring the participant for a reassessment.

DHS manages intake and responds to reports of alleged maltreatment of vulnerable adults and alleged maltreatment of children through the state's adult and child protection systems, pursuant to state statute. Maltreatment includes incidents of abuse, neglect or exploitation. State law requires mandated reporters to report suspected maltreatment immediately and encourages all people to report suspected maltreatment. Maltreatment includes, but is not limited to, criminal acts; actions that cause physical pain, injury or emotional distress; adverse or deprivation procedures not authorized under statute; unreasonable confinement; involuntary seclusion; forced separation; failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision; and, for adults, failure by the person to meet their own basic needs and financial exploitation.

Maltreatment reports involving vulnerable adults are made to the Minnesota Adult Abuse Reporting Center (MAARC), as required in statute. All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency (LIA) or agencies responsible, under statute, for investigation and for protective services. If a report is made initially to law enforcement or an LIA, those agencies are required to take the report and immediately forward it to the MAARC. LIAs include DHS, the Department of Health (MDH) and county social service agencies. Reports alleging a crime are

also referred to law enforcement for criminal investigation. The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes an immediate referral to the county for emergency protective services.

Maltreatment reports involving children are made to the county/tribal social service agency or the police. (Reports involving state-licensed facilities may, but rarely, come directly into the state licensing entity.) The county local welfare agency that receives a maltreatment report is responsible for assessing allegations and providing child protection services. County agencies undertake family assessment or, where they have jurisdiction, investigation activities. When a maltreatment allegation involves a state-licensed facility, the county forwards the maltreatment report to the appropriate state lead investigative entity: Department of Human Services or Department of Health. County lead investigative agencies follow up, to conclusion, on the vast majority of maltreatment reports involving children.

Monitoring Metrics:

Percent of CFSS participant plans reviewed that include an emergency back-up plan during the review period. *Numerator: Number of CFSS participant files that include an emergency back-up plan. Denominator: Number of CFSS participant files reviewed during the current review period.*

Percent of new and existing CFSS support workers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters during the review period*. Numerator: Number of CFSS support workers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters. Denominator: Number of support workers approved to deliver CFSS services during the reporting period.*

Percent of reports involving CFSS Program participants that were submitted to the Minnesota Adult Abuse Reporting Center (MAARC) and then referred to a Lead Investigative Agency (LIA) within two working days. *Numerator: Number of reports involving CFSS Program participants that were submitted to the MAARC and then referred to LIA within two working days. Denominator: Number of reports involving CFSS Program participants that were submitted to MAARC and then referred to LIA.*

Describe how the state measures individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered CFSS service delivery plan, particularly for the health and welfare of individuals receiving such services and supports. (These measures must be reported to CMS upon request.)

DHS measures individual outcomes associated with CFSS service delivery plans through participant reports received at reassessment and via participant satisfaction surveys administered by consultation services providers.

The reassessment process includes a discussion between the assessor and participant on progress toward last year's goals, if services are meeting identified needs and whether any service changes are needed. The consultation services provider uses documentation of that discussion with the participant when developing the CFSS service delivery plan.

Under the agency model, the CFSS provider agency must evaluate services within 90 days of initiation and quarterly thereafter. The provider agency must conduct the first year of quarterly reviews in person. After the first year, DHS requires a minimum of one in-person quarterly review per year. CFSS

quarterly evaluations include assessment of whether:

- The participant's CFSS service delivery plan accurately identifies the current service need
- The services are supporting the participant to accomplish goals in the service delivery plan
- The support worker(s) are competent to perform the tasks in the service delivery plan
- The provider agency, participant or participant's representative has any other concerns about the services or service delivery plan

DHS tracks outcomes associated with CFSS services through review and analysis of the data it requires consultation services providers to collect and submit. This includes responses on questions during CFSS service delivery planning sessions with participants, information gathered at required semi-annual reviews and responses from annual participant satisfaction surveys. DHS directs consultation services providers to measure participant satisfaction with the:

- Participant's chosen consultation services provider
- Provision of consultation services information and support
- Participant's CFSS service delivery plan in meeting their assessed needs
- Provision of CFSS services in safeguarding their health and safety
- Provision of CFSS services in helping them meet their service goals

Monitoring Metrics:

Percent of CFSS participants that reported they were satisfied with their CFSS service delivery plan adequately addressing their health and safety needs. *Numerator: Number of CFSS participants that reported their CFSS service delivery plan adequately addressed their health and safety needs. Denominator: Number of participants providing response during the review period.*

Percent of CFSS participants that reported that their CFSS support worker assisted them in meeting their service goals. *Numerator: Number of participants that reported that their CFSS support worker assisted them in meeting their service goals. Denominator: Number of participants providing response during the review period.*

Percent difference between the dollar amount encumbered for CFSS services compared to the dollar amount claimed for CFSS services provided to participants. *Numerator: Dollar amount claimed for CFSS fee-for-service (FFS) services. Denominator: Dollar amount encumbered for CFSS services provided to FFS participants during the review period.*

Describe the standards for all service delivery models for training, appeals for denials and reconsideration procedures for an individual's person-centered CFSS service delivery plan:

Training:

Support workers are required to complete standardized and person-centered training. This training also is available to CFSS participants at a variety of levels, depending on their chosen service model.

Support workers must successfully complete CFSS certification training and the additional training determined necessary to meet the participant's needs. All CFSS participants must have a worker training and development plan that describes necessary support worker training and the plan for evaluating support worker competency. The support worker's employer (i.e., CFSS provider agency or budget model participant) is responsible to monitor support workers' completion of training and evaluate support workers' competency. The worker training and development plan is updated at

reassessment, whenever there is a change in support workers or the service delivery plan or whenever the support worker's performance review reveals a need for additional training.

Consultation services providers offer training to help all participants understand CFSS services, service model options and how to write, implement and evaluate their CFSS service delivery plan. They also help participants acquire skills for interviewing, selecting, managing, evaluating and dismissing support workers. Additionally, consultation services providers offer training to budget model participants to assist in the role as a managing employer, including overseeing the training of support workers.

Support workers provide assistance and training to the participant (as directed by the participant's service delivery plan) that is intended to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. This includes functional-skills training through hands-on assistance, supervision and cueing to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs and health-related tasks.

DHS monitors person-centered CFSS participant training and satisfaction. Across both service models, consultation services providers report annually on participant satisfaction with the training and assistance provided to them in developing their CFSS service delivery plan.

Fair Hearings:

DHS requires that CFSS participants receive fair hearing information when they apply for Medicaid, are assessed for services and whenever a service authorization is initiated or modified. Consultation service providers educate and help participants understand their appeal rights related to the CFSS service delivery plan.

When a budget, good or service is reduced, denied or terminated, the county, tribal human services organization, or managed care organization provides the participant with a Notice of Action (Service Plan) (PDF). The notice of action includes:

- The reason (including the legal basis) for the decision and corresponding action
- Timeline associated with the action
- Information about the appeals process, including how to file an appeal if the participant disagrees with the decision, timelines and the participant's right to request continuation of services during an appeal

Managed care organizations (MCOs) must notify their enrolled members with written notice of denial of payment or the denial, termination or reduction (DTR) of services that the member or the member's health care provider requested. This notice includes:

- The action the MCO is taking
- The reason the MCO is taking this action
- The state and federal laws or MCO policies that support the MCO's action
- The process the member must follow to file an appeal with the MCO or the state

Participants may also submit fair hearing requests if they feel that they have not been offered free choice of service provider.

DHS also tracks patterns in eligibility, service/budget allocation, service delivery plan and termination.

Monitoring Metrics:

Percent completion of support worker training, as directed by the support worker training and

development plan of CFSS participants. *Numerator: Number of participants for whom support worker training was completed as directed by the support worker training and development plan of CFSS participants. Denominator: Number of participants for whom training was due to be completed during the review period.*

Percent of CFSS participants who reported they were satisfied with the training/assistance provided by consultation services providers in developing their CFSS service delivery plan. *Numerator: Number of CFSS participants who reported they were satisfied with the training provided by consultation services providers in developing their CFSS service delivery plan. Denominator: Number of CFSS participants providing response during the review period.*

Percent of CFSS fee-for-service (FFS) participants who did not file an appeal that progressed to a hearing before an appeals judge. *Numerator: Number of CFSS FFS participants who did not file an appeal that progressed to a hearing before an appeals judge. Denominator: Number of CFSS FFS participants during the review period.*

Describe the methods used to monitor provider qualifications:

DHS authorizes CFSS services for delivery exclusively by actively enrolled Minnesota Health Care Programs (MHCP) service providers. Approved MHCP CFSS providers must meet and maintain relevant certification, service standards and contract requirements as required by state and federal law.

Support workers must complete a background study and standardized CFSS certification course, including a passing competency test, before they can enroll as an MHCP provider eligible to deliver services. The certification course includes training on first aid, Occupational Safety and Health Administration (OSHA) universal precautions, person-centered planning and self-direction, recognition and reporting of maltreatment and a comprehensive review of support worker roles and responsibilities. MHCP monitors enrolled, qualified support workers on an ongoing basis through monthly review of federal and state provider integrity lists and recertification process whenever the worker changes CFSS provider agencies or FMS provider affiliation.

The support worker's employer (i.e., the CFSS provider agency or the budget model participant) oversees the support worker's training and development plan and evaluates the support worker's competency and performance. CFSS provider agencies must evaluate workers within 30 days of them beginning to deliver services, including shared services. The provider agency verifies and maintains evidence of, minimally annual performance reviews and completed training per the support worker's training and development plan. Consultation services providers assist budget model participants with support worker monitoring and management functions, including the charting of worker performance improvement initiatives and, when needed, assistance with worker discharge.

Consistent with state and federal law, DHS requires all enrolled providers to be screened based on the level of risk of fraud, waste or abuse to the Medicaid (Medical Assistance) program. CFSS provider agencies are classified as providers who are at a "high risk" of perpetrating fraud, waste or abuse. These providers receive both pre-enrollment and post-enrollment site visits by DHS' Office of Inspector General (OIG) as part the MHCP enrollment screening process. OIG's Surveillance and Integrity Review Section (SIRS) Provider Screening unit conducts pre-enrollment and post-enrollment on-site visits to verify that enrollment information submitted to DHS is accurate and complies with federal and state law. This includes a review of employee qualifications and provider policies and procedures. When program integrity concerns are identified, they are referred to the SIRS Provider Investigations unit.

Consultation Service providers are considered limited risk. These providers are required to respond to a Request for Proposal and execute a contract with DHS. They also undergo the MHCP enrollment screening process to validate all provider requirements have been met in accordance with federal and state law. This includes a review of employee qualifications and provider policies and procedures. When program integrity concerns are identified that cannot be remedied with technical assistance, they are referred to the SIRS Provider Investigations unit. Consultation Service provider contracts are subject to audit provisions as outlined in the contracts. Consultation service providers are also audited annually by DHS through the quality assurance measures including systemic review of person-centered service delivery plans and through administration of participant surveys. Contracts are renewed every 5 years, or a time period determined by DHS. Revalidation of enrollment occurs every five years. FMS providers must successfully complete a readiness review through an external FMS review vendor before responding to DHS' request for proposal. Once awarded a contract and enrolled as a qualified MHCP provider, the FMS provider receives a site visit conducted by DHS within the first year of service provision. Every three years thereafter, DHS conducts a contract-monitoring desk audit. If the desk audit indicates the provider failed to comply with tasks and deliverables, DHS will develop a corrective action plan and may ultimately require an external review.

DHS maintains a list of active MHCP providers in the Medicaid Management Information System (MMIS) provider subsystem. MMIS system edits ensure that payment is made only to enrolled, active MHCP providers authorized to provide the service(s) for which they have billed. If a provider's certification expires or is revoked or if a provider's contract no longer applies, DHS removes the provider from the MHCP database, unless there is correction of cited deficiencies. DHS rejects claims from providers that are not actively enrolled.

Monitoring Metrics:

Percent of CFSS claims paid to active MHCP providers. *Numerator: Number of CFSS claims paid to active MHCP providers. Denominator: Number of all CFFS claims paid during the review period.*

Percent of CFSS budget model participants served by support workers determined at performance review to perform job functions adequately. *Numerator: Number of budget model participants served by support workers determined at performance review to perform job functions adequately. Denominator: Number of CFSS budget model participants who evaluated support worker performance during the review period.*

Describe the methods for assuring that individuals are given a choice between institutional and community-based services:

As part of the assessment process, the support plan and service delivery plan requires the participant or representative to initial a series of statements indicating they understand the available choices. These choices include receiving Medicaid-funded care in an institution, Medicaid-funded community-based services, only non-Medicaid services or no services at all. The assessor presents participants who meet institutional level of care with a choice of services in the community, including 1915(c) waiver services, or in an institutional setting. The assessor documents the participant's choice of service setting and revisits the participant's choices at least annually, as part of the reassessment process.

Monitoring Metric:

Percent of CFSS participant plans reviewed that document the choice between institutional and community-based services given to participants who meet institutional level of care*. Numerator:*

Number of CFSS participant plans reviewed that document the participant's choice between institutional and community services. Denominator: Number of CFSS participant plans reviewed during the review period.

Describe the methods for assuring that individuals are given a choice of services, supports and providers:

A participant assessed as eligible to receive CFSS services and supports receives a list of qualified consultation services providers. From this list, the participant selects the provider who will help to develop a CFSS service delivery plan. The consultation services provider presents the participant with information about and provides guidance in selecting a service model. This includes information about services and supports and the providers qualified to deliver them. The participant receives a list of qualified CFSS provider agencies (if participating in the agency model) and a list of qualified FMS providers (if participating in the budget model or intending to purchase goods in the agency model). In an ongoing capacity, the consultation services provider helps the participant change the service delivery plan, service model and/or service providers as needed.

The consultation services provider is required to document that each participant was offered a choice of service model, CFSS provider agency and FMS provider as relevant to the service delivery plan. As part of completing and approving a CFSS service delivery plan, a certified assessor or case manager/care coordinator confirms and documents that the participant was offered a choice of services, support and providers. DHS' waiver review team monitors compliance with participant choice requirements for participants on a 1915(c) waiver. DHS is able to access the consultation services provider's documentation of participant choice through desk reviews, as specified by contract.

Monitoring Metric:

Percent of CFSS participant plans reviewed that document the participant's choice between/among services and providers. *Numerator: Number of plans reviewed in which participant choice was documented. Denominator: Number of participant plans reviewed during the review period.*

Describe the methods for monitoring that the services and supports provided to each individual are appropriate:

The participant's support plan is a written summary of the needs the assessor identified through the assessment process, aligned to the services and supports the participant selected. DHS monitors the alignment of services and supports to meet the participant's needs identified in the assessment. Participants receive reassessments on an annual basis or whenever there is a change in need that requires a modification to the existing CFSS service delivery plan. DHS monitors the frequency of CFSS participant reassessments and determinations of appeals.

Consultation services providers help CFSS participants develop the person-centered CFSS service delivery plan. This includes helping the participant make informed choices of service model and service provider. DHS monitors the quality of the assistance CFSS participants receive through participant satisfaction surveys. When it identifies patterns of poor performance, DHS provides technical assistance to the consultation services provider.

CFSS provider agencies monitor the delivery of CFSS services to agency model participants. Agency model participants may request a change in service support worker, provider agency or CFSS service model at any time. Consultation services providers respond to participant requests for assistance and

ensure adjustment of the participant's service delivery plan to direct delivery of appropriate services and supports.

Consultation services providers help budget model participants with the ongoing evaluation and management of CFSS services and supports. DHS monitors the effectiveness of the assistance provided to budget model participants in ensuring support worker skill and competency and successful implementation of their CFSS service delivery plan.

DHS monitors participant satisfaction with the CFSS service delivery plan as a key indicator of the adequacy and appropriateness of the services and supports participants receive through the program. When it identifies dissatisfaction, DHS assesses underlying issues and works with the Consultation services provider to address problems as needed.

Monitoring Metrics:

Percent of CFSS participant service delivery plans that document services to address ADL and IADL domains of assessed need. *Numerator: Number of CFSS participant plans that document services to address ADL and IADL domains of assessed need. Denominator: Number of budget model CFSS participant plans reviewed.*

Percent of CFSS participant service delivery plans reviewed that are updated annually. *Numerator: Number of service delivery plans reviewed in which the most recent plan has been updated annually. Denominator: Number of CFSS participants reevaluated during the review period.*

Percent of CFSS participants who reported they were satisfied with their CFSS service delivery plan adequately addressing their needs. *Numerator: Number of CFSS participants who reported satisfaction with their CFSS service delivery plan. Denominator: Number of participants providing response during the review period.*

Describe the state process for ongoing monitoring of compliance with the home and community-based setting requirements, including systemic oversight and individual outcomes:

CFSS is a participant-directed method of selecting and providing services and supports that allows the participant maximum control of services and supports. CFSS services, by their nature, are individualized, provided in the community, the participant's private home or non-disability-specific setting and allow full access to the broader community according to the participant's needs and preferences. Participants choose which services and supports to receive and who provides them.

The CFSS service provider does not own or control the setting. This means:

- The CFSS provider does not have a direct or indirect financial relationship with the property owners in the settings described below. Participants do not need to use a specific CFSS provider in order to live in the residence. Therefore, the nature of the relationship does not affect the care provided or the financial conditions applicable to tenants.

Although the CFSS provider does not own or control the setting, person-centered planning remains an important protection to ensure participants have opportunities for full access to the greater community, to the same degree as people who do not receive Medicaid HCBS.

DHS will use several strategies at the provider and recipient levels to ensure ongoing compliance with the HCBS requirements and to ensure person-centered practices are at the forefront of CFSS service

delivery:

- Support workers complete required person-centered training as part of worker training and development for both the agency and budget models
- Provider agencies complete initial CFSS training that includes person-centered practices, as well as service and protection-related rights
- Consultation service providers offer choices to participants regarding the services and supports to receive and from whom, and they record the alternative HCBS settings the participants considered in the service delivery plans
- Consultation service providers educate participants on CFSS service expectations and person-centered practices and their service and protection-related rights upon initial orientation and annually upon participant request
- DHS surveys participants annually on their experience with CFSS services to ensure person-centered practices are being followed and their rights are asserted and protected
- Provider agencies attest to their compliance with HCBS requirements when they enroll with DHS
- Desk audits of provider attestation
- Site specific review(s) where identified as outlined in settings standard review document and settings crosswalk related to HCBS settings standards.

CFSS Program Monitoring Metrics cited in other quality assurance sections that ensure compliance with HCBS Settings requirements:

- Percent of CFSS participants who reported that they were satisfied with the training/assistance provided by Consultation services providers in developing their service delivery plan
- Percent of CFSS participants who reported that their Consultation services provider informed them adequately of the program's person-centered practices and their service/protection-related rights
- Percent of CFSS participant plans reviewed that document the participant's choice between/among services and providers
- Percent of CFSS participants who reported that they were satisfied with their CFSS service delivery plan adequately addressing their needs
- Percent of CFSS participants who reported that their CFSS support worker assisted them in meeting their service goals
- Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights

Choice and Control

Describe the quality assurance system's methods to (1) maximize consumer independence and control, (2) provide information about the provisions of quality improvement to each individual receiving CFC services and supports:

The state's CFSS quality assurance system provides for the detection and response to deficiency at the individual and system level. A cornerstone of the program is person-centeredness and the positioning of participants to maximize independence and control. DHS ensures attainment of these goals by

monitoring the training CFSS participants receive in designing their service delivery plan and the extent of choice they are afforded in selecting their service model and their service provider(s). When a performance issue arises involving a Consultation services provider, DHS provides technical assistance and addresses persistent problems through contract modifications.

DHS also directs monitoring toward identifying the need for system-level improvements (e.g., improved provider training or service standards). The CFSS Implementation Council convenes quarterly to review and assess emerging issues.

Budget model participants exercise ultimate control in overseeing the delivery of CFSS services. Through monitoring the quality of assistance participants receive in assuming the employer responsibilities, DHS ensures that budget model participants are set up for success in achieving optimal outcome, as well as maximum independence. DHS tracks performance trends across Consultation services providers and addresses the need for improvement.

Annually, the assessor and the Consultation services provider explain the participant's ability to ask questions, update goals and/or change the service delivery plan. Case managers/care coordinators have more frequent discussions with participants where they are involved in support planning.

Monitoring Metrics:

Percent of CFSS participants who reported that their Consultation services provider informed them adequately of the program's person-centered practices and their service/protection-related rights. *Numerator: Number of CFSS participants who reported that their Consultation services provider informed them adequately of person-centered practices and their service/protection-related rights. Denominator: Number of CFSS participants providing response during the review period.*

Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights. *Numerator: Number of participants who reported that their CFSS support worker adequately safeguarded their service/protection-related rights. Denominator: Number of participants providing response during the review period.*

Stakeholder Feedback

Describe how the state will elicit feedback from key stakeholders to improve the quality of the community-based attendant services and supports benefit:

The CFSS Development and Implementation Council for CFSS is established in accordance with state statute. As required by statute and federal requirements for Community First Choice (also known as §1915(k)), the council is made up of a majority of people receiving services or family members of people receiving services. The 24-member council comprises:

- Thirteen people receiving services or family members of people receiving services
- Two managed care representatives
- Two county assessors or case managers
- One Individual Education Program (IEP) or school representative
- Two advocate representatives
- Two PCA agency representatives
- Two fiscal support entity or financial management services (FMS) representatives.

Additional membership details can be found on the Office of the Minnesota Secretary of State Board

and Commission page.

The CFSS Development and Implementation Council meets quarterly and incorporates stakeholder feedback into its quality improvement strategy in the following ways:

1. DHS requests feedback from all CFSS participants using the annual consultation services survey. This survey collects information about the support planning process and service delivery. DHS uses this information as a key data source in its quality management strategy that was described earlier.
2. DHS convenes quarterly with the CFSS Implementation Council to review participant survey data and trends and other program quality data.
3. DHS makes summary information about the CFSS program available on the program website and fact sheets.
4. DHS holds webinars and community forums to review major program changes that are being considered or implemented.

Identify the stakeholders from whom the state will elicit feedback:

☒ Box checked: The state will elicit feedback from the following stakeholders: (1) Individuals receiving CFC services and if applicable, their representatives, (2) disability organizations, (3) providers, (4) families of elderly individuals or individuals with disabilities, (5) and members of the community.

☐ Box unchecked: Other Describe:

State Assurances

☒ Box checked: The state assures there are necessary safeguards in place to protect the health and welfare of individuals provided services under this state Plan Option, and to assure financial accountability for funds expended for CFC services.

☒ Box checked: With respect to expenditures during the first full year in which the state plan amendment is implemented, the state will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under §1905(a), §1915, §1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding year.

☒ Box checked: The state assures the collection and reporting of information, including data regarding how the state provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the state provides individuals with disabilities who otherwise qualify for institutional care under the state plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care, and the impact of CFC on the physical and emotional health of individuals.

☒ Box checked: The state shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this option during the fiscal year.
(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.
(iv) Whether the specific individuals have been previously served under any other home and community-based services program under the state plan or under a waiver.

☒ Box checked: The state assures that home and community-based attendant services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable federal and state laws.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(k) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates)*:

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☒	HCBS Personal Care
	HCBS Personal Care Assistance Payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant's approved service allocation: Personal Care 1:1 unit $5.95 Personal Care 1:2 unit $4.47 Personal Care 1:3 unit $3.92 NOTE: One unit is equal to 15 minutes. Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above. Shared care: For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed. Rate formulas are as follows: For 1:2 shared care the formula is: $5.95 multiplied by 1.5 = $8.93 divided by 2 = 4.47

	This formula enables us to not exceed the maximum rate of 1.5 times the payment rate for serving one participant. For 1:3 shared care the formula is: $5.95 multiplied by 1.98 = 11.79 divided by 3 = 3.92 This formula enables us to not exceed the maximum rate of two times the payment rate for serving one participant. Direct staffing wage costs were the main driver of rates. The rate methodology consisted of: • A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook. • A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook. • The average wages were adjusted to differentiate between shared and individual staffing. • Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual. • These wage expenses were multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming. **Personal Care Assistance--Budget Model** Under the budget model, an amount equal to the participant's authorized service units multiplied by the amount listed above for a 1:1 unit (@ $5.95), is authorized for use by the participant. Shared care: For 1:2 and 1:3 shared care under the budget model, services are billed in the shared care formula outlined above. An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.
☐	HCBS Adult Day Health
☐	HCBS Habilitation

☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)
	Personal Emergency Response Systems (PERS) Personal emergency response systems include three parts. Each part has its own limit per service agreement year: • 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). The CFSS participant receives up to $3,000 total of personal emergency response equipment and related services per service agreement year.
	Individual Directed Goods and Services When a participant chooses to purchase goods and services through CFSS, the cost for the goods and services is covered using the particpant's service budget. Goods and Services must not exceed an individual's budget allocation.

Financial Management Services

Financial Management Services (FMS) providers must provide their service rates to the state agency as a part of the contracting process. They are required to notify the state agency immediately of any changes to their established rates. FMS providers must make public the maximum rate(s) for their services and a public site with approved providers and rates is maintained by DHS at https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp. The rate and scope of FMS is negotiated between the participant or the participant's representative and the FMS provider, and included in the service delivery plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges.