

Support Planning Professionals Learning Community Webinar Q&A

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Provider Signature Requirements

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State of MN Department of Human Services, Disability Services Division

Question 1: Can you explain why this is a new requirement and when it goes into effect?

Answer 1: This required change brings Minnesota into compliance with the Centers for Medicaid & Medicare (CMS) expectations. The CMS requirements apply to when and how lead agencies inform providers of their role in a person's plan.

The provider's signature indicates its acknowledgement and agreement to deliver the specified services and supports as outlined in the recipient's plan.

The requirement to have providers sign starts 1/6/17 for all new and updated plans. It does not apply to already complete plans. Therefore, you do not need to update completed plans until either a change needs to be made or the plan is renewing. This requirement is necessary for any plans you are developing now and moving forward for new plans.

Question 2: How are providers being notified that their signatures are now being requested/required?

Answer 2: Providers were notified via e-list notification; this information was also published in their MHCP newsletter.

Question 3: Does this requirement apply to all providers? Who decides which providers will receive copies of the CSSP requesting signature? How should this occur?

Answer 3: This requirement applies to all home and community-based service (HCBS) providers. Each person, who receives a support plan, needs to make an informed decision regarding which providers of service receive a copy of their support plan. The case manager should discuss the value of sharing information from the person-centered support plan with providers, in order to assist providers in delivering services in a person-centered way. The person may decide to share the support plan with each provider in part or in whole. The person may decide that some providers should not receive the support plan. For example, depending on the type of service being delivered, the provider may not need the person-centered

information in the plan in order to deliver services. If the person makes an informed choice not to send the plan to a provider, that provider would not be asked to sign the support plan.

Signatures are obtained when the plan is given to the provider. This may be via mail, secure email, or in person.

Question 4: Say half way through the service agreement, the individual needs a simple medical supply item, is a signature of that medical supply company required (along with an updated CSSP to be signed again by the client)?

Answer 4: When there are changes to the plan that affect how the service is provided: (e.g. changes to service frequency, updates to the tasks assigned to provider, or addition of new a provider) you must:

- Create a new document
- Give a copy to the person
- Give a copy to the provider including the section(s) relevant to services.

Changes require an updated signature by both the person and the provider. Their signatures denote the agreement to the changes to the plan.

Question 5: We are required to send plans to some residential providers and vocational. What if the client indicates they do not want them to have it?

Answer 5: Each person, who receives a support plan, needs to make an informed decision regarding which providers of service receive a copy of their support plan. The case manager should discuss the value of sharing information from the person-centered support plan with providers, in order to assist providers in delivering services in a person-centered way. The person may decide to share the support plan with each provider in part or in whole.

Question 6: Who at the provider agencies are "authorized" to sign the CSSP?

Answer 6: The person who is authorized to agree to deliver the services is someone who can sign the plan. The provider should designate person(s) who are able to sign off on the agreement to deliver the service as authorized.

Question 7: There are two different signature pages for the 6791 eDocs series. Which signature page do I use?

Answer 7: If you use the 6791 eDocs series for a support plan, use the [MnCHOICES Coordinated Services and Supports Plan Signature Sheet, DHS-6791D, \(PDF\)](#) to obtain signatures. DHS will update the [MnCHOICES Community Support Plan with Coordinated Services and Supports Form, DHS-6791B \(PDF\)](#) to remove the signature section. We will alert you when that update is complete. DHS-6791D form will continue to be available.

Question 8: Can you send out the plan to the client and other providers if another provider has not signed or returned signature page?

Answer 8: Yes, the CSSP must be provided to the person within 10 business days of the CSP being completed. There is not a need to wait for all providers to sign and send the signature(s) back to the lead agency to forward the CSSP to the person.

Question 9: Can a provider still provide services to a client who has not yet signed the current CSSP at the point of referral?

Answer 9: DHS has no requirement that the support plan is signed by person first. That provider's signature simply conveys their agreement to serve the person.

Question 10: If the participant does not want the plan sent to a provider, is that provider expected to sign a plan that they do not receive?

Answer 10: If the person makes an informed choice not to send the plan to a provider, that provider would not be asked to sign the support plan.

Question 11: What if we are not able to obtain a signature from a provider? How many attempts to gain the signature are required?

Answer 11: Lead agencies should document the date the person's plan with a request for a signature was sent to the provider. If the provider does not sign and return the plan, the lead agency should make an additional attempt, for a total to two attempts. The second attempt to gain the providers signature can be via phone, in-person meeting, email or mail. This attempt should also be documented.

Question 12: Do people getting a long-term care consultation (LTCC) on health plans need something signed?

Answer 12: If the person is on the Elderly Waiver, then yes, the lead agency should send the person's support plan with a signature request as agreed to by the person.

Question 13: Can providers opt out from receiving a person's CSSP?

Answer 13: No, the person chooses who receives a copy of the support plan.

Question 14: Just to clarify, the person who typically creates the plan (case manager) is required to provide the residential provider with the plan correct?

Answer 14: The person makes an informed choice as to what is sent to providers of service. The case manager's role is to discuss the importance of sharing his or her plan with each service provider.

Question 15: Can the EW Residential Services Tool (RS Tool) be used to obtain signatures? Will this form be updated to add additional lines for provider signatures?

Answer 15: The Print RS Plan from the RS Tool should be sent as part of the person's CSSP. However, this form will not be updated to add fields for provider signatures, so the provider should sign the 4166, 6791D, collaborative care plan or other health plan support plan.

Question 16: Will the forms be updated so that we can easily do electronic signatures?

Answer 16: DHS is researching the possibility of obtaining this information electronically in the future. At this time, signatures are required using paper documentation. If lead agencies currently have a method of obtaining electronic signatures, those signatures would meet this requirement.

Question 17: Why can't we document verbal signatures?

Answer 17: CMS requires that there is written documentation of the provider's acknowledgement and agreement to the support plan.

Question 18: Can the form be signed at a meeting with the provider after reviewing the support plan?

Answer 18: Each lead agency can determine their own best practices for obtaining signatures.

Question 19: When there is a change to a service, do we have to send and receive signatures from the provider and person again?

Answer 19: When there are changes to the plan that affect how the service is provided: (e.g. Changes to service frequency, updates to the tasks assigned to provider, or addition of new a provider) you must:

- Create a new document
- Give a copy to the person
- Give a copy to the provider including the section(s) relevant to services.

Changes require an updated signature by both the person and the provider. Their signatures denote the agreement to the changes to the plan.

Question 20: If we are required to "close" the plan in MnCHOICES. How are we able to simply "update" the plan when something (like a provider) changes?

Answer 20: The MnCHOICES electronic support plan will allow you to create a 'New CSSP' that is a copy of the previous plan to update/change any new information.

Question 21: Can more than one provider sign the same signature sheet?

Answer 21: Each provider should receive their own signature sheet, unless the person has made an informed choice to share their entire plan with all providers.

Ethical Dilemmas: Right to Take Risks v. Right to be Safe

Anita Raymond, Program Manager

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Question 1: For duty to warn, if someone states they hear voices that tell them to harm someone, have no plan, states won't do it. Then is seen by behavioral health. Is there more duty I have as assessor to warn the individuals mentioned or is this enough?

Answer 1: This was discussed in the session: this example of need for conversation w/ supervisor, document decision, etc.

Question 2: What methods are suggested when we are up against these bottom line self-determination vs. protection choices that we have to use for person's happiness vs provider liability? Is it the person's decision to make, or does it fall under purview of guardian/health care agent/other legal decision maker?

Answer 2: Sort out person's capacity to make that particular decision: if person able to understand risks/benefits, etc., advocate to provider that person has the right to make that choice.

Approach your advocacy from perspective of benefit/harm analysis. E.g., Is it really going to bring harm to the person to do this one thing this one time?

(This one is hard to discuss in abstract; more detailed scenario would make for an interesting case discussion)

Question 3: How far does a guardian's rights reach? If a guardian says, "Joe is not allowed to eat hot dogs," but Joe wants to eat an occasional hot dog and there are no medical reasons why he cannot, do we go against the direction of the guardian?

Answer 3: Guardian's authority does not expand beyond duties granted by the Court. The guardian has no authority over areas not granted by the court. If there is no medical reason (i.e., MD prescribed diet), then the person gets to eat a hot dog, and guardian has no right to deny this. Don't get caught up "going against the guardian" because you are giving guardian authority he/she doesn't actually have. Rather, have a discussion with all, including guardian, clarifying what areas the guardian has say over, and what areas they don't, and discussion of allowing for choices the person still possesses right to make. Like eating a hot dog. Might be good time to involve Ombudsman?

Question 4: For individuals with guardians, guardians often limit right to self-determination and dignity of risk. As a case manager, how can we combat this when we know the individuals behaviors or quality of life could improve?

Answer 4: Advocate, advocate, advocate. Use your power and skills of educating others to discuss the dignity of risk, quality of life over quantity (perfect health). Guardians need to be practicing person-centered thinking as well.

Question 5: Can a power of attorney be out of state?

Answer 5: Not sure of the question. If you are asking if the person appointed to serve as attorney-in-fact in the POA document, then the answer is yes. The attorney in fact can live out of state, just as long as they are able to keep abreast of needs, adequately protect the person's assets, etc. from afar. Same goes for Health Care Agent.

Question 6: When a client is reporting to another staff that they have a gun and want to kill a staff they are mad at but when an interview is conducted, the client reports they were kidding, what should a provider do to assure safety for the staffing of the agency?

Answer 6: See above question/answer. This is a question for supervisor.

Question 7: We have situations where needs are met however there is concern about them signing things like consent forms. Can a person do that? Case managers have concerns about their having clients do that.

Answer 7: Unless the person's legal rights to sign on their own behalf have been removed (such as a guardian was appointed), the person has legal right to sign on their own behalf. Does the person understand what they are signing/agreeing to (have you adequately explained to them in ways/words they can understand)? Then they can probably sign it.

Question 8: There are many clients' families who would like to address certain legal issues and ask for an attorney. We are not able to suggest, as there is legal aid, and VOA as we mentioned. Other than legal aid, are there other resources that can be suggested?

Answer 9: Legal Aid is good, as is VOA's Estate and Elder Law. There is also a MN Bar sponsored Volunteer Lawyer's Network 612-752-6677

Question 10: Great presentation! Where can one find an ethics committees for cases similar to those you discussed?

Answer 10: Thank you! Ethics committees are typically only available in hospital settings. Some nursing homes have. Sometimes, the MD's affiliated health system that is linked to a hospital may be accessible by the MD team.

Question 11: I met with our county attorney and discussed the guardian decision-making dilemma regarding decisions that are not health and safety related. Our attorney said nothing in the law allows them to make this choice but nothing in the law prevents this either.

Answer 11: MN statute's Bill of Rights are pretty clear that guardian does not have authority outside of powers specifically granted to the guardian.

524.5-120 BILL OF RIGHTS FOR WARDS AND PROTECTED PERSONS.

The ward or protected person retains all rights not restricted by court order and these rights must be enforced by the court. These rights include the right to...

Question 12: What about rights restrictions and use of them?

Answer 12: Not sure what is meant by this question

Question 13: where do I find the protected person's bill of rights?

Answer 13: <https://www.revisor.mn.gov/statutes/?id=524.5-120524.5-120>

524.5-120 BILL OF RIGHTS FOR WARDS AND PROTECTED PERSONS.

Question 14: Supported decision making info was very very good. I was not able to get my question in: Our previous county attorney has stated that a health care directive is only legal for social service purposes if the doctor has invoked it. There are many health care agents who believe having the form signed and/or notarized gives them carte blanche authority to make decisions even when the person is able to decide or speak for themselves, OR, we have persons who want their appointed agent to sign on their behalf even when they are fully capable to do this themselves. Does a doctor need to invoke the HCD to make it a legal tool for social services? Can Anita answer this question and add it to the Q & A from today's webinar. Thank you.

Answer 14: Unlike a POA which is effective at execution, the Health Care Agent's authority is not granted until the attending MD states that the principal is not capacitated to make medical decisions (this is statutory default triggering of

authority; principals can write in a different trigger if they wish, such as on the word of their religious leader, or two MDs, for example)

So, legally, the HCA does not have actually decision making authority until the MD says the person is incapacitated. However, the principal also has the right, as we all do, to request that a person of their choosing, or as appointed in the document, can speak for them, even if they are currently fully capable but just don't want to face it, or their culture grants decision making authority to another person, such as husband or eldest son.

Finally, we don't have to let lack of MD declaration of incapacity be a barrier; when there is no controversy, and the agent is available and willing to make decisions but for some reason we can't get an incapacity opinion (can't get to doctor, doctor won't state until sees and next appointment isn't available for 3 months, etc.) we can presume that the person would want this person to be involved, make decisions, etc. Again, as long as there is no controversy (such as principal is refusing to have that person involved, or the team feels that person is not making sound decisions for the principal, etc.), it may be appropriate to engage with that "informal" decision maker.

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