

Amendments to Minnesota's BI, CAC, CADI and DD Waiver Plans

DHS Disability Services Division

Summer 2017

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Overview of amendments

Respite

Respite amendments affect **Appendix C: Participant Services – Service Definition and Provider Specifications for Service:**

- Adds a new licensed facility type and expands the size limitation for these types of facilities
- Expands options for respite provided in unlicensed settings
- Adds camps as a provider type
- Revises language in CAC and DD to be consistent with BI and CADI.

Begins on [Page 6](#).

Transitional services

Transitional service amendments affect **Appendix C: Participant Services – Service Definition:**

- Aligns the settings where a person can be living in order to receive this service, with the settings listed in Housing Access Coordination services
- Corrects statutory references
- Revises the language in CADI, BI and CAC to be consistent with DD.

Begins on [Page 18](#).

Consumer directed community supports (CDCS)

Below is an overview of CDCS amendments, organized by waiver-plan section:

Appendix C: Participant Services – C-1/C-3: Provider Specifications for Service:

- Changes Fiscal Support Entity (FE) to Financial Management Services (FMS)
- Changes the FMS provider qualifications
- Removes the option for counties to enroll as an FE
- Changes the term 'rate' to 'fee'
- Changes eligibility for enrollment (i.e. successfully complete a readiness review prior to enrollment)
- Changes frequency of qualification verification to a performance review every three years
- Changes frequency of verification to performance reviews every three years

Begins on [Page 25](#).

Appendix C: Participant Services – C-2: General Service Specifications (3 of 3):

- Changes FMS enrollment criteria

Begins on [Page 34](#).

Appendix C: Participant Services – Qualified Providers:

- Changes certification to include Support Planners only

Begins on [Page 35](#).

Appendix E: Participant Direction of Services – E-1: Overview (1 of 13):

- Changes the scope of fiscal services an FMS provider will offer
- Clarifies that the agreement between the FMS provider and the participant does not determine who the employer of record and managing employer are. FMS providers will not offer an agency model

Begins on [Page 41](#).

Appendix E: Participant Direction of Services – E-1: Overview (2 of 13):

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan

Begins on [Page 41](#).

Appendix E: Participant Direction of Services – E-1: Overview (4 of 13):

- Deletes certified FE's and adds enrolled FMS providers

Begins on [Page 42](#).

Appendix E: Participant Direction of Services – E-1: Overview (7 of 13):

- Clarifies that governmental entities will not be used as a third party entity

Begins on [Page 44](#).

Appendix E: Participant Direction of Services – E-1: Overview (8 of 13):

- Updates FMS oversight

Begins on [Page 44](#).

Appendix E: Participant Direction of Services – E-1: Overview (12 of 13):

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan

Begins on [Page 46](#).

Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (1 of 6):

- Removes co-employment as an option since the FMS providers will not offer agency services

Begins on [Page 47](#).

Respite

Respite amendments affect **Appendix C: Participant Services – Service Definition and Provider Specifications for Service:**

- Adds a new licensed facility type and expands the size limitation for these types of facilities
- Expands options for respite provided in unlicensed settings
- Adds camps as a provider type
- Revises language in CAC and DD to be consistent with BI and CADI.

See the sections below to review the waiver-specific amendments.

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (Scope):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as the owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:

- Foster care home or community residential setting
- **[add]** Residential hospice facilities defined under Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**
- Medicaid certified hospital
- Medicaid certified nursing facility
- Unlicensed settings where agency and individual providers must be licensed under Minnesota Statutes, Chapter 245D.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite care is not available to participants living in settings where Customized Living, Residential Care or shift staff Foster Care are provided, with the exception of community emergencies or disasters.

Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, unless the provider has received a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

[add] Respite care provided in facilities licensed under MN Statute 144A.75, Subd. 13 (a) (1) is limited to serving a maximum of 8 people. **[end add]**

Respite care is limited to 30 consecutive days per respite occurrence when provided 24 hours a day.

Provider Specifications:

Individual – Individuals that meet the respite service standards

Agency – Providers that meet the respite service standards

[add] Agency – Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2)

Agency – Camps **[end add]**

Provider Category:

[add] Agency **[end add]**

Provider Type

[add] Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**

Provider Qualifications

License (specify): **[add]** Licensed under Minnesota Statutes, sections 144A.75 to 144A.756. **[end add]**

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Health **[end add]**

Frequency of Verification:

[add] Every one to three years. **[end add]**

Provider Category:

Individual

Provider Type

Individuals that meet the respite service standards

Provider Qualifications

License (specify): Providers that are not **[delete]** exempt **[end delete]** **[add]** excluded **[end add]** from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (*specify*):

Other Standard (*specify*): Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute ~~[add]~~, Chapter ~~[end add]~~ 245D.

Individuals who are excluded from licensure under of Minnesota Statutes, 245A.03, subd. 2 must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the ~~[delete] home~~ ~~[end delete]~~ ~~[add]~~ setting ~~[end add]~~ is appropriate to meet the needs of the participant. Documentation will be in the person’s community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03, subd.2(1)and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

Agency

Provider Type

Agencies that meet the respite service standards

Provider Qualifications

License (*specify*): Providers that are not ~~[delete] exempt~~ ~~[end delete]~~ ~~[add]~~ excluded ~~[end add]~~ from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (*specify*):

Other Standard (*specify*): Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D.

Agencies that are excluded from licensure under Minnesota Statutes, 245A.03, subd. 2(1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the ~~home~~ **[end delete] [add]** setting **[end add]** is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.

For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

[add] Agency **[end add]**

Provider Type

[add] Camps **[end add]**

Provider Qualifications

License (*specify*): **[add]** Licensed under Minnesota Statutes, Chapter 245D. **[end add]**

Certificate (*specify*): **[add]** Certified by the American Camp Association. **[end add]**

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Human Services, Provider Enrollment **[end add]**

Frequency of Verification:

[add] Annually. **[end add]**

CAC Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (*Scope*):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as the owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:

- Foster care home or community residential setting
- **[add]** Residential hospice facilities defined under Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**
- Medicaid certified hospital
- Medicaid certified nursing facility
- Unlicensed settings where agency and individual providers must be licensed under Minnesota Statutes, Chapter 245D.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite care is not available to participants living in settings where shift staff Foster Care are provided, with the exception of community emergencies or disasters.

[delete] Providers may not furnish respite services to more than four people in one home or setting at the same time **[end delete]** **[add]** Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, **[end add]** unless the provider has received a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

[add] Respite care provided in facilities licensed under MN Statute 144A.75, Subd. 13 (a) (1) is limited to serving a maximum of 8 people. **[end add]**

Respite care is limited to 30 consecutive days per respite **[delete]** ~~stay in accordance with the community support plan,~~ **[end delete]** **[add]** occurrence **[end add]** when provided 24 hours a day.

Provider Specifications:

Individual – Individuals that meet the respite service standards

Agency – Agencies that meet the respite service standards

[add] Agency – Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2)

Agency – Camps **[end add]**

Provider Category:

[add] Agency **[end add]**

Provider Type

[add] Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**

Provider Qualifications

License (specify): **[add]** Licensed under Minnesota Statutes, sections 144A.75 to 144A.756. **[end add]**

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Health **[end add]**

Frequency of Verification:

[add] Every one to three years. **[end add]**

Provider Category:

Individual

Provider Type

Individuals that meet the respite service standards

Provider Qualifications

License (specify): Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (specify):

Other Standard (specify): **[add]** Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute, Chapter 245D. **[end add]**

Individuals ~~exempt~~ **[add]** who are excluded **[end add]** from licensure under of Minnesota Statutes, 245A.03, subd. 2 **[add]** (1) and (2) **[end add]** must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the ~~home~~ **[end delete]** **[add]** setting **[end add]** is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

Agency

Provider Type

Agencies that meet the respite service standards

Provider Qualifications

License (*specify*): Providers that are not ~~exempt~~ **[add]** excluded **[end add]** from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (*specify*):

Other Standard (*specify*): **[add]** Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D. **[end add]**

Agencies **[add]** that are **[end add]** excluded from licensure under Minnesota Statutes, 245A.03, subd. 2(1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication

monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the **[delete]** home **[end delete]** **[add]** setting **[end add]** is appropriate to meet the needs of the participant. Documentation will be in the person’s community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.

For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

[add] Agency **[end add]**

Provider Type

[add] Camps **[end add]**

Provider Qualifications

License (*specify*): **[add]** Licensed under Minnesota Statutes, Chapter 245D. **[end add]**

Certificate (*specify*): **[add]** Certified by the American Camp Association. **[end add]**

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Human Services, Provider Enrollment **[end add]**

Frequency of Verification:

[add] Annually. **[end add]**

DD Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (*Scope*):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as an owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:

- Foster care home or community residential setting
- **[add]** Residential hospice facilities defined under Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**
- Medicaid certified hospitals
- Unlicensed settings where agency and individual providers must be licensed under Minnesota Statutes, chapter 245D

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

[delete] Specify applicable (if any) limits on the amount, frequency, or duration of this service:

~~Respite care is not available to participants living in settings where Customized Living, 24-Hour Customized Living, Residential Care, or shift staff foster care are provided, with the exception of community emergencies or disasters.~~

~~Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care.~~

~~Respite care is limited to 30 consecutive days per respite stay in accordance with the community support plan.~~

[end delete]

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

[delete] ~~Providers may not furnish respite services to more than four people in one home or setting at the same time~~ **[end delete]** **[add]** Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, **[end add]** unless the provider has a foster care license with a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

[add] Respite care provided in facilities licensed under MN Statute 144A.75, Subd. 13 (a) (1) is limited to serving a maximum of 8 people. **[end add]**

Respite care is not available to participants living in settings that are not the primary residence of the license holder, with the exception of community emergencies or disasters.

Respite care is limited to 30 consecutive days per respite stay when provided 24 hours a day in a location that is not the participant’s own home. In this instance, “home” means a setting that the participant, or their family, owns or leases.

Provider Specifications:

Individual – Individuals that meet the respite service standards

Agency – Providers that meet the respite service standards

[add] Agency – Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2)

Agency – Camps **[end add]**

Provider Category:

[add] Agency **[end add]**

Provider Type

[add] Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, Subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, Subd. 6 (2) **[end add]**

Provider Qualifications

License (specify): **[add]** Licensed under Minnesota Statutes, sections 144A.75 to 144A.756. **[end add]**

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Health **[end add]**

Frequency of Verification:

[add] Every one to three years. **[end add]**

Provider Category:

Individual

Provider Type

Individuals that meet the respite service standards

Provider Qualifications

License (specify): Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (*specify*):

Other Standard (*specify*): Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute 245D.

Individuals meeting the licensing exclusions of Minnesota Statutes, 245A.03, subd. 2, (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the ~~home~~ **[end delete] [add] setting [end add]** is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

Agency

Provider Type

Providers that meet the respite service standards

Provider Qualifications

License (*specify*): Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate (*specify*):

Other Standard (*specify*): Agencies meeting the licensing exclusions of Minnesota Statutes, 245A.03, subd. 2(1) and (2). must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6)

and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subs. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting, the case manager must assess whether the **[delete] home [end delete] [add] setting [end add]** is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.

For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every one to three years.

Provider Category:

[add] Agency [end add]

Provider Type

[add] Camps [end add]

Provider Qualifications

License (*specify*): **[add] Licensed under Minnesota Statutes, Chapter 245D. [end add]**

Certificate (*specify*): **[add] Certified by the American Camp Association. [end add]**

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

[add] Minnesota Department of Human Services, Provider Enrollment [end add]

Frequency of Verification:

[add] Annually. [end add]

Transitional services

Transitional service amendments affect **Appendix C: Participant Services – Service Definition:**

- Aligns the settings where a person can be living in order to receive this service, with the settings listed in Housing Access Coordination services
- Corrects statutory references
- Revises the language in CADI, BI and CAC to be consistent with DD

See the sections below to review the waiver-specific amendments.

CADI Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (Scope):

Transitional services covers goods, housing-related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following ~~licensed~~ settings:

- ~~licensed~~ **[add]** Unlicensed settings **[end add]**;
- hospitals licensed under Minnesota Statutes, sections 144.50 to ~~144.585~~ **[end delete]** **[add]** 144.586 **[end add]**;
- adult foster care homes licensed under Minnesota Rules, parts ~~9555.5105~~ **[end delete]** **[add]** 9555.5050 **[end add]** to 9555.6265;
- family and group family foster care licensed under Minnesota Rules, parts 9560.0500 to 9560.0670;
- nursing facilities ~~and~~ **[end delete]** **[add]** licensed under Minnesota Statutes, Chapter 144A **[end add]**;
- intermediate care facilities **[add]** for persons with developmental disabilities (ICF/DD's) **[end add]** licensed under Minnesota ~~Rules, part 9505.0175, subpart 23~~ **[end delete]** **[add]** Statutes, Chapter 144A **[end add]**;
- intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
- **[add]** Institution for Mental Diseases (IMD) **[end add]**;
- **[add]** Housing with services establishments as defined in Minnesota Chapter 144D **[end add]**.

For purposes of this service, home means a setting that **[add]** a **[end add]** participant owns, rents, or leases that is not operated, owned or leased by a provider of services or supports.

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three-year period. Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore, homemaker services, and environmental accessibility adaptations, specialized equipment and supplies).

Durable household goods include but are not limited to:

- Living **[add]** room **[end add]**, dining **[add]** room **[end add]** and bedroom furniture
- Kitchen equipment and tableware
- Lamps

Moving expenses include but are not limited to:

- Moving vehicle rental
- Packing and unpacking

Rent and mortgage payments; food and clothing; and, recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access **[delete]** ~~etc~~ **[end delete]** **[add]**, etc. **[end add]**

Eligibility

Transitional services are not covered unless all of the following requirements are met:

- 1) There is no other funding source available for **[delete]** ~~the~~ **[end delete]** transitional services.
- 2) The participant is at least 18 years of age.
- 3) The participant is moving to a setting in which these items and expenses are not normally furnished.
- 4) The lead agency determines that the participant will be eligible for and reasonably expected to enroll in the waiver within 180 days. This includes a determination by the lead agency that sufficient resources are available to meet the participant's needs.
- 5) The lead agency reasonably expects the participant to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting.

Authorization and Billing

Transitional services must be reasonable and necessary as determined by the case manager. The case manager determines whether transitional services will be authorized. If authorized, the case manager must clearly define in the participant's community support plan what will be covered to assure that there is no duplication with other waiver or State plan services. Transitional services must be provided prior to or within 45 days **[delete]** ~~after~~ **[end delete]** **[add]** of **[end add]** the participant's move from the licensed setting. Waiver services may only be billed after the participant is enrolled in the waiver.

If for any **[delete]** ~~unseen~~ **[end delete]** **[add]** unforeseen **[end add]** reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the local agency may bill for the transitional services as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. One-time household supplies are limited to a maximum of \$300 (of the \$3000). The cost of essential furniture may not exceed \$1000 (of the \$3000). **[delete]** ~~Supports are limited to a maximum of 40 hours of paid assistance and are in the \$3000 maximum.~~ **[end delete]**

BI Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (Scope):

Transitional services covers goods, housing-related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following ~~licensed~~ settings:

- ~~licensed~~ Unlicensed settings;
- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.586;
- adult foster care homes licensed under Minnesota Rules, parts ~~9555.5105~~ 9555.5050 to 9555.6265;
- family and group family foster care licensed under Minnesota Rules, parts 9560.0500 to 9560.0670;
- nursing facilities ~~and~~ licensed under Minnesota Statutes, Chapter 144A;
- intermediate care facilities for persons with developmental disabilities (ICF/DD's) licensed under Minnesota ~~Rules, part 9505.0175, subpart 23~~ Statutes, Chapter 144A;
- intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
- Institution for Mental Diseases (IMD);
- Housing with services establishments as defined in Minnesota Chapter 144D.

For purposes of this service, home means a setting that a participant owns, rents, or leases that is not operated, owned or leased by a provider of services or supports.

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore or homemaker services, environmental accessibility adaptations, specialized equipment and supplies).

Durable household goods include but are not limited to:

- Living room, dining room and bedroom furniture
- Kitchen equipment and tableware
- Lamps

Moving expenses include but are not limited to:

- Moving vehicle rental
- Packing and unpacking

Rent and mortgage payments; food and clothing; and, recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access, etc.

Eligibility:

Transitional services are not covered unless all of the following requirements are met:

- (1) There is no other funding source available for ~~the~~ transitional services.
- (2) The participant is at least 18 years of age.
- (3) The participant is moving to a setting in which these items and expenses are not normally furnished.
- (4) The lead agency determines that the participant will be eligible for and reasonably expected to enroll in the waiver within 180 days. This includes a determination by the lead agency that sufficient resources are available to meet the participant's needs.
- (5) The lead agency reasonably expects the participant to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting.

Authorization and Billing:

Transitional services must be reasonable and necessary as determined by the case manager. The case manager determines whether transitional services will be authorized. If authorized, the case manager must clearly define in the participant's community support plan what will be covered to assure that there is no duplication with other waiver or State plan services. Transitional services must be provided prior to or within 45 days of the participant's move from the licensed setting. Waiver services may only be billed after the participant is enrolled in the waiver.

If for any ~~unseen~~ unforeseen reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the local agency may bill for the transitional services as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. One-time household supplies are limited to a maximum of \$300 (of the \$3000). The cost of essential furniture may not exceed \$1000 (of the \$3000). ~~Supports are limited to a maximum of 40 hours of paid assistance and are in the \$3000 maximum.~~

CAC Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (Scope):

Transitional services covers goods, housing-related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following ~~licensed~~ settings:

- Unlicensed settings
- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.58
- adult foster care homes licensed under Minnesota Rules, parts ~~9555.5105~~ 9555.5050 to 9555.6265;
- family and group family foster care licensed under Minnesota Rules, parts 9560.0500 to 9560.0670;
- nursing facilities ~~and~~ licensed under Minnesota Statutes, Chapter 144A

- intermediate care facilities **[add]** for persons with developmental disabilities (ICF/DD's) **[end add]** licensed under Minnesota **[delete]** Rules, part 9505.0175, subpart 23 **[end delete]** **[add]** Statutes, Chapter 144A **[end add]**;
- intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670**[add]**;**[end add]**
- **[add]** Institution for Mental Diseases (IMD); **[end add]**
- **[add]** Housing with services establishments as defined in Minnesota Chapter 144D. **[end add]**

For purposes of this service, home means a setting that **[add]** a **[end add]** participant owns, rents, or leases that is not operated, owned or leased by a provider of services or supports.

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore or homemaker services, environmental accessibility adaptations, specialized supplies and equipment).

Durable household goods include but are not limited to:

- Living **[add]** room **[end add]**, dining **[add]** room **[end add]** and bedroom furniture
- Kitchen equipment and tableware
- Lamps

Moving expenses include but are not limited to:

- Moving vehicle rental
- Packing and unpacking

[delete] Rent and mortgage payments; food and clothing; and, recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access. Etc. **[end delete]**

Rent and mortgage payments; food and clothing; and recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access, etc.

Eligibility:

Transitional services are not covered unless all of the following requirements are met:

- 1) There is no other funding source available for **[delete]** the **[end delete]** transitional services.
- 2) The participant is at least 18 years of age.
- 3) The participant is moving to setting in which these items and expenses are not normally furnished.
- 4) The lead agency determines that the individual will be eligible for and reasonably expected to enroll in the waiver within 180 days. This includes a determination by the lead agency that sufficient resources are available to meet the participant's needs.
- 5) The lead agency reasonably expects the participant to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting.

Authorization and Billing

Transitional services must be reasonable and necessary as determined by the case manager. The case manager determines whether transitional services will be authorized. If authorized, the case manager must clearly define in the participant's community support plan what will be covered to assure that there is no duplication with other waiver or state plan services. Transitional services must be provided prior to or within 45 days of the participant's move from the licensed setting. Waiver services may only be billed after the individual is enrolled in the waiver.

If for any unforeseen reason the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), the local agency may bill for the transitional services as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. One-time household supplies are limited to a maximum of \$300 (of the \$3000). The cost of essential furniture may not exceed \$1000 (of the \$3000). ~~Supports are limited to a maximum of 40 hours of paid assistance and are in the \$3000 maximum.~~ **[end delete]**

DD Waiver

Appendix C-1/C-3: Participant Services – Service Definition and Provider Specifications

Service Definition (Scope):

Transitional services covers goods, housing-related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following ~~licensed~~ **[end delete]** settings:

- **[add]** Unlicensed settings: **[end add]**
- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.586;
- adult foster care homes licensed under Minnesota Rules, parts 9555.5050 to 9555.6265;
- family and group family foster care licensed under Minnesota Rules, parts 9560.0500 to 9560.0670;
- nursing facilities ~~and~~ **[end delete]** **[add]** licensed under Minnesota Statutes, Chapter 144A; **[end add]**
- intermediate care facilities **[add]** for persons with developmental disabilities (ICF/DD's) **[end add]** licensed under Minnesota Statutes, Chapter 144A;
- intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670**[add];****[end add]**
- **[add]** Institution for Mental Diseases (IMD); **[end add]**
- **[add]** Housing with services establishments as defined in Minnesota Chapter 144D. **[end add]**

For purposes of this service, home means a setting that a participant owns, rents, or leases that is not operated, owned or leased by a provider of services or supports.

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three-year period. Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver

(e.g., chore, homemaker services, and environmental accessibility adaptations, specialized equipment and supplies).

Durable household goods include but are not limited to:

- Living room, dining room and bedroom furniture
- Kitchen equipment and tableware
- Lamps

Moving expenses include but are not limited to:

- Moving vehicle rental
- Packing and unpacking

Rent and mortgage payments; food and clothing; and, recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access, etc.

Eligibility

Transitional services are not covered unless all of the following requirements are met:

- 1) There is no other funding source available for transitional services.
- 2) The participant is at least 18 years of age.
- 3) The participant is moving to a setting in which these items and expenses are not normally furnished.
- 4) The lead agency determines that the participant will be eligible for and reasonably expected to enroll in the waiver within 180 days. This includes a determination by the lead agency that sufficient resources are available to meet the participant's needs.
- 5) The lead agency reasonably expects the participant to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting.

Authorization and Billing

Transitional services must be reasonable and necessary as determined by the case manager. The case manager determines whether transitional services will be authorized. If authorized, the case manager must clearly define in the participant's community support plan what will be covered to assure that there is no duplication with other waiver or State plan services. Transitional services must be provided prior to or within 45 days of the participant's move from the licensed setting. Waiver services may only be billed after the participant is enrolled in the waiver.

If for any unforeseen reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the local agency may bill for the transitional services as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. One-time household supplies are limited to a maximum of \$300 (of the \$3000). The cost of essential furniture may not exceed \$1000 (of the \$3000).

Consumer directed community supports (CDCS)

CDCS amendments affect the following sections of the waiver plans:

- [Appendix C: Participant Services – C-1/C-3: Provider Specifications for Service](#)
- [Appendix C: Participant Services – C-2: General Service Specifications \(3 of 3\)](#)
- [Appendix C: Participant Services – Qualified Providers](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(1 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(2 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(4 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(7 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(8 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-1: Overview \(12 of 13\)](#)
- [Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction \(1 of 6\)](#)

See the sections below (linked to above) to review the amendments.

Appendix C: Participant Services – C-1/C-3: Provider Specifications for Service

Overview of amendments to Appendix C: Participant Services – C-1/C-3: Provider Specifications for Service:

- Changes Fiscal Support Entity (FE) to Financial Management Services (FMS)
- Changes the FMS provider qualifications
- Removes the option for counties to enroll as an FE
- Changes the term 'rate' to 'fee'
- Changes eligibility for enrollment (i.e. successfully complete a readiness review prior to enrollment)
- Changes frequency of qualification verification to a performance review every three years
- Changes frequency of verification to performance reviews every three years

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Provider Specifications for Service

Service Name:

Consumer-directed community supports (CDCS): personal assistance

Consumer-directed community supports (CDCS): treatment and training

Consumer-directed community supports (CDCS): environmental modifications and provisions

Consumer-directed community supports (CDCS): self-direction support activities

Provider Category:

Agency

Provider Type

[delete] Fiscal support entities (FEs) **[end delete] [add]** Financial Management Services (FMS) providers **[end add]**

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*): CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the ~~[delete] fiscal support entity (FE)~~ ~~[end delete]~~ ~~[add] financial management services (FMS) provider.~~ ~~[end add]~~ ~~[delete]~~ The FE must have a written agreement with the person or entity providing goods or services, or the participant may submit an invoice from the person or entity providing goods and services and to the FE for payment. ~~[end delete]~~

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the community support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. ~~[delete]~~ This does not preclude them from payment for their work in providing community support plan development services. This provision does not apply to: spouses, parents of minors, legally responsible representatives, or case managers employed by county agencies. ~~[end delete]~~

~~[add]~~ A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for support planning activities. ~~[end add]~~

~~[delete]~~ This provision precludes FEs ~~[end delete]~~ ~~[add]~~ FMS providers ~~[end add]~~ or their representatives ~~[add]~~ cannot ~~[end add]~~ ~~[delete]~~ from participating ~~[end delete]~~ ~~[add]~~ participate ~~[end add]~~ in the development of a community support plan for participants who are purchasing ~~[delete]~~ FE ~~[end delete]~~ ~~[add]~~ financial management ~~[end add]~~ services from them.

Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

~~[delete]~~ FEs ~~[end delete]~~ ~~[add]~~ FMS providers ~~[end add]~~ are the CDCS Medicaid enrolled provider for all CDCS services. ~~[delete]~~ Counties may enroll as an FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the participant, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods. ~~[end delete]~~ ~~[add]~~ The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Service (IRS) code, and revenue Procedure Code 2013-39, as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. ~~[end]~~

[add] The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** may not in any way limit or restrict the participant's choices of services or support providers.

[delete] FEs **[end delete]** **[add]** FMS providers **[end add]** must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]**.

[delete] FEs **[end delete]** **[add]** FMS provider **[end add]** must establish and make public the maximum rate(s) for their services. The rate and scope of **[delete]** FE **[end delete]** **[add]** financial management **[end add]** services is negotiated between the participant or the participant's representative and the **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]**, and included in the community support plan. **[delete]** FE rates **[end delete]** **[add]** FMS provider fees **[end add]** 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. Maximum **[add]** FE rates **[end delete]** **[add]** FMS provider fees **[end add]** may be established by the state agency. **[delete]** Fes **[end delete]** **[add]** FMS providers **[end add]** who have any direct or indirect financial interest in the delivery of personal assistance, treatment **[delete]** , **[end delete]** **[add]** and **[end add]** training, **[add]** or **[end add]** environmental modifications and provisions provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's community support plan.

The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must have current and adequate liability insurance and bonding, **[add]** be a financially solvent organization with **[end add]** sufficient cash flow, and have on staff **[add]** an Information Technology Security Officer and certified payroll professional, or a **[end add]** **[delete]** or by contract a **[end delete]** certified public accountant or an individual with a **[delete]** baccalaureate **[end delete]** **[add]** bachelor's **[end add]** degree in accounting. **[add]** The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS under a collective bargaining contract. The FMS provider must have an established customer service system, a HIPAA-compliant system to secure private data, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors. **[end add]**

[delete] The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE. FE **[end delete]** **[add]** FMS **[end add]** providers must **[delete]** the pass the **[end delete]** **[add]** successfully complete a **[end add]** readiness review prior to **[delete]** providing services **[end delete]** **[add]** enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years. **[end add]** **[delete]** A certificate is issued to FE providers that successfully complete the readiness review. Recertification reviews are conducted every four years. **[end delete]**

[add] The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant. **[end add]**

The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must also receive a copy of the participants' community support plan approved by the county. Claims submitted by the **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must correspond with services, amounts, time frames, etc. as authorized in the community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

[delete] The state agency determines whether provider standards are met through a written readiness review submitted by the FE. **[end delete]**

[add] As established by the state agency, a performance review will include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards. **[end add]**

Frequency of Verification:

[delete] Recertification reviews are conducted every four years. **[end delete]**

[add] Enrolled FMS providers will be subject to a performance review every three years. **[end add]**

CAC Waiver

Appendix C-1/C-3: Participant Services – Provider Specifications for Service

Service Name:

Consumer-directed community supports (CDCS): personal assistance
Consumer-directed community supports (CDCS): treatment and training
Consumer-directed community supports (CDCS): environmental modifications and provisions
Consumer-directed community supports (CDCS): self-direction support activities

Provider Category:

Agency

Provider Type

[delete] Fiscal support entities (FEs) **[end delete]** **[add]** Financial Management Services (FMS) providers **[end add]**

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*): CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the **[delete]** fiscal support entity (FE) **[end delete]** **[add]** financial management services (FMS)

~~provider. [end add] [delete] The FE must have a written agreement with the person or entity providing goods or services, or the participant may submit an invoice from the person or entity providing goods and services and to the FE for payment. [end delete]~~ Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the community support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. ~~[delete] This does not preclude them from payment for their work in providing community support plan development services. This provision does not apply to: spouses, parents of minors, legally responsible representatives, or case managers employed by county agencies. [end delete]~~

~~[add] A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for support planning activities. [end add]~~

~~[delete] This provision precludes FEs [end delete] [add] FMS providers [end add] or their representatives [add] cannot [end add] [delete] from participating [end delete] [add] participate [end add] in the development of a community support plan for participants who are purchasing [delete] FE [end delete] [add] financial management [end add] services from them.~~

Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

~~[delete] FEs [end delete] [add] FMS providers [end add] are the CDCS Medicaid enrolled provider for all CDCS services. [delete] Counties may enroll as an FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the participant, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods. [end delete] [add] The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Service (IRS) code, and Revenue Procedure Code 2013-39, as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. [end add] The [delete] FE [end delete] [add] FMS provider [end add] may not in any way limit or restrict the participant's choices of services or support providers.~~

~~[delete] FEs [end delete] [add] FMS providers [end add] must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The [delete] FS [end delete] [add] FMS provider [end add] must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written~~

summary of what CDCS services were billed including charges from the ~~FE~~ FMS provider.

~~FEs~~ FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of ~~FE~~ financial management services is negotiated between the participant or the participant's representative and the ~~FE~~ FMS provider, and included in the community support plan. ~~FE rates~~ 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. Maximum ~~FE rates~~ FMS provider fees shall be established by the state agency. ~~FEs~~ FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment~~;~~ and training, or environmental modifications and provisions provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's community support plan.

The ~~FE~~ FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The ~~FE~~ FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an Information Technology Security Officer and certified payroll professional, or a ~~or by contract a~~ certified public accountant or an individual with a ~~baccalaureate~~ bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS under a collective bargaining contract. The FMS provider must have an established customer service system, a HIPAA-compliant system to secure private data, and a quality assurance and program integrity system to prevent, detect, and report suspected fraud, abuse or errors.

~~The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE. FE~~ FMS providers must ~~the pass the~~ successfully complete a readiness review prior to ~~providing services~~ enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years. ~~A certificate is issued to FE providers that successfully complete the readiness review. Recertification reviews are conducted as determined by the department.~~

The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The ~~FE~~ FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods

Provider Type

~~Fiscal support entities (FEs)~~ **[end delete] [add]** Financial Management Services (FMS) providers **[end add]**

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*): CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the ~~fiscal support entity (FE)~~ **[end delete] [add]** financial management services (FMS) provider **[end add]**. ~~The FE must have a written agreement with the person or entity providing goods or services, or the participant may submit an invoice from the person or entity providing goods and services and to the FE for payment.~~ **[end delete]** Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, Chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the community support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. ~~This does not preclude them from payment for their work in providing community support plan development services. This provision does not apply to: spouses, parents of minors, legally responsible representatives, or case managers employed by county agencies.~~ **[end delete]**

[add] A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for support planning activities. **[end add]**

~~This provision precludes Fes~~ **[end delete] [add]** FMS providers **[end add]** or their representatives **[add]** cannot **[end add] [delete]** ~~from participating~~ **[end delete] [add]** participate **[end add]** in the development of a community support plan for participants who are purchasing ~~FE~~ **[end delete] [add]** financial management **[end add]** services from them.

Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

~~Fes~~ **[end delete] [add]** FMS providers **[end add]** are the CDCS Medicaid enrolled provider for all CDCS services. ~~Counties may enroll as an FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the participant, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.~~ **[end delete] [add]** The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Service (IRS) code, and Revenue Procedure Code 2013-39, as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant

served including payroll of individual workers and vendor payments, initiating criminal backgrounds studies, and filing federal and state payroll taxes for support workers on behalf of participants. **[end add]** The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** may not in any way limit or restrict the participant's choices of services or support providers.

[delete] FEs **[end delete]** **[add]** FMS providers **[end add]** must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]**.

[delete] FEs **[end delete]** **[add]** FMS providers **[end add]** must establish and make public the maximum rate(s) for their services. The rate and scope of **[delete]** FE **[end delete]** **[add]** financial management **[end add]** services is negotiated between the participant or the participant's representative and the **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]**, and included in the community support plan. **[delete]** FE rates **[end delete]** **[add]** FMS provider fees **[end add]** 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. Maximum **[delete]** FE rates **[end delete]** **[add]** FMS provider fees **[end add]** may be established by the state agency. **[delete]** FEs **[end delete]** **[add]** FMS providers **[end add]** who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, **[add]** or **[end add]** environmental modifications and provisions provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's community support plan.

The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The **[delete]** FE **[end delete]** **[add]** FMS provider **[end add]** must have current and adequate liability insurance and bonding, **[add]** be a financially solvent organization with **[end add]** sufficient cash flow, and have on staff **[add]** an Information Technology Security Officer and certified payroll professional, or a **[end add]** **[delete]** or by contract a **[end delete]** certified public accountant or an individual with a **[delete]** baccalaureate **[end delete]** **[add]** bachelor's **[end add]** degree in accounting. **[add]** The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS under a collective bargaining contract. The FMS provider must have an established customer service system, a HIPAA-compliant system to secure private data, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors. **[end add]**

[delete] The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE. FE **[end delete]** **[add]** FMS **[end add]** providers must **[delete]** pass the **[end delete]** **[add]** successfully complete a **[end add]** readiness review prior to **[delete]** providing services **[end delete]** **[add]** enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review

every three years. ~~[end add] [delete]~~ A certificate is issued to FE providers that successfully complete the readiness review. Recertification reviews are conducted every four years. ~~[end delete]~~

~~[add]~~ The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant. ~~[end add]~~

The ~~[delete]~~ FE ~~[end delete]~~ ~~[add]~~ FMS provider ~~[end add]~~ must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The ~~[delete]~~ FE ~~[end delete]~~ ~~[add]~~ FMS provider ~~[end add]~~ must also receive a copy of the participants' community support plan approved by the county. Claims submitted by the ~~[delete]~~ FE ~~[end delete]~~ ~~[add]~~ FMS provider ~~[end add]~~ must correspond with services, amounts, time frames, etc. as authorized in the community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

~~[delete]~~ The state agency determines whether provider standards are met through a written readiness review submitted by the FE. ~~[end delete]~~

~~[add]~~ As established by the state agency, a performance review will include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards. ~~[end add]~~

Frequency of Verification:

~~[delete]~~ Recertification reviews are conducted every four years. ~~[end delete]~~

~~[add]~~ Enrolled FMS providers will be subject to a performance review every three years. ~~[end add]~~

Appendix C: Participant Services – C-2: General Service Specifications (3 of 3)

Overview of amendments to Appendix C: Participant Services – C-2: General Service Specifications (3 of 3)

- Changes FMS enrollment criteria.

BI, CAC, CADI and DD waivers

Appendix C-2: Participant Services – General Service Specifications

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department enrolls providers who meet state qualifications, complete a required state provider training, and submit a signed Minnesota Health Care Program Provider agreement. Providers access all service enrollment information, including enrollment forms, on the Department's web site.

Every waiver service provider must comply with state requirements. Direct enrollment with the Department is required for most waiver services. Enrolled waiver service providers will be listed in an on-line

(MinnesotaHelp.info) directory as of 1/1/14. Enrollment, while available to market and receipt-based waiver service providers, is not required.

Market services are those purchased at a price typically charged on a community market basis. Market services include three basic services directed to a broad community market: Chore, cleaning only component of homemaker, and home construction component of environmental accessibility adaptations. Lead agencies or the financial management service contractor will assure compliance with non-enrolled market services and maintain payment records in a manner directed by the state.

Receipt-based services are services that involve the purchase of goods and supports from vendors on a retail basis (i.e. public transportation, community classes). Receipt-based service providers have the choice of enrolling as a Medicaid provider, or receiving reimbursement for goods and supports through lead agencies. The state directs lead agencies to authorize the purchase of waiver goods and supports in compliance with federal waiver requirements, and to maintain payment records in a manner directed by the state.

[add] On an annual basis, the state agency will review qualifications of applicants for Financial Management Services (FMS) providers through a Request for Proposal process. **[end add]**

Federally recognized tribes may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7, item (c). A tribe that intends to implement standards for credentialing health professionals must submit the standards to the department, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The department maintains a copy of the standards and supporting evidence to enroll health professionals approved by tribes. If the tribe also requests the ability to obtain a license under the alternative licensing standards, they must establish separation of authority from the tribal licensing agency and the provider agency to mitigate potential conflicts of interests.

Appendix C: Participant Services – Qualified Providers

Overview of amendments to Appendix C: Participant Services – Qualified Providers

- Changes certification to include Support Planners only.

CADI Waiver

Appendix C: Participant Services – Qualified Providers

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Licensing. Many waiver service providers are required to be licensed by either the Department, local lead agencies under delegation from the Department, or the Minnesota Department of Health. In addition to periodic compliance reviews (usually annual or biennial), these agencies provide ongoing monitoring via

complaint and maltreatment investigations involving the providers they license. Corrective actions and other sanctions may be imposed when deficiencies are identified.

Requisite provider and staff training is reviewed and verified as a condition of licensure for many waiver service provider types.

Minnesota Health Care Programs. MHCP verifies that waiver providers meet and maintain many program requirements as a condition of initiating and maintaining enrollment.

Disability Services Division. The Disability Services Division receives complaints from lead agency case managers of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The division may independently, through the Department's enrollment area, or with the affected lead agency(ies) seek to remedy the situation with the provider.

Certification. The Department certifies Support Planners ~~[delete]~~ and Fiscal Support Entities ~~[end delete]~~ (for Consumer Directed Community Supports service). Initial certification requires ~~[delete]~~ verification of provider standards met and ~~[end delete]~~ successful completion of ~~[delete]~~ initial review or ~~[end delete]~~ test requirements prior to providing services. ~~[delete]~~ Fiscal Support Entity recertification reviews are conducted every four years. ~~[end delete]~~ Support Planners must verify training requirements ~~[add]~~ are ~~[end add]~~ met (if applicable) and pass the Department's recertification test every two years.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. When licensed providers are found to be out of compliance with applicable requirements, the licensing agency will issue a citation for each violation determined and require corrective action. Depending on the nature, severity, and/or chronicity of the violation, the licensing agency establishes the method and timeframe by which evidence of remediation must be submitted or observed. Other sanctions available include fines and conditional, suspended, and revoked licensure.

Requisite provider and staff training is reviewed and verified as a condition of licensure for most waiver service provider types.

~~[delete]~~ Certification. ~~[end delete]~~ When ~~[delete]~~ certified Fiscal Support Entities (FSE) ~~[end delete]~~ ~~[add]~~ enrolled Financial Management Services (FMS) providers ~~[end add]~~ are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The ~~[delete]~~ FSE ~~[end delete]~~ ~~[add]~~ FMS provider ~~[end add]~~ must submit evidence of remediation ~~[delete]~~ before certification or recertification is issued ~~[end delete]~~. Depending on the nature, severity, and/or chronicity of the violation, ~~[delete]~~ a provider's certification may be placed in probationary

~~status, the length of certification may be shortened, or certification may be revoked.~~ **[end delete] [add]** the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;
- Limiting a provider's ability to receive payment;
- Suspending or terminating the provider's enrollment; or
- Terminating the contract with the State. **[end add]**

When a participant's Support Planner is found to be out of compliance with applicable requirements, the Department may deny recertification unless/until remediation is made. Depending on the nature, severity, and/or chronicity of the violation, certification may be revoked.

Provider Enrollment. When the Department's Provider Enrollment unit identifies an enrolled provider that does not meet the applicable qualifications or standards required by the waiver, the provider is subject to monetary recovery, administrative sanctions (up to and including disenrollment), or civil or criminal action. Providers have appeal rights under Minnesota Statutes, Chapter 14.

Provider Training and Technical Assistance. Central office, provider help desk and regionally-based Department staff provide training and/or technical assistance to providers and local lead agencies upon request or when waiver requirement compliance issues are identified.

CAC Waiver

Appendix C: Participant Services – Qualified Providers

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. Certain waiver service providers as indicated in Appendix C-1/C-3 are required to be licensed by either the Department, local lead agencies under delegation from the Department, or the Minnesota Department of Health. In addition to periodic compliance reviews (annual or biennial), these agencies provide ongoing monitoring via complaint and maltreatment investigations involving the providers they license. Corrective actions and other sanctions may be imposed when deficiencies are identified.

Requisite provider and staff training is reviewed and verified as a condition of licensure for certain waiver service provider types.

Disability Services Division. – The Disability Services Division receives complaints from lead agency case managers of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The division may independently, through the department’s enrollment area, or with the affected lead agency(ies) seek to remedy the situation with the provider.

Certification. The Department certifies Support Planners ~~and Fiscal Support Entities (FE)~~ ~~for Consumer Directed Community Supports service~~. Initial ~~FE~~ certification requires ~~verification of provider standards being met and~~ successful completion of ~~initial review~~ ~~test requirements prior to providing services~~. ~~FE recertification reviews are conducted as determined by the department.~~ Support Planners must verify training requirements are met (if applicable) and pass the Department’s recertification test every two years.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

~~Certification.~~ When ~~certified Fiscal Support Entities (FE)~~ enrolled Financial Management Services (FMS) providers are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The ~~FE~~ FMS provider must submit evidence of remediation ~~before certification or recertification is issued~~. Depending on the nature, severity, and/or chronicity of the violation, ~~a provider’s certification may be placed in probationary status, the length of certification may be shortened, or certification may be revoked.~~ the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider’s expense;
- Limiting a provider’s ability to receive payment;
- Suspending or terminating the provider’s enrollment; or
- Terminating the contract with the State.

When a participant’s Support Planner is found to be out of compliance with applicable requirements, the Department may deny recertification unless/until remediation is made. Depending on the nature, severity, and/or chronicity of the violation, certification may be revoked.

Provider Enrollment. When the Department’s Provider Enrollment unit identifies an enrolled provider that does not meet the applicable qualifications or standards required by the waiver, the provider is subject to monetary recovery, administrative sanctions (up to and including disenrollment), or civil or criminal action. Providers have appeal rights under Minnesota Statutes, Chapter 14.

Provider Training and Technical Assistance. Central office, provider help desk and regionally-based Department staff provide training and/or technical assistance to providers and local lead agencies upon request or when waiver requirement compliance issues are identified.

BI and DD waivers

Appendix C: Participant Services – Qualified Providers

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. Many waiver service providers are required to be licensed by either the Department, local lead agencies under delegation from the Department, or the Minnesota Department of Health. In addition to periodic compliance reviews (usually annual or biennial), these agencies provide ongoing monitoring via complaint and maltreatment investigations involving the providers they license. Corrective actions and other sanctions may be imposed when deficiencies are identified.

Requisite provider and staff training is reviewed and verified as a condition of licensure for many waiver service provider types.

Disability Services Division. – The Disability Services Division receives complaints from lead agency case managers of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The division may independently, through the department’s enrollment area, or with the affected lead agency(ies) seek to remedy the situation with the provider.

Certification. The Department certifies Support Planners ~~[delete]~~ and Fiscal Support Entities (FE) ~~[end delete]~~ ~~[add]~~~~[end add]~~ for Consumer Directed Community Supports service~~[add]~~~~[end add]~~. Initial ~~[delete]~~ ~~FE~~ ~~[end delete]~~ certification requires ~~[delete]~~ verification of provider standards being met and ~~[end delete]~~ successful completion of ~~[delete]~~ initial review ~~[end delete]~~ ~~[add]~~ test requirements prior to providing services ~~[end add]~~. ~~[delete]~~ FE recertification reviews are conducted every four years. ~~[end delete]~~ Support Planners must ~~[delete]~~ pass a certification test prior to providing services, ~~[end delete]~~ ~~[add]~~ verify training requirements are met (if applicable) ~~[end add]~~ and pass the Department’s recertification test every two years.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. When licensed providers are found to be out of compliance with applicable requirements, the licensing agency will issue a citation for each violation determined and require corrective action. Depending on the nature, severity, and/or chronicity of the violation, the licensing agency establishes the method and timeframe by which evidence of remediation must be submitted or observed. Other sanctions available include fines and conditional, suspended, and revoked licensure.

Requisite provider and staff training is reviewed and verified as a condition of licensure for most waiver service provider types.

[delete] Certification. [end delete] When **[delete] certified Fiscal Support Entities (FE) [end delete] [add]** enrolled Financial Management Services (FMS) providers [end add] are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The **[delete] FE [end delete] [add]** FMS provider [end add] must submit evidence of remediation **[delete] before certification or recertification is issued [end delete]**. Depending on the nature, severity, and/or chronicity of the violation, **[delete] a provider's certification may be placed in probationary status, the length of certification may be shortened, or certification may be revoked. [end delete] [add]** the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;
- Limiting a provider's ability to receive payment;
- Suspending or terminating the provider's enrollment; or
- Terminating the contract with the State. [end add]

When a participant's Support Planner is found to be out of compliance with applicable requirements, the Department may deny recertification unless/until remediation is made. Depending on the nature, severity, and/or chronicity of the violation, certification may be revoked.

Provider Enrollment. When the Department's Provider Enrollment unit identifies an enrolled provider that does not meet the applicable qualifications or standards required by the waiver, the provider is subject to monetary recovery, administrative sanctions (up to and including disenrollment), or civil or criminal action. Providers have appeal rights under Minnesota Statutes, Chapter 14.

Provider Training and Technical Assistance. Central office, provider help desk and regionally-based Department staff provide training and/or technical assistance to providers and local lead agencies upon request or when waiver requirement compliance issues are identified

Appendix E: Participant Direction of Services – E-1: Overview (1 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (1 of 13)

- Changes the scope of fiscal services an FMS provider will offer
- Clarifies that the agreement between the FMS provider and the participant does not determine who the employer of record and managing employer are. FMS providers will not offer an agency model.

BI, CAC, CADI and DD Waivers

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver, and alternatives that support participants. Four categories of CDCS are covered: personal assistance; treatment and training; environmental modifications and provisions; and, self direction support activities. Refer to Appendix C, Summary of Services Covered. Participants or their representative hire, fire, manage and direct their support workers. The participants or their representative ~~may~~ purchase assistance with these functions through a ~~fiscal support entity (FE)~~ financial management services (FMS) provider.

~~FEs~~ FMS providers offer a range of supports as defined in the agreement between the FMS and the participant; the contract with the State; and provider enrollment standards. ~~The agreement between the FE and the participant determines who the employer of record and managing employer are.~~ The employer of record must be identified and documented in the participant's community support plan. Flexible case managers may also provide assistance with employee related functions as defined in the ~~provider~~ service standards. Flexible case managers shall not be the employer of record ~~with the exception of those operating within section 305 of the Internal Revenue Code under revenue procedure 80-4 and IRS notice 2003-70 related to government entities~~.

Appendix E: Participant Direction of Services – E-1: Overview (2 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (2 of 13)

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan.

CADI Waiver

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

[selected – no change] Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

[selected – no change] Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

[selected – no change] The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Participants are not eligible for CDCS if they or their representative have at any time been assigned to the Minnesota Restricted Recipient program. ~~CDCS services are not available to waiver participants~~ ~~People~~ receiving licensed foster ~~are~~ or home care services while residing in ~~a~~ residential ~~setting~~ ~~settings~~ licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) ~~,~~ or registered as a housing with services establishment ~~with MDH,~~ are not eligible for CDCS.

BI, CAC and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

[selected – no change] Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

[selected – no change] Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

[selected – no change] The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Participants are not eligible for CDCS if they or their representative have at any time been assigned to the Minnesota Restricted Recipient program. ~~People~~ ~~living in~~ ~~receiving~~ licensed foster care ~~or home care services while residing in residential~~ settings, settings licensed by DHS or MDH, or registered as a housing with services establishment with MDH ~~,~~ are not eligible for CDCS.

Appendix E: Participant Direction of Services – E-1: Overview (4 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (4 of 13)

- Deletes certified FE's and adds enrolled FMS providers.

BI, CADI and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants have had the option to self-direct their waiver services through the consumer directed community supports (CDCS) service, since 2004.

(CADI): Approximately 7% of CADI participants are currently using CDCS.

(BI): Approximately 4.4% of BI participants are currently using CDCS.

(DD): Approximately 12.8% of DD participants are currently using CDCS.

CDCS allows participants to design an individualized set of supports to meet their needs. The service includes four categories of supports: personal assistance; treatment and training; environmental modifications and provisions; and, self direction support activities. Participants choose the level of support they want to assist them in developing community support plans, monitoring services, and managing budgets and payments. This model provides far more opportunity to individually tailor and staff services compared to simply allowing a participant to “self direct” a pre-designed waiver service.

Waiver participants are given information upon waiver eligibility regarding their choice of CDCS services. The lead agency case manager provides the participant with information regarding benefits, responsibilities and liabilities of self-direction, so the participant can make an informed choice.

The lead agency is charged with providing information and consumer education about the goods and services that may be purchased under CDCS; information that helps consumers understand their roles and responsibilities, information about resources, tools and technical assistance; information about ~~certified FEs~~ ~~enrolled financial management services (FMS) providers~~ that are available to the participant; and information about the qualifications for and activities of a ~~flexible case manager~~ ~~support planner~~. This is all done before or during community support plan development.

CAC Waiver

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants have had the option to self-direct their waiver services through the consumer directed community supports (CDCS) service, since 2004. Approximately 36.3% of CAC participants are currently using CDCS.

CDCS allows participants to design an individualized set of supports to meet their needs. The service includes four categories of supports: personal assistance; treatment and training; environmental modifications and provisions; and, self direction support activities. Participants choose the level of support they want to assist them in developing community support plans, monitoring services, and managing budgets and payments. This model provides far more opportunity to individually tailor and staff services compared to simply allowing a participant to “self direct” a pre-designed waiver service.

Waiver participants are given information upon waiver eligibility regarding their choice of CDCS services.

~~There is a brochure entitled "You Decide. Your Help." that is available for case managers to provide to consumers, as well as a video of the same name that is used for both case managers and consumers. The video is available on the DHS website. Both the brochure and the video provide information about the benefits,~~

~~responsibilities and liabilities of self-direction.~~ **[end delete] [add]** The lead agency case manager provides the participant with information regarding benefits, responsibilities and liabilities of self-direction, so the participant can make an informed choice. **[end add]**

The lead agency is charged with providing information and consumer education about the goods and services that may be purchased under CDCS; information that helps consumers understand their roles and responsibilities, information about resources, tools and technical assistance; information about **[delete]** certified FEs **[end delete] [add]** enrolled financial management services (FMS) providers **[end add]** that are available to the participant; and information about the qualifications for and activities of a **[delete]** flexible case manager **[end delete] [add]** support planner **[end add]**. This is all done before or during community support plan development.

Appendix E: Participant Direction of Services – E-1: Overview (7 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (7 of 13)

- Clarifies that governmental entities will not be used as a third party entity.

BI, CAC, CADI and DD Waivers

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

[selected – no change] ● **Yes. Financial Management Services are furnished through a third party entity.**

(Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

[change from selected to not selected] Governmental entities

[selected – no change] Private entities

Appendix E: Participant Direction of Services – E-1: Overview (8 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (8 of 13)

- Updates FMS oversight

BI, CAC, CADI and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

[selected – no change] ● FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Consumer-directed community-supports: self-direction support activities

[not selected – no change] FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

See Appendix C, Consumer-directed community-supports: Self-direction support activities

The fees are negotiated between the participant and the ~~[delete] FE [end delete]~~ [add] FMS provider [end add], and documented in the community support plan.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

These services are included in the global budget, under the category of consumer-directed community supports: self-direction support activities.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

[selected – no change] Assist participant in verifying support worker citizenship status

[selected – no change] Collect and process timesheets of support workers

[selected – no change] Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

[not selected – no change] Other

Supports furnished when the participant exercises budget authority:

[selected – no change] Maintain a separate account for each participant's participant-directed budget

[selected – no change] Track and report participant funds, disbursements and the balance of participant funds

[selected – no change] Process and pay invoices for goods and services approved in the service plan

[selected – no change] Provide participant with periodic reports of expenditures and the status of the participant-directed budget

[not selected – no change] Other services and supports

Additional functions/activities:

[selected – no change] Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

[selected – no change] Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

[selected – no change] Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

[not selected – no change] Other

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Oversight is achieved through ~~[delete] the [end delete]~~ [add] a [end add] readiness review ~~[delete] and certification process, the community support planning process, and the FE recertification process. FE~~

recertification occurs every four years unless an earlier review is indicated. ~~[end delete]~~ ~~[add]~~ prior to enrollment and a performance review every three years. Entities completing the readiness and performance reviews have previously performed a VF/EA readiness review for a vendor that has an agreement (including subcontract) with a government entity to provide services under a Medicaid or another federally funded health care program. ~~[end add]~~

Appendix E: Participant Direction of Services – E-1: Overview (12 of 13)

Overview of amendments to Appendix E: Participant Direction of Services – E-1: Overview (12 of 13)

- Clarifies CDCS eligibility when living in licensed settings to align with the rest of the waiver plan

CAC Waiver

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The case manager will initiate a revision of the community support plan in order to provide waiver services other than CDCS.

CDCS services are not available to an individual or representative who has at any time been restricted by the Minnesota Restricted Recipient Program ~~[add]~~ ~~(MRRP)~~ ~~[end add]~~. Also, if a CDCS participant exits with the waiver more than once during a service plan year, the participant is ineligible for CDCS services for the remainder of that service plan year. Finally, a participant can become ineligible for CDCS services ~~[delete]~~ ~~by moving to~~ ~~[end delete]~~ ~~[add]~~ if they move to and receive licensed foster care or home care services in ~~[end add]~~ a residential setting licensed by DHS or MDH, ~~[delete]~~ ~~because CDCS services are not available to residents at these sites~~ ~~[end delete]~~ ~~[add]~~ or a setting registered as a housing with services establishment ~~[end add]~~.

In these situations, the full array of traditional waiver services is available to the participant, and the lead agency case manager is responsible for revision of the ~~[delete]~~ ~~care~~ ~~[end delete]~~ ~~[add]~~ community support ~~[end add]~~ plan and arranging for waiver services. There are no gaps in service availability during the transition.

Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (1 of 6)

Overview of amendments to Appendix E: Participant Direction of Services – E-2: Opportunities for Participant Direction (1 of 6):

- Removes co-employment as an option since the FMS providers will not offer agency services.

BI, CAC, CADI and DD waivers

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

[change from selected to not selected] - **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

[delete] The Fiscal Entity serves as the co-employer. See Appendix C. **[end delete]**

[selected – no change] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer

Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

[selected – no change] Recruit staff

[change from selected to not selected] - Refer staff to agency for hiring (co-employer)

[selected – no change] Select staff from worker registry

[selected – no change] Hire staff common law employer

[selected – no change] Verify staff qualifications

[selected – no change] Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Background checks are paid outside of the participant's CDCS budget.

[selected – no change] Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

[selected – no change] Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

[selected – no change] Determine staff wages and benefits subject to State limits

[selected – no change] Schedule staff

[selected – no change] Orient and instruct staff in duties

[selected – no change] Supervise staff

[selected – no change] Evaluate staff performance

[selected – no change] Verify time worked by staff and approve time sheets

[selected – no change] Discharge staff (common law employer)

[change from selected to not selected] Discharge staff from providing services (co-employer)
[not selected – no change] Other