COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS)

Guidelines

BlueCross BlueShield Minnesota

Community First Services and Supports (CFSS)

Community First Services and Supports (CFSS) is a Minnesota healthcare program that offers flexible options to meet members' unique needs. CFSS enables individuals to maintain greater independence in their homes and within the community. CFSS will replace Personal Care Assistance (PCA) and the Consumer Support Grant (CSG). The CFSS Policy Manual is the primary source of guidance for care coordinators in authorizing CFSS.

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

Members who use the CFSS option must understand their rights and responsibilities when using these services. Well-informed recipients may more easily exercise the increased freedom, authority, and control over resources enabled by CFSS.

Agency and Budget Models

CFSS funds using the Agency or Budget service option do not equate to a cash allowance. The care coordinator authorizes services and/or goods that may be purchased as part of an approved person-centered plan. All CFSS expenditures must be written in the members' CFSS Support Plan and approved by the care coordinator before being entered into Bridgeview.

Agency Model: The CFSS model involves a member having approved units and a chosen provider agency that serves as the employer of the members' workers and is responsible for completing the required employer tasks. This model is like traditional PCA. The agency manages recruiting, hiring, training, supervising, scheduling, and setting workers' wages. The members still have a say in who their workers are and in setting their workers' schedules. Members can also participate in training and supervising their staff.

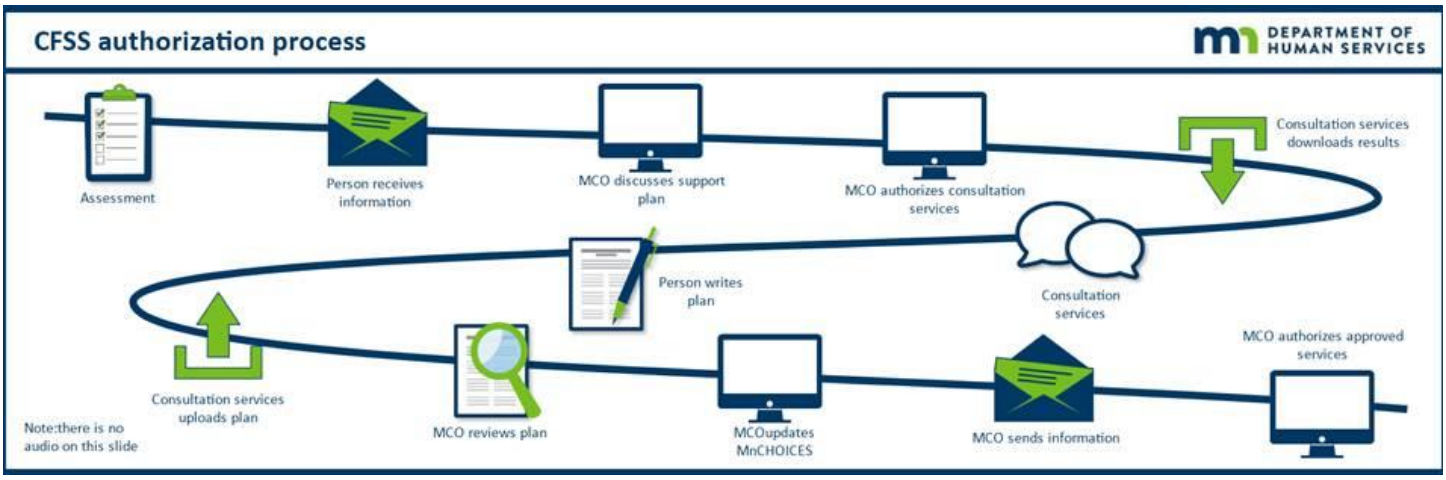
- Members may NOT choose the Agency Model if only using goods, services, and/or PERS
- Agency Model MUST be used for a 45-day temporary start of CFSS
- The agency pays workers
- The members must select an FMS provider to help with purchasing goods and services
- Provider agency requests reassessment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

Budget Model: The CFSS model, where a member has a budget with dollars and is the employer of their workers. The member selects an FMS to help with the employer-related tasks outlined in the Budget Model.
Members MUST choose the Budget Model when CFSS purchases only goods, services, and/or PERS without personal care services.

- Members on the Minnesota Restricted Recipient Program (RRP) are NOT allowed to use the Budget Model
  - CCs can confirm participation in the MN RRP program in MN-ITS
- The member handles recruiting, hiring, training, supervising, and scheduling workers, sets workers' wages, and arranges backup staffing.
- Neither the members nor the participant representatives may use the worker training and development budget to meet employer responsibilities
- The member arranges for backup staffing
- The member must select an FMS Provider to assist with payroll tasks and the purchase of goods and services

- The member reviews and submits support workers' timesheets to the FMS provider
- The FMS Provider requests reassessment 60 days before the current authorization

CFSS Authorization Process Flow



CARE COORDINATOR RESPONSIBILITIES

COMPLETE DHS ONLINE TRAINING:

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

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

MNCHOICES/LEGACY ASSESSMENT AND SUPPORT PLAN:

Complete an annual or reassessment with the member within 365 days of the last assessment and before the waiver end date if EW, 30 days of enrollment notification, or 20 days of the request.

PROVIDE EDUCATION TO MEMBERS AT ASSESSMENT:

The Care Coordinator should provide the members with information to enable them to make informed choices about services. Example of conversation:

- Discuss the services that could meet the person's needs, i.e., CFSS models (Agency | Budget)
- Explanation of self-direction and the roles and responsibilities of the member, care coordinator, Consultation Provider, etc.
- Assist the member with locating contracted Consultation Providers and/or CFSS provider agencies.
    - Ensure the Consultation Provider collaborates with the members.
- What CFSS could provide for the member, i.e., goods, services, and supports, the person can purchase with their CFSS budget.
- Provide the CFSS Fact Sheet DHS-8477A and Information for people eligible for CFSS DHS-6893U to the members at the time of assessment.

CARE COORDINATOR TASKS AFTER ASSESSMENT:

Send the member/representative and provider (if known or once known) within **10 business days** of the assessment:

- A copy of Supplemental Summary Charts and Assessment Summary from the MnCHOICES assessment.
- A copy of the Support Plan, if complete (with members' documented approval)
- A copy of "My Supports" of the Support Plan if the Support Plan is not completed

MEMBERS THAT REQUIRE TRANSITION FROM PCA:

- Enter PCA and consultation service authorizations in Bridgeview in 6-month increments.
- Ensure that the member selects a Consultation Provider and gets connected with them.

MEMBERS WHO REQUIRE AN EXTENSION OF MORE THAN 6 MONTHS:

When a member needs additional time to create their CFSS support plan, due to circumstances outside of their control:

- Enter the additional time as a new authorization in Bridgeview
- In the service description, include the reason for the extension
    - Acceptable Examples:
        - Problems with consultation services
        - Provider not yet enrolled
    - Unacceptable Examples:
        - Lack of action by the member/consultation provider in creating a support plan
- Members who are currently utilizing PCA must fully transition to CFSS on or before September 30, 2026

MEMBERS THAT ARE NEW TO CFSS:

- Enter Consultation Services authorization in Bridgeview.

REFERENCE ON HOW TO ENTER INTO BRIDGEVIEW:

- Agency CFSS BV Service Agreements
- Budget CFSS BV Service Agreements
    - NOTE: Providers access CFSS authorizations in Availity

CFSS SUPPORT PLAN:

- The Consultation Service Provider is responsible for uploading the member's DHS-6893P Individual Service Delivery Plan to MnCHOICES as an attachment and notifying the CC when it is ready for review.
    - The care coordinator reviews the member's DHS-6893P to ensure it meets all requirements (refer to CFSS Manual—PCA/CFSS service delivery plan) and does not include services or goods that are not covered (refer to CFSS Manual—PCA/CFSS covered services).
    - CC ensures that the needs identified in the assessment results are included in the CFSS service delivery plan:

Must include/lead agency must confirm are listed	Must include and lead agency must confirm coverable	Not required, consultation encourages the person include
All assessed ADL dependencies and/or ADLs the worker will do	Coverable health-related procedures and tasks the worker will do	Non-covered IADLs: heavy housekeeping, leisure, recreation and hobbies
All coverable assessed IADLs	Coverable observation/redirection of behaviors the worker will do	Coverable health-related procedures and tasks the worker will not do
		Coverable observation/redirection of behaviors the worker will not do

- CC ensures the correct services come out of a person's CFSS units/dollars:

Come out of total eligible CFSS units/dollars	Do not come out of total units/dollars
Personal care (T1019)	Consultation services (T1023)
Goods and services (T5999)	Worker training and development (S5116)
PERS (S5160, S5161, S5162)	
FMS fee (T2040 UB UA)	
Failed background study (T2040 UB UA U6)	

- CC ensures that the correct CFSS services come out of the member's elderly waiver cap:

Come out of cap	Do not come out of cap
Personal care (T1019)	Consultation services (T1023)
Goods and services (T5999)	
PERS (S5160, S5161, S5162)	
FMS fee (T2040 UB UA)	
Failed background study (T2040 UB UA U6)	
Worker training and development (S5116)	

- CCs approve/deny the Service Delivery Plan DHS-6893P within **30 days of receipt**.
    - **Pending:** If a service delivery plan does not meet CFSS requirements, the care coordinator should work with the member to update it or refer them back to their consultation service provider for plan adjustments.
        - The CC cannot approve a partial CFSS service delivery plan. Members must receive final approval, including the care coordinator's signature, before implementing the service delivery plan.
    - **Approved:** Review the DHS-6893P Service Delivery Plan and send the signed DHS-6893W Lead Agency Addendum to the CFSS Individual Service Delivery Plan to the member and consultation provider.
        - Enter authorizations into Bridgeview
        - The service start date is the date the CC signed and approved the support plan, which will be the date on the DHS-6893W
            - Note: Effective dates can be in the future, but not retroactive.
    - **Denied:** If the CC denies part or all of the plan, they must DTR the item(s) or plan.
        - Complete and sign the DHS-6893W Lead Agency Addendum to the CFSS Individual Service Delivery Plan with the changes and get appropriate signatures.
- The CC must send the final copy of the approved DHS-6893P and DHS-6893W to the member, CS provider, CFSS provider agency, and/or FMS provider.
- CC must attach the approved DHS-6893P and signed DHS-6893W to MnCHOICES.

IMPORTANT: If any areas of the CFSS Service Delivery Plan require clarification, as the CC, you can ask questions and request additional documents as needed.

IMPORTANT: If the member completes the DHS-6893P Service Delivery Plan before completing the PCA 6-month transition authorization, the member may move to CFSS once the CFSS Support Plan is completed. A DTR is *NOT* needed to discontinue the transitional PCA when the member's DHS-6893P Service Delivery Plan is approved.

ONGOING MONITORING OF CFSS SUPPORT PLAN:

- Care coordinators monitor and evaluate the plan's implementation, including the member's health, safety, satisfaction, effectiveness, and possible need for revision, at least every six months, and document this in case notes.
- The FMS provides a spending summary.
    - CCs document in the member's case notes a review of the spending summary.
- If concerns are present, the CC follows up with the member/consultation services provider to review and provide guidance.
- Care coordinators may not conduct early assessments if members exhaust their budget before completing their CFSS authorization. However, a new assessment may be appropriate if a member's condition changes.

REVISIONS TO THE CFSS SUPPORT PLAN:

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

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

The CC may also adjust the service delivery plan for the "amount, duration, and or frequency" of the CFSS services outlined on the DHS-6893P by completing the DHS-6893W. Care Coordinators would follow the process outlined above in the section "CFSS Support Plan."
Including:

- The CC must send the final copy of the approved DHS-6893P and DHS-6893W to the member, CS provider, CFSS provider agency, and/or FMS provider.
- CC must attach the approved DHS-6893P and signed DHS-6893W to MnCHOICES.

REQUESTING ADDITIONAL FUNDS | TRAINING AND DEVELOPMENT

To request additional funds for the member's worker and training development budget, the CFSS provider agency (agency model) or the FMS provider (budget model) must submit the increase request to the member's CC.

The CFSS provider agency or FMS provider must submit the following documentation to the CC:

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

The CC will need to:

- Ensure it is not a duplication of previous training (s).
- Directly relates to the members' needs.
- Ensure that the additional funds will keep the members within their EW budget.

- Create an authorization in Bridgeview.
    - In the comments, provide this statement:
        - "CC has reviewed for appropriateness, and the member remains within the EW budget."
- Document in the member's case notes and respond to the reasoning for the additional funds.

REASSESSMENTS:

Agencies and FMS providers must request a reassessment at least 60 days before the current Service Delivery Plan expires by submitting DHS-6893B to the care coordinator.

Care Coordinators (CCs) are strongly encouraged to complete reassessments 30–60 days before the end of service authorization.

This ensures:

- Timely confirmation of CFSS eligibility
- Collaboration with Consultation Services providers on a new Service Delivery Plan
- Adequate time for CCs to review, approve, or deny the plan

Reassessment requirements:

- Conduct annually: within 30 days of enrollment or 365 days after the last assessment
- Complete an early reassessment if the member's condition changes
    - Each assessment is valid for 60 days from the date completed
        - *Note:*
            - *Late reassessments may result in gaps in CFSS services.*
            - *CW members can have a face-to-face every 3 years, and EW members need a face-to-face every other year.*

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

IMPORTANT:

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

When a member is new to PCA/CFSS and has urgent service needs before the MnCHOICES assessment is completed, the CC may use clinical judgment to authorize CFSS for up to 45 days temporarily. The CC will gather information over the phone to assess the need and document the justification in the member's record. The DHS-6893A form may be used to help determine the number of hours needed.

During the 45-day temporary start, a member can only utilize the CFSS agency model. The 45-day temporary start of CFSS cannot be extended. An in-person MnCHOICES assessment is required to authorize ongoing CFSS.

Any unused units from the 45-day temporary start do not carry over to the CFSS service authorization.

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

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

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

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

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

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

TEMPORARY APPROVAL

If a person using CFSS at the time of their reassessment will not have an approved CFSS service delivery plan before the end of their current service plan year, the CC must:

- Authorize a year of the same CFSS services the person is currently using, as follows:
  - Six units of consultation services.
- If using personal care:
  - Worker training and development budget using the current state-set rate.
  - A personal care authorization equal to the person's total eligibility based on their **new** assessment minus the amount authorized for PERS, goods and services, and FMS fees.
  - A goods and services authorization with the same amount authorized on the person's previous service agreement, if applicable.
- If not using personal care:
  - A goods and services authorization to the person's total eligibility based on their **new** assessment minus the amount the lead agency authorizes for PERS and FMS fees. If using a monthly PERS service: 12 months of PERS.
- If using the CFSS budget model:
  - An FMS authorization with the same amount authorized on the person's previous service agreement.
- Complete Temporary CFSS Individual Service Delivery Plan Approval, DHS 6893L
  - Upload it to MnCHOICES.
  - Send it to the person and all their CFSS providers.

IMPORTANT: The person and their providers cannot request that the CC or DHS change their temporary authorization amounts until the CC approves a new CFSS service delivery plan.
All parties must follow the standard process to complete and approve the person's new CFSS service delivery plan. Once approved, the CC must create an authorization (s) in Bridgeview with the approved amounts for each service.

FROM ANOTHER MCO OR FEE-FOR-SERVICE WITH EXISTING PCA/CFSS AUTHORIZATION

BCBS will honor the member's current DHS-6893A. The CC will enter an authorization for services into Bridgeview minus what has already been used for the current authorization span. Members receiving transition PCA services remain on their 6-month timeline. Members should continue working with their selected consultation services provider to complete the DHS-6893P Service Delivery Plan and transition to CFSS.

MEMBERS ON ANOTHER WAIVER

When MSC+/MSHO members are approved for a disability waiver (such as CADI, BI, DD, or CAC), the primary responsibility for completing the MnCHOICES Assessment rests with the disability waiver case manager. This case manager will collaborate with the Consultation Service (CS) provider and will review and approve the member's DHS-6893P Service Delivery Plan.

The disability waiver case manager submits the DHS-5841 to the BCBS CC, ensuring that the authorizations are entered into Bridgeview.

CFSS PROVIDERS

Care Coordinators frequently contact Bridgeview asking where to find the authorizations for CFSS. Authorizations are in Availity-Payer Spaces, not Helios.

If contacted, CC's can:

- Inform the provider (s) to access the authorizations in Availity-Payor Spaces. They can view and print those authorizations.
- Advise that when providers are submitting their claims for CFSS, they must choose Bridgeview as the payor, not Blue Plus Medicaid.
- Direct providers to contact Bridgeview directly for any questions at 1.800.584.9488 or email: EWProviders@bluecrossmn.com.

Resources

CFSS Policy Manual
CFSS PCA/CFSS covered personal care services
CFSS Forms and Documents
Person's Rights and Responsibilities in CFSS
CFSS consultation services overview (state.mn.us)
Financial Management Services (FMS) for CFSS
PCA/CFSS unit determination (state.mn.us)
Goods and services through CFSS (state.mn.us)
CFSS personal emergency response systems (PERS) (state.mn.us)
DHS CFSS Codes & Rates
CFSS Budget Calculator
CFSS service delivery plan development and approval process (state.mn.us)
PCA/CFSS service delivery plan changes (state.mn.us)
CFSS Frequently Asked Questions (FAQ) CFSS Budget Calculator
CFSS Consultation Services Provider List
DSD Training Handouts Archive