Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Minnesota** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Elderly Waiver (EW)

C. Waiver Number:MN.0025
Original Base Waiver Number: MN.0025.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)

Approved Effective Date of Waiver being Amended: 07/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment makes the following changes:

Adult Day Health
- Clarifies that remote support is not available when adult day is provided in a family foster care setting

Consumer Directed Community Supports
- Clarifies terms used when referencing legal guardians and conservators paid to provide personal assistance
- Changes the number of hours for which spouses can be paid to provide personal assistance
- Updates references to “lead agency” with “county, tribal nation and MCO” where appropriate, as required by CMS
- Updated terminology for participant direction to “in person” in Appendix E-1 f.

Cost Neutraility
- Updates the projected cost estimates in Appendix J-2 for certain services

Fair Hearing
- Adds “MnCHOICES Assessment Summary” where appropriate
- Clarifies that notice of action forms must be provided when the county, tribal nation or MCO issues a denial, decrease or termination of the partiicpant’s services

MnCHOICES: Waiver Eligibility, Assessment and Support Planning
- Updates Qualifications of Individuals Performing Evaluations

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A Waiver Administration and Operation**	
☒ **Appendix B Participant Access and Eligibility**	B-6-f
☒ **Appendix C Participant Services**	C-1/C-3, C-2-3
☐ **Appendix D Participant Centered Service Planning and Delivery**	
☒ **Appendix E Participant Direction of Services**	E-1-f
☒ **Appendix F Participant Rights**	F-1
☐ **Appendix G Participant**	

Component of the Approved Waiver	Subsection(s)
Safeguards	
☐ Appendix H	
☐ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	J-2-c, d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☒ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☒ **Other**

Specify:

See previous page

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Minnesota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Elderly Waiver (EW)

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MN.0025
Draft ID: MN.016.09.01

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/23
Approved Effective Date of Waiver being Amended: 07/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and

community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities
Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☒ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

•§1915(a)
Minnesota Senior Health Options (MSHO) is a voluntary managed care option that is authorized under §1915(a) authority. MSHO is available to people aged 65 and older. The program provides care coordination and includes Medicaid and Medicare benefits. If an individual enrolled in MSHO is determined to be eligible for waiver services, the waiver services are provided by the managed care organization.
•§1915(b)(1)
Minnesota Senior Care Plus (MSC+) is a mandatory managed care program that is authorized under §1915(b)(1) authority, CMS control number MN 02. MSC+ is the basic Medicaid plan for enrollees aged 65 and older. If an individual enrolled in MSC+ is determined to be eligible for waiver services, the waiver services are provided by the managed care organization.
•§1915(b)(4)
We have an approved waiver to provide case management services through county agencies and tribes that contract with the department under §1915(b)(4) authority, CMS control number MN-03.M01.
•For purposes of the waiver plan and its appendices and attachments, and unless otherwise specified, with respect to MSHO and MSC+ enrollees: (1) the requirements and conditions governing case management are the requirements and conditions governing care coordination by the managed care organization (MCO); (2) the obligations of the case manager are the obligations of the MCO care coordinator; and (3) all references to "lead agency" are deemed to be references to the MCO.
•For MSHO and MSC+ enrollees, the MCO may offer alternative and additional services in accordance with its contract with the department. MCOs are not precluded from spending more on home and community-based waiver or alternative services than the capitation payment for waiver services.
•Any differences in the waiver plan (e.g., operations, procedures, etc.) related to MSHO and MSC+ are noted as applicable.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☒ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose: The purpose of the waiver is to provide community-based services as an alternative to institutional care for people who are 65 or older.

Goals: The waiver provides community-based services in the most integrated and least restrictive setting to support and maintain older adults in their own homes and communities and delay nursing facility admission. This is accomplished through the use of comprehensive person-centered support planning methods.

Objectives: Objectives for the waiver include:
• Supporting older adults in their homes and communities and supporting informal caregivers
• Offering services to enhance self-sufficiency in the community.
• Ensuring that people have the right to make choices and to live in the most integrated setting of their choice.
• Offering the opportunity to receive services from formal providers, natural supports and through technology
• Offering the option to direct their own services

Organizational Structure:
The waiver is managed and administered by the Minnesota Department of Human Services (department), the State's Medicaid agency. The department delegates certain waiver operations to county agencies, managed care organizations, and federally recognized tribal nations including evaluating Medicaid participants' waiver eligibility; completing needs assessments and level of care determinations; support plan development; authorizing services; and monitoring the services provided. Counties, managed care organizations, and tribal nations that carry out delegated waiver operations are referred to as lead agencies. Unless otherwise noted, references to lead agencies in this document include these entities. The department monitors the practices of lead agencies through a wide array of quality management activities described in Appendix A-6. The department provides direction and oversees all operational activities carried out by counties, managed care organizations, and tribal nations.

Service Delivery Methods:
Twenty-one services are covered through the waiver. Participants' needs are assessed and an individualized support plan is developed. The waiver also includes an option for self-direction through the consumer-directed community supports (CDCS) service. Person-centered planning is required for all assessment activities and support plan development.

Approximately 92% of Elderly Waiver participants receive their Medicaid benefits through MCOs. Medical Assistance participants age 65 and over are required to receive their Medical Assistance benefits through MCOs, with two exceptions: participants who are required to pay a medical spenddown; and, certain people served by tribal nations. These participants and those who are not yet enrolled in managed care may receive waiver services covered fee-for-service.

There are two managed care program options for people age 65 and over, Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+). The primary differences between MSHO and MSC+ are that MSHO integrates Medicare coverage, provides care coordination services, and is voluntary. A monthly capitation payment is paid to the MCO for all waiver services provided to the participant.

MSHO is available to participants age 65 and older, who are not required to pay a medical spenddown. MSHO operates under §1915(a) and §1915(c) authority and has been available since 1997. The department contracts with MCOs to provide MSHO and MSC+. Participants may select from MCOs that operate in their county of residence. For individuals enrolled in the MSHO program, Medical Assistance and Medicare benefits and, for eligible participants, waiver services are covered by the MCO. The MCO also provides care coordination services to all participants, including health risk assessment for all new participants to assess for potential health or other service or support needs. Care coordination is provided through "care systems." An MCO may offer more than one care system and some MCOs contract with counties as care system providers. Participants may choose a care system in the same way they select a primary clinic.

MSC+ is the basic Medicaid plan for participants. If an individual enrolled in MSC+ is determined to be eligible for waiver services, the waiver services are provided by the managed care organization.

Members of tribal nations and others identified under contracts between the department and tribal nations (e.g., a spouse living with a tribal member) may elect to be assessed for waiver services and receive waiver case management through their tribal nation. The tribal nation acts as a lead agency for these service populations, and is responsible for assessing for eligibility, development of support plans, and arranging, authorizing, and monitoring services. These participants may also elect to be assessed for and receive waiver case management through their county of residence or through managed care rather than the tribal nation. Members of tribal nations are not required to enroll in managed care.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The Department published a notice for public comment on the proposed Elderly Waiver renewal via an e-mail listserv for stakeholders and advocates. The notice included a copy of the full waiver that includes the proposed changes. The notice was published on our public website at the following link: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/aging/. The Department also sent the notice to tribal nations for purposes of consultation. CMS approved an Appendix K submitted by the Department that waives the requirement for non-electronic public notice due to the public health emergency related to COVID-19. The public comment period began on January 26, 2023 and ended on February 24, 2023. Individuals could submit comments electronically to a Department e-mail address listed in the notice or they could mail comments nonelectronically to the postal address listed in the notice.

There were positive comments concerning the proposed inflationary adjustment to costs for some of the waiver services including Environmental Accessibility Adaptations. There were comments that proposed a concern to the clarification that Environmental Accessibility Adaptations cannot be approved as a separate waiver service for participants receiving services in a provider owned or controlled residential setting, specifically Adult Foster Care and Customized Living services settings. We also received a comment that stated – overall, the changes are person centered and appropriate.

The remaining comments were unrelated to the content of the amendments. We did not make any changes in response to the public comments.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Hultman

First Name:

Patrick

Title: Deputy Medicaid Director

Agency: Minnesota Department of Human Services

Address: P.O. Box 64983

Address 2: 540 Cedar Street

City: Saint Paul

State: **Minnesota**

Zip: 55164-0983

Phone: (651) 431-4311 **Ext:** ☐ **TTY**

Fax: (651) 431-7421

E-mail: patrick.hultman@state.mn.us

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Minnesota**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Minnesota**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

TRANSITION PLAN FOR CONSUMER DIRECTED COMMUNITY SUPPORTS

This amendment removes two categories of consumer directed community supports (CDCS) in the process of unbundling the CDCS categories; CDCS: self-direction support activities and CDCS: environmental modifications and provisions. The unbundling of the four CDCS categories creates eight categories for participants within the CDCS option. The categories are:

1. CDCS: Financial Management Services
2. CDCS: Support planning
3. CDCS: Environmental modifications – home modifications
4. CDCS Environmental modifications – vehicle modifications
5. CDCS: Individual directed goods and services
6. CDCS: Personal Assistance
7. CDCS: Treatment and Training
8. CDCS: Community Integration

Participants who currently receive CDCS: self direction support activities and CDCS: environmental modifications and provisions will not experience any loss or interruption of such services. CDCS: self directions support activities will instead be authorized as CDCS: support planning and/or CDCS: Financial Management Services, as appropriate. CDCS: environmental modifications and provisions will instead be authorized as CDCS: Environmental modifications – home modifications, CDCS: Environmental modifications-vehicle modifications, and/or CDCS: individual directed goods and services, as appropriate.

This transition is anticipated to begin June 2022, or upon federal approval of this amendment and the Department's completion of system updates, whichever is later. The unbundled CDCS categories are expected to be authorized at a participant's annual eligibility reevaluation. At any annual reevaluation on or after June 2022, or up to 180 fays following federal approval of this amendment and the Department's completion of system updates, whichever is later, case managers/care coordinators must transition participants to the unbundled CDCS categories. After December 2023, or up to 18 months following federal approval of this amendment and the Department's completion of system updates, whichever is later, all participants receiving CDCS will have transitioned to the unbundled eight categories of CDCS as appropriate. CDCS: self direction support activities and CDCS environmental modifications and provisions will not be provided under this waiver effective January 2024 or up to 18 months following federal approval of this amendment and the Department's completion of systems updates, whichever is later.

Participants receiving CDCS will be notified that their services will be transitioning to the unbundled CDCS categories at annual reviews occurring in June 2022 or later. Lead agencies, FMS providers and support planners will also be given guidance and instructions on communicating changes with participants. This communication will also include information on the participant's right to request a fair hearing as set forth in Appendix F-1.

During the transition, the Department will ensure that participants, lead agencies, service providers, and other stakeholders are informed of these changes to CDCS. Prior to June 2022 the Department will send a notice to all participants receiving CDCS explaining the transition and how it will affect them. The Department will employ other communication methods as appropriate for participants, which may include website updates and eList announcements. The Department will release guidance, conduct training webinars, and host regional meetings to help train service professionals on the new service and prepare them for the transition.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

On Feb. 12, 2019, CMS gave its final approval to Minnesota's Home and Community-Based Services Rule Statewide Transition Plan (STP) to bring settings into compliance with the federal HCBS regulations.

Final approval is granted due to the state completing the following activities:

- Conducted a comprehensive site-specific assessment and validation of all settings serving individuals receiving Medicaid-funded HCBS, included in the STP the outcomes of these activities, and proposed remediation strategies to rectify any issues uncovered through the site specific assessment and validation processes by the end of the transition period.
- Outlined a detailed plan for identifying settings that are presumed to have institutional characteristics, including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under heightened scrutiny;
- Developed a process for communicating with beneficiaries who are currently receiving services in settings that the state has determined cannot or will not come into compliance with the home and community-based settings criteria by March 17, 2023; and
- Established ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

Details can be found in Minnesota's STP: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7817B-ENG

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

For purposes of this waiver plan, and unless otherwise specified, the term "participant" mean a person who is eligible for and enrolled in the waiver program. Where the waiver plan confers certain rights or obligations that the participant (or a court of law acting on the participant's behalf) has conferred to a guardian, conservator or authorized representative, the use of the terms "participant" does not preclude the representative from meeting those obligations or exercising those rights, to the extent of the representative's authority.

The following are waiver requirements:
1. An individual written support plan must be developed for each participant. Services included in the support plan must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's condition. Some services that support caregivers such as respite, Family Caregiver Training and Education/Coaching and Counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support.

2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Alternative therapies are only covered under the service of consumer directed community supports (CDCS), educational expenses, and utilities are not covered under the waiver. In addition, goods and services are not covered when they:
a) are provided prior to the development of the support plan;
b) are not included in the support plan;
c) duplicate other services in the support plan;
d) supplant natural supports that appropriately meet the participant's needs;
e) are recreational or diversionary in nature;
f) are not the least costly and effective means to meet the participant's needs;
g) are available through other funding sources (Note: Older Americans Act (OAA) funding does not meet the definition of other funding source" for this purpose); or
h) are for comfort or convenience.

The Department and the MCOs comply with the requirements at 42 CFR §§ 433.137 and 433.139 regarding third party liability. The Department and the MCOs participate in data exchange to identify other payers, instruct providers to bill other sources of payment first (cost avoidance) and recover reimbursement (paid under pay-and-chase). Capitation payments to the MCO are adjusted to account for amounts recovered from other liable third parties, including other insurance.

3. Services are only provided to Minnesota residents who maintain enrollment in Minnesota Medicaid, and services are not covered outside of Minnesota except when: (1) the provider is located within the participant's local trade area in North Dakota, South Dakota, Iowa, or Wisconsin and the service is provided in accordance with state and federal laws and regulations; or (2) the services provided are limited to direct care staff (that are authorized in the participant's support plan) provided when the participant is temporarily outside of Minnesota and within the United States. Direct care staff services are defined as extended personal care assistance, extended home care nursing and a CDCS worker that provides assistance with ADLs under the category of personal assistance.

The local trade area is defined in Minnesota Rules, Part 9505.0175, subp. 22, as the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services. Temporary travel is defined as a maximum of 60 days per calendar year with the exception of emergencies. In situations in which temporary travel may exceed 60 days due to an emergency (e.g., cancelled flights by airlines, family emergencies, etc.), the case manager must be notified as soon as possible prior to the 60th day. The case manager determines whether the situation constitutes an emergency and whether additional waiver services will be authorized.

All waiver plan requirements continue to apply to services provided outside of Minnesota including, prior authorization, provider standards, participant health and safety assurances, etc. Travel expenses for participants and their companions (including paid or non-paid caregivers), such as airline tickets, mileage, lodging, meals, entertainments, etc. are not covered.

4. Unless otherwise noted, spouses and professional guardians or conservators of a participant may not be paid to provide waiver services for that participant. A professional guardian or conservator is an individual, agency, organization or business entity that provides guardianship or conservatorship services for a fee. Legal representatives who are not otherwise legally responsible to provide a support service may be paid to provide waiver services when it is part of the participant's approved support plan.

5. Context for health-related performance measures:

The department monitors access to primary health care on a waiver population basis using performance on two nationally recognized, validated Healthcare Effectiveness Data and Information Set (HEDIS) measures: http://www.ncqa.org/HEDISQualityMeasurement.aspx

Use of HEDIS allows for the rigorous, standardized measurement of health care received by participants. Both the department and CMS monitor HEDIS performance in Medical Assistance populations. (Examples include the Adult Core Set (as required by the Affordable Care Act, Section 1139), and the Quality of Care External Quality Review (42 C.F.R. § 438.310 - 438.370)).

6. With the exception of CDCS and chore, enrolled individual providers must be 18 years of age or older. This does not limit persons who are 16-17 from working for an agency when in compliance with federal or state labor laws.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Aging and Adult Services Division, Aging and Disability Services Administration

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Medicaid Director is charged with the oversight of all home and community-based waivers, and maintains all waiver documents. The Aging and Adult Services Division, part of the Aging and Disability Services Administration, operates and manages the Elderly Waiver, which includes policy development and issuance, quality assurance and monitoring oversight, training, budget allocation and other operational functions of the waiver program.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

For participants who receive services through managed care, the MCOs perform certain operation and administrative functions. Refer to Appendix A, 7.

For participants who receive waiver assessment and case management through a tribal nation, the tribal nation performs certain operation and administrative functions.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Minnesota is a county-based system. Counties are required by state law to conduct certain waiver administrative functions. State law and rule govern the functions that are carried out by counties. Refer to Minnesota Statutes, section 256B.0911 and chapter 256S.

The department monitors county activity through on-site reviews, quality assurance plans completed by counties as part of the on-site review, and contact with policy staff. These monitoring functions are discussed in greater detail later in the waiver application. In addition, counties are enrolled providers and there is a provider agreement between the counties and the department.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The department is the single state Medicaid agency and is responsible for assessing the performance of lead agencies in conducting waiver operational and administrative functions. Lead agencies carry out certain waiver activities under parameters established by the department. The department retains authority over the waiver in accordance with 42 CFR §431.10(e).

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The department employs several methods to monitor waiver functions delegated to lead agencies. The waiver quality review that was submitted in 2021 included evidence of these monitoring activities. The department also employs program design features such as MMIS system edits to maximize compliance with department policies and procedures, and provides tools and supports to proactively manage the waiver. For example, the department publishes and maintains provider and MMIS manuals, provides technical assistance through a variety of means including electronic and call-in help centers, and offers substantial training opportunities.

The department's waiver monitoring includes:

1. Lead agency reviews: The Department conducts reviews of all counties and tribal nations administering home and community-based waiver programs. The purpose of the reviews is to monitor lead agencies' compliance with program requirements, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Lead agency reviews are continuous and ongoing, and all agencies are reviewed at least once approximately every three years. Reviews include a case file review of a randomly selected representative sample of cases. See Attachment A for a complete description of the sampling method used for this case file review. The Lead agency review protocol dictates that DHS complete case file reviews for a sample of EW participants who receive case management from the county agency, including cases where the participant is enrolled in managed care and the MCO has contracted with a county agency to provide care coordination for that member.

If the Department finds deficiencies in any required activity, they are identified in a report and the county or tribal nation must submit a corrective action plan to correct the identified deficiencies. The corrective action plan is posted on the Department's website at https://mn.gov/dhs/hcbs-lead-agency-review/. All individual cases that are found out of compliance with waiver requirements during the review are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

2. Care plan audits: The contracts between the Department and MCOs require the MCOs to annually audit a sample of care plans for EW participants, using a protocol submitted to and approved by the Department. The MCO audits all delegate agencies who perform care coordination for members. The MCOs contract with various types of delegate agencies including care systems, private case management agencies, and counties agencies. The protocol must follow established guidelines and include a review of required waiver case management tasks. Corrective actions are issued as needed, and the care plan audit results are provided to and reviewed by the Department. A randomly selected, representative sampling method is used for care plan audits. A description of the "8 and 30 File Sampling" method used, which was developed by the National Commission on Quality Assurance (NCQA) can be found at https://www.ncqa.org/wp-content/uploads/2018/07/20180110_830_Procedure.pdf

The MCO care plan audit rewards delegate agencies that are consistently high performers in audits. If the delegate agency achieves 100% compliance with all care plan audit items, in the MSHO, MSC+ and SNBC audit for two consecutive years and submits an attestation that internal monitoring of performance will continue to be completed by the delegate agency, then the delegate agency will not be required to participate in an on-site care plan audit for one year following the second year of 100% compliance across all three managed care products.

3. Quality assurance plans: Counties and tribal nations submit a quality assurance plan for waiver services to the Department as part of the preparation for on-site lead agency review. The plan includes self-assessment questions regarding operational and administrative activities. If the self-report is not fully compliant, the lead agency must submit a remediation plan. Information contained in the QA Plan is subject to verification during the on-site review.

MCOs submit quality assurance plans to the Department upon request. These plans are primarily used for self-assessment by the MCO and provide administrative verification of requirements. Some elements of this administrative verification tool are reviewed during the External Quality Review Organization (EQRO) and/or triennial compliance review. Requirements related to operational and administrative activities are included in the Department's contracts with MCOs.

4. Triennial compliance assessment: Federal statutes require the Department of Human Services (DHS) to conduct on-site assessments of each contracted Managed Care Organization (MCO) to ensure they meet minimum contractual standards. Under an interagency agreement between the Minnesota Department of Health (MDH) and DHS, MDH collects on-site supplemental compliance information during MDH's managed care licensing examination (QA Examination). The integration of the MDH QA Examination findings along with supplemental information collected by MDH as part of the triennial compliance assessment meets the DHS federal requirement. The triennial compliance assessment protocol includes specific validation of the MCO care plan audit findings for EW participants. This activity also includes a mid-cycle review to assure corrective actions issued in the triennial assessment are in process or completed. The Department receives a report after each assessment and issues additional corrective actions as necessary. The MCOs submit evidence to DHS of completed corrective actions; MDH also confirms corrective actions at the mid-cycle review. The most recent compliance assessments, including verification of care plan auditing conducted by the MCOs, can be found at: https://www.health.state.mn.us/facilities/insurance/managedcare/reports/quality.html

5. MMIS data analyses: MMIS data includes information about assessed needs, level of care determination, and planned

services for all waiver participants. MMIS integrates information from several subsystems, including those used for provider enrollment, prior authorization of services, participant MA eligibility, long term care assessment, and claims (including MCO encounter claims). MMIS supports automation of assurances in each subsystem via programmed editing. Minnesota's MMIS includes multi-functional editing related to eligibility verification for Medical Assistance and the waiver, validation of level of care determination, prior authorization of waiver and state plan services, verification of provider qualifications and enrollment, and appropriate claims payments. MMIS data is available within DHS' data warehouse to provide ongoing reports such as encumbrance and payment reports that may be used to monitor authorization patterns and other trends. MMIS data is also used for a variety of quality assessment and program improvement purposes. For managed care participants, annual analyses of utilization data is performed with encounter claims data to populate performance measures calculated using HEDIS methodology.

6. Fair hearing requests: The Department monitors fair hearing requests, including grievances submitted by MCO participants and captured in the database managed by the Ombudsman for Managed Care, to identify patterns or trends that may indicate a lead agency's need for additional technical assistance or training.

7. Managed care contracts: For MSHO and MSC+, the Department contracts with MCOs to provide certain Medicaid services, including waiver services. The contracts between the Department and MCOs specify the waiver activities delegated to the MCOs and the required standards for compliance. The contracts provide a basis to require corrective action should a compliance issue be identified. Contract managers at the Department are available to provide technical assistance to MCOs. Managed care contracts can be found at http://www.dhs.state.mn.us/main/dhs16_139710

The Department's contracts with the MCOs include requirements regarding quality management that are specific to the Elderly Waiver. For example, audits of care plans must include audits of EW assessments and waiver support plan requirements in addition to auditing for compliance with all other MCO care plan requirements, such as those related to the provision of preventive health services or advanced directives.

8. Consumer surveys: Participants are surveyed every 2 years through the National Care Indicators – Aging and Disabilities initiative. Information about participants' experiences and outcomes informs monitoring and improvement activities, especially in assessing person-centered planning requirements.

9. Audits of enrolled waiver services providers: The department's Provider Eligibility and Compliance division conducts monthly internal audits to ensure compliance with provider screening and enrollment regulations and operational procedures. Twenty percent of HCBS waiver service provider enrollment actions are randomly selected and reviewed each month. All unresolved issues discovered through the audits are resolved by provider enrollment specialists.

10. Adult protection system. Minnesota manages intake and response to reports of maltreatment of vulnerable adults through the state's adult protection system pursuant to Minnesota Statutes, sections 626.557 to 626.5572. https://www.revisor.mn.gov/statutes/cite/626.557

Maltreatment includes, but is not limited to, criminal acts, actions that cause physical pain, injury or emotional distress, adverse or deprivation procedures not authorized under statute, unreasonable confinement, involuntary seclusion, forced separation, the failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision, failure by the person to meet their own basic needs, and financial exploitation. State law requires immediate reporting of suspected maltreatment by mandated reporters and encourages reporting of suspected maltreatment by any person.

Mandated reporters include professionals or a professional's delegate engaged in the care of vulnerable adults, those engaged in social services, law enforcement, vocational rehabilitation, licensed health care providers, and those who work in a health care facility or licensed service. The Department provides information and training regarding the reporting of suspected maltreatment. Reports of maltreatment involving vulnerable adults are made to the Minnesota Adult Abuse Reporting Center (MAARC) as required in statute. Minnesota's reporting system currently captures all reports of adult maltreatment collected by the centralized Minnesota Adult Abuse Reporting Center and reflects dispositions of county investigations for adult waiver participants. The MAARC operates on a 24-hour basis. All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency responsible for investigation and for the provision of protective services. If a report is made initially to law enforcement or a lead investigative agency, those agencies are required to take the report and immediately forward it to the MAARC. Lead investigative agencies include the Department of Human Services, the Department of Health, and county social service agencies. Reports alleging a crime are also referred to law enforcement for criminal investigation. When an allegation includes death as a result of maltreatment, referral is also made to the medical examiner and the Ombudsman for Mental Health and Developmental Disabilities. The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes immediate referral to the county for emergency protective services.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☐	☒
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which

each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of administrative waiver requirement compliance deficiencies resolved per waiver year. Numerator: Number of waiver requirement corrective actions resolved, per waiver year Denominator: Number of waiver requirement corrective actions issued, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Research Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: See Appendix D-1, item g, for a complete description of the sampling method used for this case file review
	☒ **Other** Specify:	

	Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of administrative waiver requirement compliance deficiencies resolved, per calendar year. Numerator: Number of waiver requirement corrective actions resolved, per calendar year. Denominator: Number of waiver requirement corrective actions issued, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

Administrative Systems: The Department has an established infrastructure to manage the waiver. This includes use of MMIS to collect data on the individuals who are assessed to determine eligibility for the waiver, to authorize MA and waiver services, and pay claims that meet certain criteria. Our MMIS includes a comprehensive network of edits that support waiver policies and minimize data entry errors. MMIS also ensures proper capitation payments to MCOs for waiver participants.

The department also has:
- A robust and comprehensive assessment and care planning process to determine eligibility for the waiver and services (referred to as long term care consultations) and identify service needs, including health and safety needs
- Maltreatment reporting, investigation and remediation processes
- Systems to address participant concerns through conciliation and formal fair hearing processes
- Methods to monitor that providers meet standards
- Multiple automated assurances to pay only those claims that meet certain criteria (e.g., being authorized and corresponding with an appropriate eligibility period, provided by a qualified and enrolled provider, etc.) for FFS and to control for appropriate capitation payments to MCOs.

Additional information about each of these design features is provided in related Appendices.

Technical Assistance, Training, and Consultation: The department provides ongoing training related to MMIS tools and processes, LTCC and level of care determinations, case management, vulnerable adult and maltreatment reporting and prevention, etc.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Lead Agency Reviews: Corrective actions are issued when patterns of non-compliance are found. Individual or case-specific problems are addressed with the lead agency before the conclusion of the review, and correction is required.

If the department finds the county or tribal nation deficient in a required waiver activity, the deficiency is identified in a report and the county or tribal nation must submit a corrective action plan to correct 100% of identified deficiencies. The corrective action plans are posted on the department website. 100% of cases that are found out of compliance with waiver requirements during the review are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

Care Plan Audits: Each MCO annually reports to the department corrective actions issued and resolved. This information is maintained in a Care Plan Audit Database.

See also Appendix A-6.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Specify:	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Participants must:
- be assessed in accordance with the LTCC and determined to require the level of care provided in a nursing facility. The LTCC and level of care determination must be conducted in accordance with Minnesota Statutes, section 256B.0911.
- have assessed needs that cannot be met through the state plan

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

◉ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The LTCC provides a comprehensive assessment of the participant's needs. Information from the LTCC is used to evaluate what waiver services may be required, develop a proposed support plan, and establish the case mix classification. As described above, the case mix classification sets a maximum budget amount that parallels nursing facility rates. The support plan must reasonably assure the participant's health and safety. The assessor or case manager evaluates whether the cost of the services identified in the proposed support plan can be met within the case mix budget amount.

In Relation to the No Cost Limit For the Individuals:
Applicable to participants whose waiver services are covered through managed care:
When the MCO is responsible to cover waiver services, the department pays an add-on to the basic capitation amount for each participant who is determined eligible for waiver services. The add-on amounts are based on historical fee-for-service expenditure data, are actuarially sound, and are included in the contracts between the department and the MCO. Factor D of the waiver cost neutrality formula includes a line for the add-on capitation payment. Refer to Appendix J for the Factor D estimates. MCOs are not held to providing participants' services within the case mix budget limits under fee-for-service as described below.

In Relation to the Institutional Cost Limit:
Applicable to participants whose waiver services are covered fee-for-service:
We use a case mix methodology to establish the maximum monthly budget amount for waiver services. The methodology assigns participants a case mix level based on their assessed needs. There are 13 case mix classifications (A through L and V (vent dependent)) that reflect different levels of needed care related to activities of daily living, behavioral issues, cognitive impairments, medical treatment and clinical monitoring. The individual maximum dollar amount limit available for each case mix level is equivalent to the statewide average amount that would be covered for nursing facility care (for a person assessed at the same case mix level). These are collapsed into the corresponding 13 case mix classifications to determine the maximum amount available for waiver services. Because the case mix amount for nursing facilities are facility specific, we use statewide averages for waiver limits. Maximum monthly budget amounts are adjusted each January 1 based on the annual average statewide percentage increase in nursing facility operating payment rates (see Minnesota Statutes, section 256S.18 subdivision 6), and at other times based on legislative action.

The case mix classifications and the method to determine an individual's case mix classification are found in DHS Form 3428B. All forms are available on the department's web site at: https://mn.gov/dhs/general-public/publications-forms-resources/edocs/ Case mix classification budget amounts are published at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG and are also displayed in MMIS.

Elderly waiver cost limits are described in Minnesota Statutes, section 256S.18 subdivision 1 as follows: a) The elderly waiver case mix classifications A to K shall be the resident classes A to K established under Minnesota Rules, parts 9549.0058 and 9549.0059
b) A participant assigned to elderly waiver case mix classification A must be reassigned to elderly waiver case mix classification L if an assessment or reassessment performed under section 256B.0911 determines that the participant has:
(1) no dependencies in activities of daily living; or
(2) up to two dependencies in bathing, dressing, grooming, walking, or eating.
(c) A participant must be assigned to elderly waiver case mix classification V if the participant meets the definition of ventilator-dependent in section 256B.0651, subdivision 1, paragraph (g).

For participants who reside in a nursing facility, the participant may convert their specific nursing facility case mix monthly amount as their individual monthly limit for waiver services when additional funding (above the EW case mix budget limit) is needed for community-based services. The department reviews these individual-specific amounts, referred to as a monthly conversion budget limit, to determine whether they are necessary based on the participant's assessed needs and proposed support plan.

Conversion rates are available for a participant who has been a resident of a nursing facility for at least 30 days. Conversion budgets are submitted to and approved by DHS, are intended to support an participant's return to community-based living, and are only made available upon the participant's discharge from the facility.

In the event a person exits the waiver prematurely due to death or institutionalization, claims for all services authorized and provided will be paid.

Exceptions to case mix classification budget amounts may be allowed for individuals who meet the following criteria:
1. The participant is eligible for 10 or more daily hours of personal care assistance; and
2. The participant's services are provided by a worker who has completed training requirements

Participants who meet this criteria may request a budget exception to increase their case mix classification budget amount up to the value enacted by the Minnesota Legislature.

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☒ **Other safeguard(s)**

Specify:

Participants who receive waiver services covered by fee-for-service:
When there is a significant change in the participant's condition or circumstance (e.g., loss of a primary caregiver), the participant is reassessed. The reassessment results in modifications to the support plan and may also result in a new case mix classification that changes the maximum amount that can be used for waiver services. If this occurs, the support plan is revised accordingly. The reassessment may also lead to revisions in the support plan without a change in case mix classification.

Participants who receive waiver services covered through managed care:
When there is a significant change in the participant's condition or circumstance (e.g., loss of a primary caregiver), the participant is reassessed and the support plan revised accordingly. Because the add-on capitation amount for waiver services is in the aggregate, the department does not adjust capitation for changes at the individual level. The MCO is responsible to assure that the support plan meets participants' health and safety needs.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	37232
Year 2	38518
Year 3	40083
Year 4	41746
Year 5	

Waiver Year	Unduplicated Number of Participants
	43756

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

- ◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Medicaid participants must be determined to meet service eligibility requirement through the LTCC consultation process. Entrance to the waiver is based on the date the LTCC is completed and the participant is determined to be otherwise eligible. Enrollment capacity is managed by the department on a statewide basis.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☒ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional state supplement recipients**
- ☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ◉ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: 95

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in**

§1902(a)(10)(A)(ii)(XIII)) of the Act)

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☒ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☒ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

◉ **% of FPL, which is lower than 100%.**

Specify percentage amount: 95

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify percentage:

    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:

  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:

  - (●) **Other standard included under the state Plan**

    Specify:

The amount of the maintenance needs allowance is the sum of the state's personal needs allowance and the state's supplemental aid program maximum payment for room and board. The amount will be adjusted annually by the amount of the cost of living percentage increase (to the nearest whole dollar) applicable to the social security or supplemental security income benefit.

When the participant's waiver services are covered by an MCO, the MCO applies the participant's obligation (waiver obligation) only to home and community-based services received by the participant. The department provides each MCO with monthly data on participants' waiver obligations. The MCO reduces its payment for an participant's waiver services up to the amount of the waiver obligation. Providers collect the participant's waiver obligation.

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ○ **AFDC need standard**
- ◉ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:
- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state establishes the following reasonable limits**

Specify:

Deductions for medical and remedial care are permitted with the exception of:

- deductions for medical expenses that were incurred as the result of imposition of a transfer of assets penalty period;
- deductions that were previously applied to the participant's income ; and
- deductions that were incurred more than three months prior to the application month.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  The amount of the maintenance needs allowance is the sum of the state's personal needs allowance and the state's supplemental aid program maximum payment for room and board. The amount will be adjusted annually by amount of the cost of living percentage increase (to the nearest whole dollar) applicable to the social security or supplemental security income benefit.

  When the participant's waiver services are covered by an MCO, the MCO applies the participant's obligation (waiver obligation) only to home and community-based services received by the participant. The department provides each MCO with monthly data on participants' waiver obligations. The MCO reduces its payment for a participant's waiver services up to the amount of the waiver obligation. Providers collect the participant's waiver obligation.
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Most participants receive waiver services on a monthly basis. Case managers are responsible for on-going monitoring of participants' health and safety.

A participant must receive case management and a waiver service as documented in the support plan, that addresses a need identified in the participant's assessment related to an activity of daily living or instrumental activity of daily living, cognitive or behavioral needs, or medical need for clinical monitoring. Case Management services may be authorized for a maximum of 60 calendar days without the authorization of an additional waiver service. If the cause of not authorizing an additional waiver service is the result of a transition between providers, services or settings, an additional 60 days to authorize waiver services may be allowed. If services are not authorized during this time frame, the participant must exit the waiver until determined eligible and additional waiver services can be authorized.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The policy staff at the SMA responsible for developing and maintaining the eligibility rules within the MnCHOICES system must have extensive knowledge and expertise in Home and Community Based Services. Individuals must have a bachelor's degree in psychology, social work, education, public health, nursing or a closely related field, or equivalent experience. Individuals must have experience in or complete training on the eligibility requirements for the waiver and the assessment process. Individuals must have a comprehensive understanding of the regulatory requirements related to the assessment process and benefit eligibility criteria.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The following tools and related policies are used to determine applicants' level of care:
- Long Term Care Consultation Services Assessment Form, (DHS-3428 or DHS-3428A, and MnChoices)
- Level I Pre-Admission Screening for Persons with Mental Illness/Developmental Disability: Determination for Nursing Facility Admission, (DHS form 3426)
- Determining the Need for Nursing Facility Level of Care, DHS-7028.

Nursing facility level of care determinations may be based on a variety of conditions or needs, including complex medical needs, unstable health, need for assistance with activities of daily living or instrumental activities of daily living, or dementia or other cognitive or behavioral impairments and subsequent need for supervision or assistance.

The determination includes evaluating whether the applicant is able to:
- Meet their personal care needs
- Perform household management tasks
- Communicate basic wants and needs, and ensure their own safety
- Access community resources

A person is determined to need nursing facility level of care if they meet one of the five following categories of need:
1. Does/would live alone or be homeless without current housing type and meets one of the following:
- Has had a fall resulting in a fracture within the last 12 months
- Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence
- Is at risk of maltreatment or neglect by another person, or is at risk of self-neglect

2. Has a dependency in four or more activities of daily living (ADLs)
3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention
4. Needs the assistance of another person or constant supervision to complete toileting, transferring or positioning, and this assistance cannot be scheduled
5. Needs formal clinical monitoring at least once a day.

The LTC Screening Document (DHS-3427) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

All forms can be found at: http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The state Medicaid agency (SMA) developed and manages a comprehensive electronic assessment tool, referred to as MnCHOICES, that is used for determining and re-establishing waiver eligibility, including level of care. Assessments are conducted by county, tribal and MCO assessors. Assessors are trained and certified by the SMA. Assessments are conducted upon request by or on behalf of the applicant. The initial assessment is conducted within 20 calendar days of the request. Assessors meet with individuals to gather information about assessed needs to enter into the tool. The information entered into the tool is analyzed using a series of algorithms developed and maintained by the SMA to determine whether the person meets waiver eligibility. The SMA determines eligibility through this process. The SMA maintains authority over the process and determinations cannot be overridden by an assessor. There is no difference between the initial evaluation and reevaluation.

Initial assessments of level of care must be performed in person. Reevaluations of level of care must be performed at least annually, may be in person or remote per Statute 256B.0911.

The LTCC includes an assessment of needs and level of care determination.

Fee for Service:
County and tribal nation human services agency staff conducting an LTCC for people enrolled in fee for service MA must have a bachelor’s degree in social work, nursing with a public health nursing certificate, or other closely related field or be a registered nurse with at least two years of home and community-based experience who has received training and certification specific to assessment and consultation for long-term care services in the state.

Managed Care:
The contracts with the MCOs require that the individuals completing the LTCCs for people enrolled in managed care be qualified health professionals, which, in addition to the staff who may perform assessments for people enrolled in fee for service, may include nurse practitioners, physician assistants, and physicians.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

  Specify the other schedule:

Annually every 365 or 366 days and additionally as warranted by changes in the participant's condition.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Fee-for-Service:
Claims are not paid unless there is a current level of care reevaluation entered in MMIS. Claims are processed through MMIS. In order for a claim to be paid, there must be a valid screening document in MMIS that re-establishes waiver eligibility, including level of care. Waiver services cannot be prior authorized in MMIS until a valid screening document is entered that establishes and re-establishes waiver program eligibility. Prior authorization is required for claims payment. The screening document summarizes key information from the annual reevaluation including the level of care and is valid for a maximum of 365 or 366 days from an initial evaluation and for a maximum of 365 or 366 days from each subsequent reevaluation.

Managed Care:
The additional capitation payment for the participant is not forwarded to the MCO unless there is a current level of care reevaluation for the participant entered in MMIS. Capitation payments are processed though MMIS. In order for the additional capitation for waiver services to be forwarded to the MCO, there must be a valid screening document in MMIS that re-establishes waiver eligibility, including level of care. The screening document summarizes key information from the annual reevaluation including the level of care and is valid for maximum of 365 or 366 days from an initial evaluation and for a maximum of 365 or 366 days from each subsequent reevaluation.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The original of evaluation and reevaluation records are maintained within the MnCHOICES system maintained by the SMA. As described above, key information from the evaluation and reevaluation is entered into MMIS screening document. Screening documents are maintained in MMIS for a minimum of three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of people who receive a level of care determination within

required timelines, per waiver year. Numerator: Number of requested assessments completed within required timelines, per waiver year. Denominator: Number of requested assessments, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of completed assessments that include a level of care determination, per waiver year. Numerator: Number of completed assessments that include a level of care determination, per waiver year. Denominator: Number of assessments completed, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of assessments entered into MMIS for EW consumers where all required fields are completed, per waiver year. Numerator: Number of waiver assessments where all required fields are completed, per waiver year. Denominator: Number of total assessments entered per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Since MMIS audits 100% of cases for the performance measure related to sub-assurances a.i.a and a.i.c. there is 100% compliance and no remediation method is needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The department publishes a pamphlet titled “Older Minnesotans- Know Your Rights About Services” (DHS-4134). The pamphlet includes information about eligibility assessment, service options, fair hearing rights, vulnerable adult protections, etc. For managed care participants, similar information is included in the MCO’s certificate of coverage (COC). Managed care participants receive a COC each year. The department reviews and approves all member materials distributed by the MCOs to participants. The department’s website also provides information about service options and rights. See DHS website on services for seniors at https://mn.gov/dhs/people-we-serve/seniors/

County, tribal nation and managed care organization (MCO) staff who conduct LTCC assessments and case managers are required to provide participants choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. The support plan includes a signature page that includes a statement that the participant received information regarding service alternatives, understands feasible service options, and has made informed choices.

There is a field on the MMIS screening document that asks the assessor if the participant was given a choice between waiver services and institutional placement and choice of providers for waiver services. MMIS edits prohibit a screening document from being authorized when an assessor indicates in this field that choice was not provided or if the field is left incomplete. In addition, the participant's support plan form includes a signature section that asks whether the participant was provided choice between institutional and community-based services and among waiver services and service providers. Case managers use a support plan form that is either developed or approved by DHS and includes all required information. Participants also sign the Long Term Services and Supports Assessment and Program Information Sheet (DHS-2727) at the time of the initial assessment and subsequent reassessments.

Counties, tribal nations and MCOs’ practices are monitored through: Reviews of participants' files as part of the site reviews conducted by the department and the annual care plan audits conducted by MCOs and reported to the department. In addition, the member materials distributed by the MCOs include information concerning the availability of providers of waiver services in the MCO’s network and information about choice. These materials must be approved by the department prior to distribution.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Assessment and support planning records are maintained by counties, tribal nations and MCOs for three years. Electronic MMIS screening document summaries are maintained by the department for a minimum of three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

For fee-for-service participants:

When people are assessed for waiver services, they receive the Long Term Services and Supports Assessment and Program Information and Signature Sheet (DHS-2727). This form provides information in 15 languages about how to obtain assistance with language translation.

Support plan forms also provide information in 15 languages about how to obtain assistance with translation.

In addition, counites, tribal nations and MCOs are required to have plans addressing how they provide language assistance services to people with limited English proficiency. The plans are required to outline approaches and services to provide meaningful access for all applicants and participants in programs and services. The department provided instructional information to counites, tribal nations and MCOs regarding requirements related to limited English proficiency and we provide a significant amount of information available on the department's web site at: www.dhs.state.mn.us/id_000073

For managed care participants:

At the time of enrollment and annually thereafter, participants receive a certificate of coverage from the MCO that includes all information about benefits and services, including how to access interpreter services. The contract between the department and the MCOs require the MCOs to provide interpreter services, culturally appropriate assessment and treatment, and bilingual staff in certain situations.

Any written materials provided by MCOs to participants must include information in 15 languages on how to obtain assistance with translation.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Adult Day Service**
Statutory Service	**Case Management**
Statutory Service	**Homemaker**
Statutory Service	**Respite**
Extended State Plan Service	**Extended Home Care Nursing**
Extended State Plan Service	**Extended State Plan Home Health Care Services**
Extended State Plan Service	**Extended State Plan Personal Care Assistance (PCA)**
Other Service	**Adult Companion Services**
Other Service	**Adult Day Service Bath**
Other Service	**Adult Foster Care**
Other Service	**Chore Services**
Other Service	**Consumer Directed Community Supports (CDCS): Community Integration and Support**
Other Service	**Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions**
Other Service	**Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications**
Other Service	**Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications**
Other Service	**Consumer Directed Community Supports (CDCS): Financial Management Services**
Other Service	**Consumer Directed Community Supports (CDCS): Individual-Directed Goods and**

Service Type	Service
	Services
Other Service	Consumer Directed Community Supports (CDCS): Personal Assistance
Other Service	Consumer Directed Community Supports (CDCS): Self-direction Support Activities
Other Service	Consumer Directed Community Supports (CDCS): Support Planning
Other Service	Consumer Directed Community Supports (CDCS): Treatment and Training
Other Service	Customized Living Services
Other Service	Environmental Accessibility Adaptations - Home Modifications
Other Service	Environmental Accessibility Adaptations – Vehicle Modifications
Other Service	Family Caregiver Services
Other Service	Home Delivered Meals
Other Service	Individual Community Living Supports
Other Service	Managed Care Premiums
Other Service	Specialized Equipment and Supplies
Other Service	Transitional Services
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

The purpose of adult day service is to provide supervision, care, assistance, training and activities based on the participant's needs and directed toward the achievement of specific outcomes as identified in the support plan. Services must be designed to meet both the health and social needs of the participants.

In order to be covered as a waiver service, the adult day service must:
A. Comply with all requirements for home and community-based settings set forth in 42 CFR 441.301(c);
B. Offer a variety of meaningful and age-appropriate activities that are responsive to the goals, interests and needs of participants;
C. Maximize opportunities for community inclusion by offering or providing activities designed to increase and enhance each participant's social and physical interaction with people in their community who are not paid caregivers or staff members; and
D. Afford flexible scheduling of adult day services to accommodate a participant's work schedule.

Meals provided as part of this service shall be in accordance with 42 CFR 441.310(a)(2)(ii).

Adult day services, remote support is a provision of adult day services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time. Remote support is initiated by the person or the caregiver on a scheduled basis as documented in the person's support plan. A participant who receives remote services must receive services in person at least quarterly. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service. The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• respect and maintain the person's privacy at all times, including when scheduled support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
• ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement. *Enabling technology is the technology that makes the on-demand remote supervision and support possible. **Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

Adult day services must be furnished two or more hours per day on a regularly scheduled basis, for one or more days per week. A person can receive a combination of in-person adult day services and remote adult day services on the same day but not at the same time. A participant who receives remote services must receive in person services at least quarterly.

In a 24-hour period, a participant may receive:
(1) up to six hours of remote adult day services and
(2) a combination of in-person and remote adult day services that does not exceed 12 hours in total.

The cost of transportation is not included in the rate paid to providers of adult day services.

Adult day services remote support cannot be delivered by family adult day services (FADS) providers.

Remote support does not fund the enabling technology. Technology may be covered through CDCS-Environmental Modification and Provisions, CDCS-Environmental Modifications-Home Modifications, CDCS-Individual directed goods and services, Environmental Accessibility Adaptations-Home Modification or Specialized Equipment and Supplies.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family Adult Day Services (FADS)
Agency	Boarding Care Providers, Hospitals, and Nursing Homes
Agency	Adult Day Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Individual

Provider Type:

Family Adult Day Services (FADS)

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, section 245A.143 or Minnesota Rules, parts 9555.5050 to 9555.6265 with additional licensing authorization to provide family adult day services.

Certificate *(specify):*

Other Standard *(specify):*

The service must be provided in the license holder's primary residence and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24

Licensed adult foster care providers cannot provide family adult day services to foster care participants residing in the adult foster care home.

The license holder is responsible to assess the compatibility of all persons being served in the home to ensure each person's health and safety needs are being met. This assessment must be conducted prior to admission and on an ongoing basis.

Prior to providing adult day care services in a licensed adult foster care home, the license holder must obtain written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to live in a home that provides adult day services. The informed consent must include a statement that the resident's refusal to consent will not result in service termination.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services-Licensing Division.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Boarding Care Providers, Hospitals, and Nursing Homes

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730 with the exception of multifunctional organizations; nursing homes, hospitals, and boarding care settings that serve five or fewer people who are not residents or patients in the setting are exempted from the licensing requirement to provide adult day care.

Certificate *(specify):*

Other Standard *(specify):*

The provider must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.24, with the exception of section 245A.143. Providers providing Adult day services remotely must also meet requirements in Minnesota sections 245A.70 through 245A.75.

For the purposes of this service, multifunctional organization is defined in Minnesota Rule 9555.9600 Subp. 21. as an organization such as a nursing home that operates a center licensed under parts 9555.9600 to 9555.9730 as well as one or more other programs or facilities simultaneously and within the same administrative structure.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Licensing Division

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Adult Day Centers

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.24, with the exception of section 245A.143. Providers providing Adult day services remotely must also meet requirements in Minnesota sections 245A.70 through 245A.75.
For purposes of this service, a center is defined as a free-standing setting that is only licensed to provide adult day services and is not an individual’s home.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services-Licensing Division.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services to assist participants in accessing needed waiver and other state plan services, assist individuals in appeals under Minnesota Statutes, section 256.045, as well as needed medical, social, educational and other services, regardless of the funding source for the services.

Case aides may assist the case manager in carrying out administrative activities of case management. Case aides must not assume responsibilities that require professional judgment, including assessments, reassessments, and support plan development. The case manager is responsible for providing oversight of the case aide.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the participants' support plans. When the case manager is not the assessor, case managers shall refer the participant for a reassessment of participants' level of care and provide necessary information to the assessor. Case managers shall review their support plans at least annually, or more frequently as warranted by changes in participants' conditions.

Case managers shall develop the support plan, inform the participant of service options, assist in identifying potential service providers, assist in accessing services, coordinate services, evaluate and monitor services identified in the support plan, provide participants with information concerning their rights, and review support plans at least annually.

The case manager or case aide shall not have a personal financial interest in the services provided to the participant. Case management must not be provided to a participant by a private agency that has a financial interest in the provision of any other services included in the participant’s support plan.

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

Minnesota holds a section 1915(b) waiver that restricts the provision of case management services to employees and contractors of counties and tribal nations that are enrolled as a medical assistance provider.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Aides
Individual	Physicians, Physician Assistants, and Nurse Practitioners for MCOs
Agency	Case Managers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Aides

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Case aides must be high school graduates with one year of experience as a case aide or in a closely related field. One year of education beyond high school, such as business school or college, may be substituted for the experience.

Case aides must be employed by or under contract with agency providing case management.

Verification of Provider Qualifications

Entity Responsible for Verification:

County and Tribal Nation Agencies:

MCOs:
MCOs complete care plan audits annually and report the results including corrective actions to the department for review. MCOs report annually to the department, including corrective actions and review. The department verifies the care plan audits every three years through the Triennial Review conducted by Department of Health, with mid-cycle review of corrective actions. DHS receives these reports and approves corrective action plans for any corrections related to waiver participants or waiver services, including case management.

Frequency of Verification:

County and Tribal Nation Agencies:
For case aides that are employees of the county or tribal nation, verification occurs at hire. For case aides under contract with the county or tribal nation, verification occurs with contract cycles, which can be from one to three years.

MCOs:
A random sample of case files is audited annually by the MCO.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Individual
Provider Type:

Physicians, Physician Assistants, and Nurse Practitioners for MCOs

Provider Qualifications

License *(specify):*

Must meet all prevailing state standards and possess all professional licenses necessary to practice.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

MCOs complete care plan audits annually and report the results including corrective actions to the department for review. MCOs report annually to the department, including corrective actions and review. The department verifies the care plan audits every three years through the Triennial Review conducted by Department of Health, with mid-cycle review of corrective actions. DHS receives these reports and approves corrective action plans for any corrections related to waiver participants or waiver services, including case management.

Frequency of Verification:

Annually.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Managers

Provider Qualifications

License *(specify):*

Public health or registered nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

Social workers must be graduates from an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate of an accredited four-year college with a major in any field and one year experience as a social worker/case manager/care coordinator in a public or private social service agency. Social workers must also pass an assessment process through the Minnesota Merit System or another county merit system in Minnesota.

For counties that use the Minnesota Merit System or a county civil service system, social workers must:
• Apply to the Merit System to be considered for an open social worker position and be put on an eligible employment list
• Meet the minimum qualifications of a social worker under MN Rule 9575 or the county civil service system

Authority to set personnel standards is granted to the commissioner of human services under Minnesota Statutes, section 256.012.

Alternative credentialing standards may be applied to services provided by Tribal Governments if accepted by the Commissioner of Human Services under Minnesota Statutes, section 256B.02, subd. 7. MCOs may establish alternative credentialing standards in accordance with the contracts between the MCOs and department.

Standards for the Minnesota Merit System are authorized under Minnesota Rules, parts 9575.0010 to 9575.0090.

If the case manager is not an employee of the county, tribal nation or MCO, then the provider of case management services will be required to execute a contract with the county, tribal nation or MCO in order to provide case management services. The county, tribal nation or MCO will be responsible for monitoring the terms of the contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

County and Tribal Nation agencies:
The department verifies that case management activities are conducted in accordance with policies and regulations during county and tribal nation site reviews.

MCOs:
MCOs complete care plan audits annually and report the results including corrective actions to the department for review. MCOs report annually to the department, including corrective actions and review. The department verifies the care plan audits every three years through the triennial review conducted by Department of Health, with mid-cycle review of corrective actions. DHS receives these reports and approves corrective action plans for any corrections related to waiver participants or waiver services, including case management.

Frequency of Verification:

County and Tribal Nation Agencies:
For case managers that are employees of the county or tribal nation, verification occurs at hire. For case manages under contract with the county or tribal nation, verification occurs at the time of hire and every one to three years. RN licenses are renewed every 2 years.

MCOs:
A random sample of case files is audited annually by the MCO.
RN licenses are renewed every 2 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08050 homemaker
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08010 home-based habilitation
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Homemaker services are delivered when the participant is unable to manage the general cleaning and household activities or when the individual regularly responsible for these activities is unable to manage the household activities or is temporarily absent. All homemakers may assist in monitoring of the client's well-being and safety while in the home.

Homemaker service tasks are divided into three different components. The three homemaker components that may be authorized to meet the needs defined in the participants support plan include:

Homemaker/home management providers deliver home cleaning services and provide assistance with home management activities.. Homemaker/home management is a service that includes light housekeeping and assistance with laundry, meal preparation, shopping for food, clothing and supplies, simple household repairs and arranging for transportation.

Homemaker/assistance with activities of daily living providers deliver cleaning services and while on-site, provide assistance as needed with activities of daily living. This service includes: cleaning and providing assistance as needed with activities of daily living., such as bathing, toileting, grooming, eating and ambulating.

Homemaker/cleaning providers deliver only home cleaning services. This service includes light housekeeping and laundry tasks. Homemaker/cleaning services must meet the needs defined in the participant's support plan and not duplicate other homemaker or cleaning services.

Homemaker (home management only), remote support is the following:
Remote support is a provision of Homemaker service by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
- respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
- respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
- ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

This service is not covered as a separate service when the participant resides in a licensed foster care home or supervised living facility, or receives customized living, or 24 hour customized living service.

Homemaker Service remote support is only available when homemaker/home management services are being provided.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions; CDCS – environmental modifications-home modifications; CDCS individual directed goods and services; Environmental Accessibility Adaptations - home modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Homemaker/Home management
Agency	Homemaker/Home management
Individual	Homemaker/Cleaning
Agency	Homemaker/Assistance with activities of daily living
Individual	Homemaker/Assistance with activities of daily living
Agency	Homemaker/Cleaning

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Homemaker/Home management

Provider Qualifications

License *(specify):*

Individuals that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (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 Statutes-chapter 245D

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

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 (a) (1) and (2) the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

county, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker/Home management

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a)(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

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd 2 (a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). subds 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; 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 restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers 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 providers who are excluded under Minnesota Statutes, section 245A.03 sub 2 (a) (1) and (2), the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

county, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Homemaker/Cleaning

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Homemaker/cleaning services must comply with the standards outlined in Minnesota Statutes, Chapter 245C concerning criminal background studies. Homemaker/cleaning providers must be able to perform the cleaning duties expected and provide a cost-effective means of meeting the client's home cleaning needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled individuals: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-Enrolled individuals: County, tribal nation or MCOs

Frequency of Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance - Every five years
County, tribal nation or MCOs – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker/Assistance with activities of daily living

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (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
Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes-chapter 245D

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd 2 (a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). Subds 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants;sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and probited and restricted procedures; section 245D.061 regarding the emergency use of manual restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers holding a licenses under Minnesota Statutes, Chapter 245D. The Minnesota Department of Health monitors providers holding a home care license under Minnesota Statutes, chapter 144A.

For providers who are excluded under Minnesota Statutes, section 245A.03 sub 2 (a) (1) and(2), the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

County, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Homemaker/Assistance with activities of daily living

Provider Qualifications

License *(specify):*

Individuals that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (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 excluded from licensure under Minnesota Statutes, section 245A.03, subd 2(a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). subds. 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; 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 restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a licensense 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 (a) (1) and (2) the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

County, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Homemaker/Cleaning

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of homemaker/cleaning services must comply with the standards outlined in Minnesota Statutes, chapter 245C concerning criminal background studies must be applied.Homemaker/cleaning providers must be able to perform the cleaning duties expected and provide a cost-effective means of meeting the participant's home cleaning needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-Enrolled providers: Counties, tribal nations or managed care organizations (MCOs)

Frequency of Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance - Every five years

County, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Respite care may be provided to participants who are unable to care for themselves. The service is furnished on a short-term basis because of the absence or need for relief of the person who normally provides the care and who is not paid or is only paid for a portion of the total time of care or supervision provided. The unpaid caregiver does not need to reside in the same home as the participant.

Respite care may be provided in:
- the participant's home or place of residence;
- community settings used by the general public;
- a home licensed to provide foster care;
- a community residential setting (CRS);
- a Medicare certified hospital or nursing facility;
- a licensed assisted living facility; certified camps;
- unlicensed settings where agencies or individual providers must be licensed under Minnesota Statutes, chapter 245D or meet the exclusion requirements
- or another private home that is identified by the participant.

Respite care may be provided in a private (unlicensed) home identified by the participant when it is determined by the case manager that the service and setting can safely meet the participant's needs. The case manager must take into account the accessibility and condition of the physical setting, ability and skill level of the respite caregiver, and the participant's needs and preferences. The unlicensed home and caregiver identified by the participant cannot otherwise be in the business or routine practice of providing respite services.

Respite Services remote support is the following:
Remote support is a provision of Respite service by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person’s health, safety and other support needs through remote support must:
- respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
- respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person’s health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
- ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Coverage for respite care provided in licensed facilities will include both services and room and board, as

appropriate. Room and board will not be covered for respite care provided in the participant's home, participant's family home, or in an unlicensed, private home.

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. This does not allow the primary caregiver to provide respite services. 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 limited to 30 consecutive days per respite stay in accordance with the support plan. Participants who live in settings that are responsible to provide customized living, 24-hour care, supervision, residential care or shift staff foster care or supports are not eligible for this service with the exception of community emergencies or disasters requiring relocation of waiver participants.

The person or people who provide the care or supervision and for whom the respite service is to provide relief shall not be paid to provide the respite service.

Respite Service remote support is only available when in home respite is being provided.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS –Environmental Modification – home modifications; CDCS-individual–directed goods and services, Environmental Accessibility Adaptations-home modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Long Term Care Facilities
Agency	Assisted living facilities
Agency	Hospitals as defined in Minnesota Statutes, section 144.696, subd 3
Individual	Individuals who meet the respite service standards
Agency	Camps
Agency	Agencies that meet the respite service standards
Agency	Adult Foster Care Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Long Term Care Facilities

Provider Qualifications

License *(specify):*

Facilities providing respite care outside of the participant's home must be:
- licensed in accordance with Minnesota Statutes, chapter 144A; and must meet the definition of a long-term care facility under Minnesota Rules part 9505.0175 subpart 23.

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health.
Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Long term care facilities are reviewed every 2 years by the state and receive federal certification annually.
Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted living facilities

Provider Qualifications

License *(specify):*

Assisted living facilities licensed in accordance with Minnesota Statutes, Chapter 144G.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Health monitors agencies holding an assisted living facility license under Minnesota Statutes, Chapter 144G.
Minnesota Department of Human Services, Eligibility and Compliance.

Frequency of Verification:

Providers licensed under Minnesota Statutes, Chapter 144G. Minnesota Department of Health shall conduct a survey of each assisted living facility on a frequency of at least once every two years. Surveys may be conducted more frequently than every two years based on the license category, the facility's compliance history, the number of residents served, or other factors as determined by the commissioner deemed necessary to ensure the health, safety, and welfare of residents and compliance with the law.

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospitals as defined in Minnesota Statutes, section 144.696, subd 3

Provider Qualifications

License *(specify):*

Hospitals must be licensed under Minnesota Statutes, sections 144.50 to 144.591.

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Accredited hospitals are surveyed when CMS notifies MDH to conduct validation surveys or the state may survey based on complaint investigations.

Enrolled providers: every 5 years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals who meet the respite service standards

Provider Qualifications

License *(specify):*

Providers 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 Statutes, chapter 245D

Individuals providing in-home respite services must demonstrate to the case manager that they are able to provide, on a temporary, short term basis, the care and services needed by the participant. Documentation will be in the person's community support plan. In addition, in-home respite providers who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the participant: 1) the provider is physically able to care for the participant; 2) the provider has completed training identified as necessary in the care plan; and, 3) the provider complies with monitoring procedures as described in the care plan. The case manager must evaluate and document whether the provider meets the standards to provide respite services.

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2)must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; 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 applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation of such an assessment will be included in the person's community support plan.

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.
Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance
For individuals who are excluded under Minnesota Statutes, section 245A.03, sub 2(a) (1) and (2)the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

Enrolled providers: Every five years
County, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License *(specify):*

Licensed under Minnesota Statutes, chapter 245D.

Certificate *(specify):*

Certified by the American Camp Association.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services Provider Eligibility and Compliance agencies.

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:

Enrolled Providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies that meet the respite service standards

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 sub 2(a) (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, section 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 excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must meet the requirements of: section 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; 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 applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation of such assessment will be included in the person's community support plan.

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.
Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance
For agencies who are excluded under Minnesota Statutes, section 245A.03,subd.2(a) (1) and (2), the county, tribal nation or MCO monitors the provider.
The Department of Human Services – some licensing functions are delegated to counties to complete under department supervision

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

Enrolled providers: Every five years

County, tribal nation or MCO: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Foster Care Providers

Provider Qualifications

License *(specify):*

Out-of-home providers furnishing respite care outside of the participant's home must be licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a) (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):*

Providers must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, section 256B.0919 subds. 1 and 2.

Adult foster care providers must deliver the services in one of the following licensed facilities:
- adult foster care providers licensed under Minnesota Statutes, chapter 245A must deliver the services in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265;
- providers that are licensed under Minnesota Statutes, chapter 245D, in addition to chapter 245A, are required to meet the 245D licensing standards;
- adult foster care providers licensed under Minnesota Statutes, chapter 245D must deliver services in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265; or licensed community residential setting (CRS) facility as defined under Minnesota Statutes, chapter 245D.

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.

Counties, under department supervision, are responsible to complete 245A licensing verification and review the 245D CRS facility license.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

For providers who are excluded under Minnesota Statutes, section 245A.03, subd 2(1) and (2) the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

CRS licensed facilities and providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year. Counties must be certified by the department to conduct licensing reviews. The department reviews the licensing activities of county agencies at least once every four years to determine whether they continue to meet the certification standards.

Provider Eligibility and Compliance: Every five years

County, tribal nation or MCO – Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Extended Home Care Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Extended home care nursing (HCN) are HCN services as defined in the state plan except that the limitations on the amount (the number of units) and duration of the service (the period the service may be authorized) do not apply. The scope of the service is the same as defined in the state plan. To be eligible, the participant must receive and exhaust the HCN benefit for each month that the extended service is authorized.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home care nursing agencies
Individual	Licensed Practical Nurses (LPN)
Individual	Registered Nurses
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended Home Care Nursing

Provider Category:

Agency

Provider Type:

Home care nursing agencies

Provider Qualifications

License *(specify):*

Comprehensive home care license in accordance with Minnesota Statues, section 144A.43 through 144A.484

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended Home Care Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurses (LPN)

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, sections l48.171 to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

LPNs must be supervised by a registered nurse and may only provide care that is delegated by the registered nurse.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended Home Care Nursing

Provider Category:

Individual

Provider Type:

Registered Nurses

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, sections l48.l7l to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended Home Care Nursing

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Providers must be licensed as a comprehensive home care provider in accordance with Minnesota Statutes, sections 144A.43 through 144A.484.

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.
Nurses who provide HCN services as an employee of a home health agency must have a valid license to practice in Minnesota.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services Provider Eligibility and Compliance.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Extended State Plan Home Health Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
05 Nursing	05020 skilled nursing
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Extended home health care services are home health aide and nursing services provided by a home health agency as defined in the state plan except that the limitations on the amount (the number of units) and duration of the service (the period of time the service may be authorized) do not apply. The scope of the home health aide and nursing services (i.e., what is covered) is the same as defined in the state plan. To be eligible, the participant must receive and exhaust the home health service (to be extended) for each month that the extended service is authorized.

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

Medical supplies and equipment, audiology services, specialized maintenance therapies, and therapy services including those provided by therapy assistants are not covered.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended State Plan Home Health Care Services

Provider Category:

Agency

Provider Type:

Home Health Agencies

Provider Qualifications

License *(specify):*

Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484.

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

Must meet the standards as specified under the Medicaid state plan and Minnesota Rules, part 9505.0290.
Employees of the home health agency must meet the standards in Minnesota Rules, part 9505.0290 and must comply with or meet any other professional requirements that may apply to their specialty or scope of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health.

Frequency of Verification:

Every one to three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Extended State Plan Personal Care Assistance (PCA)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Extended personal care assistance (PCA) are PCA services as defined in the state plan except that the limitations on the amount (the number of units) and duration of the service (the period the service may be authorized) and frequency of the service do not apply. The scope of the service (i.e., what is covered) is the same as defined in the state plan. To be eligible, the participant must receive and exhaust the PCA benefit for each month that the extended service is authorized. The need, amount and duration of the service is determined on completion of the Supplemental Waiver PCA assessment and Service Plan (DHS-3428D) or MnCHOICES assessment.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider Agencies and personal care choice provider agencies
Agency	Medicare Certified Home Health Care Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended State Plan Personal Care Assistance (PCA)

Provider Category:

Agency

Provider Type:

Personal Care Provider Agencies and personal care choice provider agencies

Provider Qualifications

License *(specify):*

Must meet the standards and requirements under Minnesota Statutes, section 256B.0659, subds. 21, and 23.

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements for PCA services as specified in the state plan and under Minnesota Statutes, section 256B.0659.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Every three years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Extended State Plan Personal Care Assistance (PCA)

Provider Category:

Agency

Provider Type:

Medicare Certified Home Health Care Agencies

Provider Qualifications

License *(specify):*

Must meet the standards and requirements under Minnesota Statutes, section 256B.0659, subds. 21, and 23.

Certificate *(specify):*

Medicare Certification.

Other Standard *(specify):*

Must meet the standards and requirements for PCA services as specified in the state plan and under Minnesota Statutes, section 256B.0659.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Companion Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult companion services are non-medical care, supervision and socialization, provided to a participant. This service must be provided in accordance with a therapeutic goal identified in the support plan and must not be solely diversional in nature.

Providers may assist or supervise the participant with tasks such as meal preparation, laundry and shopping when the tasks are incidental to the companion service, but may not perform these activities as discrete services.

Providers may complete light housekeeping tasks that are incidental to the care and supervision of the participant.

Provider may provide verbal instructions or cues to help the person complete a task.

Activities that support therapeutic socialization could be associated with a support plan goal to reduce social isolation, or help the individual maintain the most inclusive community life. Socialization activities that is therapeutic is directly tied to the individual's goal(s) in the support plan. Companion services are also specifically intended to support an individual to maintain and enhance community integration and social relationships, and can be used to support community relationships. Companion services are not limited to remediation of a medical condition.

Adult Companion Service remote support is the following:
Remote support is a provision of Adult Companion Service by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person’s health, safety and other support needs through remote support must:
- respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
- respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person’s health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
- ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

Adult companion services do not include:
-hands-on nursing care, but may include verbal instruction or cuing;
-services provided by people related to the participant by blood, marriage, or adoption; except as allowed for individuals excluded from licensure under Minnesota Statutes, section 245A.03 subd 2(a) (1) and (2)
-activity fees (e.g. movie or event fees)
-socialization that is not directly tied to a participant's goal(s) in the support plan

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services; Environmental Accessibility Adaptations - Home Modifications; or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who meet the standards to provide adult companion services
Agency	Organizations that provide companion service under the Corporation for National and Community Service Senior Companion Programs
Agency	Agencies that meet the service standards for adult companion services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:
Individual
Provider Type:

Individuals who meet the standards to provide adult companion services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a) (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 who provide adult companion services must have:
1) Communication skills; be able to read, write, follow written and verbal instruction, and effectively converse on the telephone.
2) Homemaking skills; must have experience and/or training in homemaking skills, and/or in caring for people with cognitive or physical limitations, or other functional impairments.
3) The ability to perform essential job functions as identified in the participant's support plan.
4) Good physical and mental health and maturity of attitude toward work assignments, and may be required to pass a job related physical examination.
5) The ability to work under intermittent supervision and to manage minor emergencies. Individuals who provide companion services must be aware of their own limitations to handle crisis situations and report these to the case manager.
6) An understanding of, respect for, and ability to maintain confidentiality and data privacy.
The case manager determines whether the individual meets these standards.
Apply the standards in Minnesota Statutes, chapter 245C concerning criminal background checks.

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of Minnesota statutes section 245D.04, subd. 1(4), subd 2 (1), (2), (3), (6) and subd. 3 regarding the rights of participants; 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 as applicable.

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(a) (1) and (2) the county, tribal nation or MCO monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

County, tribal nation or MCO – Every five years
Provider Eligibility and Compliance – every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Organizations that provide companion service under the Corporation for National and Community Service Senior Companion Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must meet the standards established by the Corporation for National and Community Service National and Community Service Senior Companion program grantees must undergo a National Service criminal history check. This check includes: A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW); a statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and a fingerprint-based FBI criminal history repository check.

If the provider of Adult Companion Services is a National Community Services Senior Companion Program grantee, they are exempt from the background study requirements of MN Statute 245C.

Verification of Provider Qualifications

Entity Responsible for Verification:

Federal Corporation for National and Community Service And Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Agencies that meet the service standards for adult companion services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a) (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):*

Providers must assure that individual workers have:
1. Communication skills including the ability to communicate with the participant(s) use a telephone (or comparable device);
2. Experience or training in homemaking skills or in caring for people with functional limitations
3. The ability to perform essential companion tasks as identified in the participant's support plan;
4. The ability to work effectively under intermittent supervision, and to appropriately address emergencies that may arise; and,
5. Understand and maintain confidentiality and data privacy.

Apply the standards in Minnesota Statutes, chapter 245C concerning criminal background checks.

Understand and maintain confidentiality and data privacy.
Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2)must meet the requirements of Minnesota statutes, section 245D.04, subd. 1(4), subd 2 (1), (2), (3), (6) and subd. 3 regarding rights of participants; 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.

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, the county, tribal nation or MCO monitors the providers

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

County, tribal nation or MCO – Every five years
Provider Eligibility and Compliance – every 5 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Adult Day Service Bath

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A bath may be provided by an adult day or a family adult day services (FADS) provider when the bath is not able to occur in the person's home. In order to receive an Adult Day Bath, the participant must be receiving Adult Day Services. The reason for not providing the bath in the participant's home must be documented in the participant's support plan.

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

This service is limited to two 15 minute units of service per day.
A person cannot receive an adult day services bath and foster care waiver services from the same provider.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Homes, Hospitals, Medical Clinics
Individual	Family Adult Day Services (FADS)
Agency	Adult Day Centers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Adult Day Service Bath

Provider Category:

Agency

Provider Type:

Nursing Homes, Hospitals, Medical Clinics

Provider Qualifications

License *(specify):*

Licensed under Minnesota Rules, Parts 9555.9600-9730 with the exception of nursing homes, hospitals, and board and care settings that serve five or fewer people who are not residents or patients in the setting are exempted from the licensing requirement to provide adult day services.

Certificate *(specify):*

Other Standard *(specify):*

The provider must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.16, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Service Bath

Provider Category:

Individual

Provider Type:

Family Adult Day Services (FADS)

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, section 245A.143. or Minnesota Rules, parts 9555.5105 to 9555.6265 with additional licensing authorization to provide family adult day services.

Certificate *(specify):*

Other Standard *(specify):*

Providers must meet the standards as provided in Minnesota Statutes, sections 245A.01 to 245A.16. The service must be provided in the license holder's primary residence and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

Licensed adult foster care providers cannot provide family adult day services to foster care participants residing in the adult foster care home.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services-Licensing Division.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Service Bath

Provider Category:

Agency

Provider Type:

Adult Day Centers

Provider Qualifications

License *(specify):*

Adult day centers must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.16, with the exception of section 245A.143.

For purposes of this service, a center is defined as a free-standing setting that is only licensed to provide adult day services and is not an individual's home.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services- Licensing Division.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Foster Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adult foster care is ongoing residential care and supportive services and may also include the provision of assistance with activities of daily living, household and living skills assistance or training, chore, companion services and medication oversight (to the extent permitted under State law) provided in a licensed home or Community Residential Setting (CRS). Adult foster care is furnished to participants who receive these services in conjunction with residing in the licensed setting.

The total number of individuals (including waiver participants) living in the home who are diagnosed with serious and persistent mental illness or a developmental disability and who are unrelated to the principal care provider, cannot exceed four; otherwise, the total number of individuals (including waiver participants) living in the home, who are unrelated to the principal care provider, cannot exceed five.

In order for adult foster care services to be covered by the waiver, the services must comply with all requirements for home and community-based settings set forth in 42 CFR 441.301(c).

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

The following are not covered in adult foster care:
1) Room and board; items of comfort or convenience; payments directly or indirectly to the participant; and, the costs of facility maintenance, upkeep and improvement.

2) Homemaker, chore services and Home Delivered Meals are not covered as separate services, because these services are integral to and inherent in the provision of foster care services.

3) A person cannot receive Individual community living supports (ICLS) as a separate service if they receive Adult foster care.

4) Environmental Accessibility Adaptations cannot be authorized as a separate waiver service for a participant who is also receiving Adult Foster Care Services

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Relatives providing foster care
Individual	Adult Foster Care Providers
Agency	Adult Foster Care Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:
Individual
Provider Type:

Relatives providing foster care
Provider Qualifications
License *(specify):*

Exempt.
Certificate *(specify):*

Must meet the requirements in Minnesota Statutes, §256b.0919 subd. 3 related to county certification.
Other Standard *(specify):*

Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, section 256B.0919 subds. 1 and 2.
Verification of Provider Qualifications
Entity Responsible for Verification:

Counties evaluate and issue certifications to provide foster care for relatives who meet the criteria. The department monitors this process and counties are reviewed every three years to evaluate their compliance with department policies.

Frequency of Verification:

County-certified providers are reviewed every one to three years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Individual

Provider Type:

Adult Foster Care Providers

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

Certificate *(specify):*

Other Standard *(specify):*

Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, section 256B.0919 subds. 1 and 2.

Providers licensed under Minnesota Statutes, chapter 245D, in addition to chapter 245A, are required to meet the 245D licensing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services completes licensing verification of providers that are licensed under Minnesota Statutes, chapter 245D.

Counties, under Department supervision, are responsible to complete licensing verification of providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year. Counties must be certified by the department to conduct licensing reviews. The department reviews the licensing activities of county agencies at least once every four years to determine whether they continue to meet the certification standards.

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Agency

Provider Type:

Adult Foster Care Providers

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.5l05 to 9555.6265 and Minnesota Statutes, chapter 245A or under Minnesota Statutes, Chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, §256B.0919 subdivisions 1 and 2.

Adult foster care providers licensed under Minnesota Statutes, chapter 245A must deliver services in a facility licensed under one of the licensed facilities: Minnesota Rules, parts 9555.5505 to 9555.6265. Providers licensed under Minnesota Statutes, chapter 245D, in addition to chapter 245A, are required to meet the 245D licensing standards.

Adult foster care providers licensed under Minnesota Statutes, chapter 245D must deliver services in a licensed community residential setting (CRS) facility as defined under Minnesota Statutes, Chapter 245D.

The Department of Human Services verifies adult foster care provider qualifications that are licensed under Minnesota Statutes, chapter 245D.

Counties, under department supervision, are responsible to review the 245D CRS facility license and complete licensing verification of providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

Enrolled providers: Minnesota Department of Human Services Provider Enrollment

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services verifies provider qualifications that are licensed under Minnesota Statutes, chapter 245D.

Counties, under department supervision, are responsible to review the 245D CRS facility license and complete licensing verification of providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D–Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.
Counties: CRS licensed facilities and providers licensed under under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year. Counties must be certified by the department to conduct licensing reviews. The department reviews the licensing activities of county agencies at least once every four years to determine whether they continue to meet the certification standards.

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Chore services support or assist a participant or his/her primary caregiver to maintain a clean, sanitary, and safe home environment. Chore services can be provided when the participant or their primary caregiver is not capable of performing the household tasks, neither the person nor anyone else in the household is financially able to provide chore services, or when the provision of chore services work allows for the caregiver to provide other needed supports to the participant.

Chore services may include, but are not necessarily limited to:
1) heavy household chores such as washing floors, windows and walls;
2) indoor and outdoor general home maintenance work;
3) moving or removal of large household furnishings and heavy appliances to provide safe access and egress from the home;
4) rearrangement of the home furnishings or the securing of household fixtures and items in order to or prevent falls or injuries;
5) extermination and pest control;
6) customary service charges made for the delivery of grocery store products when these products represent the majority of the participant's total grocery needs for at least seven days;
7) dumpster rental and refuse disposal;
8) packing the participant's belongings

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

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

This service shall not be covered in licensed settings or rental situations in which the lease agreement identifies the chore services as the responsibility of the landlord.

If the support plan also includes homemaker or Individual Community Living services, the support plan must be specific enough to assure that there is no duplication.

Extermination and pest control services are limited to reasonable number of treatments required to alleviate the pest problem.
For participants receiving chore services the following services are not covered: Adult Foster Care or Customized Living.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Structural Pest Control Applicators
Agency	Structural Pest Control Applicators

Provider Category	Provider Type Title
Individual	Chore Service Providers
Agency	Chore Service Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Structural Pest Control Applicators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements under Minnesota Statute, chapter 18B.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:

Enrolled providers: Every five years

Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Structural Pest Control Applicators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements under Minnesota Statutes, chapter 18B.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:

Enrolled providers: Every five years

Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Chore Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Chore Service Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Community Integration and Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS Community Integration and support focuses specifically on successful participation in community membership that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service provides the participant with development and maintenance of skills related to community membership through engagement in community-based activities.

This service will provide the participant access and supports to engage in acquisition, training and maintenance of skills to increase the participant's independence related to community integration through community-based activities.

CDCS Community Integration and support promotes positive growth and develop the skills and social supports necessary for the participant to:
a. Acquire, improve, or retain living skills necessary to live in and be a member of the community safely;
b. Develop and pursue meaningful day supports and community engagement for individuals who have elected not to pursue further employment opportunities;
c. Improve social skills and community behavior through social skills development and relationship building training
d. Improve positive behavior skills and improve mental health

CDCS Community Integration and support includes caregiver assistance, training and accompaniment to support the person while participating or engaging in the following activities:
1. Engaging in activities that facilitate, develop, and strengthen personal relationships with community members chosen by the person;
2. Self-designing day support services that provide the person with opportunities for regular connections to members of the broader community
3. Self-designing independent living skills training based on the persons assessed needs
4. Participating in local community events;
5. Assisting with a person's preferred volunteer experiences focused on community contribution rather than preparation for employment;
6. Participating in community support groups, organizations and clubs, formal and informal community associations and neighborhood groups.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

CDCS Community Integration and Support must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

CDCS Community Integration and Support cannot be used to cover expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers.

CDCS Community Integration and Support remote support is the following:
Remote support is the provision of Community Integration and support by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

The cost of the CDCS services must be within the participant’s individual budget. See Appendix E.

Unallowable Expenditures.
The participant’s budget shall not be used for Community Integration and Support for the following:
• Insurance except for insurance costs related to direct support worker employee coverage;
• CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• Vacation expenses other than the cost of direct services;
• Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers;
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.
Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS-Individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual selected by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Community Integration and Support

Provider Category:

Individual

Provider Type:

Individual selected by the participant

Provider Qualifications

License *(specify):*

Valid business license in good standing if applicable.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

All individuals providing CDCS-Community Integration and Support must:
a) Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
b) Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
c) Receive customized training provided by the participant and/or his/her representative
d) Be able, willing and have the capacity to perform the requested work outlined in the participant's support plan
e) Have the ability to successfully communicate with the person

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of community integration and support.

Frequency of Verification:

At time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support participants. Environmental modifications and provisions is one of the four categories of CDCS that can be purchased within an established budget. Participants or their representative hire, fire, manage and direct their support workers.
CDCS: environmental modifications and provisions includes supports, services, and goods provided to the participant to maintain a physical environment that assists the person to live in and participate in the community or are required to maintain health and well-being. The following are typically covered under this category:
Assistive technology
Home and vehicle modifications
Environmental supports (snow removal, lawn care, heavy cleaning)
Supplies and equipment
Special diets
Adaptive clothing
Transportation
For adults, costs related to health clubs and fitness centers
Providers of modifications must have a current license or certificate if required by Minnesota statutes or administrative rules to perform their service. A provider of modification services must meet all professional standards and or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes.

Participants or their representatives have control over the goods and services to be provided through developing the support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) participants by the managed care organization. Prior to the development of a CDCS support plan, counties, tribal nations or MCOs will inform the participant of the amount that will be available for implementing the plan over a one-year period. The county, tribal nation or MCO is responsible for reviewing and approving final spending decisions in the participant's CDCS support plan. The cost of background studies is not included in the individual budget amount. In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Individual Budget Methodology: Participants' budgets may not exceed the length of their service agreement span (i.e., a maximum of 12 months). If the span is less than 12 months, the budget amount will be prorated. Participants shall not carry forward unspent budgeted amounts from one plan year to the next. If a participant experiences a significant change in need or condition that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted. Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's maximum case mix amount that is set by the state. These supports must be identified in the CDCS support plan. Required case management functions are provided by counties, tribal nations or MCOs and are not included in the participant's budget. Required case management functions are described in Appendix E-1-j and Appendix E-2-b-v.

An individualized written CDCS Support Plan must be developed for each participant. The participant or their representative will direct the development and revision of the CDCS support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the participant's strengths, needs, and preferences. The support plan may include a mix of paid and non-paid services and may include traditional goods and services provided by the waiver as well as alternatives that support participants. The support plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS support plan identifies:
- the goods and services that will be provided purchased to meet the participant's assessed needs;
- safeguards that are required to reasonably maintain the participant's health and safety;
- the participant's emergency needs and how they will be met.
- overall outcome(s) of the participant's plan
- how monitoring of the plan will occur
- qualifications including training requirements of staff and
- who is responsible to assure that the qualification and training requirements are met

Criteria for allowable expenditures:
• The waiver shall cover only those goods and services authorized in the support plan and must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant.
• Goods and services are not covered when they are provided prior to the development of the CDCS support plan.
• Do not duplicate other services in the CDCS support plan,
• Do not supplant natural supports and
• Are the least costly and effective means appropriately meeting the participant's needs and are not available through other funding sources.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the county, tribal nation or MCO when the revision does not change or modify parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the participant or their representative will work with the county, tribal nation or MCO to have the CDCS community support plan reviewed and re-authorized.). See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or home care services while residing in a residential setting registered by the Minnesota Department of Health (MDH) as a housing with services establishment.

Goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:
• Maintain the ability of the participant to remain in the community;
• Enhance community inclusion and family involvement;
• Develop or maintain personal, social, physical, or work related skills;
• Decrease dependency on formal support services;
• Increase independence of the participant
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures, it cannot be authorized and the case manager must provide the participant or the participant's representative a notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities. Additionally budgets may include:
(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are included in the CDCS support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CDCS support plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. Services included in the CDCS support plan must be necessary to meet a need identified in the participant's assessment. This is may include hiring a support planner. Support planner functions are described in Appendix E-1-j. The CDCS support plan must include specific tasks to be performed by a paid support planner
(6) FMS costs incurred to manage the budget; advertise and train staff;
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Costs related to internet access based on criteria established by the state.

(9) Maintenance of vehicle modifications (i.e. wheelchair lift)

Criteria for allowable expenditures:
• The waiver shall cover only those goods and services authorized in the support plan and must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant.
• Goods and services are not covered when they are provided prior to the development of the CDCS support plan.
• Do not duplicate other services in the CDCS support plan,
• Do not supplant natural supports and
• Are the least costly and effective means appropriately meeting the participant's needs and are not available through other funding sources.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the county, tribal nation or MCO when the revision does not change or modify parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the participant or their representative will work with the county, tribal nation or MCO to have the CDCS community support plan reviewed and re-authorized.). See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or home care services while residing in a residential setting registered by the Minnesota Department of Health (MDH) as a housing with services establishment.

Goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:
• Maintain the ability of the participant to remain in the community;
• Enhance community inclusion and family involvement;
• Develop or maintain personal, social, physical, or work related skills;
• Decrease dependency on formal support services;
• Increase independence of the participant
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures, it cannot be authorized and the case manager must provide the participant or the participant's representative a notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities. Additionally budgets may include:
(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are included in the CDCS support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets, thickening agents and behavioral supports that are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CDCS support plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. Services included in the CDCS support plan must be necessary to meet a need identified in the participant's assessment. This is may include hiring a support planner. Support planner functions are described in Appendix E-1-j. The CDCS support plan must include specific tasks to be performed by a paid support planner
(6) FMS costs incurred to manage the budget; advertise and train staff;
(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
(8) Costs related to internet access based on criteria established by the state.

(9) Maintenance of vehicle modifications (i.e. wheelchair lift)

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

CDCS cannot be used to cover goods and services that:
- Are provided prior to the development of the CDCS support plan
- Duplicate other goods and services in the CDCS support plan
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Goods and services that shall not be purchased within the participant's budget are:
- Any fees incurred by the participant such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items;
- Home modifications that add any square footage with the exception of an accessible bathroom-the county, tribal nation or MCO can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-Home Modifications)
- Home modifications for a residence other than the primary residence of the participant
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS support plan
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs;

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

TRANSITION PLAN: CDCS: environmental modifications and provisions under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS: environmental modifications and provisions will be replaced by CDCS: environmental modifications-home modifications, CDCS: environmental modifications-vehicle modifications and CDCS: individual-directed goods and services. No new authorizations for CDCS: environmental modifications and provisions will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: environmental modifications and provisions for a participant who was not previously receiving CDCS: environmental modifications and provisions before December 2023.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services (FMS) providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions

Provider Category:

Agency

Provider Type:

Financial Management Services (FMS) providers

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 financial management services (FMS) provider.

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 CDCS support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a CDCS support plan for participants who are purchasing financial management services from them.

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 plan activities.

The CDCS support plan will define the qualifications that the worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Transportation. Standards for common carrier transportation are bus, taxicab, other commercial carrier, or county owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the participant’s needs and preferences in a cost-effective manner. Drivers must have a valid driver’s license and meet state requirements for insurance coverage.

Fitness and Exercise. Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant’s actual and projected use of the health club or fitness center. Participants must periodically provide verification to the county, tribal nation or MCO that they are using the health club fitness center or fitness center.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 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. The FMS provider may not in any way limit or restrict the participant’s choices of services or support providers.

FMS providers 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 FMS 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 FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant’s representative and the FMS provider, and included in the CDCS support plan. FMS provider fees must

be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, individual directed goods and services, community integration and support or environmental modifications (home or vehicle) provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's CDCS support plan.

The 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 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 certified public accountant or an individual with a 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 organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to 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.

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

The FMS provider 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 FMS provider must also receive a copy of the participants' CDCS support plan approved by the county, tribal nation or MCO. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the CDCS support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS: Environmental Modifications-Home Modifications can be purchased in a consumer directed manner within a global budget. See Appendix E. CDCS: Environmental Modifications-Home Modifications include modifications or items to maintain the person's home that assists the person to live in and participate in the community or are required to maintain health and well being. For purposes of home modifications, 'home' refers to the participant's primary place of residence (i.e.) not vacation homes)

The following are covered under this category:
Home modifications
Monitoring technology

Monitoring technology is defined as monitoring including cameras, motion detectors, GPS trackers, home security systems, and door and window alarms. A CDCS participant that wants to use their funds to purchase monitoring technology must follow service guidelines for monitoring technology usage as described in "Environmental Accessibility Adaptations – home modifications" as follows:

(a)Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:

(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
(2) the Minnesota Government Data Practices Act as codified in Minnesota Statutes, chapter 13.

(b)The agency or individual shall be monitored for compliance as follows:

(1) the agency or individual must control access to data on participants according to the definitions of public and private data on individuals under Minnesota Statutes, section 13.02; classification of the data on individuals as private under Minnesota Statutes, section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to Minnesota Statutes, section 13.05, in which the agency or individual is assigned the duties of a government entity;

(2) the agency or individual must provide each participant with a notice that meets the requirements under Minnesota Statutes, section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;

(3) In accordance with Minnesota Statutes, section 245A.11, Subd. 7a(f)(5) "a resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring." If an existing resident does not consent to electronic monitoring, the application for an alternative overnight technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant's needs are met by alternative means.

(4) The use of environmental accessibility adaptations for monitoring technology requires a process for obtaining and maintaining informed consent. To ensure informed consent , the case manager and the participant or legal guardian must collaborate and determine:
a) how the monitoring technology will be used;
b) how their needs will be met if they choose not to use monitoring technology;
c) possible risks created by the use of the technology;
d) who will have access to the data collected and how their personal information will be protected; and
e) their right to refuse, stop, or suspend the use of monitoring technology at any time.

(5) The participant's community support plan must describe how the use of monitoring technology:
a) is the least restrictive option and the person's preferred method to meet an assessed need;
b) achieves an identified goal or outcome; and
c) addresses health, potential individual risks and safety planning.

(6) Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.

(7) cameras used for electronic monitoring must not be installed in bathrooms;

(8) cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Department approval is not required when parents are monitoring minor children living in their home using cameras in bedrooms for purposes of health and safety. Electronic monitoring cameras must not be concealed from the participant;

(9) equipment that is bodily invasive, auto door or window locks, and concealed cameras are not allowed;

(10) the state must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs; and

(11) electronic video and audio recordings of participants shall be stored for five days unless: (i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under Minnesota Statutes, Chapters 260E or 626.557 or a crime under Minnesota Statutes, chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section Minnesota Statutes, 626.557, subdivision 12b.

A provider of modification services must meet all professional standards and or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

CDCS Environmental modifications: home modifications must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

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

The cost of CDCS services must be within the participants individual budget. See Appendix E.
Unallowable Expenditures- CDCS Environmental modifications: home modifications that shall not be purchase with the participants budget are:

• Provided prior to the development of the CDCS support plan
• Home modifications that add any square footage with the exception of the addition of square footage necessary to make an accessible bathroom-The county, tribal nation or MCO can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-home modifications)
• Home modifications for a residence other than the primary residence of the participant

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of CDCS Environmental Modifications-Home Modifications
Individual	Providers of CDCS Environmental Modifications-Home Modifications

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications

Provider Category:

Agency

Provider Type:

Providers of CDCS Environmental Modifications-Home Modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS: Environmental Modifications-Home Modifications must bill through the financial management services (FMS) provider.

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

Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Home Modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications

Provider Category:

Individual

Provider Type:

Providers of CDCS Environmental Modifications-Home Modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS Environmental Modifications-Home Modifications must bill through the financial management services (FMS) provider.

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

Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS environmental modifications-home modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS Environmental Modifications-Vehicle Modifications can be purchased in a consumer directed manner within a global budget. See appendix E. CDCS Environmental Modifications–Vehicle Modifications are physical adaptations to the participant's primary vehicle required by the participant's support plan that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence.

Examples of adaptations include: adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions and wheelchair securing devices. The service may also cover installation, maintenance and repairs of vehicle modifications and equipment. Repairs may only be covered when they are cost effective given the condition of the item and compared to the replacement of the item.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

CDCS Environmental Modifications-Vehicle Modifications must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

Additionally, CDCS Environmental modifications – vehicle modifications can cover maintenance of vehicle modifications(i.e. wheelchair lift).

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

The cost of the CDCS services must be within the participant's individual budget. See Appendix E
The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

CDCS Environmental Modifications-Vehicle Modifications cannot cover general vehicle maintenance.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of CDCS Environmental Modifications-Vehicle Modifications
Individual	Providers of CDCS Environmental Modifications-Vehicle Modifications

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications

Provider Category:

Agency

Provider Type:

Providers of CDCS Environmental Modifications-Vehicle Modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS Environmental Modifications-Vehicle Modifications must bill through the financial management services (FMS) provider.

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

Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Vehicle Modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications

Provider Category:

Individual

Provider Type:

Providers of CDCS Environmental Modifications-Vehicle Modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS Environmental Modifications-Vehicle Modifications must bill through the financial management services (FMS) provider.

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

Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Vehicle Modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial management services (FMS) provide help with financial tasks, billing and employer-related responsibilities for people who self-direct their services through consumer directed community supports (CDCS). These services are provided by financial management services (FMS) providers.

FMS providers perform vendor fiscal/employer agent (VF/EA) tasks. This means the FMS provider's role is to support the person to fulfill his/her responsibilities in being the employer of his/her workers. The FMS provider's tasks include:

- Billing DHS and paying vendors or the person's individual workers for authorized goods and services
- Ensuring what the person spends his/her funds on follows the rules of the program and the plan approved by the county, tribal nation or MCO
- Helping the person obtain workers' compensation
- Educating the person on how to employ workers
- Documenting and reporting all spending of program funds
- Initiating background studies for workers
- Filing federal and state payroll taxes for workers on the person's behalf

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.

FMS providers 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 FMS 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 FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the support plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, community integration and support, individual-directed goods and services, support planning services or environmental modifications and provisions, environmental modifications – home modifications, or environmental modifications – vehicle modifications provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's support plan.

CDCS Financial Management services remote support is the following:
Remote support is the provision of financial management services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through

remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

The FMS provider may not in any way limit or restrict the participant’s choices of services or support providers.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS-Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS- individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services (FMS) Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Financial Management Services

Provider Category:

Agency

Provider Type:

Financial Management Services (FMS) Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable.

The 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 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 certified public accountant or an individual with a 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 organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to 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.
The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.
The FMS provider 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 FMS provider must also receive a copy of the participant's CDCS support plan approved by the county, tribal nation or MCO. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individual-Directed Goods and Services can be used to purchase items within a global budget. See Appendix E. Individual-directed goods and services includes services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the support plan (including improving and maintaining the participant's opportunities for full membership in the community) and the item or services meets all of the following requirements:

- Decreases the need for other Medicaid services;
- Promotes inclusion in the community;
- Increases the participant's safety in the home environment; and
- The participant does not have the funds to purchase the item or service and the item or service is not available through another source.

Participants may purchase individual-directed goods and services that are included in their support plan, meet the criteria for allowable expenditures described below, and are within the means of their CDCS budget to purchase. CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

Individual-Directed Goods and Services must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

Allowable Expenditures: Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. Individual directed goods and services also covers special diets and thickening agents not otherwise available through the State plan that mitigate the participants disability or condition when prescribed by a physician, advanced practice registered nurse or physican assistant who is enrolled as a MHCP provider.

Individual-directed goods and services remote support, is the following:
Remote support is the provision of individual-directed goods and services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:

- Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
- Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
- Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow

both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

The cost of the CDCS services must be within the participant's individual budget. See Appendix E.

Unallowable Expenditures. Goods and services that shall not be purchased within the participant's budget are:
• Any fees incurred by the participant such as MHCP fees and co-pays;
• Attorney costs or costs related to advocate agencies;
• Room and board and personal items;
• CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.
Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS Environmental Modifications and Provisions, CDCS individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications, or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual/Vendor as selected by the participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual/Vendor as selected by the participant

Provider Qualifications

License *(specify):*

Valid Business license in good standing, if applicable.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

All individuals/vendors providing individual-directed goods and services must be able to:
(1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and
(2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Private individuals may be designated to provide transportation when they meet the participant's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant's actual and projected use of the health club or fitness center. Participants must periodically provide verification to the county, tribal nation or MCO that they are using the health club or fitness center.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of individual-directed goods and services.

Frequency of Verification:

Upon purchase of goods/support.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Personal Assistance

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

08 Home-Based Services	08030 personal care

Category 2: **Sub-Category 2:**

12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Consumer Directed Community Supports (CDCS) Personal Assistance can be purchased in a consumer directed manner within an established budget.

CDCS Personal Assistance includes direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are covered under CDCS Personal Assistance:
-Assistance with activities of daily living
-Assistance with instrumental activities of daily living (i.e. meal planning and preparation; basic assistance with paying bills; shopping for food, clothing and other essential items; performing household tasks integral to the personal assistance services)
-Caregiver Relief

The participant or his/her designated representative as applicable, is the employer of the worker providing personal assistance services. These workers are recruited, selected, employed and managed by the participant or his/her representative. As described in Appendix E supports are available to assist the participant or his/her representative with employer related responsibilities through the Financial Management Services (FMS) provider.

Services provided under CDCS personal assistance are provided on a one-to-one basis unless the county, tribal nation or MCO approves the use of shared services. Shared services can only be authorized for services in the personal assistance category and within the scope of personal assistance services.

Shared services are defined as services provided simultaneously to no more than three participants by the same direct care worker. The participants must jointly develop and enter into an agreement to share services.

The need for shared services must be identified in each participant’s support plan. Each participant’s county, tribal nation or MCO must authorize the use of shared services based on a determination that the shared service is appropriate to meet the assessed needs of its participant.

Participants sharing services must use the same provider of FMS to ensure program integrity and simplify the processing of worker time sheets claims. The use of one FMS provider will ensure there is no duplication of services or overlapping of worker shifts. This safeguard will also ensure that workers are receiving overtime for applicable hours worked.

A participant or the participant’s representative may withdraw from participating in a shared services agreement at any time.

CDCS Personal Assistance remote support is the following:
Remote support is a provision of CDCS-Personal Assistance services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;

• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

Services provided under CDCS Personal Assistance must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

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

The cost of CDCS services must be within the participants individual CDCS budget.

Shared services cannot be provided:
• To more than three participants by one worker at one time;
• When more than one worker is providing services at the same time to participants who are sharing personal assistance services;

Unallowable Expenditures
Services under CDCS Personal Assistance that shall not be purchased within the participant's budget are:

Goods and services that shall not be purchased within the participant's budget are:
- Attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Vacation expenses other than the cost of direct services;
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs;

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications and Provisions, CDCS Environmental Modifications–Home Modifications, Environmental Accessibility Adaptations–Home Modifications, CDCS-individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CDCS worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Personal Assistance

Provider Category:

Individual

Provider Type:

CDCS worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CDCS workers must meet the following qualifications:
a) Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
b) Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
c) Receive customized training provided by the participant and/or his/her representative
d) Be able and willing to provide the service-related responsibilities outlined in the participant's support plan
Providers of CDCS-Personal Assistance excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of Minnesota Statutes section 245D.06, regarding incident reporting and prohibited and restricted procedures; and section 245D.061 regarding the emergency use of manual restraint.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or authorized representative if designated as the employer of the worker and the FMS provider determine if the worker has met the minimum qualifications.

Frequency of Verification:

At the time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Self-direction Support Activities

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

CDCS: self direction support activities includes services, supports and expenses incurred for administering or assisting the participant or their representative in administering CDCS. The following are typically covered under this category:

- liability insurance and workers compensation,
- payroll expenses including FICA, FUTA, SUTA and wages, processing fees,
- employer shares of benefits, assistance in securing and maintaining workers,
- development and implementation of the CDCS support plan,
- monitoring and provision of services.

Support Planner services are covered under this CDCS category. Participants may select who they want to provide this service. People reimbursed through CDCS to assist with the development of the participant's person-centered CDCS support plan must: be 18 years of age or older; pass a certification test developed by the department on person-centered support planning approaches including the Vulnerable Adult Act; provide a copy of their training certificate to the participant; use the CDCS support plan template or a community support plan format that includes all of the information required to authorize CDCS and, be able to coordinate their services with the county, tribal nation or MCO case manager to assure that there is no duplication between functions. Participants may require additional provider qualifications tailored to their individual needs. These will be defined in the participant's CDCS support plan. The provider must provide the participant or the participant's representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

Participants or their representatives have control over the goods and services to be provided through developing the support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state or for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) participants by the managed care organization. Prior to the development of a CDCS support plan, counties, tribal nations or MCOs will inform the participant of the amount that will be available for implementing the plan over a one-year period. The county, tribal nation or MCO is responsible for reviewing and approving final spending decisions in the participant's CDCS support plan. The cost of background studies is not included in the individual budget amount. In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's maximum case mix amount that is set by the state. These supports must be identified in the CDCS support plan. Required case management functions are provided by counties, tribal nations or MCOs and are not included in the participant's budget.

An individualized written CDCS Support Plan must be developed for each participant. The participant or their representative will direct the development and revision of the CDCS support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the participant's strengths, needs, and preferences. The support plan may include a mix of paid and non-paid services and may include traditional goods and services provided by the waiver as well as alternatives that support participants. The support plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS support plan identifies:

- the goods and services that will be provided purchased to meet the participant's assessed needs;
- safeguards that are required to reasonably maintain the participant's health and safety;
- the participant's emergency needs and how they will be met.
- overall outcome(s) of the participant's plan
- how monitoring of the plan will occur
- qualifications including training requirements of staff and
- who is responsible to assure that the qualification and training requirements are met

Criteria for allowable expenditures:

- The waiver shall cover only those goods and services are not covered when they are provided prior to the

development of the support plan and must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant.

- Do not duplicate other services in the CDCS support plan,
- do not supplant natural supports and
- Are the least costly and effective means appropriately meeting the participant's needs and are not available through other funding sources.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the county, tribal nation or MCO when the revision does not change or modify parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the participant or their representative will work with the county, tribal nation or MCO to have the CDCS community support plan reviewed and re-authorized. See also Appendix E-2-b-iv.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

Goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:

- Maintain the ability of the participant to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the participant
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures, it cannot be authorized and the case manager must provide the participant or the participant's representative a notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

Additionally budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are included in the CDCS support plan.

(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.

(3) Therapies, special diets, thickening agents and behavioral supports that are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.

(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CDCS support plan and monitored by a MHCP enrolled physician.

(5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. Services included in the CDCS support plan must be necessary to meet a need identified in the participant's assessment. This is may include hiring a support planner. Support planner functions are described in Appendix E-1-j. The CDCS support plan must include specific tasks to be performed by a paid support planner.

(6) FMS costs incurred to manage the budget; advertise and train staff;

(7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.

(8) Costs related to internet access based on criteria established by the state.

(9) Maintenance of vehicle modifications (i.e. wheelchair lift)

Consumer Directed Community Supports: self-direction support activities remote support is the following:
Remote support is a provision of CDCS Financial management services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way

communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
• ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS: environmental modifications - home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible. **Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

CDCS cannot be used to cover goods and services that:
- Are provided prior to the development of the CDCS support plan
- Duplicate other goods and services in the CDCS support plan
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
- Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Goods and services that shall not be purchased within the participant's budget are:
- Any fees incurred by the participant such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items;
- Home modifications that add any square footage with the exception of an accessible bathroom-the county, tribal nation or MCO can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-Home modifications)
- Home modifications for a residence other than the primary residence of the participant
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS support plan
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

TRANSITION PLAN: CDCS: self-direction support activities under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS: self-direction support activities will be replaced by CDCS: financial management services and CDCS: support planning. No new authorizations for CDCS: self-direction support activities will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: self-direction support activities for a participant who was not previously receiving CDCS: self-direction support activities before December 2023.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services (FMS) providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Self-direction Support Activities

Provider Category:

Agency

Provider Type:

Financial Management Services (FMS) providers

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 financial management services (FMS) provider.

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 CDCS support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a CDCS support plan for participants who are purchasing financial management services from them.

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 plan activities.

The CDCS support plan will define the qualifications that the worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 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. The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

FMS providers 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 FMS 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 FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the CDCS community plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, individual-directed goods and services, community integration and support or environmental modifications (home and vehicle) provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's CDCS support plan.

The 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 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 certified public accountant or an individual with a 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 organizations under a collective bargaining contract. The FMS

provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to 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.

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

The FMS provider 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 FMS provider must also receive a copy of the participants' CDCS support plan approved by the county, tribal nation or MCO. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the CDCS support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Support Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

CDCS support planning is an optional service that is available to help participants develop and implement their person-centered CDCS Support Plan. The cost of support planning services is included in the participant's budget. When selected, support planning services are provided by certified CDCS support planners. The CDCS support planner is selected by the participant.
CDCS support planning services include tasks outlined in the written work agreement between the support planner and the participant
Tasks include:
- Providing information about CDCS and provider options
- Applying person-centered thinking and planning principles to facilitate the development of a person-centered CDCS support plan
- Developing a quality CDCS support plan that includes all required components and information required to authorize CDCS services
- Ensuring the CDCS support plan is developed based on assessed needs identified in the person's assessment
- Submitting the CDCS support plan to the county, tribal nation or MCO for approval
- Implementing, monitoring and evaluating the approved CDCS support plan and budget on an ongoing basis
- Modifying the CDCS support plan as needed, including revisions and addendums
- Helping and teaching the person to recruit, screen, hire, train, schedule and monitor workers
- Providing information about community resources related to the CDCS support plan.

A CDCS support planner performs support planning services according to established CDCS policy, self-direction principles, federally approved waiver plans and the written work agreement established between the individual and the support planner. The CDCS support planner helps the individual comply with DHS policies, waiver regulations and all applicable Minnesota rules and statutes.
A CDCS support planner must ensure that support planning service are provided within the scope of DHS support planner service standards and are related to an approved CDCS Community Support Plan (CSP). The CDCS support planner must also ensure that support planning services do not duplicate services provided under CDCS required case management or other services available to the person (e.g., services provided by certified assessors, FMS providers, Office of the Ombudsman, advocacy organizations, free civil legal assistance with appeals and other direct services covered under Minnesota Health Care Programs)
CDCS Support planning remote support is the following:

Remote support is the provision of CDCS support planning services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
- Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
- Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
- Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

CDCS Support planners cannot:
- Be the employer of people or legal representatives to whom they are delivering support planner services
- Be the parent of a minor child or spouse of the person receiving services
- Have any direct or indirect financial interest in the delivery of the services in the CDCS Support Plan beyond support planning (e.g., a person receiving payment to help develop a support plan cannot employ others or hire independent contractors to deliver services and supports, even if chosen by the CDCS participant).

A parent of a minor or adult, spouse or legal representative can provide many of the same types of support to the person that a support planner can provide. However payment for support planning activities cannot be made to a parent of a minor or adult, spouse, or legal representative.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS-Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS-individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CDCS Support Planners

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Support Planning

Provider Category:

Individual

Provider Type:

CDCS Support Planners

Provider Qualifications

License *(specify):*

Certificate *(specify):*

For initial certification, a person must:
- Be at least 18 years old
- Complete a minimum of six hours of person-centered planning coursework within three years before taking the initial certification test
- Successfully pass the Support Planner Initial Certification for CDCS test (TrainLink course DS651) with at least 80% correct.

A CDCS Support planner must be recertified every two years. A CDCS support planner must:
- Complete and document 20 hours of training or education if providing support planner services to more than one family.
- Successfully pass the Support Planner Recertification for CDCS test (TrainLink course DS651C) with at least 80% correct.

Support planners must maintain their own training documentation. This documentation must include:
- Name of the trainer
- Course outline
- Course objectives
- Length of training.

Documentation of training is subject to DHS audit.

A person providing support planning services (i.e. CDCS support planners) must:
- Comply with the DHS support planner service standards
- Establish a written work agreement with the person outlining the tasks they are hired to perform
- Provide a copy of the training certificate to the person/legal representative and county, tribal nation or MCO as requested
- Provide evidence they meet any additional required training and qualifications requested by the person and defined in the CDCS support plan
- Coordinate services with the county, tribal nation or MCO (i.e., case manager/care coordinator) to ensure there is no duplication of functions/tasks
- Have effective written communication skills sufficient to write a CDCS support plan that includes all required components.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS is responsible for verifying the qualifications of CDCS support planners.

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Community Supports (CDCS): Treatment and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS Treatment and Training can be purchased in a consumer directed manner within an established budget. See Appendix E.

CDCS: treatment and training includes services that promote the person's health and ability to live in and participate in the community. The following are covered under this category:
- *Specialized therapies or behavioral supports
- Training and education to paid or unpaid caregivers
- Training and education to participants to increase their ability to manage CDCS services

*Specialized therapies and behavioral supports are services that a Minnesota Health Care Program (MHCP) medical provider prescribes to relieve the person's disability and/or condition that are not included in the Medical Assistance State Plan or waiver plans. This includes therapies in the CDCS plan as an alternative to state plan services. These services are not intended to be used to either replace medical treatment or services available through Medical Assistance (MA) or exceed current Medical Assistance coverage limits.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services.

Services provided under Treatment and Training must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

Additionally, treatment and training: includes supports that provide alternatives to waiver or state plan services, such as alternative therapies and behavioral supports, when those supports:
- Are not otherwise available through the State Plan;
- Mitigate the participants disability or condition; and
- Are prescribed by an MHCP medical provider.

CDCS Treatment and Training Services remote support is the following:
Remote support is the provision of CDCS Treatment and Training services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

The cost of the CDCS services must be within the participant's individual CDCS budget. See Appendix E.

Unallowable Expenditures: Services under CDCS: Treatment and Training that shall not be purchased are:
- Services available through other funding sources
- Any fees incurred by the participant such as MHCP fees and co-pays.
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Animals, including service animals, and their related costs;

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications and Provisions, CDCS Environmental Modifications-Home Modifications, Environmental Accessibility Adaptations–Home Modifications, Individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of CDCS Treatment and Training
Individual	Providers of CDCS Treatment and Training

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Treatment and Training

Provider Category:

Agency

Provider Type:

Providers of CDCS Treatment and Training

Provider Qualifications

License *(specify):*

Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the services being provided.

Providers of training and education must meet the qualifications as specified in the participants CDCS Support Plan. For services and supports that do not require professional licensing, credentialing or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing specialized therapies, behavior supports, or training and education to caregivers or participants covered by CDCS must bill through the financial management services (FMS) provider.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS Treatment and Training.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Community Supports (CDCS): Treatment and Training

Provider Category:

Individual

Provider Type:

Providers of CDCS Treatment and Training

Provider Qualifications

License *(specify):*

Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the services being provided.

Providers of training and education must meet the qualifications as specified in the participants CDCS Support Plan. For services and supports that do not require professional licensing, credentialing or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing specialized therapies, behavior supports, or training and education to caregivers or partipants services must bill through the financial management services (FMS) provider.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties, tribal nations and MCOs are responsible for verifying the qualifications of providers of CDCS Treatment and Training.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Customized Living Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02033 in-home round-the-clock services, other

Category 2:

05 Nursing

Sub-Category 2:

05020 skilled nursing

Category 3:

08 Home-Based Services

Sub-Category 3:

08020 home health aide

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Customized living services are provided as defined in the following section:
-in a licensed assisted living facility as defined in Minnesota Statute 144G; or
-in an affordable housing setting, as defined under Minnesota Statutes, section 256S.20 subd. 1 or subsequent provisions.

In order for customized living services to be covered by the waiver, Customized living services must:
A. Comply with all requirements for home and community-based settings set forth in 42 CFR 441.301(c);
B. Enforce a written lease providing protections to address eviction processes and appeals with each participant;
C. Ensure that participants are treated with dignity and respect and are free from coercion and restraint;
D. Ensure participants have the right to privacy in his/her sleeping or living unit, including a lockable door;
E. Provide participants with the freedom to furnish and decorate their bedroom/living and if sharing a bedroom/living unit, share with a roommate of their choice;
F. Provide participants the freedom and support to control their daily schedules by accommodating a participant's work schedule with flexible scheduling and providing access to food and visitors at any time;
G. Maximize opportunities for community inclusion opportunities by offering or providing activities designed to increase and enhance each participant's social and physical interaction with their community; and
H. Have an individualized service plan based on each participant's documented needs. This is a separate and distinct plan from the care support plan developed with the case manager that includes all waiver services.

The participant must be given the opportunity to accept, revise, or reject the service plan and the case manager determines whether the plan is approved as part of the participant's overall support plan. Service plans that contain supervision of the participant must include documentation of the participant's specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact will occur. Service plans must also document whether or not there is a need to for 24-hour supervision of the participant and whether or not 24-hour supervision is included in the CL plan.

Individualized CL services may include supervision, home care aide tasks (e.g., assistance with activities of daily living), home health aide tasks (e.g., delegated nursing tasks), home management tasks, meal preparation and service, socialization, assisting participants with arranging meetings and appointments, money management, scheduling medical and social services, and arranging for or providing transportation. If socialization is provided, it must be part of the service plan, related to established goals and outcomes and not diversional or recreational in nature. CL providers must make available, and if authorized, provide meal preparation adequate to meet the nutritional needs of participants as defined by current FDA guidelines.

Central storage of medication, administration of medications, medications set ups, individualized home health aide tasks, home health aide-like tasks, and delegated nursing tasks may be provided as allowed by the assisted living facility or home care licensure.

Providers must furnish each participant with a means to effectively summon assistance. Staff in the congregate living setting who are providing supervision, oversight and supportive services must have: experience and/or training in caring for individuals with functional limitations; the physical ability to provide the services identified in the participants' service plans; and, if they provide transportation, they must have a valid driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Rules, Part 9505.0315 and 8840.6000.

In addition staff must be able to:
- work under intermittent supervision
- communicate effectively
- read, write, and follow written and verbal instructions
- follow participants' individualized service plans
- recognize the need for and provide assistance or arrange for appropriate assistance
- identify and address emergencies including calling for assistance
- understand, respect, and maintain confidentiality

Staff providing supervision must also:
- Work onsite in the customized living setting
- Have their primary work responsibility be the supervision of participants in the customized living setting
- Have an on-going awareness of the participant's needs and activities

• Be able to respond in-person to a participant within a time frame that meets the participant's needs and that does not exceed ten minutes

Participants of customized living services cannot be employed to provide customized living services.

The county, tribal nation or MCO must establish individualized service rates according to Minnesota Statutes, section 256S.202 when authorizing customized living services that include 24-hour supervision.

The county, tribal nation or MCO must establish individualized service rates according to Minnesota Statutes, section 256S.201 when contracting for customized living services that do not include 24 hour supervision.

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

Homemaking and chore services are integral to customized living. For participants receiving customized living services, homemaking, chore, Individual community living supports (ICLS) and respite services are not covered as separate waiver services. For participants receiving services that include 24-hour supervision personal emergency response systems and home monitoring devices are not covered under specialized equipment and supplies. This does not preclude covering emergency response technology (e.g. pendant call systems) that may be appropriate for participants to use outside of the residential setting. The personal emergency response system provider cannot be the same provider as the participant's 24 hour Customized Living provider.

Environmental Accessibility Adaptations cannot be authorized as a separate waiver service for a participant who is receiving Customized Living services.

Participants receiving customized living may receive home delivered meals when services are delivered by separate providers and there is no duplication of meal preparation.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers with an assisted living facility license from the Minnesota Department of Health
Agency	Providers with a comprehensive home care license from the Minnesota Department of Health

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Customized Living Services

Provider Category:

Agency

Provider Type:

Providers with an assisted living facility license from the Minnesota Department of Health

Provider Qualifications

License *(specify):*

Minnesota Department of Health assisted living license in accordance with Minnesota Statutes, Chapter 144G

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

As scheduled by Minnesota Department of Health. Providers must renew their license annually. Enrolled providers: every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Customized Living Services

Provider Category:

Agency

Provider Type:

Providers with a comprehensive home care license from the Minnesota Department of Health

Provider Qualifications

License *(specify):*

Minnesota Department of Health comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484

Certificate *(specify):*

Other Standard *(specify):*

Deliver services in an affordable housing setting defined under Minnesota Statutes Chapter 144G.08, subd. 7 paragraphs 11-13

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

As scheduled by Minnesota Department of Health. Providers must renew their license annually.
Enrolled providers: every 5 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations - Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental Accessibility Adaptations-Home Modifications are physical adaptations to the participant's primary home, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or that enable participants to function with greater independence in the home. For purposes of the waiver, "home" means the participant's primary place of residence (i.e., not vacation homes).

Exceptions to the requirement that home modifications be limited to the participant's primary place of residence, may be authorized by the case manager when the following criteria are met and documented in the participant's support plan. The accessibility adaptation:
1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, counties tribal nations or MCOs may authorize home modifications in separate payment amounts, for example:
• Line 1: Materials and permits
• Line 2: Down payment
• Line 3: Completion and inspection, or final payment.

This service also covers the necessary assessments to determine the most appropriate adaptation or equipment and oversight of the project by an assessment provider to assure ADA requirements or accessibility needs are met.

EAA also covers the installation, purchase, maintenance and repairs of portable or permanent equipment, materials, devices and systems that are integral to the home modification project. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

Modifications and adaptations to the home may include, but are not limited to: the installation of ramps, grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate medical equipment and supplies and modifications to adaptive equipment such as adaptive furniture, adaptive positioning devices, and utensils. EAA also includes the installation, maintenance and repairs of monitoring systems, and motion detectors when the equipment installation requires modifications to the physical structure of the home that are not easily removed.

Environmental Accessibility Adaptations-Home Modifications may not be furnished as a separate waiver service for participants that live in settings that are owned or leased by providers of waiver services, such as:
1) homes that are licensed to provide foster care, or
(2) in a licensed assisted living facility as defined in Minnesota Statute 144G; or
(3) in an affordable housing setting, as defined under Minnesota Statutes, section 256S.20 subd. 1 or subsequent provisions.

Adaptations that add to the square footage of the home may be covered when it is necessary to build a new bathroom or modify an existing bathroom when the following criteria are met:
- The accessibility adaptation is necessary to accommodate a wheelchair or scooter.
- The accessibility adaptation is to an unlicensed private residence of the individual and is owned by the individual or a family member
- At least two comparison bids were received.
- An evaluation by an expert in the field of home modifications must be completed to determine whether the accessibility adaptation is necessary based on the health and safety needs identified in the participant's support plan. The expert must have no financial interest in the delivery of the accessibility adaptation.
- The accessibility adaptation is reasonable and is limited to materials that are the most cost effective and of reasonable standards.

The county, tribal nation or MCO will determine whether the above criteria are met and will submit all documentation to the department or appropriate managed care organization for the final determination.

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 county or tribal nation may bill for environmental accessibility adaptations - home modification as a Medicaid administrative cost. Managed care organizations shall not claim Medicaid administrative expenses.

If the individual unexpectedly exits the waiver prematurely (due to death, or due to a move to a nursing facility or institution) after the completion of an environmental accessibility home modification, the provider shall be paid for the full cost of work completed, up to the amounts prior authorized by the county, tribal nation or MCO.

When EAA is used to authorize monitoring technology installation, maintenance or repair, the following requirements under (a) and (b) must be met;
(a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:
(1)the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
(2)The Minnesota Government Data Practices Act as codified in chapter 13.
(b) The agency or the individual shall be monitored for compliance as follows:
(1) The agency or the individual must control access to data on participants according to the definition of public and private data on individuals under section 13.02; classification of the data on individuals as private under section 13.46, subd.2; and control over the collection, storage, use, access, protection, and contracting related to data according to section 13.05, in which the agency or individual is assigned the duties of a government entity.
(2)The agency or individual must provide each participant with a notice that meets the requirements under section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;
(3)In accordance with Minn. Stat. § 245A.11, Subd. 7a (f) “a foster care recipient may not be removed from a program under this subdivision for failure to consent to electronic monitoring.” If an existing resident does not consent to electronic monitoring, the application for an alternative overnight supervision technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant’s needs are met by alternative means.
(4) The use of environmental accessibility adaptations - home modifications for monitoring technology requires an informed consent process. To ensure informed consent, the case manager and the participant or legal guardian must collaborate and determine:
a)how the monitoring technology will be used;
b)how their needs will be met if they choose not to use monitoring technology;
c)possible risks created by the use of the technology;
d)who will have access to the data collected and how their personal information will be protected; and
e)their right to refuse, stop, or suspend the use of monitoring technology at any time.
(5)The participant’s support plan must describe how the use of monitoring technology:
a)is the least restrictive option and the person’s preferred method to meet an assessed need;
b)achieves an identified goal or outcome; and
c)addresses health, potential individual risks and safety planning.
(6)Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.
(7)cameras used for electronic monitoring must not be installed in bathrooms;
(8)cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Electronic monitoring cameras must not be concealed from the participant;
(9)Equipment that is bodily invasive, concealed cameras, and auto door or window locks are not allowed.
(10)The State must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual’s needs.
(11)Electronic video and audio recordings of participants shall be stored for five days unless: (i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under Chapter 260E or 626.557 or a crime under chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in Minnesota Statutes section 626.557, subdivision 12b.

If the individual unexpectedly exits the waiver prematurely (due to death, or due to a move to a nursing facility or institution) after the completion of an environmental accessibility home modification, the provider shall be paid for the full cost of work completed, up to the amounts prior authorized by the county, tribal nation or MCO.

When EAA is used to authorize monitoring technology installation, maintenance or repair, the following requirements under (a) and (b) must be met;
(a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:
(1)the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
(2)The Minnesota Government Data Practices Act as codified in chapter 13.
(b) The agency or the individual shall be monitored for compliance as follows:
(1) The agency or the individual must control access to data on participants according to the definition of public and private data on individuals under section 13.02; classification of the data on individuals as private under section 13.46, subd.2; and control over the collection, storage, use, access, protection, and contracting related to data according to section 13.05, in which the agency or individual is assigned the duties of a government entity.
(2)The agency or individual must provide each participant with a notice that meets the requirements under section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;
(3)In accordance with Minn. Stat. § 245A.11, Subd. 7a (f) “a foster care recipient may not be removed from a program under this subdivision for failure to consent to electronic monitoring.” If an existing resident does not consent to electronic monitoring, the application for an alternative overnight supervision technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant’s needs are met by alternative means.
(4) The use of environmental accessibility adaptations - home modifications for monitoring technology requires an informed consent process. To ensure informed consent, the case manager and the participant or legal guardian must collaborate and determine:
a)how the monitoring technology will be used;
b)how their needs will be met if they choose not to use monitoring technology;
c)possible risks created by the use of the technology;
d)who will have access to the data collected and how their personal information will be protected; and
e)their right to refuse, stop, or suspend the use of monitoring technology at any time.
(5)The participant’s support plan must describe how the use of monitoring technology:
a)is the least restrictive option and the person’s preferred method to meet an assessed need;
b)achieves an identified goal or outcome; and
c)addresses health, potential individual risks and safety planning.
(6)Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.
(7)cameras used for electronic monitoring must not be installed in bathrooms;
(8)cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Electronic monitoring cameras must not be concealed from the participant;
(9)Equipment that is bodily invasive, concealed cameras, and auto door or window locks are not allowed.
(10)The State must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual’s needs.
(11)Electronic video and audio recordings of participants shall be stored for five days unless: (i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under Chapter 260E or 626.557 or a crime under chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in Minnesota Statutes section 626.557, subdivision 12b.

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

Modifications and adaptations to the home that are of general utility, and are not of direct medical or remedial benefit to the participant, such as roof repair, central air conditioning, major household appliances, etc. and modifications that add to the total square footage of the home are not covered.

Coverage is limited to modifications and adaptations to the participant's primary residence.

For new construction or unfinished rooms in existing homes, the waiver will only pay for the additional costs directly related to the participant's accessibility needs and not the typical costs related to building or finishing a room.

An assessment provider completing an evaluation of the person's home and collecting comparison bids cannot also bid on the same project unless there are no other installation providers within the participant's region as documented by the county, tribal nation or MCO in the support plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptations/Home Modification/Installations
Individual	Environmental Accessibility Adaptations/Home Modification Assessments
Agency	Environmental Accessibility Adaptations/Home Modification Assessments
Individual	Environmental Accessibility Adaptations/Home Modification/Installations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Home Modification/Installations

Provider Qualifications

License *(specify):*

Providers who meet the definition of residential building contractor as defined in Minnesota Statutes, section 326B.802, subd. 11, must be licensed as a residential building contractor.

As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

Limited Install Providers: Providers who provide only one “special skill” as defined in Minnesota Statutes, Chapter 326B.802, subd. 15 are exempt from licensure.

Certificate *(specify):*

Other Standard *(specify):*

The provider must be qualified, by professional certification or references, to install, repair, and/or maintain the home modification defined in the participant’s support plan. All installations shall be executed in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Home Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
• An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, sections 148.6401 to 148.6449
• A Physical Therapist licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
• A Certified Aging-in-Place Specialist
• A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry under Minnesota Statutes, section 326B.133, Subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Home Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
• An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, sections 148.6401 to 148.6449
• A Physical Therapist licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
• A Certified Aging-in-Place Specialist
• A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry under Minnesota Statutes, section 326B.133, Subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Home Modification/Installations

Provider Qualifications

License *(specify):*

Providers who meet the definition of residential building contractor as defined in Minnesota Statutes section 326B.802, subd. 11, must be licensed as a residential building contractor.

As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

Limited Install Providers: Providers who provide only one “special skill” as defined in Minnesota Statutes, Chapter 326B.802, subd. 15 are exempt from licensure.

Certificate *(specify):*

Other Standard *(specify):*

The provider must be qualified by professional certification or references, to install, repair, and or maintain thehome modification defined in the participant’s support plan. All installations shall be executed] in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations – Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental accessibility adaptations – vehicle modifications are physical adaptations to the participant's primary vehicle, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence. Examples of adaptations include adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions, wheelchair securing devices. The service also covers the necessary assessments to determine the most appropriate adaptation or equipment. The service may also cover installation, maintenance and repairs of vehicle modifications, and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

For purposes of the waiver, "vehicle" refers to the participant's primary vehicle. Exceptions to the requirement that vehicle modifications be limited to the participant's primary vehicle may be authorized by the case manager when the following criteria are met and documented in the participant's support plan. The accessibility adaptation:

1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, counties, tribal nations or MCOS may authorize vehicle modifications in separate payment amounts, for example:
• Line 1: Materials and permits
• Line 2: Down payment
• Line 3: Completion and inspection, or final payment

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 county or tribal nation may bill for environmental accessibility adaptation - vehicle modifications as a Medicaid administrative cost. Managed care organizations shall not claim Medicaid administrative expenses.

If the individual unexpectedly exits the waiver prematurely (due to death, or due to a move to a nursing facility or institution) after the completion of an environmental accessibility vehicle modification, the provider shall be paid for the full cost of work completed, up to the amounts prior authorized by the county, tribal nation or MCO.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Accessibility Adaptations/Vehicle Modification Installations
Agency	Environmental Accessibility Adaptations/Vehicle Modification Assessments
Individual	Environmental Accessibility Adaptations/Vehicle Modification Assessments
Agency	Environmental Accessibility Adaptations/Vehicle Modification Installations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations – Vehicle Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Installations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals that provide vehicle installation service must:
• Install equipment according to the manufacturer's requirements and instructions
• Meet state and federal Americans with Disabilities Act (ADA) requirements
• Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 CFR Part 595.7)
• Follow the Society of Automotive Engineers' recommended practices
• Register as a "vehicle modifier" with the National Highway Traffic Safety Administration

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled Providers: Minnesota Department of Human Services Provider Eligibility and Compliance
Non enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations – Vehicle Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide vehicle modification assessment must meet one of the following:
1) Certified driver rehabilitation specialist
2) Occupational therapist with a specialty certification in driving and community mobility
3) Five years of full time experience in the field of driver rehabilitation
4) Four year undergraduate degree in a health related field and each of the following:
a. One year of full time experience in the degree area of study; and
b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
c. Supervision by one of the following:
i. certified driver rehabilitation specialist; or
ii. An occupational therapist with a specialty certification in driving and community mobility; or
iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations – Vehicle Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals that provide vehicle modification assessment must meet one of the following:
1) Certified driver rehabilitation specialist
2) Occupational therapist with a specialty certification in driving and community mobility
3) Five years of full time experience in the field of driver rehabilitation
4) Four year undergraduate degree in a health related field and each of the following:
a. One year of full time experience in the degree area of study; and
b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
c. Supervision by one of the following:
i. A certified driver rehabilitation specialist; or
ii. An occupational therapist with a specialty certification in driving and community mobility; or
iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations – Vehicle Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Installations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide vehicle installation service must:
• Install equipment according to the manufacturer’s requirements and instructions
• Meet state and federal Americans with Disabilities Act (ADA) requirements
• Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 CFR Part 595.7)
• Follow the Society of Automotive Engineers’ recommended practices
• Register as a “vehicle modifier” with the National Highway Traffic Safety Administration

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled Providers: Minnesota Department of Human Services Provider Eligibility and Compliance
Non enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Caregiver Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Family caregiver services encompasses both “Training and Education” and “Caregiver Counseling”.

Services may be delivered to participants or their caregivers. For purposes of this service, "caregiver" is defined as people who routinely provide care to the participant, and may include a parent, spouse, adult children, relatives, or in-laws, friends and neighbors. Caregivers who are employed to care for the participant cannot be reimbursed for training/education and counseling activities that are the responsibility of their employer.

Training and Education:
Training and Education is a service that provides caregivers with instruction to improve knowledge and performance of specific skills relating to their caregiving roles and responsibilities and builds caregiver capacity to provide, manage and cope with the caregiving role.
It covers training and education on topics, including:

- activities related to health, nutrition, and financial management
- providing personal care
- disease management
- managing risk factors;
- mental health;
- navigating long-term care systems
- communicating with health care providers and other family members
- family dynamics,
- self-care skills,
- dealing with difficult behaviors, and other areas as specified in the support plan
- the use of equipment and technology to maintain the health and safety of the participant

Evaluation of the need for equipment and/or devices is covered under Specialized Equipment and Supplies.

Training and Education service pays for the costs of training or conference registration fees for family informal caregivers Areas of training and intended outcomes (i.e., a course syllabus, training objectives, workshop description, etc.) must be submitted to the county, tribal nation or MCO for approval by provider or by the individual requesting the training and documented in the participant’s support plan. Training may be provided by professionals listed as provider types both inside or outside of the home or by individuals, agencies, or educational facilities offering classes, courses or conferences.

Caregiver Counseling
Caregiver Counseling is an individualized person-centered service designed to support caregivers by assisting them in in their decision-making and problem solving. Caregiver Counseling is provided by enrolled Caregiver Consultant providers who will conduct an assessment of the caregiver’s needs and strengths. Providers will develop a support plan based on the caregiver’s identified needs and provide ongoing support to reach established goals. Ongoing support may include, but is not limited to:

- facilitation of a person-centered learning and discovery process
- development of a service description and plan to reach established goals
- family counseling, family meetings
- implementing tools and strategies for coping with changes in personality and behavior,
- problem solving and conflict resolution,
- finding resources.

For all Family Caregiver Services, providers will submit a service description and plan to county, tribal nation or MCO for approval.

Based on the information provided and the participant’s needs, the case manager/care coordinator determines whether the service will be authorized. If the service is authorized, the submitted documentation is maintained in the participant’s file by the county, tribal nation or MCO.

Family Caregiver Services remote support is the following:
Remote support is a provision of Family Caregiver Services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and

preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:

- respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
- respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
- ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

Costs related to transportation, travel, meals, and lodging to receive Training and Education are not covered. If any such costs are included in the registration fee, they must be deducted. Caregiver Counseling is limited to enrolled Caregiver Consultant providers and pays for staff time spent with participants. Provider costs such as preparation time, travel, and materials are not covered.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations - Home Modifications; or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Caregiver Counseling and/or Training and Education: Caregiver Consultants
Agency	Training and Education: Medical Equipment Suppliers
Agency	Training and Education: Centers for Independent Living

Provider Category	Provider Type Title
Agency	Training and Education: Technical Colleges and Schools
Agency	Training and Education: Home Health Agencies
Agency	Training and Education: Care or Support Related Organizations
Individual	Training and Education: Health Care Professionals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Individual

Provider Type:

Caregiver Counseling and/or Training and Education: Caregiver Consultants

Provider Qualifications

License *(specify):*

Providers who are required to be licensed, certified or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

Certificate *(specify):*

1. Complete all trainings required by the Minnesota Board on Aging (MBA) to be considered a fully-trained Caregiver Consultant.
2. Participates in continuing education offered by the Minnesota Board on Aging (MBA) and area agencies on aging, including cultural diversity topics

Other Standard *(specify):*

Caregiver Consultants must:
1. Have a bachelor's degree from an accredited program in social work, nursing, counseling, gerontology, health education, rehabilitation therapy, health and human services, or a related degree; and

• Have at least one year of experience providing either:
i. Home care or long-term care services to older adults, or
ii. Training, education or counseling to caregivers of older adults;
Or,
An alternative to a Bachelor's degree is 5 years of experience supporting older adults/families in social services, health care or other relevant settings, or a combination of work and college credits.

Caregiver Consultants must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Agency

Provider Type:

Training and Education: Medical Equipment Suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be authorized by the case manager to provide training in use of equipment and must be a provider under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Agency

Provider Type:

Training and Education: Centers for Independent Living

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Centers for Independent Living must have the ability to train the caregiver on home modifications or the use of specialized equipment that relates to the needs of the participant.
Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: every five years
Non-enrolled providers: every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Agency

Provider Type:

Training and Education: Technical Colleges and Schools

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training and education of caregivers may also be provided by health educators or vocational and technical schools offering courses such as home health aide and certified nursing assistant training when it is determined by the county, tribal nation or MCO that the content of the training or conference directly applies to the care and well-being of the participant.
Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non –enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non–enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Agency

Provider Type:

Training and Education: Home Health Agencies

Provider Qualifications

License *(specify):*

Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.

Individual practitioners employed by a home health agency must meet the standards in Minnesota Rules, part 9505.0290.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled Providers: Every five years
Non-enrolled providers: Every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Agency

Provider Type:

Training and Education: Care or Support Related Organizations

Provider Qualifications

License *(specify):*

Providers who are required to be licensed, certified or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

Certificate *(specify):*

Other Standard *(specify):*

Training and Education may be provided by caregiver support professionals of:
- social service agencies,
- healthcare organizations,
- community or faith-based agencies,
- counties,
- area agencies on aging,
- state and local chapters of chronic disease organizations such as the Alzheimer's Association.

Providers must have:
1. demonstrated expertise in the topic that relates to the needs of the participant or the ability of the caregiver to provide care and support to the participant,
2. at least one year of experience in providing home care or long term care services to the elderly, or at least one year of experience providing training and education to caregivers of elderly persons,

3. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Caregiver Services

Provider Category:

Individual

Provider Type:

Training and Education: Health Care Professionals

Provider Qualifications

License *(specify):*

Providers who are required to be licensed, certified, or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

Certificate *(specify):*

Other Standard *(specify):*

Providers may include:
- advanced practice registered nurse
- dieticians
- Gerontologists
- Health educators
- licensed practical nurses
- Nutritionists
- Pharmacists
- Physicians
- physician assistants
- Public health nurses
- Registered nurses
- Rehabilitation therapists
- Social workers

Providers must have:
1. at least one year of experience in providing home care or long term care services to the elderly or at least one year of experience providing training, education or counseling to caregivers of elderly persons.

2. Physical cares requiring a specific technique for the safety of both the caregiver and participant must be taught by a professional specializing in such techniques, such as public health nurses, registered nurses and licensed practical nurses.
3. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance
Non–enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: every five years

Additionally, the following licensing requirements apply:

Nurses must renew their licenses every two years.

Nutritional therapists and nutritionists must renew their licenses annually.

Medical licenses must be renewed annually.

Non–enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A home delivered meal is an appropriate, nutritionally balanced meal that is delivered to the participant's home or in a common dining space where they can eat their meal that must be located in the building where the participant resides. Meals must contain at least one-third of the current Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, and must be modified, as needed, to meet the participant's dietary requirements. Menu plans must be reviewed and approved by a licensed dietician, or licensed nutritionist.
A unit of service equals one meal.

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

For participants receiving home delivered meals, the following services are not covered: community residential services, and adult foster care.
Participants receiving home delivered meals may receive customized living when services are delivered by separate providers.
No more than one meal per day will be covered by the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals that meet the provider standards
Agency	Hospitals, Schools, Restaurants. and Any Entity Providing Home Delivered Meals that meet the provider standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Individuals that meet the provider standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must comply with all state and local health regulations and ordinances concerning food preparation, handling and serving of food as defined under Minnesota Rules, Chapter 4626. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietician or nutritionist must meet requirements as specified in Minnesota Statutes, section 148.621 and Minnesota Rules, chapter 3250.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Provider Eligibility and Compliance

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Hospitals, Schools, Restaurants. and Any Entity Providing Home Delivered Meals that meet the provider standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must comply with all state and local health regulations and ordinances concerning food preparation, handling and serving of food as defined under Minnesota Rules, Chapter 4626. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietician or nutritionist must meet requirements as specified in Minnesota Statutes, section 148.621 and Minnesota Rules, chapter 3250.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Community Living Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

ICLS includes six service categories. ICLS services offer assistance and support for older adults who need reminders, cues, intermittent/moderate supervision or physical assistance to remain in their own homes.
ICLS includes the following service categories:
• Active cognitive support
• Adaptive support service
• Activities of daily living (ADLs) support
• Household management assistance
• Health, safety and wellness
• Community living engagement.

ICLS workers must deliver support in a minimum of two service categories to a participant. In-person support must be scheduled at least weekly.

The service is flexible and scalable in order to meet a broad range of needs over time in a coordinated, cost-effective manner with all workers able to provide supports needed by the participant.

ICLS will complement and extend the use of informal caregiving and community supports and provide specialized support based on the participant's identified risk factors.

ICLS must be delivered in a single-family home or apartment owned or rented by the participant as demonstrated by a lease agreement or is leased or owned by a friend or family member who has no financial interest in the service.
An ICLS provider cannot:
- Be the person’s spouse;
- Be a licensed Assisted Living provider where the person resides;
- Be a home care provider in an affordable housing setting as defined under Minnesota Statutes, section 256S.20 Subd. 1 where the person resides;
- Be the person’s professional legal guardian or conservator;
- Be the person’s landlord; or
- Have any financial interest in the person’s housing.

ICLS remote support is the following:

Remote support is a provision of ICLS by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person’s health, safety and other support needs through remote support must:
• respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person’s health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
• ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability

and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

- Participants receiving ICLS services can not be authorized to receive customized living, foster care or comprehensive community support offered through Moving Home Minnesota.
- To receive ICLS participants must be authorized to receive two or more categories of the service
- Case managers must assure there is no duplication of service when participants are authorized for State Plan home care or other EW services.
- Equipment is not covered by ICLS, but may be selected by the participant and authorized separately by the case manager/care coordinator as the service of specialized equipment and supplies or as an environmental accessibility adaptation service.
- Transportation is not covered by ICLS but may be selected by the participant and authorized separately by the case manager/care coordinator as the service of transportation.
- The person can receive up to 12 hours per day of service.
- Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers who meet the Individual Community Living Support (ICLS) service standards
Agency	Providers who meet the Individual Community Living Support (ICLS) service standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Community Living Supports

Provider Category:
Individual
Provider Type:

Providers who meet the Individual Community Living Support (ICLS) service standards

Provider Qualifications
License *(specify):*

Providers must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for Comprehensive 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):*

Providers must be able to provide support in all categories of ICLS in compliance with basic support service requirements in Minnesota Statutes, chapter 245D.

ICLS workers are trained and competent to provide all services in the individual's ICLS plan and work under the supervision of the provider coordinator and manager as specified in Minnesota Statutes, chapter 245D.

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a)(1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2), (3), (6) and subdivision 3 regarding the rights of participants; 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers licensed under Minnesota Statutes, chapter 245D.
The Minnesota Department of Health monitors providers holding a home care license under Minnesota Statutes, chapter 144A.
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Community Living Supports

Provider Category:

Agency

Provider Type:

Providers who meet the Individual Community Living Support (ICLS) service standards

Provider Qualifications

License *(specify):*

Providers must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for Comprehensive 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):*

Providers must be able to provide support in all categories of ICLS in compliance with basic support service requirements in Minnesota Statutes, chapter 245D.

ICLS workers are trained and competent to provide all services in the individual's ICLS plan and work under the supervision of the provider coordinator and manager as specified in Minnesota Statutes, chapter 245D.

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2), (3), (6) and subdivision 3 regarding the rights of participants; 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers licensed under Minnesota Statutes, chapter 245D.
The Minnesota Department of Health monitors providers holding a home care license under Minnesota Statutes, chapter 144A.

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A - Every one to three years

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Managed Care Premiums

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

It is the capitation payment to MCO – it is what we pay for all EW services per month for a person on managed care
It is not just one service, it is all services, and it is a payment

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	N/A

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Managed Care Premiums

Provider Category:

Individual

Provider Type:

N/A

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

N/A

Frequency of Verification:

N/A

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment and Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**
17 Other Services	17010 goods and services

Specialized equipment and supplies include devices, controls, or appliances, mobility aids, and assistive technology devices including augmentative communication devices and personal emergency response systems, sensing equipment, controls or medical appliances as specified in the support plan that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, interact or communicate with their environment.

This service may cover evaluation of the need for equipment and/or device and, if appropriate, subsequent selection and acquisition. This service also includes equipment rental during a trial period, customization, training and technical assistance to participants, maintenance, repair of devices, and rental of equipment during periods of repair, unless covered by warranty. Training is not covered separately. Shipping and handling costs are covered under this service if the shipping cost is included in the price of the item and the waiver is purchasing the item. Installation can be covered regardless of who purchased the item, it if the item meets HCBS authorization criteria.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not covered under the state plan. Specialized Equipment and Supplies does not cover utilities that may be required to operate the supplies and/or equipment purchased for a participant.

All items must meet applicable standards of manufacture, design, and installation. Items, equipment, and supplies that exceed the scope or limits in the state plan may be covered.

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

Items that are not of direct medical or remedial benefit to the participant. Items that are covered by the state plan as durable medical equipment are not covered, including related assessments, repairs, and service. The following items are not covered:
- experimental treatments;
- items that restrict a participant’s rights;
- items that restrain a participant; and;
- items that are not adaptive aids or equipment, orthotic devices or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition
- utilities that operate the equipment or supply.

For participants who reside in settings that are responsible to provide 24 hour supervision, emergency response systems are not covered as a separate item or service nor may they be used in lieu of staff supervision in accordance with the service description. This does not preclude covering emergency response technology (e.g., pendant call systems) that may be appropriate for participants to use outside of the residential setting.

All prescription and over-the counter medications, compounds and solutions, and related fees including premiums and co-payments are not covered.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacies
Agency	Agencies who provide supplies and equipment
Individual	Individuals who provide supplies and equipment
Agency	Home Health Agencies and Medical Equipment Providers and Supplies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

Pharmacies are licensed by the Minnesota Board of Pharmacy in accordance with Minnesota Rules, parts, 6800.0100 to 6800.9954.

Certificate *(specify):*

Other Standard *(specify):*

State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310. Providers must also meet the definition under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Agencies who provide supplies and equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services - Provider Eligibility and Compliance

Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Upon purchase of goods/supports and every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Individual

Provider Type:

Individuals who provide supplies and equipment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services - Provider Eligibility and Compliance

Non-enrolled providers: County, tribal nation or MCO

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Upon purchase of goods/supports and every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Home Health Agencies and Medical Equipment Providers and Supplies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310. Providers must also meet the definition under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:

Home Health Agencies: Minnesota Department of Health.

Medical Equipment Providers and Suppliers: Minnesota Department of Human Services

Frequency of Verification:

Every one to three years

Enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
17 Other Services	17010 goods and services
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Transitional services include expenses related to establishing community-based housing for persons transitioning to an independent or semi-independent community residence from the following licensed settings:
- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.591;
- adult foster care homes licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, Chapter 245A or under Minnesota Statutes, Chapter 245D; and,
- nursing facilities and intermediate care facilities as defined under Minnesota Rules, part 9505.0175, subpart 23 and licensed under Minnesota Statutes, Chapter 144.

Transitional Services are solely for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement where the person is directly responsible for their own living expenses.

Items and expenses that may be covered include lease and rental deposits, essential furniture, utility set up fees and deposits, basic household items, window coverings, personal items, and one time pest and allergen treatment of the setting. Used items may be purchased if they are safe by reasonable standards.

Supports that can be covered include assistance in locating and transitioning to the community based housing, move personal items from the licensed facility to the home, arrange for utilities to be connected and help with purchasing the household items and essential furniture.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses.

The case manager determines whether the items, expenses, and supports are necessary and reasonable for the participant to establish an independent or semi-independent community living arrangement.

To be eligible an individual must:

(1) not have another source to fund or attain the items or support; and,

(2) be moving from a living arrangement were these items were provided; and,

(3) be moving to a residence where these items are not normally furnished (e.g., items cannot be provided in a setting where the setting is otherwise responsible to provide them);

(4) if the individual is not presently enrolled in the waiver, the local county, tribal nation or MCO must evaluate and reasonably expect that the person will be eligible for and will open to the waiver within 180 days; and,

(5) incur the expense within 90 days of the waiver opening date.

Transitional services must be identified on the participant's support plan. There are no limitations on frequency of use for this service.

Transitional Services remote support is the following:

Remote support is a provision of Transitional service by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology * that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person’s health, safety and other support needs through remote support must:

- respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;

• respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
• ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.
For participants who do not receive their waiver services through managed care, the service will be considered provided and may be billed after the waiver is open. In these situations, the county or tribal nation is responsible to make the determination that the individual meets all of the applicable eligibility criteria and is expected to move to the community within 180 days.
If for an unforeseen reason the person does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transitional service(s) that was(were) provided may be covered through Medicaid administrative funds. MCOs may not bill for administrative funds under these circumstances.

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

Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore, homemaker services, home modifications and adaptations, environmental accessibility adaptations, supplies and equipment, etc.).

Items and Expenses that cannot be covered:
Expenses related to on-going rent, or housing costs, food or clothing, recreational or diversional items. Recreational and diversionary items include but are not limited to computers, VCR's, DVD players, televisions, cable access, etc.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers of Items and Expenses (receipt services)
Individual	Providers of Support (market services)
Agency	Providers of Support (market services)
Agency	Providers of Items and Expenses (receipt services)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Individual

Provider Type:

Providers of Items and Expenses (receipt services)

Provider Qualifications

License *(specify):*

Must maintain all applicable licenses, permits, registrations as required for their business.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Must maintain all applicable licenses, permits, registrations as required for their business.

Frequency of Verification:

All receipts or other documentation related to the item or expense covered must be maintained in the participant’s file at the county, tribal nation or MCO.
Services must provide a cost effective, appropriate means of meeting the needs defined in the participant’s support plan.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Individual

Provider Type:

Providers of Support (market services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Support providers as determined by the county, tribal nation or MCO to have all of the following:
-General knowledge of disabilities and chronic illnesses and their effect on an individual's ability to live independently in the community; and
- Ability to assess the individual's community based housing needs; and
-Functional knowledge of community based housing options; and
–Sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the individual regarding these matters; and
–Ability to assist the individual in attaining the items that are covered by transitional services; and

–Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

County, tribal nation or MCO or Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

County, tribal nation or MCO: Upon purchase of goods and supports
Enrolled provider: DHS review every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Agency

Provider Type:

Providers of Support (market services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Support providers as determined by the county agency must meet all of the following:
-General knowledge of disabilities and chronic illnesses and their effect on an individual's ability to live independently in the community; and
- the ability to assess the individual's community based housing needs; and
-functional knowledge of community based housing options; and
–a sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the individual regarding these matters; and
–the ability to assist the individual in attaining the items that are covered by transitional services; and

–Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

County, tribal nation or MCO: Upon purchase of goods/supports
Enrolled provider: Minnesota Department of Human Services: Provider Eligibility and Compliance

Frequency of Verification:

County, tribal nation or MCO or Enrolled Provider: DHS review – every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional Services

Provider Category:

Agency

Provider Type:

Providers of Items and Expenses (receipt services)

Provider Qualifications

License *(specify):*

Must maintain all applicable licenses, permits, registrations as required for their business.

Certificate *(specify):*

Other Standard *(specify):*

All receipts or other documentation related to the item or expense covered must be maintained in the participant's file at the county, tribal nation or MCO.
Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

County, tribal nation or MCO or Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

County, tribal nation or MCO: Upon purchase of goods/supports
Enrolled provider DHS review – every 5 years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation services may be covered to enable participant to gain access to waiver and other community services, resources, employment, and activities related to goals specified in the participant's support plan. When possible, family, neighbors, friends, or community agencies that are able to provide the service without charge will be utilized.

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

This service does not replace medical transportation services covered by the state plan (e.g., to medical appointments) or supplant transportation that is available at no charge. This service does not cover transportation provided by providers for which the cost of transportation is included in their rates.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Non-Profit Groups that Provide Transportation (receipt service)
Agency	Taxi and Commercial Companies including buses and county-owned or leased vehichles (receipt service)
Individual	Individual who are not common carriers (receipt services)
Agency	Special Transportation Vendors to transport a participant because of physical or mental impairment is unable to use a common carrier and does not require ambulance transportation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Non-Profit Groups that Provide Transportation (receipt service)

Provider Qualifications

License *(specify):*

Drivers or carriers must have a valid Minnesota driver’s license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statues, chapter 65B.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Taxi and Commercial Companies including buses and county-owned or leased vehichles (receipt service)

Provider Qualifications

License *(specify):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statues, chapter 65B.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

County, tribal nation or MCO or Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

County, tribal nation or MCO review: Upon purchase of goods and supports
Enrolled provider DHS review every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individual who are not common carriers (receipt services)

Provider Qualifications

License *(specify):*

Drivers must have a valid driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, chapter 65B.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

County, tribal nation or MCO or Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

County, tribal nation or MCO review: Upon purchase of goods/supports
Enrolled provider DHS review – every 5 years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Special Transportation Vendors to transport a participant because of physical or mental impairment is unable to use a common carrier and does not require ambulance transportation

Provider Qualifications

License *(specify):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

Certificate *(specify):*

Providers of special transportation, not excluded in Minnesota Statutes, section l74.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections l74.29 to l74.315.

Other Standard *(specify):*

Additional qualifications that are necessary to meet a participant's unique needs and preferences will be documented in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:

Enrolled provider DHS review every 5 years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) Minnesota Statutes, chapter 245C establishes the Background Studies Act that applies to certain providers. The Act identifies who is required to have a background study, scope and time lines that apply. It also describes what constitutes a disqualification and the appeal process available to providers.

Positions for which background studies apply: Minnesota Statutes, chapter 245C requires criminal and maltreatment background checks to be completed for:
- All employees: owners, managers, contractors and volunteers within programs and organizations licensed by the Minnesota Department of Human Services (DHS), licensed, registered and certified by the Minnesota Department of Health, regulated by the Minnesota Department of Corrections, or operating as a personal care or home care provider organization that provide "direct contact" services under the home and community based waiver programs.

- People who are not providers but who reside in a setting in which direct contact waiver services are provided to waiver participants. This required background check is limited to individuals aged 13 years or older, and can apply to individuals aged 10 to 12 where there is reasonable cause.

- All individuals, including current and prospective employees, contractors, volunteers, etc., regardless of setting, who will have direct contact with people enrolled in the waiver.

Direct contact means providing face-to-face care, support, training, supervision, counseling, consultation, or medication assistance to a person. Direct contact services always include the following services:

- Consumer directed community supports (personal assistance, treatment and training, financial management services, support planning, community integration and support, self-directed support, and fiscal management services)

- Adult companion services
- Adult Day Services and Adult Day Bath
- Customized Living/includes 24 hour Customized living
- Family Caregiver Services (if direct contact with the participant)
- Extended Home Health Care
- Extended Personal Care Assistance
- Extended Home Care Nursing
- Foster Care
- Homemaker
- Individual Community Living Support (ICLS)
- Respite
- Transitional Services (if direct contact with client)

(b) Scope of the background studies: Background studies are completed through an on-line system to the department. A background study must be initiated prior to an individual providing direct service. The scope of the study includes search of history information maintained by the Bureau of Criminal Apprehension (BCA), the Minnesota Department of Health and applicable county agencies, a search of other states' criminal records, a search of maltreatment records maintained by the state and counties within the Social Service Information System (SSIS), and if there is reasonable cause, a Federal Bureau of Investigation (FBI) fingerprint check, along with a search of FBI investigation case files and criminal arrest records.

A complete list of the information the department reviews as part of a background study can be found in Minnesota Statutes, section 245C.08.

(c) Process for ensuring background studies are completed: Providers are responsible for completing, submitting and maintaining all mandatory background study forms. Providers are responsible to maintain records of employees' background studies.

Respective government agencies with regulatory enforcement authority (e.g. DHS licensing division, the Minnesota Department of Health, the Minnesota Department of Corrections, counties, tribal agencies, etc.) review providers for compliance. Disqualified employees of a provider are barred from service. Disqualified providers do not have a provider identification number from the Department's Provider Eligibility and Compliance unit and cannot bill for or

be paid for their services. The provider Eligibility and Compliance unit will terminate an existing enrollment effective the date of the disqualification. Provider compliance is monitored through routine licensing reviews.

For a limited number of services, providers are not required to enroll with DHS. In these instances, lead agencies are responsible to determine that providers meet qualifications, including ensuring that background studies are completed, where applicable.

Managed care: The process described above also applies to providers who deliver services to participants enrolled in managed care.

The Corporation for National and Community Service: Senior Companion Program:
National and Community Service Senior Companion program grantees must undergo a National Service criminal history check. This check includes: A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW); a statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and a fingerprint-based FBI criminal history repository check.

If the provider of Adult Companion Services is a National Community Services Senior Companion Program grantee, they are exempt from the background study requirements of Minnesota Statutes, chapter 245C because of the background check requirements in the previous paragraph for these individuals.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The entity responsible for maintaining the abuse registry is the Department of Human Services Office of Inspector General, Background Studies Division. As described in response to C-2(a), General Service Specifications, the department maintains a database of individuals who were determined through vulnerable adult investigations to have committed maltreatment. The Minnesota Department of Health also maintains a database of individuals who have been determined to commit maltreatment and shares that information with the department. When the department completes a background study, the individual is screened against both databases.

Appendix C-2-a addresses which positions require background studies and the process to complete them, including review of the databases described above.

The following state laws apply and are available upon request: Minnesota Statutes, chapter 245C; Minnesota Statutes, Section 144.057; and Minnesota Statutes, chapter 144A

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

(a) Who may be paid and for what services:
Non-paid legal guardians and relatives who are not the participant's responsible party [as defined in state law related to personal care assistance (PCA) services] may provide extended PCA services. Spouses, paid guardians and responsible parties may not be paid to provide PCA services.
PCAs must be employed by an enrolled agency and the PCA must:
•be over 18 years of age unless between the ages of 16 and 18 years. If the PCA is between the ages of 16 and 18 years, the PCA must only be employed by one provider agency and be supervised by a qualified professional every 60 days.
• successfully complete training requirements. The provider is required to maintain documentation of the PCA's training.
• be able to provide PCA services according to the participant's support plan, respond appropriately to the needs of the participant, and report changes in the participant's condition as required.
• pass a background study as specified in Minnesota Statutes, Chapter 245C. Pass a background study means the individual must not be disqualified or have a disqualification set-aside.
• enroll as an individual PCA provider with the Minnesota Health Care Programs
• not be receiving PCA services.
• complete training and orientation on the needs of the participant within no more than 14 days after services begin.
• be supervised by the participant or the qualified professional.

(b) Authorization criteria:
The screening and support plan process is used to determine the participant's PCA service needs and whether the service is appropriately provided by a legal guardian. This includes use of the Long Term Care Consultation (DHS-3428) and Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D). The information from the assessment identifies the amount of state plan PCA services that can be authorized and is documented in the support plan. Additional time can be authorized as Extended PCA services based on the participant's needs identified in the assessment and support planning process. The case manager authorizes PCA hours in the participant's waiver service agreement.
(c) Payment controls:
Participants must sign PCAs' time sheets to verify that the time recorded was provided. All PCAs are also required to have an individual provider number. The number allows the department to monitor the total number of hours an individual PCA provides. This is important because PCAs may provide services to multiple participants and be employed by more than one provider. Reports can be run on individual PCAs to monitor that the number of hours being billed is reasonable and does not duplicate other claims.
In addition:
- The department uses automated reports to identify potential overuse of services. As part of the automated process, MMIS sends letters to participants, providers, and lead agency case managers to notify them the potential overuse of services. In cases where there are questions regarding the use of PCA services, department staff may request additional information, such as signed time sheets and documentation of services provided, assessments that indicate a change in condition that would necessitate the need for increased services, etc. Department staff work with the provider and participant concerning accurate billing and use of services.
- The department can cross reference PCA's billing with IRS information to verify that the PCA was not employed at another setting at the time they recorded providing PCA services.
- The department conducts random audits to evaluate provider's billing practices and appropriate use of services.
- Case managers are responsible for monitoring the use of service.

For participants who receive personal care assistance services covered by managed care, the MCO applies payment controls similar to those described above, including coordinating with the department to use individual provider numbers.

For participants who elect CDCS services, individuals who are related by blood, marriage or adoption, and legal guardians or conservators may be paid to provide services under the category of personal assistance. Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.

☒ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Unless otherwise specified in the waiver application, professional guardians and conservators shall not be paid to provide waiver services. This does not preclude non-professional guardians and conservators who meet the criteria in this section from being paid to provide waiver services as an employee of an enrolled provider. The following information responds to the questions in Appendix C-3 related to what services may be provided by a legally responsible person or relative/legal guardian and is not repeated in each service description in Appendix C-3.

Extended Home care nursing (this is an extended home health care service)
Spouses, legal guardians, and conservators may receive a home care nursing hardship waiver to be paid to provide extraordinary services that require specialized nursing skills when the following criteria are met:
- The service is not legally required of the individual;
- The service is necessary to prevent hospitalization of the participant; and
- One of the following hardship criteria is met. The individual:
(i) resigns from a part-time or full-time job to provide the service; or
(ii) changes from a full-time to a part-time job with less compensation to provide the service; or
(iii) takes a leave of absence without pay to provide the service; or
(iv) is needed to meet the medical needs of the participant because of labor conditions, special language needs, or intermittent hours of care needed.

The individual must be a nurse licensed in Minnesota, must have a current RN or LPN license and employed by a home health or home care nursing agency. The individual must also pass a criminal background study in accordance with Minnesota Statutes, chapter 245C. The service cannot be used in lieu of nursing services covered under and available through a liable third-party payer. The service also cannot be used to replace the individual's responsibilities as a primary caregiver or to provide emergency backup without payment.

The number of hours shall not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. The service shall not be covered if the home health agency, the case manager/care coordinator, the physician, advanced practice registered nurse, or physician assistant determines that the nursing care provided by the spouse or legal guardian is unsafe or may potentially jeopardize the participant's health and safety.

The home care nursing hardship waiver is not available when a participant is using consumer directed community supports (CDCS).

Adult foster care
Counties may certify people related to the participant to provide foster care in accordance with Minnesota Statutes, section 256B.0919 subd. 3 in situations in which the provider will or is experiencing financial hardship as a result of providing the care.

Consumer-directed service provided to adults:
Legal guardians or conservators who are related by blood, marriage or adoption may be paid to provide services through the CDCS service under the category of personal assistance. Legal guardians or conservators who are not related by blood, marriage or adoption whose guardianship or conservatorship responsibilities are limited to one participant or to participants who are siblings may be paid to provide services to adults and children through CDCS under the category of personal assistance services as defined in Appendix C-1/C-3. Parents of minors and spouses must meet the provider qualification for this service.

For a participant's spouse to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:
- meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;
- be a service/support that is specified in the participant's support plan;
- be provided by a spouse who meets the qualifications and training standards identified as necessary in the participant's support plan;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;
- be related to the participant's assessed need/disability and NOT be an activity that a spouse would ordinarily perform or is responsible to perform;

- be necessary to meet at least one identified dependency in activities of daily living (ADL) which is determined based on the ADL items included in the assessment the person receives.

Any ADL dependency documented in the MnCHOICES/LTCC assessment, which meets the eligibility criteria for any program, is valid for determining the ADL dependency requirement for paying a spouse or parent of a minor for personal assistance services.

The LTCC/MnCHOICES assessment is used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a family member would ordinarily perform and those activities that go beyond what is normally expected to be performed.

In addition to the above:
- spouses may not provide more than 60 hours of CDCS personal assistance home and community-based services in a seven-day period. For spouses, 60 hours is the total amount per family.
- the spouse must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the support plan.
- spouses may only be paid for providing supports that fall within the Personal Assistance service category
- spouses may not be reimbursed for mileage expenses.

Monitoring Requirements for CDCS: These additional requirements apply to participants electing to employ a spouse or legal guardian for CDCS services:
- monthly reviews by the financial management services provider of hours billed for family provided care and the total amounts billed for all goods and services during the month;
- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the financial management services provider when billing;
- at least quarterly reviews by the county, tribal nation or MCO on the expenditures and the health and safety status of the participant
- in-person visits with the participant by the county, tribal nation or MCO at least an annual basis.

Waiver services, other than CDCS and Extended Home Care Nursing Provided to Adults
Primary caregivers, including related individuals, guardians and conservators, cannot be paid to provide a service intended to provide relief or support for themselves. This includes chore services, homemaker and respite.

Related individuals cannot provide case management.

Relatives, legal guardians and conservators may be paid to provide waiver services if they meet all of the following criteria. The service must be included in the participant's support plan and the relative, guardian or conservator must:
- Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, only be the guardian or conservator for one participant or more than one participant if they are siblings;
- not be otherwise responsible to provide the care or service;
- not be an enrolled MA provider for the service being rendered or a controlling entity of an enrolled Medicaid provider where the person gains financially;
- be qualified to provide the service; and
- be employed by a provider to furnish the service.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

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:

Fee-for-service providers

The Department enrolls provider that fulfill state qualifications, complete required state provider training and submit a signed Minnesota Health Care Provider Agreement. Providers access all service information concerning enrollment including enrollment forms on the department's web site: https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/

Every waiver service provider must comply with state requirements. Direct enrollment with the department is required for most waiver services. For market and receipt-based services, providers are not required to enroll with DHS, but they have the option to enroll if they choose. Enrolled waiver service providers will be listed in an on-line (MinnesotaHelp.info) directory.

Market services are those purchased at a price typically charged on a community market basis. Market services include services directed to a broad community market: Chore, cleaning only component of homemaker, home construction and vehicle installation components of environmental accessibility adaptations, the training component of family caregiver training and education, and transportation.

Counties, tribal nations and MCOs 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 counties, tribal nations and MCOs. The state directs counties, tribal nations and MCOs 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.

Annually, the Department will review qualifications of applicants for Financial Management Services (FMS) providers through a Request for Proposal process.

Providers must have an agreement with the Department of Human Services and be enrolled as an MHCP provider. A web based provider directory, found is available. Instructions for accessing the directory can be found here: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6933-ENG

New MHCP providers are required to take training developed by the department. All counties, tribal nations and MCOs utilize any qualified provider who has enrolled with DHS Eligibility and Compliance. MCOs are required to use enrolled providers. For market and receipt service providers who choose not to enroll with DHS, the MCOs follow the same process as counties and tribal nations to determine a provider meets qualifications. MCOs are permitted by contract to create a limited network of providers by service type. If an MCO selects this option, the MCO must develop contracts with providers included in their network. This is used by MCO's that may want to add contract quality incentives or other contract requirements.
All counties, tribal nations and MCOs will utilize any MHCP enrolled provider. For MCOs, which can use non-enrolled providers under the contract with DHS, the MCO is responsible to ensure the provider meets qualifications, and must submit this information to DHS.

Federally recognized tribal nations may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7, item (c). A tribal nation 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 tribal nations. If the tribal nation elects to become a provider 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

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of total EW claims paid to active MHCP providers, per waiver year. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per waiver year. Denominator: Number of all EW claims paid for services provided to EW participants, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of HCBS provider applications randomly selected, reviewed and determined to meet all required standards per waiver year. Numerator: Number of HCBS provider applications selected and reviewed that were determined to meet all required standards. Denominator: Number of HCBS provider applications randomly reviewed, per waiver year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Health Care Program (MHCP) Quality Control Audit Record

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: MHCP program area random audit sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of HCBS provider applications that randomly selected, reviewed and determined to meet all required standards per waiver year. Numerator: Number of HCBS provider applications selected and reviewed that were determined to meet all required standards, per waiver year. Denominator: Number of HCBS provider applications randomly selected and reviewed, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Health Care Program (MHCP) Quality Control Audit Record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: MHCP program area random audit sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of total EW claims paid to active MHCP providers, per waiver year. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per waiver year. Denominator: Number of all EW claims paid for services provided to EW participants, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of lead agencies that use a state-directed procedure to verify, track and document the qualifications of non-enrolled providers, per waiver year. Numerator: Number of lead agencies that use a state-directed procedure to verify, track and document the qualifications of non-enrolled providers, per waiver year. Denominator: Number of lead agencies, per waiver year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Lead Agency

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of total EW claims paid to active MHCP providers, per waiver year. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per waiver year. Denominator: Number of all EW claims paid for services provided to EW participants, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

To participate as a Minnesota Health Care Programs (MHCP) provider and provide waiver services, providers must meet professional, certification and/or licensure requirements (including waiver requirements) according to state and federal laws and regulations. The Department's Provider Eligibility and Compliance Unit verifies that these requirements are met before a provider is enrolled. All waiver providers must be enrolled through the Provider Eligibility and Compliance Unit. Before they can provide services, bill and be reimbursed for providing waiver services, providers must: (1) enroll as a MHCP provider, (2) receive prior authorization to deliver services to an individual waiver participant and (3) bill for services appropriately.

The Department maintains a list of active MHCP providers in the MMIS provider subsystem. Edits in MMIS ensure that payment is made only to providers that (1) are enrolled as a MHCP provider, and (2) have been authorized to provide the service for which they are claiming. If a provider's license or certification expires or is revoked and it does not respond in a timely manner to the Department's request for information related to the expiration or revocation, the provider is removed from active enrollment status. Payment claims submitted for services delivered after removal from active enrollment status are rejected.

Non-licensed providers have had qualifications reviewed and monitored through the lead agency. The department monitors the practices of lead agencies through site visits and care plan auditing activities. The department provides direction and oversees all operational activities carried out by counties, managed care organizations, and tribal nations. Counties, managed care organization, and tribal nations that carry out delegated waiver operations are referred to as lead agencies. Unless otherwise noted, references to lead agencies in this document include these entities.

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

Providers must be reviewed by the Provider Eligibility and Compliance unit to remain enrolled as an MHCP provider.

Enrolled waiver service providers are listed in an on-line (MinnesotaHelp.info) directory as of 1/1/14. Licensing. Certain waiver service providers as indicated in Appendix C-1/C-3 are required to be licensed by either the Department, lead agencies, 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.

New MHCP providers will be required to take training that has been developed by the department.

Aging Services Division. – The Aging 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 for Consumer Directed Community Supports service. Initial certification requires successful completion of test requirements prior to providing services. 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 States 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.

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

Provider Enrollment. When the Department's Provider Eligibility and Compliance unit 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.

MMIS edits ensure that only enrolled providers can be authorized to provide services, and must remain actively enrolled throughout any authorization and claiming dates. The enhanced waiver provider qualification review process underway statewide for all waiver providers will augment current MMIS editing at the service authorization and claims payment level. The enhanced review provides additional assurances at the provider enrollment level.

When 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 FMS provider must submit evidence of remediation depending on the nature, severity, and/or chronicity of the violation, 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, the support planner's certification may be revoked.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

See Appendix C-3 and Appendix E

Customized living services are limited by monthly service limits that correspond to a participant's case mix. See Appendix B-2-b for a description of our case mix methodology. The monthly service limit amounts are based on a methodology in Minnesota Statutes, section 256S.202, and are adjusted at least annually as directed by Minnesota Statutes, section 256S.18. The limits are published at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG

Effective through December 31, 2023, environmental accessibility adaptations for home modifications and vehicle modifications are limited to $20,000 per the participant's service plan year. Effective January 1, 2024, and each January 1 thereafter, the limit will be adjusted based on a methodology described in Appendix I-2-a.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☒ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

Participants are assigned a maximum monthly budget for waiver services based on the person's assessed needs and their resulting case mix. See Appendix B-2-b for a description of our case mix methodology, including how the budgets are applied under fee-for-service and Managed Care Organizations, and allowable exceptions to the budgets. The monthly budget amounts are determined and adjusted at least annually as directed by Minnesota Statutes, section 256S.18. The budgets are published at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

On Feb. 12, 2019, CMS gave its final approval to Minnesota's Home and Community-Based Services Rule Statewide Transition Plan to bring settings into compliance with the federal HCBS regulations.
Minnesota will use the following strategies to ensure compliance with the HCBS settings rule:
1. Provider attestation requirement for every setting
2. Desk audit of every setting's attestation and submitted documentation to support compliance
3. Identify Prong 1, 2 and 3 – Presumed not to be HCBS settings
4. Assess and validate Prong 1, 2 and 3 – Presumed not to be HCBS settings: On-site visits and outreach
5. Implement person's experience assessments
6. Implement methods for ongoing HCBS compliance, including assessing people's ongoing experience and assessing lead agencies and service gaps.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Support Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best

interests of the participant. *Specify:*

Case managers are responsible to develop service plans that reflect individual participation in plan development, choices in services, and choice in available providers of those services. Counties, tribal nations and managed care organizations that provide case management services to waiver participants may only provide other waiver services to the consumer if they are provided by areas or division that is organizationally separate from the area that provides case management services. For example, a county or tribal nation public health agency may provide home care services while the social service agency is responsible for case management. There are circumstances when the county or tribal nation may provide case management and other waiver services. In these circumstances, it is generally a service provided by another arm of the county or tribal nation (e.g., county, or tribal public health agencies may provide home care services that a waiver participant may use). Case managers are never allowed to be the direct provider of another waiver service. The county, tribal nation or managed care organization may provide other services but the case manager role is separated from service provision.

All DHS enrolled providers are listed in the on-line MinnesotaHelp.Info directory at https://www.minnesotahelp.info.

The case manager or case aide shall not have a personal financial interest in the services provided to the participant. Case management must not be provided to a participant by a private agency that has a financial interest in the provision of any other services included in the participant's support plan per Minnesota Statutes, section 256S.08. This is described in Minnesota's approved 1915(b)(4) waiver under Part 1, Section C(2) which states:
In accordance with 42CFR part 441.301(c) the case manager or case aide shall not have a personal financial interest in the services provided to the participant. Minnesota Statutes section 256S.08, subdivision 1 prohibit the provision of case management services to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan
Additional policies, regulations and/or procedures on conflict of interest /monitoring safeguards are also in Appendix D-2-b which states:
Case managers are responsible for monitoring the support plan implementation including monitoring that the health and safety needs of the participant, as identified in the support plan, are addressed. Case managers are never allowed to be the direct provider of another waiver service.
Participant safeguards related to possible conflicts of interest include fair hearing rights, free choice of provider, and the ability to request a different case manager from the same lead agency or seek case management services from another allowable provider. Fair hearings are governed by Minnesota Statutes, §256.045 The contracts between the department and tribal nations require that tribal nations offer participants the option of accessing waiver services through an MCO (as applicable) or county.

We also describe this in Minnesota's approved 1915(b)(4) waiver under Part 1, Section C (1) which states:
Waiver participants are limited to using a single provider in their service area, referred to as the lead agency, (which may be a tribal or county entity or an entity contracted with the lead agency as the provider of case management services). Lead agencies can contract with multiple case management providers and are required under Minnesota Statutes, section 256B.0911, subdivision 3a, paragraph (e), clause (2) to provide a different case manager upon request. Minnesota Statutes, section 256S.09, subdivision 1 allows eligible recipients choice among any qualified provider of case management services within the agency. The waiver program operates statewide.

Case managers are responsible for monitoring the support plan implementation including monitoring that the health and safety needs of the participant as identified in the support plan are addressed.
Participant safeguards related to possible conflicts of interest include fair hearing rights, free choice of provider, and the ability to request a different case manager from the same lead agency or seek case management services from another lead agency.

Information regarding informed choice of providers is found in Appendix D-1-f.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made

available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Person-centered planning principles must be applied to all support plans developed for participants. Person-centered planning begins during the long term care consultation assessment process. This includes engaging participants and their representatives, as appropriate, in the assessment and support planning process, and supporting participants in directing these processes to the extent that they choose. A primary task of the long term care consultant is the provision of decision-making support related to long term care choices, including HCBS.

The assessment is comprehensive and includes a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred participant, and provides information necessary to develop a support plan that meets the participant's needs and goals, using an assessment form provided by the commissioner.

The initial assessment must be conducted in an in-person interview and reassessments in an in-person or remote interview per MN Statute 256B.0911, with the participant being assessed and the participant's legal representative, and other individuals as requested by the participant, who can provide information on the needs, strengths, and preferences of the participant necessary to develop a support plan that ensures the participant's health and safety.

Under Minnesota Statutes, section 256B.0911, long term care consultation, any individual with long term or chronic care needs can request and receive an assessment and the development of a support plan.

For individuals eligible for the Elderly Waiver, additional support plan requirements are found at Minnesota Statutes, section 256S.10.

The support plan format published by the department and used by long term care consultant/case managers reflects person-centered planning components. Participants are asked to verify, by signature, if they participated in the development of and agree with the support plan, were offered choices between services, and between providers. See more detailed support plan requirements at Minnesota Statutes, section 256S.10.

The department’s web site offers a considerable amount of information and training for case managers, assessors, participants and families regarding consumer direction. These are found at http://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/cdcs.jsp, and offers training for case managers on helping participants understand and access consumer-directed options by providing training and materials. See also the Lead Agency Consumer Directed Community Supports (CDCS) Operations Manual (DHS-4270), the CDCS Consumer Handbook (DHS-4317), and the CDCS Consumer Brochure (DHS-4124). Additional person-centered planning components are required for participants as reflected in the support plan. Additional information for case managers can be found in the CDCS Policy manual
https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleas

Managed care organizations are required under contract to provide information to all of the enrolled participants about how to access HCBS, the assessment and support planning process, the HCBS provider network available, and self-directed options.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid

agency or the operating agency (if applicable):

The following applies to participants who have not elected consumer-directed services. For individuals who elect participant direction under Consumer Directed Community Supports (CDCS), the service plan development process is described in the CDCS service description in Appendices C-3 and Appendix E.

The following applies to all participants:

(a) who develops the plan, who participate in the process, and the timing of the plan:
The case manager works with the participant and others, as directed by the participant, to develop and finalize the support plan based on information gathered during the assessment. The support plan must be finalized, with providers selected and services authorized, within no more than 60 calendar days from the assessment. This process applies to both initial and annual reassessments. Family members frequently participate in the support plan development. If the participant has a guardian or conservator, the guardian or conservator must participate in the development of the support plan.

(b) the types of assessments that are conducted to support the plan development process, including securing information about participant needs, preference and goals, and health status:
The Long Term Services and support (LTSS) assessment under 256B.0911 is the assessment process used to identify participant's needs, condition, goals, and preferences. Lead agencies are required to perform the LTSS assessment within 20 calendar days of the referral or request for services. Minnesota Statutes, section 256B.0911 requires assessments and support plan development for all individuals who have long term or chronic care needs, regardless of public programs eligibility (https://www.revisor.mn.gov/statutes/?id=256B.0911). The LTSS assessment may result in a determination that the individual is eligible for waiver service and meets nursing facility level of care. The LTSS assessment and support plan are used and developed for initial assessments and re-evaluations.

The LTSS process includes assessment of the participant’s health, psychological, functional, and social needs. Assessment information may be obtained from the individual, family members, providers, or from medical or other records. The LTSS assessor must assess the individual’s:
- Health and safety, including physical and dental health, vision, hearing, medication management, mental and cognitive health, and emotional well-being
- Social connections and interpersonal relationships
- Communication or sensory impairments
- Self-care, including toileting, eating, dressing, hygiene, and grooming
- Home living skills, including clothing care, housekeeping, food preparation and cooking, shopping, daily schedule management, and home maintenance
- Community access and use, including transportation and mobility, leisure and recreation, and other community resources
- Environment, including needs related to mobility, accessibility, safety, and sanitation
- Vulnerability to maltreatment or exploitation by another or vulnerability for self-neglect
- Legal representation, and
- Caregiver’s support needs (i.e., the ability to continue to provide informal care)

Once this information is collected and reviewed, it is summarized in MMIS using the LTCC Screening Document (DHS-3427).

(c) how the participant is informed of the choice of services that are available:
As described in Appendix B-7, Freedom of Choice, the case manager or assessor is responsible to provide information to the participant about waiver services and providers. Information about waiver services is also available on the department’s web site. Case managers/assessors also provide information to participants about other services that may be appropriate (e.g., community programs, housing, state plan home care services, etc.). Participants enrolled in managed care receive waiver provider network information as part of their member materials; all member materials are approved by the department.

(d) how the plan development process ensures that the support plan addresses participant goals, needs (including health care needs), and preferences:
The LTSS assessment is a comprehensive assessment and summarizes information about needs to inform the support plan development process. Completing the support plan and including family members in the planning process, assists the case manager in addressing the participant's needs, goals, and preferences. The support plan includes:
- Information that is important to and important for the participant

- The participant's strengths, preferences, needs and desired outcomes
- Assessed needs and options and choices of how needs will be addressed, including the use of informal or community supports
- Long- and short-range goals
- Specific supports and services, including case management services
- The amount and frequency of the services to be provided
- Personal risk management plans, as applicable, for identified needs
- The participant's preferences concerning services and providers
- Back up and emergency plans as needed to address identified risks

The department provides ongoing training and resources to support person-centered planning to address participants' strengths and preferences in the support planning process, and requires the use of person-centered planning for all support plan development. State law requires that participants receive a copy of their written support plan, including participant signatures verifying their participation in the development of, and agreement with the plan.

The support plan is developed and signed by the participant , the participant's guardian (if applicable), the case manager, and providers responsible for delivering services under the plan within 60 calendar days of the in-person assessment. The plan is distributed to the participant, the participant's guardian (if applicable), the case manager, providers responsible for delivering services under the plan, and others chosen by the participant. The participant designates on the support plan all parties who will receive a copy.

(e) how waiver and other services are coordinated:
Minnesota Statutes, chapter 256S governing the elderly waiver requires case managers to assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services regardless of the funding source. Case managers are also responsible to assist with service access, coordinate and monitor waiver services, and make appropriate referrals for other services. For participants enrolled in managed care, care coordination requirements for all enrolled participants underlie additional case management requirements for coordination of waiver and other services. All services must be included in the support plan and authorized before they can be provided. Services must be provided before they can be billed.

(f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:
Case managers must monitor each participant's support plan and service provision at least annually. Person-centered planning requirements include that the case manager specify the frequency of monitoring and evaluation activities in the participant's support plan. The amount and frequency of monitoring and evaluation is based on the participant's assessed needs, and other factors that may affect the type, amount and frequency of monitoring e.g., the availability of caregivers who are not paid, unstable medical conditions, etc. If a provider fails to carry out their responsibilities as identified in the participant’s support plan or develop an individual service plan when needed, the case manager shall notify the provider and, as necessary, the multidisciplinary team. If the concerns are not resolved by the provider or multidisciplinary team, the case manager shall notify the participant, the appropriate licensing and certification agencies, and the Aging and Adult Services division for persistent performance concerns and patterns with non-licensed waiver service providers. The case manager shall identify other steps needed to assure that the participant receives the needed services and protections.

If a participant’s health and safety are in jeopardy, action is taken immediately to address the situation. The action is dependent on the situation.

(g) how and when the plan is updated, including when the participant's needs change:
Support plans are updated any time there is a significant change in the participant's condition or supports that may warrant a change in services included in the support plan. Assessors must reevaluate level of care and support plans at least annually. Case managers also meet with participants as identified in the participants' support plans and upon request.

For participants who have elected consumer-directed services
Support planning and monitoring for participants who have elected CDCS is described in the CDCS service description in Appendix C-3 and Appendix E.

The state laws, waiver manual, provider manual, bulletins, and instructional materials applicable to support plan

development are available upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Through the assessment and support planning processes, case managers are responsible to identify a variety of needs, and to identify risks associated with these needs that may affect the participant's health and safety. For example, the assessment identifies areas in which the participant may be vulnerable by assessing the participant's:

- susceptibility to abuse, caregiver neglect, financial exploitation, or self-neglect;
- health needs including, physical disabilities, allergies, sensory impairments, memory loss, potential for seizures, diet and nutrition, medications, and the ability to obtain and follow through with medical treatment;
- physical and cognitive ability to take reasonable safety precautions;
- ability to seek assistance or medical care when needed;
- living environment, including, the type and condition of housing, neighborhood, terrain, accessibility, etc.;
- ability to respond to weather-related conditions, open locked doors, etc.;
- behavioral issues, including behaviors that may increase the likelihood of maltreatment.

Identified health and safety needs are specifically addressed in the support plan. Case managers and assessors are also responsible to develop emergency and back-up plans as necessary: this includes 24 hour plans for participants whose needs warrant them. The emergency back up plans address issues such as emergency medical care, provider no-shows, weather conditions, etc.

The support plan as a whole must reasonably ensure the participant's health and safety before it is approved by the case manager. Support plan development must also reflect personal risk management strategies, as applicable, to address identified risks, including but not limited to any remaining risk when a participant chooses to declines a service that results in a risk related to health and safety. Under person-centered approaches, a participant has the right to assume personal risk, and the case manager is responsible to help identity those risks and help the participant develop personal risk management strategies to mitigate risk. For example, adaptive equipment may be recommended as a strategy to mitigate risk of falls. If the participant declines, the support plan must reflect how the participant will manage that risk, by removing throw rugs, for instance, and agreeing to bathe only when their informal caregiver is available to assist.

In addition, home care and residential providers are required to develop individual risk management plans related to their services (i.e., in addition to the comprehensive support plan and risk management plan). The provider must review the plan at least annually and update it as needed based on the participant's needs and changes to the environment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Counties, tribal nations and MCOs are required to provide participants choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. Counties, tribal nations and MCOs are also required to assist the participant in the support planning process by providing information regarding service options and choice of enrolled waiver service providers listed in the on-line MinnesotaHelp.Info directory and as needed additional local providers qualified by state standards to deliver market rate and receipt-based services. Counties, tribal nations and MCOs must also provide information regarding service types that would meet the level and frequency of services needed by the participant, the funding streams, the general comparative costs and the location of services. Counties, tribal nations and MCOs also provide information on other community resources or services necessary to meet the participant's needs. Refer to Minnesota Statutes, section 256B.0911 and chapter 256S. Refer to appendix B-7 Freedom of choice.

MCOs must include information concerning waiver services and the network of home and community-based service providers in member materials that are provided to enrolled participants. The materials are approved by the department before distribution to participants.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

For FFS participants who are served by counties and tribal nations under a FFS purchasing model, key information from the written support plan is entered into MMIS in what is referred to as a service agreement. The service agreement is participant-specific and includes the name and enrollment number of each service provider, type and category of service, number of units authorized, time span for the service, and rate. In order for a claim to be paid, the service must be authorized in a MMIS service agreement and the information on the claim must be consistent with the authorization and other information captured in MMIS related to the assessment, eligibility and certain service-specific criteria.

Edits in MMIS compare Medicaid eligibility, individual assessment information, and maximum rates to the data entered in the service agreement. The edit structure eliminates the need to manually review service agreements. For example, a claim would not be paid unless the provider type is enrolled to provide the category of service on the claim, the rate and number of units billed is within the authorized amount and time frame, and the participant is Medicaid eligible for the period, meets the level of care for the waiver, and has a current waiver assessment. The department has access to all service agreements support plans are reviewed during reviews for counties and tribal nations.

Managed care organizations also utilize a prior authorization process for waiver services for enrolled participants; waiver providers submitting claims to the MCO must have a prior authorization on record within the MCO. The prior authorization is created by the EW case manager/care coordinator and reflects the formal services included in the support plan.

The support plan is more comprehensive than the service agreement used to authorize Medicaid-funded services. The MMIS service agreement or MCO prior authorization represents those services within a plan that will be funded by the waiver or state plan home care (which is included on the waiver service agreement). The support plan audit is intended to assess whether a sample of support plans have been developed in accordance with applicable policies and procedures, and reflect required support plan elements.
During the support plan audit, which is conducted for both FFS and managed care participants, assessment information is reviewed to assure completion of assessment content. The support plan is then reviewed to determine whether:
1)all assessed needs are addressed in the support plan (through waiver services or other strategies, such as informal caregiving or personal risk management)
2)there is an assessed need associated with all services included in the support plan
3)risk management strategies are included in the support plan for identified health and safety risks, including emergency and back up plans, and personal risk management plans, where applicable

Samples are randomly selected and representative of the waiver population. For individuals enrolled in managed care, support plan auditing is conducted annually by each plan using the sampling method developed by the National Committee for Quality Assurance (NCQA). A description of this sampling method, which relies on a random sample of 30 cases, can be found at https://www.ncqa.org/wp-content/uploads/2018/07/20180110_830_Procedure.pdf. The first 8 cases are reviewed, and if all met all requirements of the audit protocol, no further review of cases is required. In Minnesota, each MCO samples using this method for each MCO delegate managing the waiver. Delegates include contracted counties, contracted care systems and internal care systems.

The computation of state-wide performance averages, confidence levels, and confidence intervals using the MCO care plan audit data reflect the weighting of delegate performance information. The Complex Samples module of SPSS is used to compute state-wide averages, confidence levels, and confidence intervals.

It is important to note that all MCOs have agreed to use the same comprehensive support plan format and data collection protocol for support plan auditing. These comprehensive support plans are also audited for compliance with other Medicare and care coordination requirements for Special Needs Plans and to meet similar requirements under state contracts during the Triennial Review.

The review process samples support plans when counties and tribal nations are reviewed. Sampling is conducted using the sampling method described here.

Sampling Method for Reviews
The State of Minnesota uses a multi-stage sampling methodology for the Lead Agency Reviews (LARs). A multi-stage sample is a specific type of Complex Sample and a probability sample.

The first step is to select the counties and tribal nations for review. They are separated into five groups (cohorts) based on

the size of their entire waiver population served. Counties and tribal nations are then randomly selected for review out of each group based on the number of counties in each group. All counties and tribal nations are reviewed at least once approximately every three years.

The second step is to select the participants to be part of the review. This is a simple random sample of the waiver participants for the selected county or tribal nation. A list of waiver participants is generated from DHS administrative data. The lists are divided by waiver type and from each waiver list participants are selected. If there are less than ten participants on a particular waiver then all participants are selected. Otherwise, a ten percent sample is selected with a minimum of ten participants selected. The actual computation of state-wide averages, confidence level s and confidence intervals are done using the Complex Samples module of SPSS.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for monitoring the implementation of support plans and assuring that participant health and safety needs are reasonably addressed. Monitoring generally occurs through phone contacts and visits with the participant and/or service providers, and is individualized, based on the needs of the participant, and occurs as outlined in the support plan. During monitoring activity, the case manager reviews the supports and services documented within the support plan, to ensure the person's needs are being met through current supports and services, and that the person is satisfied with their services and providers. As needed, the case manager reviews the person's options to update the support plan and exercise informed choice of providers, services and supports. Monitoring includes review of the participant's back-up plans to ensure the safety and well-being of the person is being addressed. Monitoring also includes reviewing with the person any concerns with access to and navigation of social, health, educational, vocational and other community supports, and supporting the person to access non-waiver services as necessary.

Case managers must meet in-person with participants at least annually. Support plans are to be updated any time there is a change in the participant's condition or situation that warrants a reassessment (e.g., change in caregivers' capacity) in accordance with Minnesota Statutes, chapter 256S.

The methods for reporting specific issues will depend on the type of problem identified. Reporting is described in Appendices F, G and I depending on the type of problem identified.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Case managers are responsible for monitoring the support plan implementation including monitoring that the health and safety needs of the participant, as identified in the support plan, are addressed. Case managers are never allowed to be the direct provider of another waiver service. See also D-1.b.

Participant safeguards related to possible conflicts of interest include fair hearing rights, free choice of provider, and the ability to request a different case manager from the same lead agency or seek case management services from another allowable provider. Fair hearings are governed by Minnesota Statutes, §256.045 The contracts between the department and tribal nations require that tribal nations offer participants the option of accessing waiver services through an MCO (as applicable) or county.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of EW participant files reviewed during the lead agency review where the support plan documents participant goals, by waiver year. Numerator: Number of EW files reviewed where the support plan documents participant goals, by waiver year. Denominator: Number of EW participant files reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify:

		Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of EW participant files reviewed during the lead agency review where the support plan documents assessed health and safety issues, byw waiver year. Numerator: Number of EW files reviewed where the support plan documents assessed health and safety issues, by waiver year. Denominator: Number of EW participant files reviewed, by waiver year.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of audited MCO EW support plans in which issues and needs, including health and safety risk factors, identified in the assessment/reassessment are documented, per calendar year. Numerator: Number of EW support plans in which issues and need, including health and safety risk factors, are identified, per calendar year. Denominator: Number of EW care plans audited, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is the one approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percent of audited MCO EW support plans that include services and supports to address identified needs, per calendar year. Numerator: Number of EW support plans that include services and supports to address identified needs, per calendar year. Denominator: Number of EW support plans audited, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☒ **Other**

	Ongoing	Specify: Sampling methodology is the one approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of EW participant files reviewed during the lead agency review in which all domains of assessed needs are documented in the support plan, by waiver year. Numerator: Number of EW participant files reviewed in which all assessed needs are documented in the support plan, by waiver year. Denominator: Total number of EW participant files reviewed by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Waiver Review Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of EW participant files reviewed during the lead agency review where the support plan documents services and supports to address all domains of assessed need, by waiver year. Numerator:Number of EW files reviewed where the support plan documents services & supports to address all domains of assessed needs, by waiver year. Denominator:Number of EW participant files reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of audited MCO EW support plans that include participant goals, per calendar year. Numerator: Number of EW support plans that include participant goals, per calendar. Denominator: Number of EW support plans audited, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

MCO		
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is the one approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of audited MCO EW support plans where care plan is updated within the past 366 days, per calendar year. Numerator: Number of audited EW support plans where care plan is updated within the past 366 days, per calendar year. Denominator: Total number of audited EW support plans, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percent of audited MCO EW support plans where support plan is completed within required timeframes following assessment/reassessment, per calendar year.
Numerator: Number of audited EW support plans where care plan is completed within required timeframes following assessment/reassessment, per calendar year.
Denominator: Total number of audited EW support plans, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of EW participant files reviewed during the lead agency review where the community support plan was updated within the past 366 days, by waiver year. Numerator: Number of EW participant files where the support plan was updated within the past 366 days, by waiver year. Denominator: Number of EW participant files (with a documented support plan date) reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of EW participant files reviewed during the lead agency review in which support plans are completed within required timelines after assessment/reassessment, by waiver year. Numerator: Number of EW participant files in which support plans are completed within 60 days of assessment/reassessment, by waiver year. Denominator: Number of EW participant files reviewed by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of audited MCO EW support plans in which the plan is signed and dated by and disseminated to all relevant parties as required, per calendar year. Numerator: Number of audited EW support plans in which the plan is signed and dated by and disseminated to all relevant parties as required, per calendar year. Denominator: Total number of audited EW support plans, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
For participants enrolled through FFS, percent difference between the dollar amount encumbered for services for EW participants compared to the dollar amount claimed for services provided to EW participants, per wvr year. Numerator: Dollar amount claimed for services provided to EW participants, per wvr year. Denominator: Dollar amount encumbered for services for EW participants, per wvr year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of EW participant files reviewed during lead agency review in which support plan is signed, dated by and disseminated to all relevant parties as required, by waiver year. Numerator: Number of EW participant files reviewed in which support plan is signed & dated & disseminated to all relevant parties, by waiver year. Denominator: Number of EW participant files reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Per calendar year: Percent of audited EW MCO support plans identifying & documenting links to assessed needs, and including type, amount, frequency, duration, cost, and name of provider per service, including non-paid providers and other informal community supports/resources. Numerator: Number of EW support plans audited that meet the stated criteria. Denominator: All EW support plans audited.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Percentage of people whose support staff do things the way they want them done. Numerator: The number of respondents who report "Yes, All Paid Support Workers, Always or Almost Always". Denominator: The number of respondents who answered the question on the NCI-AD Adult Consumer Survey.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators-Aging and Disability Survey results

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%; Margin of Error = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: Every other year	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every other year

Performance Measure:
Percentage of people whose support staff show up and leave when they are supposed to. Numerator: The number of respondents who report "Yes, All Paid Support Workers, Always or Almost Always". Denominator: The number of respondents who answered the question on the NCI-AD Adult Consumer Survey.

Data Source (Select one):
Other
If 'Other' is selected, specify:
National Core Indicators-Aging and Disability Survey results

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95%; Margin of Error = 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Every other year	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Every other year

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Per calendar year: Percent of EW support plans in which documentation indicates the person was given information to enable the person to choose among services and providers of HCBS. Numerator: Number of audited EW support plans in which documentation indicates the person was given service options and provider information. Denominator: Total number of audited EW support plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is the one approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

Performance Measure:
Percent of EW participant files reviewed during the lead agency review in which participant choice between/among waiver services and providers is documented, by waiver year. Numerator: Number of EW participant case files in which participant choice is documented, by waiver year. Denominator: Number of EW participant case files reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis

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.

Care plan auditing is the on-site, eyes-on review of care plans developed for EW participants.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Through the lead agency review, if the department finds the county or tribal nation deficient in a required waiver activity, the deficiency is identified in a report and the county or tribal nation must submit a corrective action plan to correct the identified deficiencies. The corrective action plan is posted on the Department's website at https://mn.gov/dhs/hcbs-lead-agency-review/. All individual cases that are found out of compliance with waiver requirements during the review are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

The MCO support plan audit information provides evidence that support plans are reviewed to assess compliance with requirements, including assessing whether services are delivered in accordance with the service plan. All cases that are found out of compliance with waiver requirements during the audit are required to be corrected. The support plan audit information also provides evidence that corrective action is required as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

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.

Participants have had the option to self-direct their waiver services through the Consumer Directed Community Supports (CDCS) service since 2004.

CDCS allows participants to design an individualized set of supports to meet their needs. CDCS may include traditional goods and services provided by the waiver and alternatives that support participants. The service includes ten categories of supports: Personal Assistance; Treatment and Training; Environmental Modifications and Provisions, Self direction support activities, Environmental Modifications-Home, Environmental Modifications-Vehicle, individual-directed goods and services, Community Integration and support, Financial Management Services and Support Planning. Refer to Appendix C. Participants choose the level of support they want to assist them in developing support plans, monitoring services, and managing budgets and payments. The participants or their representatives must purchase assistance with these functions through a financial management services (FMS) provider. FMS providers offer supports as defined in the agreement between the FMS and the participant; the contract with the State; and provider enrollment standards. Support planners may also provide assistance with employee-related functions as defined in the service standards. Support planners shall not be the employer of record.

When more than one CDCS participant live in the same household and chooses to receive services from the same worker (either shared services or 1:1 service), all participants are required to use the same FMS provider.

When it is determined there is a joint employer, all participants associated with that joint employer must use the same FMS provider.

Participants or their representatives have control over the goods and services to be provided through development and revision of the CDCS support plan, selection of vendors, verification of service delivery, and management of the CDCS budget. The support plan must be developed through a person centered process that reflects the participant’s strengths, needs and preferences. The plan may include a mix of paid and non-paid services. The plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or services was delivered prior to a Medicaid claim being submitted.

The individual budget maximum amount is set by the state by case mix cap and is published at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG. Prior to the development of the support plan, lead agencies will inform the participant of the amount that will be available to the participant for implementing the support plan over a one-year period. Participants may not carry forward unspent budgeted amounts from one plan year to the next.

The support plan identifies: the goods and services that will be provided to meet the participant's needs; safeguards to reasonably maintain the participant's health and safety; and, how emergency needs of the participant will be met. The support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur.

The support plan will specify provider qualifications including training requirements (if they exceed the provider standards) The support plan will also specify who is responsible to assure that the qualification and training requirements are met.

In a 12-month service agreement period, the participant’s individual budget will include all goods and services to be purchased through the waiver and State Plan home care services, with the exception of required case management and criminal background studies.

Case management is separated into lead agency activities that are required to be performed by a lead agency for all waiver participants and other activities that individuals can elect to be performed by a Support Planner to assist them with self-direction of their services. Required case management functions are provided by lead agencies and are not included in the participant’s budget. Required case management activities cannot be completed by the Support Planner. Support planning service is included in the budget. Services to be provided by a Support Planner must be specified in the CDCS support plan as designed by the consumer.

Required Lead Agency Functions (not included in the participant’s CDCS budget):
1. Assess whether the individual is eligible for waiver services including level of care requirements.
2. Provide the participant with information regarding HCBS alternatives to ensure that they make an informed choice.
3. Determine the maximum budget amount for participants who elect CDCS;
4. Provide CDCS participants with resources and informational tool kits to assist them in managing services.

5. Ensure that the CDCS support plan addresses the participant's health and safety needs.
6. Evaluate if the plan is appropriate including that the goods and services meet the service description and provider qualifications
7. Review the CDCS support plan and service rates
8. Authorize waiver services
9. Monitor and evaluate the implementation of the CDCS support plan, including health and safety, satisfaction, the adequacy of the current plan and the possible need for revisions (this includes taking action to address suspected or alleged abuse, neglect, or exploitation of a participant as a mandated reporter according to the Vulnerable Adults Act)
10. Review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter. Monitoring requirements are increased when the provider is the spouse of a participant.
11. Monitor the management of the budget and services.
12. Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. "Budget and fiscal records management" refers to the participant's ability to manage budget and recordkeeping tasks such as retaining and submitting receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider.
13 Assist the state agency in completing satisfaction measurements as requested.

Support Planner Direct Support Functions (included in the participant's CDCS budget):
1. Provide information about CDCS and provider options.
2. Facilitate the development of a person-centered CDCS support plan.
3. Monitor and assist with revisions to the CDCS support plan.
4. Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.
5. Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.).
6. Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers.
7. Provide staff training that is specific to the consumer's CDCS support plan.

Case managers must apply the criteria for allowable expenditures (See the descriptions for CDCS services in Appendix C-1/C-3) to all CDCS services, supports, and items to determine whether the service, support, or item may be authorized in the CDCS support plan. If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures (listed in Appendix C), it cannot be authorized and the case manager must provide the participant or the participant's representative notice of appeal rights.

Budgets may include:
(1) Goods or services that augment State plan services, or provide alternatives to waiver or State plan services. The rates for these goods and services are included in the CDCS support plan.
(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
(3) Therapies, special diets and behavioral supports when they are not covered by the State plan and are prescribed by a physician, advanced practice registered nurse, or physician assistant who is enrolled as a MHCP provider.
(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. There must be no other reasonable alternative to meet the participant's fitness or exercise need, and the condition must be identified in the participant's CDCS support plan and monitored by a MHCP-enrolled physician, advanced practice registered nurse, or physician assistant.
(5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. This support may be provided via care coordination (or case management) through the lead agency or by another entity., and may include but is not limited to assistance in determining what allowable services and supports will best meet the participant's assessed needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The participant chooses who will provide the service/support and how much of each service/support will be included in the CDCS support plan, within the budget. (6) Costs incurred to manage the budget; advertise for and train staff; pay employer fees (FICA, FUTA, SUTA, and workers compensation, unemployment and liability insurance) as well as employer share of employee benefits, and retention incentives (i.e., bonus, health insurance, paid time off).

Refer to Appendix C for the CDCS service description and provider standards.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

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

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **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.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participants are not eligible for CDCS if they have been placed in the Minnesota Restricted Recipient program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the Minnesota Restricted Recipient Program. People receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or receiving customized living services are not eligible for CDCS.

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.

Waiver participants are given information about participant-directed options at assessment and during care planning. 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 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 enrolled financial management services (FMS) providers that are available to the participant; and information about the qualifications and activities of a support planner. This is all done before and/or during CDCS support plan development.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representatives are chosen freely by adult participants. The extent of the decision-making authority of the participant and their representative is part of the support planning. The lead agency case manager is required to conduct in-person visits twice per year, and is required to conduct quarterly reviews of expenditures and services provided, and monitor the health, safety and well-being of the participant. See the CDCS Community Supports Lead Agency Operations Manual at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4270-ENG

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☒	☒
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☒	☒

Waiver Service	Employer Authority	Budget Authority
Consumer Directed Community Supports (CDCS): Support Planning	☒	☒
Consumer Directed Community Supports (CDCS): Treatment and Training	☒	☒
Consumer Directed Community Supports (CDCS): Personal Assistance	☒	☒
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☒	☒
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☒	☒
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☒	☒
Consumer Directed Community Supports (CDCS): Community Integration and Support	☒	☒
Consumer Directed Community Supports (CDCS): Financial Management Services	☒	☒

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*:

◉ **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*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

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*:

◉ **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 and financial management services

○ **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: Financial Management Services and self-direction support activities.

The FMS provider must have a written agreement with the participant that identifies the duties and responsibilities of the FMS provider as well related charges.

All FMS providers must establish and make public the maximum rate(s) for their services. The scope of FMS services to be provided to an individual must be determined by the consumer, and documented in the person's CDCS support plan. The rate for these services is negotiated between the participant or the participant's representative and the FMS provider and is included in the CDCS 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 CDCS budget, under the category of Consumer Directed Community Supports: Financial Management Services and 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:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of**

the participant-directed budget

☐ **Other**

Specify:

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 a readiness review process 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.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

This section delineates and distinguishes those mandatory functions of the lead agency (required case management), and those optional functions that are covered under CDCS: Support Planning Services.
Required lead agency functions that are not included within the CDCS budget:
- Determine if individuals are MA eligible (financial assistance unit)
- Assess to determine if the individual is eligible for waiver services including level of care requirements
- Provide the participant with information regarding HCBS alternatives to make an informed choice
- If the applicant or participant elects CDCS, provide them with their maximum case mix budget amount
- Provide CDCS participants with resources and informational tool kits to assist them in managing the service
- Evaluate how the participant's CDCS support plan will reasonably ensure health and safety needs are expected to be met given the CDCS support plan, including provider training and standards.
- Evaluate whether the CDCS support plan is appropriate, including that the goods and services meet the service description and provider qualifications, rates are appropriate, etc.
- Review the service plan and MMIS service agreement, review rates, and set limits by service category
- Authorize waiver services (prior authorize the MMIS agreement) for FFS participants. MCOs perform authorizations in their own systems
- Monitor and evaluate the implementation of the CDCS support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions. This includes taking action as a mandated reporter when required to address suspected or alleged abuse, neglect, or exploitation of a participant according to the Vulnerable Adult and Maltreatment of Minors Acts.
- At a minimum, review the consumer’s budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter (monitoring requirements are increased when the provider is the spouse of a participant).
- Monitor the management of the budget and services
- Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. "Budget and fiscal records management" refers to the participant’s ability to manage budget and recordkeeping tasks such as retaining and submitting receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider.
- Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction
- Assist the state agency in completing satisfaction measurements as requested
- Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested
Optional, direct support functions (support planning) that are included in the CDCS budget:
- If the participant elects waiver services, provide information about CDCS and provider options
- Facilitate development of a person centered CDCS support plan
- Monitor and assist with revisions to the CDCS support plan
- Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers
- Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.)
- Monitor the provision of services including such things as interviews or monitoring visits with the participant or service providers
- Provide staff training that is specific to the participant's CDCS support plan.

People who are paid through CDCS to assist with the development of the participant's person-centered support plan must:
-be 18 years of age or older
-pass a test developed by the department on person-centered support planning approaches, including the Vulnerable Adult Act
-use the CDCS support plan template or format that includes all the required information to authorize CDCS

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Extended Home Care Nursing	☐
Environmental Accessibility Adaptations – Vehicle Modifications	☐
Home Delivered Meals	☐
Extended State Plan Personal Care Assistance (PCA)	☐
Adult Day Service	☐
Adult Foster Care	☐
Chore Services	☐
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☒
Consumer Directed Community Supports (CDCS): Support Planning	☒
Consumer Directed Community Supports (CDCS): Treatment and Training	☒
Homemaker	☐
Transitional Services	☐
Family Caregiver Services	☐
Respite	☐
Consumer Directed Community Supports (CDCS): Personal Assistance	☒
Specialized Equipment and Supplies	☐
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☒
Managed Care Premiums	☐
Case Management	☐
Adult Companion Services	☐
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☒
Individual Community Living Supports	☐
Adult Day Service Bath	☐
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☒
Consumer Directed Community Supports (CDCS): Community Integration and Support	☒
Extended State Plan Home Health Care Services	☐
Customized Living Services	☐
Consumer Directed Community Supports (CDCS): Financial Management Services	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Transportation	☐
Environmental Accessibility Adaptations - Home Modifications	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The lead agency case manager initiates a change in the support plan in order to provide traditional waiver services other than CDCS. All of the standard EW waiver services that are necessary to the participant are available to a participant who voluntarily terminates CDCS services. There are no gaps in services during transition.

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 support plan in order to provide waiver services other than CDCS. The CDCS option is not available to a participant during the time the participant has been placed in the Minnesota Restricted Recipient Program (MRRP).

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. A participant can become ineligible for CDCS services if they move to and receive licensed foster care in a residential setting licensed by DHS or if a participant receives customized living services.

The lead agency case manager may initiate an involuntary exit from CDCS when:

- Health and safety concerns arise;
- Suspected fraud or misuse of funds are evident; or
- A fourth occurrence from the date of CDCS authorization requiring corrective action (additional technical assistance) is encountered.

The participant may be immediately exited from CDCS and returned to traditional waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		745
Year 2		778
Year 3		806
Year 4		835
Year 5		866

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*:

☐ **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:

☒ **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*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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

☐ **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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participant Budgets. The individual budget maximum amount is set by the state based on the participant's case mix budget cap. Required case management and mandatory background studies are outside of the CDCS budgets. CDCS support planning services are included in the budget. Limits may be adjusted annually based on adjustments authorized by the legislature. The case mix budget limits are published annually. The lead agency is responsible to review and approve final spending decisions as delineated in the participant's CDCS support plan. The individual budget caps can be found at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG.

An individual's budget is based on the assessed need for services in the support plan. Goods and services are priced within the maximum budget amounts. Participants are given choice of goods and services that are assessed within their budget limits. When a CDCS participant experiences a significant change in need, the lead agency may authorize a budget change for that CDCS participant based on the results of the assessment.

Exceptions to the CDCS budget methodology may be allowed for individuals who meet the following criteria:
1. The CDCS participant is eligible for 10 or more daily hours of personal care assistance; and
2. The CDCS participant's services are provided by a worker who has completed training requirements.

Individuals who meet this criteria may request a CDCS budget exception to increase their CDCS budgets by the value enacted by the Minnesota Legislature.

All participants are afforded the opportunity to request a fair hearing when there is a denial, termination or reduction in services or the amount of their CDCS budget is reduced or a CDCS budget adjustment is denied. The procedure to request a fair hearing and how participants are informed of their fair hearing rights are described in Appendix F-1.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The lead agency case manager/care coordinator informs each participant of their budget amount based on their assessed need and resulting case mix budget cap.

Individuals in both CDCS and traditional waiver services can always contact their case manager/care coordinator to discuss changes in needs or concerns about their support plan. For CDCS individuals, support planners can also review the adequacy of the CDCS support plan with the individual. If an individual has remaining resources under their current budget cap, the support plan can be amended. If the change in need warrants a change in case mix classification, the budget amount would be changed and a revised support plan would be developed, with approval by the lead agency of the participant's revisions. The full array of traditional waiver services is available to CDCS participants.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Required Case Management:

The lead agency is responsible to:

1) Review and approve the CDCS support plan to determine if it meets the criteria in Appendix C-1/C-3. All goods and services to be covered by CDCS must be specified in the CDCS support plan and prior authorized by the lead agency case manager/care coordinator. There must be a clear audit trail.
2) Monitor and evaluate the implementation of the CDCS support plan. This includes reviewing that health and safety needs are being adequately met, the participant's level of satisfaction, the adequacy of the current plan and the possible need for revisions, the maintenance of financial records, and the management of the budget and services.
3) Review each participant's CDCS expenditures, at a minimum, within three months, six months, and twelve months of the support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved CDCS support plan.
4) Review expenditures and the participant's health and safety at least once per quarter when a spouse is being paid through CDCS.
5) Provide additional technical assistance and support to the participant or their representative if it is determined that the participant or their representative has not followed the authorized CDCS support plan. This may include a corrective action plan. If efforts to resolve problems in using CDCS are unsuccessful, the CDCS authorization will be discontinued after providing the required notifications. The participant's support plan will return to traditional waiver or state plan services.
6) Provide notice, and terminate CDCS services if there are immediate concerns regarding the participant's health and safety or misuse or abuse of public funds and report the concern to the appropriate local or state agency for investigation. The notice will include fair hearing rights and inform participants that their CDCS services are being terminated or suspended pending the outcome of the hearing if one is requested. The participants' will return to other waiver or state plan services pending the outcome of the hearing.
7) Provide or arrange for the provision of information and/or tools for participants or their representatives to direct and manage goods and services provided through CDCS. This will include information or assistance in locating, selecting, training, and managing workers as well as completing, retraining, and submitting paperwork associated with billing, payment and taxes and monitoring on-going budget expenditures.
8) Assist the state agency in conducting consumer satisfaction measurements as requested. Provide consumer satisfaction, utilization, budget and discharge summary information to the state agency as requested.

State Agency Responsibilities:
Annually, the state agency will review and analyze access and utilization data, and the number and disposition of CDCS appeals.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following identifies how participants are informed of their fair hearing rights. There are slight differences in the notification processes and documents between participants whose waiver services are covered on a fee-for-service (FFS) basis and managed care. The lead agency is responsible for providing all notices to participants. All forms are available on the department's web site at: http://mn.gov/dhs/general-public/publications-forms-resources/edocs/

How Information is Provided:
All applicants and participants: Fair hearing information is provided at the time an individual applies for Medicaid, at the time an individual is assessed for home- and community-based services, when a support plan is approved, and when a service is reduced, suspended or terminated. Participants may also submit fair hearing requests if they feel that they have not been offered free choice of provider. The participant is afforded the opportunity to request a fair hearing when their request for a budget adjustment is denied or the amount of the budget is reduced.

Participants enrolled in managed care: Each year during open enrollment, the department sends fair hearing information to participants enrolled in managed care. This information is also sent when there are legislative changes that may affect participants' services. Participants enrolled in managed care also receive a certificate of coverage at enrollment, and annually thereafter, that includes their rights and fair hearing information. The department reviews and approves all managed care member materials.

All participants: Legislative information is forwarded to all participants when there are legislative changes that may affect the individual's waivered services.

All participants: The department publishes a handbook for participants and families: Older Minnesotans, Know Your Rights About Services (DHS-4134). The handbook includes information about fair hearing rights and is available on the department's web site and through lead agencies.

Fee-for-service participants: Each service authorization, and all subsequent changes to services authorizations, generates a letter created by MMIS forwarded to FFS participants that includes information about fair hearing rights

All participants: Fair hearing information is available on the department's web site at:
https://mn.gov/dhs/general-public/about-dhs/administration-management/appeals.jsp

Notices Provided:
The following forms are used to provide fair hearing information:

Fee-for-service participants: Minnesota Health Care Programs Application, DHS-3876 or DHS-3531 and MHCP Minnesota Health Care Programs Renewal Form (DHS-3418). These forms are used to apply for and renew Medical Assistance and include fair hearing rights.

Participants enrolled in managed care: Notice about your Rights and Responsibilities For the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+), DHS-3214A. This notice is provided to participants who inquire about enrolling in managed care. This notice explains participant rights for managed health care programs MSHO and MSC+. As mentioned above, participants enrolled in managed care also receive a certificate of coverage at the time of enrollment, and annually thereafter, which provides information regarding participants' rights including fair hearing rights.

Participants enrolled in managed care: Ombudsman for State Managed Health Care Programs, DHS-6507. This describes how the ombudsman can help people in health plans for their Medical Assistance coverage and it includes examples of when to call the ombudsman office and an overview of the appeals process.

Fee-for-service participants: Long-Term Services and Supports Notice of Action (Assessments and Reassessments), DHS-2828A or MnCHOICES Assessment summary. These notices must be provided to participants after the initial assessment and subsequent reassessments to inform the participant of their eligibility for services and any changes to the services that they receive. The Long Term Services and Supports Notice of Action DHS-2828B (Service Plan). This form must be provided to FFS participants when there is a denial, decrease, or termination in waiver services and to notify the participant of their appeal rights regarding the action(s). This form also informs participants that their benefits may continue until the case is adjudicated.

Participants enrolled in managed care: The MnCHOICES Assessment summary must be provided to participants after the initial assessment and subsequent reassessments to inform the participant of their eligibility for services. Denial, Termination and Reduction notice. MCOs are required to inform participants when a service is denied, terminated, or reduced (DTR). The notice contains fair hearing information. The department reviews the notices to assure they contain required information. Each quarter,

MCOs must provide the department with copies of all DTR notices that they issued to participants. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's case file. The participant's care coordinator is responsible for sending the fair hearing notices.

Fee-for-service participants: Long Term Services and Supports Assessment and Program Information and Signature Sheet, DHS-2727. This form is provided at the time an individual initially is assessed and upon reassessment and indicates the person was informed of their appeal rights .This form also informs participants that their benefits may continue while the appeal is under consideration. This includes the continuation of services during the state fair hearing process if the individual elects to continue to receive services. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's paper or electronic case file for both FFS and Managed Care.

All forms are available on the department's web site at:
https://mn.gov/dhs/general-public/publications-forms-resources/edocs/h

State law and polices for all participants: The Department's policies and instructions regarding notice of action are available in the web-based manual, Community-Based Services Manual, in the Appeals section of the manual. Manuals can be found at http://mn.gov/dhs/general-public/publications-forms-resources/manuals/

When the person requests an appeal, he/she has the right to keep his/her benefits the same as they were before the notice of action. This is true until the human services judge makes a final decision. Participants are informed that they have a right to continue their services through the notice of action form (DHS-2828A and DHS-2828B). The Department's Appeals Division maintains all records related to appeals filed by participants.

Refer to Minnesota Statutes, section 256S.14 for regulations concerning written notice of any denial, reduction or termination of elderly waiver services.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

For participants who are enrolled in managed care, the MCOs must provide an alternative dispute resolution process. Participants may request a fair hearing through the department after they file an appeal or grievance through the health plan as required under 42 C.F.R. § 438.408(f)(1). Participants' fair hearing rights are preserved if they submit an appeal or grievance to their MCO.

The scope of issues that may be addressed through the appeal and grievance process includes a broad range of issues from the quality of a specific service to the level of courtesy shown by the staff at a clinic. This scope is included in MCO contract requirements.

There are timelines that the MCOs must abide in addressing appeals and grievances. These differ based on the nature of the issue and service involved. The MCOs' processes related to and outcomes of appeals and grievances are monitored by the department, the Office of the Ombudsman for State Managed Health Care Programs, and the Minnesota Department of Health. MCOs must also submit copies of all appeals and grievances to the department on a quarterly basis. The department monitors these submissions for trends and patterns.

In addition, participants may seek assistance from the Office of Ombudsman for State Managed Health Care Programs to help resolve an issue of concern. The Ombudsman's staff will also assist the participant with filing an appeal or grievance with the MCO or requesting a fair hearing through the department.

Participants are notified of the appeal and grievance processes and the right to a fair hearing through the Certificate of Coverage, the Annual Rights and Responsibilities Notice, and on each notice of a denial, termination, or reduction in service that they receive.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

Grievances or complaints may be reported to the following agencies:
For fee-for-service participants
Lead agencies
The Office of the Ombudsman for Long Term Care
The Office of the Ombudsman for Mental Health and Developmental Disabilities
The Minnesota Department of Health, Office of Health Facility Complaints
The Minnesota Department of Human Services, Surveillance and Integrity Review Section (SIRS)
The Minnesota Department of Human Services, Licensing Division
The Minnesota Department of Human Services, Aging and Adult Services Division

For participants enrolled in managed care:
In addition to all of the above, MSHO and MSC+ participants may also report grievances or complaints to the Office of the Ombudsman for State Managed Health Care Programs.

As discussed in response to Appendix F-2(b), MSHO and MSC+ participants may also file a grievance or appeal with the managed care organization. Contracts between the department and the MCO provide timelines that participants must follow to file a grievance or appeal, and the timelines that the managed care organization must follow to issue a response. MCOs must report all grievances to the department. Participants' fair hearing rights are preserved and they may concurrently file a fair hearing request with the department.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that

participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Fair hearing rights are not affected when a participant reports a concern to any of the entities noted below (i.e., a participant may concurrently work to resolve an issue via an Ombudsman, for example, and request a fair hearing). Participants are informed that they may request a fair hearing if they disagree with the health plan's decision on their initial appeal or if the health plan takes more than 30 days to decide the initial appeal. See DHS-3214A. Depending upon the nature of the concern, local adult protection, state or county licensing entities, or law enforcement units may also be notified.

The Ombudsman's offices listed above provide assistance and referral regarding any service concerns including those related to Medicaid waivers. Ombudsmen speak with the individual reporting the complaint or concern as quickly as possible. Depending upon the nature of the concern, they may contact the lead agency, provider, or department to assist the participant in resolving the issue. Case Managers can assist individuals in appeals under Minnesota Statutes, section 256.045

The Minnesota Department of Health, Office of Health Facility Complaints, addresses complaints and allegations concerning providers or managed care organizations that they license (e.g., home care agencies, etc.) to determine if an investigation is warranted. If there is an indication that an individual in is imminent jeopardy, the county or tribal nation adult protection unit may initiate immediate protective services.

The Office of Health Facility Complaints takes action within ten days or sooner depending upon the allegation. The Department of Health informs the provider of its findings and issues correction orders. The time frame allowed for the provider to remedy the problem is based on the risk of harm to individuals. If the problem is not remedied satisfactorily, the Department of Health takes further action, which can include license revocation.

The Department's Surveillance and Integrity Review Section and, as applicable, the Medicaid Fraud Control Unit in the Office of the Minnesota Attorney General are responsible for follow-up on and investigation of complaints related to provider billing.

The Department's Licensing Division is responsible for follow-up on complaints concerning providers that are licensed by the department. Depending upon the situation, an investigation may be conducted. The time lines and action taken are dependent on the nature and scope of the allegations(s) and findings. If a participant is determined to be in imminent jeopardy, action is taken as soon as possible to address the person's health and safety.

The Department's Aging and Adult Services Division is responsible for follow-up complaints 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 time lines and action the division undertakes depend upon the nature and scope of the allegations(s) and finding(s).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Minnesota manages intake and response to maltreatment of all vulnerable adults through the state's adult protection system described in the statute below. Safeguards are provided under state statute for adults unable to protect themselves from maltreatment which includes critical events, incidents, abuse, neglect or exploitation. Refer to Minnesota Statutes, sections 626.557 to 626.5572 at:
- https://www.revisor.mn.gov/statutes/cite/626.557;
- https://www.revisor.mn.gov/statutes/cite/626.5571; and
- https://www.revisor.mn.gov/statutes/cite/626.5572

Critical events or incidents defined as maltreatment require immediate reporting. Maltreatment includes, but is not limited to, criminal acts, actions that cause physical pain, injury or emotional distress , adverse or deprivation procedures not authorized under statute, unreasonable confinement, involuntary seclusion, forced separation, the failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision and, for adults, failure by the person to meet their own basic needs as well as financial exploitation.

State law requires immediate reporting by mandated reporters of suspected maltreatment. Mandated reporters include professionals or a professional's delegates engaged in the care of vulnerable adults, those engaged in social services, law enforcement, vocational rehabilitation, licensed health care providers, or those who work in a health care facility or licensed service. Voluntary reports of suspected maltreatment can be made by any person and are encouraged through information, training and education provided by department.

Reports of suspected maltreatment of a vulnerable adult are required to be made by mandated reporters and may be made by any person. All reports are received by the centralized Minnesota Adult Abuse Reporting Center (MAARC), the single state-wide common entry point (CEP) designated by the commissioner. MAARC enters each report into the state's Social Services Information System (SSIS) and makes required evaluation and referrals for further action.

Minnesota's reporting system currently captures all reports of adult maltreatment collected by the centralized Minnesota Adult Abuse Reporting Center for adult waiver participants, as well as dispositions of county investigations for adult waiver participants. The MAARC operates on a 24-hour basis.

The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes immediate referral to the county social service agency or tribal nation for emergency protective services. Vulnerable adults who are the subject of reports of suspected maltreatment are offered emergency and continuing protective social services for purposes of safeguarding the person and preventing further maltreatment. Immediate notification is made by MAARC to law enforcement if the report contains suspected criminal activity.

If a report is made initially to law enforcement or a lead investigative agency, those agencies are required to take the report and immediately forward it to the MAARC.

When an allegation includes death as a result of maltreatment, referral is also made to the medical examiner and the Ombudsman for Mental Health and Developmental Disabilities.

Each report is referred to the appropriate lead investigative agency (LIA) as soon as possible, but no later than two working days from the receipt of the report. All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency responsible, under statute, for investigation. The LIA's are: county adult protection agencies, DHS-OIG Licensing and the Minnesota Department of Health's Office of Health Facility Complaints (OHFC).

Lead Investigative Agencies

The Minnesota Department of Human Services Licensing Division is the agency responsible for assessing or investigating allegations of maltreatment involving providers of services licensed under Minnesota Statutes, chapters 245A and 245D, including foster care and adult day service. The Minnesota Department of Health, Office of Health Facility Complaints is the agency responsible for assessing or investigating home care providers licensed under Minnesota Statutes, chapter 144A, including customized living. The local human services agencies are responsible for assessing and investigating allegations of maltreatment by informal caregivers, self-neglect, and those involving non-licensed providers and personal careprovider organizations.

Complete information about the role of the Minnesota Adult Abuse Reporting Center, the Common Entry Point for

reporting suspected maltreatment of a vulnerable adult and policies and practice requirements for county lead investigative agencies responsible for reports and adult protective services can be found at:

- Minnesota Department of Human Services Adult Protection Manual (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6917-ENG)
- Professionals and mandated reporters: (https://tnt09.agileapps.dhs.state.mn.us/networking/sites/880862836/MAARC)
- Public, consumer content: (http://mn.gov/dhs/people-we-serve/seniors/services/adult-protection/)

In addition to reporting maltreatment to the common entry point, providers licensed under Minnesota Statutes, Chapter §245D are required to report the following incidents to the department and the Ombudsman for Mental Health and Developmental Disabilities:

1. serious injury of a person as determined by Minnesota Statutes, section 245D.06;
2. a person's death; and
3. any emergency use of manual restraint as identified in Minnesota Statutes, section 245D.061.

Providers licensed under Minnesota Statutes, chapter 245D must report the following incidents to the person's authorized representative and case manager:

1. serious injury of a person as determined by Minnesota Statutes, section 245D.06;
2. a person's death;
3. any emergency use of manual restraint as identified in Minnesota Statutes, section 245D.061;
4. any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition that requires the program to call 911, physician treatment or hospitalization;
5. any mental health crisis that requires the program to call 911 or a mental health crisis intervention team;
6. an act or situation involving a person that requires the program to call 911, law enforcement or the fire department;
7. a person's unauthorized or unexplained absence from a program;
8. conduct by a person receiving services against another person receiving services that
   a. is so severe, pervasive or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;
   b. places the person in actual and reasonable fear of harm;
   c. places the person in actual and reasonable fear of damage to property of the person; or
   d. substantially disrupts the orderly operation of the program;
9. any sexual activity between persons receiving services involving force or coercion as defined under Minnesota Statutes, section 609.341, subdivisions 3 and 14.
10. A report of alleged or suspected child or vulnerable adult maltreatment under Minnesota Statutes, section chapter 260E or section 626.557

245D license holders must report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided or within 24 hours of discovery or receipt of information that an incident occurred. 245D license holders must report the death or serious injury of a person to the department and the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours. Case managers are responsible to develop a support plan that reasonably ensures the health and safety of the participant, as well as the coordination, evaluation and monitoring of services provided. Case managers will consult with the participant and their team after an incident to evaluate if a change is necessary in the person's support plan, up to and including a change in the service provider.

Providers licensed as home care providers under Minnesota Statutes, section 144A must report suspected maltreatment to the CEP.

Compliance with mandated reporting requirements, including documentation and response at the participant level, is reviewed during licensing surveys and corrective actions issued for non-compliance.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Providers who furnish home care services are required to provide their clients with a copy of the Home Care Bill of Rights and information about how to report maltreatment concerns. The Bill of Rights is provided to waiver participants who receive services through a home health care agency. This includes participants who receive customized living services. Routine licensing reviews of providers include monitoring that participants are informed of their rights as required. The Home Care Bill of Rights, including copies in other languages, can be accessed at:
- https://www.health.state.mn.us/facilities/regulation/billofrights/index.html

The department provides training to counties, tribal nations and MCOs regarding vulnerable adult reporting, triage, and follow-up, including training for waiver case managers. The department offers an on-demand course on Vulnerable Adult Mandated Reporting, at http://registrations.dhs.state.mn.us/WebManRpt and publishes a vulnerable adult brochure "Report suspected abuse, neglect, self-neglect or financial exploitation of vulnerable adults" (DHS-6778E). The brochure includes information about what may be considered abuse, neglect, and exploitation, and how to report concerns. The department publishes a handbook for participants and families, "Older Minnesotans, Know Your Rights About Services," DHS-4134. The handbook includes information about participants' rights to "be safe and free from harm," including how to report a concern and information about advocacy assistance. The brochures and more information regarding vulnerable adult protections are available on the department's web site and the DHS Adult Protection Resource Page (https://mn.gov/dhs/people-we-serve/seniors/services/adult-protection/resources). The brochures are also available through lead agencies, who provide copies during waiver assessments. All DHS forms, including consumer products, can be found at http://mn.gov/dhs/general-public/publications-forms-resources/

The Long Term Care Consultation tool (DHS-3428) and MnCHOICES assessment used to determine waiver eligibility contains assessment questions intended to help discover any risk for maltreatment the applicant may be experiencing. Risks are to be addressed in the support plan required for each waiver participant. An assessor is a mandated reporter and is required to forward to the CEP reports of any alleged maltreatment by an informal caregiver or by a service provider. Actions taken would follow those outlined above related to the CEP and next steps related to investigation and the provision of protective services.

The Senior Linkage Line (SLL) and Minnesota Disability Hub are widely publicized public resources that include information on vulnerable adults and how to report maltreatment. These resources are operated by the department and other partners and include toll free phone numbers and a searchable web data base. Information about this resource is also provided during assessment. Information about the SLL and Disability Hubcan be seen at:
- the Senior Linkage Line website (https://mn.gov/senior-linkage-line/)
- Minnesota Disability Hub https://disabilityhubmn.org

The MinnesotaHelp Info website provides information on services for people at https://www.minnesotahelp.info/Index

Foster care providers are required to complete an "Individual Residential Placement Agreement" as defined in Minnesota Rules, part 9555.5105, subpart 19. This placement agreement must include the development of an individual abuse prevention plan with the participant.
Adult Day Care providers are required under MN Rule 9555.9640 to provide participants with a copy of their rights, and must include either a copy or written summary of MN Statute 626.557 (Reporting of Maltreatment of Vulnerable Adults).

Routine licensing reviews of providers include monitoring that participants are informed of their rights as required.

Providers licensed under Minnesota Statutes, Chapter 245D must provide participants with a written copy of their rights as defined in Minnesota Statutes, section 245D.04, subdivisions 2 and 3.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

INITIAL REPORT REVIEW AND RESPONSE
Incidents of suspected abuse, neglect, or exploitation are reported to MAARC, the centralized, statewide common entry point (CEP). MAARC staff screen all reports for immediate risk and make all necessary referrals for adult protective services before forwarding reports to the lead investigative agency. MAARC staff work with a standardized screening and decision-making framework in responding to reports. Immediate referral is made by the CEP to county social services when there is an identified safety need. Reports containing information regarding an alleged crime are forwarded immediately by the CEP to law enforcement. Reports of suspicious death are forwarded immediately to law enforcement, the medical examiner and the Ombudsman for mental health and developmental disabilities.

For reports not containing an indication of immediate risk, the CEP is responsible to notify the lead agency responsible for investigation within no more than two working days.

Investigation guidelines for all lead investigative agencies are established in statute and include interviews with alleged victims and perpetrators, evaluation of the environment surrounding the allegation, access to and review of pertinent documentation and consultation with professionals. Each lead investigative agency evaluates reports based on prioritization guidelines. The department requires county lead investigative agencies use structured decision-making tools to assess reports for investigation and to determine the need for protective services. Statewide implementation of structured decision-making tools promotes safety through consistent, accurate, and reliable assessment. Lead investigative agencies and law enforcement agencies cooperate in the pursuit of civil and criminal maltreatment investigations.

Lead investigative agencies have 60 calendar days to complete the investigation, with authority to extend the investigation when a final investigative disposition is not able to be made within this timeframe. (Upon the request of the reporter, the lead investigative agency will provide initial disposition information within five working days.)

The lead investigative agency is responsible to notify the proper agencies or individuals of the findings. Participants, who are the subject of reports, or their legal surrogate with appropriate authority, are informed of the findings of the investigation within ten calendar days following the conclusion of the investigation with an opportunity to engage an appeal process. If maltreatment is substantiated, information about the perpetrator is entered into the perpetrator registry maintained by the department. This information is made available as part of required provider employment background checks. Notification of substantiated maltreatment reports is made to licensing boards, which may refer for criminal prosecution. Information on specific categories of providers substantiated for maltreatment is available to the public on web-based information maintained by the lead investigative agencies for those providers.
See MDH: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html and
DHS Licensing : http://licensinglookup.dhs.state.mn.us/

REMEDIATION AT THE LEVEL OF THE INDIVIDUAL:
County agencies provide individual remediation to adults who are the subject of reports of suspected maltreatment, including the following:
• Offering emergency and continuing adult protective services;
• Medical examination and treatment for sexual assault;
• Seeking authority to remove the vulnerable adult from the situation;
• Seeking a restraining order for removal of the perpetrator;
• Appointment or replacement of a guardian or conservator;
• Referral to a prosecuting attorney for criminal prosecution;
• Use of a multidisciplinary adult protection team for case consultation, prevention, and intervention.

Substantiated maltreatment may be the result of relationships, scams, stranger crimes and circumstances that are unrelated to a service or provider. It is not possible for the lead investigative agency or the county agency responsible for protective services to remediate forms of maltreatment which occur in conjunction with an adult’s autonomy and right to personal choice.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Supported in part by funding under a CMS Systems Change Grant, DHS developed, implemented and manages a centralized maltreatment reporting and data collection system housed within the Social Services Information System (SSIS). This system stores adult maltreatment reports for the MAARC Common Entry Point (CEP). This system supports the referral of reports to lead investigative agencies, as well as county functions related to vulnerable adult report intake and maintenance of county investigative results. Once maltreatment investigations are completed by the county as Lead Investigative Agency, the county investigative findings are documented within SSIS.

The SSIS system has the capacity to provide statewide maltreatment summary information to DHS. DHS reviews SSIS data reports on a quarterly and annual basis, analyzing report receipt, referral, investigation and investigative dispositon patterns and trends. Data analysis yields routine reporting and efforts, with maltreatment system partners, to make preventive and response improvements. Maltreatment data gathered from SSIS is also used by the DHS to evaluate quality in preventative and protective services provided to vulnerable adults, assess trends in maltreatment, target training issues and identify opportunities for program improvement.

The existing infrastructure for vulnerable adult reporting and follow-up, as described above applies to waiver participants unable to protect themselves from maltreatment. Information from all reports taken by the CEP is submitted to the department.

Maltreatment data in SSIS can be run by waiver programs as frequently as requested by program/policy staff. Due to data entry of findings, which can take up to 60 days, analysis of data is most meaningful on a quarterly basis, State Adult Protection staff manage the SSIS data base or “data mart” housed within DHS’ data warehouse, and produce reports (still in design) related to the Adult Protection program statewide, as well as reports created for specific programs, including for the Elderly Waiver. Waiver policy staff review these reports quarterly and work with Adult Protection staff to determine appropriate systems improvement response if trends are discovered for populations, geographic regions, particular providers, or findings related to any other variables contained in the CEP report data mart (age, gender, living arrangement, etc,).

The SSIS data mart currently contains all MAARC reports, and findings from county investigations. DHS continues to work to finalize integration of findings from the Department of Health as well as the DHS Licensing division. Data from these agencies is available by DHS request until this integration is complete. DHS and MDH licensing units generate their own licensed facility/provider maltreatment reports on a regular basis.

Lead investigative agencies provide public investigation memorandums for substantiated reports of maltreatment. Substantiated findings are forwarded to the appropriate licensing boards of the substantiated perpetrator. Substantiated findings for licensed providers are available on the DHS and Minnesota Health Department public websites and are used for licensing sanctions or revocation. Please see MDH:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
and DHS Licensing : http://licensinglookup.dhs.state.mn.us/

Lead investigative agencies provide DHS with the names of substantiated perpetrators. DHS maintains a registry of perpetrators of substantiated maltreatment who are disqualified from providing direct services. People applying for a license, and including owners, managers, employees and contractors providing services in licensed programs and settings are checked against the DHS disqualified perpetrator registry.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Any adverse or deprivation procedure or involuntary seclusion is defined under Vulnerable Adult (VA) statute as reportable maltreatment. See Appendix G-1-b for reporting requirements, Appendix G-1-d for review of and response to reports, and Appendix G-1-e for oversight of reporting, review and response.

The Vulnerable Adults Act and the Maltreatment of Minors Act (Minnesota Statutes, chapter 626) require mandated reporting and investigation of abuse and neglect of vulnerable adults and children. This law defines abuse and neglect of an adult to include any use of aversive or deprivation procedures, unreasonable confinement or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against their will. Accidents and therapeutic conduct are not considered abuse.

In the context of the Vulnerable Adults Act (Minnesota Statutes, Chapter 626), therapeutic conduct includes the provision of program services, health care, or other personal care services done in good faith in the interest of the vulnerable adult by an individual, facility, or an employee or person providing services in a facility under the rights, privileges, and responsibilities conferred by state license, certification or registration, or a caregiver. A caregiver includes family members and persons or entities who have assumed responsibility for the care of an individual voluntarily, or by contract or agreement.

The Vulnerable Adults Acts include mandated reporting of abuse. The Online Mandated Reporter Training (vulnerable adults) is available at: http://registrations.dhs.state.mn.us/WebManRpt/

The Minnesota Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in settings licensed under Minnesota Statutes, chapters 245A including adult day services and foster care, and settings and services licensed under Minnesota Statutes, chapter 245D. The Minnesota Department of Health, Office of Health Facility Complaints is the agency responsible for assessing or investigating allegations of maltreatment involving home care providers licensed under Minnesota Statutes, chapter 144A, including customized living providers. The local human services agencies are responsible for assessing and investigating allegations of maltreatment by informal caregivers, those involving non-licensed providers and personal care provider organizations.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

Any use of restrictive intervention is defined under VA statute as reportable maltreatment. The state detects unauthorized use of restrictive interventions through maltreatment reports required under the Vulnerable Adults Act. See Appendix G-1-b for reporting requirements, Appendix G-1-d for review of and response to reports, and Appendix G-1-e for oversight of reporting, review and response. Appendix G-2.a provides additional information, and includes a description of the agency responsible to investigate allegations of maltreatment.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Any adverse or deprivation procedure or involuntary seclusion is defined under VA statute as reportable maltreatment. The state detects unauthorized use of seclusion through maltreatment reports required under the Vulnerable Adults Act. See Appendix G-1-b for reporting requirements, Appendix G-1-d for review of and response to reports, and Appendix G-1-e for oversight of reporting, review and response. Appendix G-2.a provides additional information, and includes a description of the agency responsible to investigate allegations of maltreatment.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The participant's support plan must address health and safety needs. This includes plans to address the need for medication assistance, and a determination by the case manager as part of support planning of whether and which provider is able to reasonably meet the medication management needs identified in the participant's support plan. The waiver includes participants who receive on-going services in foster care homes and customized living settings. These providers have on-going responsibilities related to monitoring participants that may include monitoring medication regimens.

Foster Care
Foster care regulations address the dispensing and storage of medication and the foster care operator is responsible for monitoring medication regimens along with the prescribing medical professional. The foster care operator is responsible for on-going monitoring of the participant. The operator's compliance with requirements related to medication management is reviewed during routine licensing visits.

Customized Living
Providers of customized living must maintain an assisted living facility license or a comprehensive home care license issued by the Minnesota Department of Health. Minnesota Statutes, section 144A.4792 addresses medication set-up, administration, and monitoring for providers with a comprehensive home care license. Minnesota Statutes, section 144G.71 addresses medication set-up, administration and monitoring for providers with an assisted living facility license.

Home Care
For individuals who receive state plan home care, medication assistance may be provided through the licensed home health agency.

Other medication management strategies include those made available through pharmacies, clinics, primary care physicians, advanced practice registered nurses, and physician assistants.

For individuals in managed care, medication management is part of care coordination requirements for all participants. In addition, medication set up and administration assistive devices can be utilized for individuals who can benefit from this level of assistance.

Monitoring is conducted through on-site reviews completed by either DHS Licensing or the MN Department of Health. Monitoring also occurs when medication errors occur and are reported to the Minnesota Adult Abuse Reporting Center (MAARC)

Licensing reviews occur every four years during licensing renewals, or as needed based upon report

State monitoring is performed by reviewing medication administration policies and procedures and review of medication administration records per applicable licensing requirements.

Medication administration and monitoring is the responsibility of the prescribing physician in accordance with their scope of practice. For those waiver services where medication administration and monitoring occurs as part of the licensed service, the state agency responsible for oversight and the frequency of review for each service is outlined in Appendix C-1/C-3 under "Verification of Provider Qualifications".

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Adult foster care must be licensed and follow medication standards set forth under licensing requirements in Minnesota Statutes, sections 245A or 245D. The provider is required to document the administration of the medication in the individual's medication administration record. They are required to review the record regularly, at a minimum of every three months. If there are problems identified, the provider must develop and implement a plan to correct patterns of administration errors.

When medication assistance is to be provided, the provider must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the support plan:
-Any reports made to the person's physician or prescriber;
-A person's refusal or failure to take or receive medication or treatment as prescribed; and
-Concerns about a person's self-administration of medication or treatment.

For customized living, the provider must hold an assisted living facility license or a comprehensive license as a home health agency which includes licensed nurses to complete or provide oversight to any medication management procedures. Medication management procedures include medication set up, administering medications and medication monitoring. Provider's compliance is monitored through surveys conducted by the Minnesota Department of Health. Medications may also be set up by physicians, advanced practice registered nurses, physician assistants, or pharmacists.

Case managers are responsible to develop a support plan that identifies and addresses the participant's health and safety needs, and conduct monitoring reviews as needed and in person at least annually.

Nurses are responsible for medication administration in accordance with their scope of practice as indicated in Minnesota Statutes, sections 148.171 to 148.285. The Minnesota Board of Nursing issues the license and is responsible for follow-up and oversight.

Physicians, advanced practice registered nurses, and physician assistants are responsible for prescribing and monitoring medications in accordance with their scope of practice.

Medical Assistance covers medication therapy management services for participants who are taking four or more prescriptions to treat or prevent two or more chronic conditions and who are not eligible for Medicare Part D.

Medication therapy management services are provided by licensed pharmacists who meet certain provider standards. The service includes:
1. Performing or obtaining necessary assessments of the participant's health status;
2. Formulating a medication treatment plan;
3. Monitoring and evaluating the participant's response to therapy, including safety and effectiveness;
4. Performing a comprehensive medication review to identify, resolve, and prevent medication related problems, including adverse drug events;
5. Documenting the care delivered and communicating essential information to the participant's other primary care providers;
6. Providing verbal education and training designed to enhance participant understanding and appropriate use of participant's medications;
7. Providing information, support services, and resources designed to enhance the participant's adherence with their therapeutic regimens;
8. Coordinating and integrating medication therapy management services within the broader health care management services being provided to the participant.

The Minnesota Department of Health is responsible for oversight of medication management for services regulated by Minnesota Statutes, chapters 144D or 144G. The Minnesota Department of Human Services is responsible for oversight of medication management for services regulated by Minnesota Statutes, chapters 245A or 245D.

Monitoring is conducted through on-site licensing reviews or surveys completed by either DHS Licensing or the MN Department of Health.

Licensing reviews occur every four years during licensing renewals, or as needed based upon report.

Monitoring of potentially harmful medication management practices is conducted through on-site reviews and surveys completed by either DHS Licensing or the MN Department of Health. Monitoring also occurs when medication errors occur and are reported to the Minnesota Adult Abuse Reporting Center (MAARC).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

For customized living, the assisted living facility license or the comprehensive home care license allows providers to administer, set up, or provide reminders to take medications. Licensing standards govern medication management including record keeping and storage. Refer to Minnesota Statutes, sections 144A.43 through 144A.483 and sections 144G.43 and 144G.71. Providers' compliance is monitored through surveys conducted by the Minnesota Department of Health.

Medication administration by non-medical waiver provider staff: Minnesota Statutes, chapter 245D require new staff to review and receive instruction on medication administration procedures established for the person when medication administration is assigned to the license holder according to Minnesota Statutes, section 245D.05, subd. 1(b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant or physician. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health condition that affects the service options available to the person because the health condition requires:
-specialized or intensive medical or nursing supervision; and
-nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

As described above, for participants residing in adult foster care homes licensed under Minnesota Statutes, chapter 245A or 245D, the physician informs the foster care provider when he/she must be notified concerning a medication that was not taken as prescribed. The provider must also immediately report to the lead agency whenever the participant's physician is notified.

Please reference Appendix G-3, a.ii. for additional information about requirements for license holders to document, track and review the administration of medications.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The licensing entity monitors providers compliance with regulations related to administration of medications through routine licensing reviews and in response to complaints. Foster care providers are licensed by the Department's licensing division, which delegates the onsite reviews of adult foster care settings to counties. County agencies make recommendations to the Department regarding reissuing providers' licenses. Routine reviews are conducted every one to three years depending upon the type of provider and their review history. The Department or county follows up on reported or suspected licensing violations.

Customized living providers are licensed and monitored by the Minnesota Department of Health for compliance with regulations related to medication assistance and administration of medications.

The Minnesota Department of Health is responsible for issuing licenses and monitoring home care and assisted living providers. The Minnesota Department of Human Services is responsible for issuing licenses and monitoring providers with a Minnesota Statutes, chapter 245A or 245D license.

Monitoring is conducted through on-site licensing reviews or surveys completed by either DHS Licensing or the MN Department of Health.
Monitoring concerning potentially harmful medication management practices is conducted through on-site reviews and surveys completed by either DHS Licensing or the MN Department of Health. Monitoring occurs when medication errors occur and are reported to the Minnesota Adult Abuse Reporting Center (MAARC).

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of EW participant files reviewed during the lead agency review where the support plan documents assessed health and safety issues, by waiver year. Numerator: Number of EW files reviewed where the support plan documents assessed health and safety issues, by waiver year. Denominator: Number of EW participant files reviewed, by waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver Review Research Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of EW participant deaths associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per waiver year. Numerator: Number of EW deaths associated with alleged maltreatment reported to MAARC that were referred to the ME, per waiver year. Denominator: Number of EW deaths associated with alleged maltreatment reported to MAARC, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Social Services Information System: Minnesota Adult Protection Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
For managed care participants, percent of audited care plans in which identified health and safety risks and what to do in the event of an emergency are documented, per calendar year (CY). Numerator: Number of audited care plans in which identified health and safety risks and what to do in the event of an emergency are documented, per CY. Denominator: Total number of audited care plans, per CY.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Plan Audit Research Database

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Estimated mean meets CMS recommended standards of 95% confidence level with a margin of error of +/-5%
☒ **Other** Specify: MCO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling methodology is the one approved by NCQA for auditing in MCOs.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of EW participants who are not victims of substantiated maltreatment, per waiver year. Numerator: Number of EW participants who are not victims of substantiated maltreatment, per waiver year. Denominator: Number of EW participants, per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Social Services Information System; Minnesota Adult Protection Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of EW participants who did not have determination of substantiated maltreatment within 12 mos. of a substantiated maltreatment determination, by waiver year (WY). Numerator: Number of participants who did not have determination of substantiated maltreatment within 12 mos. following a determination, by WY. Denominator: Number of participants who had a determination of maltreatment, by WY.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Social Services Information System:Minnesota Adult Protection Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of reports of maltreatment of EW participants submitted to MAARC and referred to a lead investigative agency (LIA) in a timely manner, per waiver year (WY). Numerator: Number of maltreatment allegations of EW participants reported to MAARC and referred to a LIA within two working days, per WY. Denominator: Number of maltreatment allegations of EW participants reported to MAARC, per WY.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Social Services Information System: Minnesota Adult Protection Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of EW participants who are not victims of substantiated maltreatment, per waiver year. Numerator: Number of EW participants who are not victims of substantiated maltreatment, per waiver year. Denominator: Number of EW participants per waiver year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Social Services Information System: Minnesota Adult Protection Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent EW participants who had a health care visit per calendar year. Numerator: Number of EW participants meeting HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP) per calendar year. Denominator: Number of EW participants per calendar year.

Data Source (Select one):
Other

If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Maltreatment Report Investigations: Adult Protection:
Maltreatment reports involving vulnerable adults are made to the Minnesota Adult Abuse Reporting Center (MAARC) as required in statute. Minnesota's adult protection reporting data system currently captures all adult maltreatment reports collected by the centralized Minnesota Adult Abuse Reporting Center (formerly Common Entry Point). The MAARC operates on a 24-hour basis.

State law requires immediate reporting by mandated reporters of suspected maltreatment of individuals, and encourages reporting by any person who suspects maltreatment of another person. Mandated reporters include professionals or a professional's delegates engaged in the care of vulnerable adults, those engaged in social services, law enforcement, vocational rehabilitation, licensed health care providers, and those who work in a health care facility or licensed service. Mandated and voluntary reports of suspected maltreatment are encouraged through information, training and education provided by department

All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency(ies) responsible, under statute, for investigation, determination and final disposition. The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes immediate referral to the county or tribal nation for emergency protective services. Vulnerable adults who are the subject of reports of suspected maltreatment are offered emergency and continuing protective social services for purposes of safeguarding the person and preventing further maltreatment. Immediate notification is made by MAARC to law enforcement if the report contains suspected criminal activity. The local welfare agency and/or local law enforcement authorities are required to take immediate protective measures if a serious or imminent threat to the participant's safety exists. As of March, 2017 county adult protection units are required to complete fields, utilizing a defined set of types of remediation, in the SSIS Minnesota Adult Protection data base that identifies individual remediation provided as a result of substantiated maltreatment.

Methods for addressing individual problems include protective services by local adult protective services units; criminal, civil, licensure and/or certification sanctions (as applicable) against substantiated perpetrators; and corrective action requirements for licensed/certified providers. Revisions to care plans by case managers also address identified risks.

Lead agency site reviews:
The Department conducts on-site lead agency reviews. Counties and tribal nations are randomly selected for review. The purpose of the review is to monitor lead agencies' compliance with program requirements, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Lead agency reviews are continuous and ongoing and all agencies are reviewed at least once every three years. Reviews include a case file review of a randomly selected representative sample of cases. These reviews include evaluation of how care plans identify and address identified risks, including the person's potential risk of maltreatment by another. Risk management is an important component of support planning for waiver participants.

If the Department finds the county or tribal nation deficient in a required waiver activity, the deficiency is identified in a report and the county or tribal nation must submit a corrective action plan which is posted on the department website. All individual cases reviewed that are found out of compliance with waiver requirements during the site visit are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

MCO care plan audit and follow-up reviews:
Corrective actions are issued when patterns of non-compliance are found. Individual or case-specific problems are addressed by the MCO before the conclusion of the audit, and correction is required. The audit include evaluation of how care plans identify and address identified risks, including the person's potential risk of maltreatment by another. Risk management is an important component of support planning for waiver participants. Follow-up reviews include review of completion of corrective action plans. Audit findings, corrective actions, and follow-up findings are documented in the Department's Care Plan Audit Research Data Base.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Aggregation of all but narrative remediation data.

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process:
The DHS Quality Essentials Team (QET) will review and analyze collected performance measure and remediation data ("monitoring data") according to the following process outlined below. The QET is a team made up of program and policy staff from all waiver programs.

Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate policy team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

The QET has identified and implemented a waiver quality monitoring and improvement process for identifying the level of remediation and any systems improvements required as indicated by performance monitoring.

- Input (all identified data sources): Performance Measure and Remediation (monitoring) data
- Analysis (QET)

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

- System Improvement (policy team & QET)

A. Policy Analysis Realm
1. Can the problem's cause(s) be identified from analysis of the monitoring data?
   If yes – develop data driven policy alternatives.
   If no – develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select "best" policy alternative.
4. Enact new policy and return to monitoring.

B. Process Analysis Realm
1. Is the problem an internal (DHS) or external process issue?
2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes – develop data driven internal process alternatives.
   If no – develop theory driven internal process alternatives.
2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
   If yes – develop data driven external process alternatives.
   If no – develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select "best" process alternative.
5. Enact new process(es) and return to monitoring.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other**	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
Specify:	Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:

- a web-based performance measure dashboard developed by Department located at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/public-planning-performance-reporting/performance-reports/#
- annually providing information to DHS-ADSA quality management-related stakeholder bodies; and
- mandated legislative reports.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS-ADSA leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

DHS periodically conducts studies of current capacity and gaps in long-term care services and supports. The results of these studies are used to identify short as well as long-term strategies for expanding and ensuring provider capacity and choice.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ◉ **NCI AD Survey :**

○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

This section does not apply to MSHO or MCS+ participants because managed care organizations receive capitation payments and have their own mechanisms for fiscal monitoring and integrity that must comply with state and federal regulations.

For claims paid fee-for-service, potential integrity issues and coding problems are minimized or averted through MMIS system edits related to service authorizations, eligibility, and claims. For a claim to be paid, the claim must correspond with the waiver service authorization entered by the county or tribal nation agency in the service agreement and approved in MMIS. The service agreement is based on the participant's support plan and includes rates, time spans, number of units authorized, service type and category, and provider.

MMIS edits assure that the services included on the agreement are allowable under the waiver, that the provider is currently an approved provider for the service, and that the rate entered on the service agreement aligns with the state-established rates contained in MMIS for the service. Failure to meet these service agreement criteria will result in the service agreement being denied or suspended in MMIS until identified issues are resolved. Claims cannot be paid without an approved service agreement in MMIS.

For customized living and adult foster care, the lead agency must complete the Residential Services Tool and submit the tool to the department. All service agreements that contain the service codes for customized living and foster care are routed to department staff by MMIS editing, and then reviewed by department staff to ensure that the rate calculated by the lead agency using the Residential Services Tool follows state rate-setting methodology, adheres to rate limits, and agrees with the rate entered in the service agreement. Communication between the lead agency and department staff occurs to resolve any issues uncovered during the review. The service agreement is approved by department staff only after this review is completed satisfactorily.

The claim must also correspond with Medicaid and waiver eligibility files in MMIS that include edits related to where the participant resides (living arrangement). Claims editing is extensive, validating participant as well as provider eligibility. For example, if a provider attempts to bill using a valid claim code, but is not an appropriate provider type, a systems edit will post and an electronic message would be sent describing the inconsistency. The claim would not be paid until the identified problem was corrected.

The department's surveillance and integrity review section (SIRS) is responsible for the post-payment review of provider claims paid through MMIS. This includes identifying and investigating possible Medicaid fraud. SIRS monitors claims with routine reports to identify outlier claims or unusual patterns. The SIRS unit also conducts periodic reviews of providers and responds to reported concerns. In terms of scope, SIRS reviews the information on the claim against the department policies and rules and the provider records.

Cases are generated by tips, data analytics and special projects. Claims may be selected based on the dates of service referenced in the information received to generate a case, and expanded if necessary, to ensure a thorough review.

There is no set frequency for post-payment reviews. Reviewing tips and complaints is the primary driver of post-payment reviews. These tips are reviewed first at a preliminary level which is used to identify the need for a full investigation. SIRS has the authority to issue Stipulated Provider Agreements which require providers to adhere to certain terms as a condition of their continued participation in MHCP. When necessary, Stipulated Provider Agreements contain self-audit provisions requiring the provider to audit their billings and report their findings to SIRS at regular intervals. These intervals could be quarterly, bi-annual, or at another frequency depending on the circumstances of the case.

SIRS also conducts data-driven reviews through its program integrity contractors. These reviews are also not conducted on a set frequency. The timing of reviews depends on the type of scheme being reviewed, the resources needed to conduct the review, and when (if ever) a similar review was conducted historically.

There are many different ways that a provider’s billing could be considered abnormal. For example, providers whose billing is significantly different from their similarly situated peers may be considered unusual or aberrant. Providers whose billing changes significantly within a short period of time may be considered unusual. The scope of the audit depends on the scheme being reviewed and can expand if necessary depending on the case.

Providers who consistently bill a procedure code that is considered rare for that provider type could be considered unusual. While these and other patterns do not always signify that a provider is billing improperly, they are useful tools in understanding the provider population and identifying providers who may warrant further review for potential improper payments.

SIRS conducts both onsite and desk reviews of providers. Onsite reviews are conducted most commonly when investigating an entity as opposed to an individual. SIRS conducts on site reviews to prevent providers from falsifying documentation, to better understand the provider's operations, and to ensure that we gather all requested documentation.

SIRS reviews documentation to determine whether providers are maintaining records in the manner required by law as a condition of billing. Required documentation elements will be dependent on the type of service provided. Documentation requirements are found in state statute and administrative rules. Documentation requirements specific to services provided under a waiver are found in Minnesota Statutes, section 256B.4912.

All claims for services provided under a waiver must be documented according to Minnesota Statutes, section 256B.4912, subd. 12. As such, SIRS reviews documentation in accordance with these criteria for all services provided under a waiver. For some types of waiver services, additional documentation elements are required. These services include transportation, equipment and supplies, and adult day services. SIRS reviews its cases according to the legal requirements applicable to the service under review.

SIRS has the authority to determine overpayments through a process of random sampling and extrapolation that adheres to Minnesota Rule 9505.2220. Under Minnesota Rule 9505.2220, statistical sampling must be conducted pursuant to the Medicare Program Integrity Manual (PIM) published by CMS. The PIM requires the use of a 90% confidence interval in most situations. As such overpayments identified must have a 90% confidence interval that does not contain $0 to satisfy the rule.

The manner in which SIRS communicates the results of an investigation to a provider will depend on the outcome of the investigation. If SIRS determines that the provider has been overpaid, SIRS will issue a Notice of Agency Action identifying the amount of the overpayment, the reason the claims were deemed overpaid, and informing the provider of its appeal rights. If SIRS determines that the nature, severity and chronicity of the provider's conduct warrants a sanction, SIRS will send a Notice of Agency Action identifying the conduct, the sanction it proposes to impose, and informing the provider of its appeal rights. If SIRS finds conduct that does not rise to the level of a sanction, it will send the provider a warning letter informing it of the concerning conduct and the potential ramifications if the conduct continues.

Participants receive an explanation of medical benefits (EOMB) summary from the department regarding what services Medical Assistance covered on their behalf. The EOMB includes information to contact the department to report questions or concerns regarding Medical Assistance payments.

SIRS also receives reports from a hot line, lead agencies, law enforcement, third party payers, and provider staff. If an issue is identified during a SIRS investigation that may affect other providers of the same (or similar) service type, SIRS reviews the claims histories of those providers (in the same or other counties) and investigates as appropriate.

SIRS has the authority to issue Stipulated Provider Agreements which require providers to adhere to certain terms as a condition of their continued participation in MHCP. When necessary, Stipulated Provider Agreements contain self-audit provisions requiring the provider to audit their billings and report their findings to SIRS at regular intervals. Additionally, if SIRS reviews the provider during the term of its Stipulated Provider Agreement and finds that the provider is responsible for fraud or abuse, or is otherwise not adhering to the agreement, SIRS has the authority to suspend the provider's participation in MHCP.

Improper claims paid as a result of fraud or abuse are recouped through check or deductions in the payments that the department makes to the provider. SIRS informs the Financial Operations Division (FOD) of DHS of overpayments. FOD then completes the appropriate portion of the CMS Form 64 and arranges for the return of the federal share of the overpayment.

Electronic Visit Verification (EVV) was implemented in June 2022 with personal care services phasing in by the end of calendar year 2022 and home health services before the end of calendar year 2023. For services subject to EVV requirements, EVV implementation is expected to reduce inappropriate service payments by 1% through the identification of recordkeeping inaccuracies, administrative errors, and fraud during post-payment review. The services subject to EVV as personal care services are:

- *CDCS direct support workers within the personal assistance category*
- *Extended personal care assistance*
- *Homemaker - assistance with activities of daily living*
- *Individual Community Living Supports – in person*

• Respite (in-home)

The service subject to EVV as home health care services is:
- *Extended home health care*

The Department is rolling out EVV to providers in a phased approach.

Phase 1: Financial management services (FMS) for personal care services (consumer directed community supports [CDCS] and the Consumer Support Grant [CSG]) launched in June 2022.

Phase 2: The remaining personal care service providers launched in two waves:
- *Wave 1: Nov. 14, 2022*
- *Wave 2: Dec. 12, 2022.*

Phase 3: Managed care organizations (MCOs) will launch at the beginning of 2023.

Phase 4: Home health services will launch before the end of 2023.

The Department is implementing EVV in a post-payment review context, which is the current process. The Department will use EVV data in a post-payment review process that may result in takebacks from providers if their claims are not supported by EVV data in the aggregator.

Each month participants receive an explanation of medical benefits (EOMB) summary from the Department regarding what services Medical Assistance covered on their behalf. The EOMB includes information to contact the Department to report questions or concerns regarding Medical Assistance payments.

Minnesota does not require independent audits of waiver providers' financial statements. Counties and the state agency are subject to the Single Audit Act. The State Auditor is responsible for conducting the audit required by the Single Audit Act.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
For participants enrolled through FFS, percent of EW claims properly coded and paid for services provided to EW participants for which there is corresponding prior authorization, per waiver year. Numerator: Number of EW claims paid with authorization, per waiver year. Denominator: Total number of claims paid, per waiver year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
For managed care participants, percent of MCO member months for which waiver capitation was paid based on program eligibility as identified in the screening document, per waiver year. Numerator: Number of MCOs member months for which capitation was paid, per waiver year. Denominator: Number of waiver eligible member months, per waiver year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other***	☐ ***Annually***	☐ ***Stratified***

Specify:		*Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
For participants enrolled through FFS, percent of EW claims properly coded and paid for services provided to EW participants for which there is corresponding prior authorization, per waiver year. Numerator: Number of EW claims paid with authorization, per waiver year. Denominator: Total number of claims paid, per waiver year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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.*

State reports that result in less than 100% performance in the measure related to managed care capitation reflects a lag in capitation cutoff dates for payment (e.g., an individual is open to EW in a month after capitation for the following month has already been paid and as a result the MCO does not receive payment for that month of EW eligibility, and when waiver spans are ended after the capitation cutoff date in a month, the MCO will receive an EW payment for an individual who is no longer enrolled on the waiver).

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States 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.*

The criteria for financial oversight is met through MMIS edits in place that ensure compliance with the reimbursement methodology specified in the approved waiver.

Surveillance and Integrity Review Section (SIRS). When individual problems are identified, SIRS is able to address them through various methods as appropriate, including:
• Recovering overpayments due to error, abuse, or fraud;
• Suspending or terminating provider participation in the MHCP; and/or
• Facilitating prosecution of health care fraud.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

This section does not apply to rates paid for services through MSHO or MCS+ or to rates paid for CDCS services. MCOs receive capitation payments, referred to as Managed Care Premiums in Appendices C-1/C-3, for service provided to MSHO and MSC+ participants as outlined in our concurrent 1915(b) waiver. Payment rates for employees or services for participants who elect CDCS are determined by the participant, up to state-established limits, and reflected in their CDCS support plans. CDCS budgets have been set by the state based on case mix level. These budget limits are published at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG

Minnesota's Elderly Waiver uses uniform rates for each waiver service that ensure efficiency, economy, quality of care and provider sufficiency. Beginning in 2013 and every two years thereafter, the state issues a Status of Long-Term Services and Supports (LTSS) report to the Minnesota Legislature and the public. These reports address population demographics and need for LTSS, potential service gaps or access issues across the state, and recommendations to improve the LTSS system. The reports are available here: https://mn.gov/dhs/media/legislative-information/legislative-reports/

Rates are determined using the following methods:
1) The department's Aging and Adult Services Division establishes rates for a number of EW services. Rates are based on historical statewide average rates adjusted periodically by the legislature. Rate limits were originally determined based on the rates counties were paying for these services prior to the development of the waiver.
Rate changes to the services made by the legislature are published in the state register. The following services are paid at state-established rates: Home Delivered Meals, Chore Services (15-minute), Family Caregiver Counseling, Adult Day Services, Adult Day Service Bath, Adult Companion Services, Homemaker/Assistance with Activities of Daily Living, Homemaker/Home Management, Respite, and Case Management. As described further below, all three Homemaker services rates are set by rate-setting methods in Minnesota Statutes 256S . Homemaker/Cleaning and Chore Services (15-minute) uses the state established rate as a market rate maximum limit. Family Caregiver Services-Training and Education uses the state established rate as a market rate maximum limit. The state uses the same rate whether the service is delivered in-person or is delivered remotely, as allowed within the service definition of each service. The state-established rates are published at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG
State-established rates for services set by rate-setting methods in Minnesota Statutes 256S.21 to 256S.215 were enacted in 2017, evaluated by an independent contractor in 2018, and partially implemented January 1, 2019, as directed by statute. The Minnesota Legislature further phased in the rate methods on January 1, 2022, which resulted in rate increases for all services. The department will phase in the rate methods further when directed by the legislature. The department uses its annual labor market survey and Rate Management System provider cost reports to evaluate whether state-established rates are adequate to support service access, participant choice, and service quality.
The Individual Community Living Supports (ICLS) support plan sets forth the appropriate amount of ICLS services for each participant based on the participant's assessed needs, including in-person service and remote services. The plan is based on the person-centered planning process.
For services provided on or after January 1, 2019, payment rates for Adult Day Services and Adult Day Service Bath, Chore Services (15-minutes), Adult Companion Services, Homemaker/Assistance with Activities of Daily Living, Homemaker/Home Management, in-home and out-of-home Respite, ICLS, and residential services component services will be established by the state based on calculations methodology in statute. See Minnesota Statutes, sections 256S.21, 256S.2101, and 256S.211-256S.215.
The methodology consists of: (1) base wages for each specific services constructed from Standard Occupational Classification codes from the Bureau of Labor Statistics named in statute, and (2) cost factors that are added to the base wages to account for expenses related to payroll taxes and benefits, general and administrative costs, program plan support costs, and supervision. Some cost factors are based on data from Minnesota nursing facility cost reports; other factors are applied as fixed percentages named in statute.
By January 1, 2025, DHS plans to discontinue Chore Services offered in 15-minute units. When that version of Chore Services is discontinued, Chore Services will continue to be authorized with daily units as a market rate service.

2) The department's Disability Services Division establishes rates for state plan service and extended state plan services which include home care services, home care nursing, home health care services, and personal care assistance except for individuals who elect to receive CDCS. For these services, found in attachment 4.190-B of the state plan, the department sets rates. These rates can be found at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG

3) Minnesota uses a statewide Residential Services Tool to establish Customized Living Services and Adult Foster Care rates. All lead agencies, including counties, tribal nations, and MCOs are required to use the tool to establish rates for these services.

The tool guides the development of individualized rates for Customized Living Services and Foster Care services, based on assessed need, the amount of each component service, standard component rates, and service rate limits. Effective January 1, 2019, rates for all component services, except food preparation and mileage, will be set using calculations in statute. See #1 above. The component service rate for food preparation is derived from the home management and support services component rate, which is set using calculations in statue. The mileage rate for transportation provided as a component service will be updated at least annually based on Internal Revenue Service Standard Mileage Rates for business miles driven. More information about the rate tool can be found at https://mn.gov/dhs/partners-and-providers/policies-procedures/aging/elderly-waiver-residential-services/
Effective July 1, 2022, the state will pay a rate floor, or minimum daily rate, for Elderly Waiver participants who receive 24-Hour Customized Living Services in an enrolled customized living services provider setting that serves a high percentage of waiver participants. The rate floor will ensure a minimal level of staffing required to meet the health and safety needs of elderly waiver participants. The specific percentage of waiver participants, and the dollar value of the rate floor, and an annual inflationary adjustment is directed by Minnesota Statute section 256S.205.

4) Several services are purchased at market rates, subject to department-established limits set by the Aging and Adult Services Division and must fit within a participant's case mix budget cap along with other authorized services. Market rate service payment occurs when services are purchased at the usual price typically charged on a community market basis. The following services are purchased at market rates: Chore Services (daily and 15-minute), Environmental Accessibility Adaptations-Home Modifications, Environmental Accessibility Adaptations-Vehicle Modifications, Homemaker/Cleaning, Specialized Equipment and Supplies including Personal Emergency Response systems, Transitional services, Family Caregiver Services- Training and Education (community classes) component, and Transportation. The state uses the same rate methodology whether the service is delivered in-person or is delivered remotely, as allowed within the service definition of each service. The state-established limits for Homemaker/Cleaning and Chore Services, 15-minute unit are based on the methodology set forth in Minnesota Statutes, sections 256S.21, 256S.2101, and 256S.211-256S.215 as described in item #1 above. Payments for these services can be authorized at market rates up to the established rate limits. Chore Services authorized at a daily rate must fit within a participant's case mix budget cap along with other authorized services.
Environmental Accessibility Adaptations-Home Modifications, Environmental Accessibility Adaptations-Vehicle Modifications, and Specialized Equipment and Supplies use market payment rates as described above. All services chosen within these two service categories must fit within a participant's case mix budget cap with other authorized services. Effective through December 31, 2023, Environmental Accessibility Adaptations-Home Modifications and Environmental Accessibility Vehicle Modifications cannot exceed $20,000 per participant's waiver year. Effective January 1, 2024, and each January 1 thereafter, the limit will increase based on the All Items Index within the Bureau of Labor Statistics Consumer Price Index found at https://www.bls.gov/bls/news-release/cpi.htm. The increase will be equal to the unadjusted 12-month percentage for the All Items Index during the waiver year period (July 1 to June 30) immediately preceding each January 1, except in the case of a negative percentage. If the 12-month percentage is less than zero percent, the limit will be remain unchanged that January 1.
The Department's Aging and Adult Services Division conducted an extensive study of state-established rates for most EW services in 2018. The Department summarized the findings from the study in a report to the Minnesota legislature. The Department also made several recommendations to adjust rate-setting methodologies and to review the rate methods and rate values overtime. Legislative action is needed to move forward with the department's recommendations. The report is available here: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7850-ENG During the 2018 study, the Department conducted a statewide survey of a wide array of providers to solicit input on service rates. The study was conducted in consultation with a stakeholder advisory group made up of members of the public. The broader public also comments on service rates for EW services through the legislative process.
The Department's Aging and Adult Services Division participates in two annual data collection activities that help assess state-established rates for EW services: 1) an annual labor market survey of home and community based service providers to collect data about wages, benefits, and staff retention and vacancies; and 2) all agencies that provide at least one service with a payment rate determined under the Disability Waiver Rate System (DWRS) submit documentation of the costs of providing services to the Department, through a five-year reporting cycle. The Elderly Waiver and the disability waivers share certain services, and this effort provides data regarding provider costs for these shared services.
Changes to rate methodologies and standards for waiver services are published in our State Register for public comment in accordance with the requirements set forth in 42 CFR § 447.205. Such changes are also included in proposed waiver amendments or renewals, which are published for public comment prior to submission in accordance with 42 CFR §441.304(f). A description of our process for soliciting public comments is provided in Section Main. 6-I of our application.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Providers billing fee-for-service submit claims directly through MMIS and claims are processed through MMIS. Providers bill the MCO directly for EW participants in managed care. MCOs report claims experience to the department on a continuous basis as encounter claims.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All fee-for-service claims are processed through MMIS. For a waiver claim to be paid, the claim must correspond with the applicable MMIS service authorization and eligibility information. The service authorization is based on the participant's support plan and includes the provider, type of service, rates, units, and applicable time period. Claims are not paid if any of the eligibility information is inconsistent with the information on the claim (e.g., the date a waiver service is provided must fall within the participant's Medical Assistance and waiver eligibility date spans).

The Department's Surveillance and Integrity Review Section (SIRS) is responsible for post-payment review of provider claims paid through MMIS. Providers and claims are selected for review based on data analysis, complaints and referrals. This includes identifying and investigating possible Medicaid fraud.

Services are verified in a variety of ways. First, Minnesota has access to statewide wage and employment records, which allow SIRS to identify those enrolled providers who claim to be providing services while working elsewhere, and respond accordingly.
Minnesota also has strong documentation requirements for services provided under a waiver, which require providers to fully document services as a condition of payment. This includes a record of the dates, times and types of services provided. For a full list of documentation requirements, please see Minnesota Statutes section 256B.4912 (https://www.revisor.mn.gov/statutes/cite/256B.4912).

In addition, Minnesota issues Explanations of Medical Benefits (EOMB) directly to recipients and the authorized representatives of recipients. Each recipient gets an EOMB each month that identifies services that were billed for the recipient, and a number to call if they have questions about the services.

Finally, Minnesota provides the public with multiple ways to report misconduct, including a dedicated email account, toll-free phone number and fax number. SIRS follows up on any report that a recipient is not receiving services.

Improper claims paid as a result of fraud and abuse are recouped through check or deductions in the payments that DHS makes to the provider. Improper claims are reported on the quarterly CMS-64 submissions and the federal payment for that quarter is adjusted accordingly.

Minnesota will not require pre-payment validation for claims in the EVV system.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds

expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

County-owned hospitals and nursing facilities may provide home delivered meals or respite care. Counties and tribal nations may receive payment for case management, specialized equipment and supplies, transitional services, transportation, chore, environmental accessibility adaptations – home modifications(installations), environmental accessibility adaptations-vehicle modifications(installations), homemaker cleaning services, and Family Caregiver Services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Minnesota uses a statewide Residential Services Tool to establish rates in customized living and foster care settings. This tool excludes costs related to room and board in these settings. (See Appendix I-2(a) for more details about this statewide tool.)

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18673.04	17644.00	36317.04	65069.00	5096.00	70165.00	33847.96
2	24455.26	18888.00	43343.26	68752.00	5350.00	74102.00	30758.74
3	26362.40	20286.00	46648.40	72877.00	5634.00	78511.00	31862.60
4	27680.35	21787.00	49467.35	77249.00	5933.00	83182.00	33714.65
5	29152.52	23475.00	52627.52	82148.00	6268.00	88416.00	35788.48

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	37232	37232
Year 2	38518	38518
Year 3	40083	40083

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 4	41746	41746
Year 5	43756	43756

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average length of stay of waiver participants (i.e., number of waiver service days per participant per year) estimates were developed using the average experience from our MMIS reporting system for waiver year 2022. 2024 and 2028 have an extra day due to the leap year. When we experience a leap year, the units per user will increase in that year, sometimes following up with a drop in the next year.

We have observed that ALOS increased each year from WY18 to WY22. The continuous coverage provisions that have been in effect during the Public Health Emergency may have had a role in increasing ALOS in WY21-WY22. For that reason, rather than assuming that ALOS would continue to increase, we assumed that ALOS would stay at WY22 levels in WY23-WY27.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D per capita and total waiver costs for WY 2024 – WY2028 were estimated based on participants, payments, and units from claims using our MMIS reporting system for WY 2022. We compared MMIS initial cost estimates to MMIS lagged (completed) costs for the two most recent years of complete data, WY's 2020 and 2021, and determined no completion factor adjustment would be necessary for the WY 2022 data.

Except as noted below, participants, units per user, and average cost per unit were projected for WY 2024 – WY 2028 from the WY 2022 data as follows:

- *participants for each service were the proportion of participants using the service in WY 2022 applied to the total participants projected for that waiver year*
- *units per user for each service were the units per user for that service in WY 2022, adjusted by any changes in the projected length of stay*
- *average cost per unit for each service was inflated from WY 2022 to WY 2023 with a factor of 7.86%, which only applies to WY23. The growth rate is based on the increase in managed care rates for the Elderly Waiver in calendar year 2023. This is consistent with the department's most recent forecast of average payment increase from WY 2022 to WY 2023, and reflects a 10.3% increase in managed care capitation rates in CY 2023. Costs in the following years are adjusted by a 5% factor each year. The 5% growth trend is based on assumptions for future increases for managed care rates for the Elderly Waiver. Minnesota does not develop specific growth rate projections for any of its managed care products for purposes of budgeting. Instead, assumptions are developed that are generally consistent with very long-run growth trends. This factor is consistent with department assumptions about long-term trends in managed care capitation rates for this population. Managed care capitation rate increase tend to be the largest driver of average payment increases in this waiver.*

Exceptions:

- *CDCS Unbundling: Personal Assistance was split into two categories. Using the currently approved projections, ten percent of the recipients and dollars were moved into Individual-Directed Goods and Services, ninety percent of the recipients and dollars remained in Personal Assistance. 10% of currently approved CDCS-Personal Assistance will move to the new CDCS-Individual Directed Goods and Services, phasing in over WY22 and WY23. We move dollars and persons to the new service to account for this. We round the estimated number of persons using a service to a whole number, which results in the observed units per user changes.*

Self Direction Support Activities was split into two categories, using currently approved projections, twenty percent of the recipients and dollars were moved to Support Planning and eighty percent of the recipients and dollars were moved to Financial Management.

Environmental Modifications and Provisions was split into four services in the first year of implementation. Because we are 11 months into SFY22 (WY4) 11 months-worth of recipients, units and total expenditures remained in CDCS: Environmental Modifications and Provisions. The twelfth month of data was split into the other three services. Thirty percent of recipients, units and dollars for one month of service were moved to Environmental Modifications - Home Modifications. Ten percent of recipients, units and dollars for one month of service were moved into Environmental Modifications - Vehicle Modifications. Sixty percent of recipients, units and dollars for one month of service were moved into Individual Directed Goods and Services. In SFY23 (WY5), it is anticipated that 6.5 months-worth of recipients, units and dollars will remain in the existing Environmental Modifications and Provisions based on the rolling annual assessment period. This means 5.5 months were calculated for migration to the new services. These percentages were estimated based on observed participant use and trends in similar waiver services.

Treatment and Training was split into three services. Using current projections, ten percent of recipients and dollars were moved to Individual Directed Goods and Services. Eighty-five percent of recipients and dollars remained in Treatment and Training. Five percent of recipients and dollars were moved to Community Integration and Supports.

Currently approved projections for CDCS Personal Assistance, CDCS Environmental Modifications and Provisions, CDCS Treatment and Training and CDCS Self-Direction Support Activities from WY4 and WY5 in MN.0025.R08.17 were used to determine the splits for each of the new services.

CDCS is transitioning from 4 services in WY 2022 to 10 services in WY 2024. Two of the existing CDCS services will be completely phased out by WY 2025. Those are CDCS: Environmental Modifications and Provisions and

CDCS Self-Direction Support Activities. Estimates are based on previously submitted assumptions about this transition.

CDCS Budget Increase:
Effective January 1, 2024, Consumer Directed Community Supports (CDCS) budgets will be increased to align with EW budget caps. This is incorporated into the Appendix J estimates using fiscal estimates developed by DHS for the 2023 legislative session as follows:
1. The percentage increase in the CDCS budgets will vary from 39% to 195%, depending on the specific case-mix level.
2. Using Medicaid Management Information System (MMIS) expenditure data from January 2017 on CDCS expenditures by case-mix by EW FFS recipients, a weighted average increase of 81% was estimated for CDCS budgets.
*3. The ratio of services authorized is estimated to be 82%. Therefore, the increase in expenditures after CDCS budgets are raised is expected to be 81% * 82% = 66.4%.*
4. The increased budgets will be implemented as service agreements are re-authorized over a 12 month period. The implementation effect is 13% in WY 2024, 88% in WY 2025, and 100% for WY 2026-2028.
5. It is assumed that this will mainly result in increases in units used by recipients. In the appendix J estimates, the Average Units per User for all CDCS services are increased to reflect the budget increase. This amounts to a 9% increase in average units per user for all CDCS services for WY24, a 45% increase for WY25, and a 5% increase for WY26.
6. It is expected that managed care premiums will be adjusted to reflect the increased CDCS budgets. Based on MMIS WY 2022 data on FFS expenditures and data reported to DHS by the Managed Care plans in WY 2022, CDCS was 2.6% of total waiver expenditures. We used the expected impact on FFS CDCS expenditures and multiplied by a factor of .026 to estimate an impact on Managed Care Premiums Unit Cost.

• *Adult Day Bath, Extended HHA, Extended HCN all had zero use in the WY 2022 data. Negligible use (1 participant per service) is assumed in WY 2024 and following years.*

Environmental Accessibility Adaptations Limit raised:
Effective WY 2024, the limit is raised from $20,000 to $20,600, or 3%. This increase is incorporated into the Appendix J as follows:

1.Average Units per User is increased by 3% in WY24-WY28 for the Environmental Accessibility Adaptations (Home and Vehicle).
2.These services are about 0.4% of all waiver expenditures. It is assumed the impact on Managed Care rates is negligible and no additional impact is built into the Appendix J calculations. [end add]

Customized Living Services Rate Increase:
Based on changes to the calculations of Customized Living Service Rate components effective January 1, 2024, Customized Living Service rates are expected to increase. This is incorporated into the Appendix J estimates using fiscal estimates developed by DHS for the 2023 legislative session as follows:
1. Based on data on the number of hours per month used for the component services in Customized Living, a weighted average increase of 44.78% was estimated for Customized Living rates.
2. The increased rates will be implemented as service agreements are re-authorized over a 12 month period. The implementation effect is 13% in the WY 2024, 88% in WY 2025, and 100% for WY 2026-2028.
3. In the appendix J estimates, the Unit Cost of Customized Living Services is increased to reflect these rate increases. This amounts to a 11% increase in unit cost for WY24, A 38% increase for WY25, and a 9% increase for WY26.
4. It is expected that managed care premiums will be adjusted to reflect the increased Customized Living Services rates. Based on MMIS WY 2022 data on FFS expenditures and data reported to DHS by the Managed Care plans in WY 2022, Customized Living Services were 62.5% of total waiver expenditures. We used the expected impact on Customized Living rates multiplied by a factor of .625 to estimate an impact on Managed Care Premiums Unit Cost.

3. Other Rate Increases

Effective January 1, 2024, the following rate increases will take effect:

Adult Companion Services: 170.31%
Adult Day Services: 28.63%
Caregiver Counseling and Caregiver Training: 14.99%
Chore: 75.72%
Home Delivered Meals: 8.81%
Homemaker: 56.67%
Individual Community Living Supports (ICLS): 48.21%
Respite: 58.86%
These increases are incorporated into the Appendix J as follows:

1.The implementation effect is 50% in WY 2024 and 100% in WY 2025-2028.
2. In the appendix J estimates, the Unit Cost of each of these services is increased to reflect these rate increases.
- *Adult Companion Services average unit cost increases by 94% in WY24 and 53% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Adult Day Services average unit cost increases by 20% in WY24 and 18% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Caregiver Counseling and Caregiver Training average unit cost increases by 13% in WY24 and 12% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Chore Services average unit cost increases by 45% in WY24 and 34% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Home Delivered Meals average unit cost increases by 10% in WY24 and 9% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Homemaker average unit cost increases by 35% in WY24 and 28% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Individual Community Living Supports average unit cost increases by 30% in WY24 and 25% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*
- *Respite average unit cost increases by 36% in WY24 and 29% in WY25. This includes the 5% inflation factor applied across all services. There are no additional cost increases in WY26-WY28.*

3. It is expected that managed care premiums will be adjusted to reflect the increased Services rates. Based on MMIS WY 2022 data on FFS expenditures and data reported to DHS by the Managed Care plans in WY 2022, the expenditure for each service as a percent of total waiver spending is shown here:

Adult Companion Services: 0.15%
Adult Day Services: 10.87%
Caregiver Counseling and Caregiver Training: .0012%
Chore: 0.18%
Home Delivered Meals: 1.33%
Homemaker: 6.7%
Individual Community Living Supports (ICLS): 3.15%
Respite: .08%

We used the expected impact on expenditures multiplied by the associated percent of spending for each service to estimate an impact on Managed Care Premiums Unit Cost.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

D' estimates are based on the actual non-waiver Medical Assistance (MA) costs of EW waiver participants from the MMIS reporting system for current waiver year four (WY 2022). A completion factor was not necessary since the data are considered complete. Per capita expenditures and average waiver days were used to calculate an average daily payment for these non-waiver MA costs. Units per user may increase during a leap year and decrease the following year. The average daily payment is trended with a 7.4% annual increase, consistent with observed annual average payment growth in the past 5 years, WY2017-WY2022. Per capita D' estimates are then calculated from the projected average daily payment and average waiver days.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

G estimates are based on Nursing Facility costs paid by Medical Assistance (MA) for waiver year four (WY2022). Per capita expenditures and average waiver days were used to calculate an average daily payment for these institutional costs. Units per user may increase during a leap year and decrease the following year. The average daily payment is trended with a 6% annual increase, consistent with the DHS forecast of Nursing Facility average payment increases observed in this previous period (waiver years 2017-2022). Per capita G estimates are then calculated from the projected average daily payment and average waiver days.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

G' estimates are based on the actual non-institutional Medical Assistance (MA) costs of Nursing Facility participants in waiver year four (WY2022). Per capita expenditures and average waiver days were used to calculate an average daily payment for these non-institutional MA costs. Units per user may increase during a leap year and decrease the following year. The average daily payment is trended with a 5.3% annual increase, consistent with observed annual average payment growth in the past 5 years, WY 2017 - WY 2022. Per capita G' estimates are then calculated from the projected average daily payment and average waiver days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
Case Management	
Homemaker	
Respite	
Extended Home Care Nursing	
Extended State Plan Home Health Care Services	
Extended State Plan Personal Care Assistance (PCA)	
Adult Companion Services	
Adult Day Service Bath	
Adult Foster Care	
Chore Services	
Consumer Directed Community Supports (CDCS): Community Integration and Support	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	
Consumer Directed Community Supports (CDCS): Financial Management Services	
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	
Consumer Directed Community Supports (CDCS): Personal Assistance	
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	
Consumer Directed Community Supports (CDCS): Support Planning	
Consumer Directed Community Supports (CDCS): Treatment and Training	
Customized Living Services	
Environmental Accessibility Adaptations - Home Modifications	
Environmental Accessibility Adaptations – Vehicle Modifications	

Waiver Services	
Family Caregiver Services	
Home Delivered Meals	
Individual Community Living Supports	
Managed Care Premiums	
Specialized Equipment and Supplies	
Transitional Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Adult Day Service Total:							***515795.29***
Adult Day Service	☐	*15 min*	*87*	*1388.45*	*4.27*	***515795.29***	
Case Management Total:							***6776181.17***
Case Management	☐	*15 min*	*5787*	*45.14*	*25.94*	***6776181.17***	
Homemaker Total:							***1851083.39***
Homemaker	☐	*15 min*	*467*	*572.80*	*6.92*	***1851083.39***	
Respite Total:							***188248.55***
Respite	☐	*15 min/daily*	*19*	*1080.46*	*9.17*	***188248.55***	
Extended Home Care Nursing Total:							***845.18***
Extended Home Care Nursing	☐	*15 min*	*1*	*69.22*	*12.21*	***845.18***	
Extended State Plan Home Health Care							***1885.51***

GRAND TOTAL:	***695234508.68***
Total: Services included in capitation:	*597811185.35*
Total: Services not included in capitation:	*97423323.33*
Total Estimated Unduplicated Participants:	***37232***
Factor D (Divide total by number of participants):	***18673.04***
Services included in capitation:	*16056.38*
Services not included in capitation:	*2616.66*
Average Length of Stay on the Waiver:	*312*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Extended State Plan Home Health Care Services	☐	15 min	1	164.53	11.46	**1885.51**	
Extended State Plan Personal Care Assistance (PCA) Total:							**369527.56**
Extended State Plan Personal Care Assistance (PCA)	☐	15 min	42	1666.34	5.28	**369527.56**	
Adult Companion Services Total:							**41112.96**
Adult Companion Services	☐	15 min	32	232.75	5.52	**41112.96**	
Adult Day Service Bath Total:							**524.05**
Adult Day Service Bath	☐	bath	1	49.16	10.66	**524.05**	
Adult Foster Care Total:							**2352153.97**
Adult Foster Care	☐	daily	73	194.62	165.56	**2352153.97**	
Chore Services Total:							**107766.75**
Chore Services	☐	15 min/daily	54	332.06	6.01	**107766.75**	
Consumer Directed Community Supports (CDCS): Community Integration and Support Total:							**3088.34**
Consumer Directed Community Supports (CDCS): Community Integration and Support	☐	decremental	2	16.06	96.15	**3088.34**	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions Total:							**18815.78**
Consumer Directed	☐	decremental	9	14.17	147.54	**18815.78**	

GRAND TOTAL:	**695234508.68**
Total: Services included in capitation:	597811185.35
Total: Services not included in capitation:	97423323.33
Total Estimated Unduplicated Participants:	**37232**
Factor D (Divide total by number of participants):	**18673.04**
Services included in capitation:	16056.38
Services not included in capitation:	2616.66
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Supports (CDCS): Environmental Modifications and Provisions							
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications Total:							**20611.34**
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☐	decremental	10	13.97	147.54	**20611.34**	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications Total:							**5767.34**
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☐	decremental	3	13.03	147.54	**5767.34**	
Consumer Directed Community Supports (CDCS): Financial Management Services Total:							**125206.74**
Consumer Directed Community Supports (CDCS): Financial Management Services	☐	decremental	56	117.49	19.03	**125206.74**	
Consumer Directed Community							**97087.35**

GRAND TOTAL:	**695234508.68**
Total: Services included in capitation:	597811185.35
Total: Services not included in capitation:	97423323.33
Total Estimated Unduplicated Participants:	**37232**
Factor D (Divide total by number of participants):	**18673.04**
Services included in capitation:	16056.38
Services not included in capitation:	2616.66
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports (CDCS): Individual-Directed Goods and Services Total:							
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☐	decremental	24	51.09	79.18	**97087.35**	
Consumer Directed Community Supports (CDCS): Personal Assistance Total:							**901844.83**
Consumer Directed Community Supports (CDCS): Personal Assistance	☐	decremental	85	212.88	49.84	**901844.83**	
Consumer Directed Community Supports (CDCS): Self-direction Support Activities Total:							**39631.31**
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☐	decremental	21	99.17	19.03	**39631.31**	
Consumer Directed Community Supports (CDCS): Support Planning Total:							**26170.44**
Consumer Directed Community Supports (CDCS): Support Planning	☐	decremental	14	98.23	19.03	**26170.44**	
Consumer Directed Community Supports (CDCS): Treatment and							**53083.45**

GRAND TOTAL:	**695234508.68**
Total: Services included in capitation:	597811185.35
Total: Services not included in capitation:	97423323.33
Total Estimated Unduplicated Participants:	**37232**
Factor D (Divide total by number of participants):	**18673.04**
Services included in capitation:	16056.38
Services not included in capitation:	2616.66
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training Total:							
Consumer Directed Community Supports (CDCS): Treatment and Training	☐	decremental	7	78.87	96.15	**53083.45**	
Customized Living Services Total:							**80921395.36**
Customized Living Services	☐	daily	4887	153.49	107.88	**80921395.36**	
Environmental Accessibility Adaptations - Home Modifications Total:							**688063.03**
Environmental Accessibility Adaptations - Home Modifications	☐	item	68	2.07	4888.20	**688063.03**	
Environmental Accessibility Adaptations – Vehicle Modifications Total:							**466.60**
Environmental Accessibility Adaptations – Vehicle Modifications	☐	item	1	1.03	453.01	**466.60**	
Family Caregiver Services Total:							**593.27**
Family Caregiver Services	☐	15 min	3	9.03	21.90	**593.27**	
Home Delivered Meals Total:							**466444.86**
Home Delivered Meals	☐	item	552	101.32	8.34	**466444.86**	
Individual Community Living Supports Total:							**976541.59**
Individual Community Living Supports	☐	15 min	124	958.07	8.22	**976541.59**	
Managed Care Premiums Total:							**597811185.35**

GRAND TOTAL:	**695234508.68**
Total: Services included in capitation:	597811185.35
Total: Services not included in capitation:	97423323.33
Total Estimated Unduplicated Participants:	**37232**
Factor D (Divide total by number of participants):	**18673.04**
Services included in capitation:	16056.38
Services not included in capitation:	2616.66
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Managed Care Premiums	☒	month	33240	10.03	1793.09	597811185.35	
Specialized Equipment and Supplies Total:							641888.74
Specialized Equipment and Supplies	☐	item	1191	22.07	24.42	641888.74	
Transitional Services Total:							37022.52
Transitional Services	☐	item	16	42.14	54.91	37022.52	
Transportation Total:							194476.08
Transportation	☐	trip	212	6115.60	0.15	194476.08	

GRAND TOTAL:	695234508.68
Total: Services included in capitation:	597811185.35
Total: Services not included in capitation:	97423323.33
Total Estimated Unduplicated Participants:	37232
Factor D (Divide total by number of participants):	18673.04
Services included in capitation:	16056.38
Services not included in capitation:	2616.66
Average Length of Stay on the Waiver:	312

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							627782.40
Adult Day Service	☐	15 min	90	1384.00	5.04	627782.40	
Case Management Total:							7338864.60
Case Management	☐	15 min	5987	45.00	27.24	7338864.60	

GRAND TOTAL:	941967784.26
Total: Services included in capitation:	807168891.20
Total: Services not included in capitation:	134798893.06
Total Estimated Unduplicated Participants:	38518
Factor D (Divide total by number of participants):	24455.26
Services included in capitation:	20955.63
Services not included in capitation:	3499.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							**2446283.91**
Homemaker	☐	15 min	483	571.00	8.87	**2446283.91**	
Respite Total:							**254602.80**
Respite	☐	15 min/daily	20	1077.00	11.82	**254602.80**	
Extended Home Care Nursing Total:							**884.58**
Extended Home Care Nursing	☐	15 min	1	69.00	12.82	**884.58**	
Extended State Plan Home Health Care Services Total:							**1972.92**
Extended State Plan Home Health Care Services	☐	15 min	1	164.00	12.03	**1972.92**	
Extended State Plan Personal Care Assistance (PCA) Total:							**396397.65**
Extended State Plan Personal Care Assistance (PCA)	☐	15 min	43	1661.00	5.55	**396397.65**	
Adult Companion Services Total:							**64769.76**
Adult Companion Services	☐	15 min	33	232.00	8.46	**64769.76**	
Adult Day Service Bath Total:							**548.31**
Adult Day Service Bath	☐	bath	1	49.00	11.19	**548.31**	
Adult Foster Care Total:							**2563096.96**
Adult Foster Care	☐	daily	76	194.00	173.84	**2563096.96**	
Chore Services Total:							**149029.44**
Chore Services	☐	15 min/daily	56	331.00	8.04	**149029.44**	
Consumer Directed Community Supports (CDCS): Community							**4714.36**

GRAND TOTAL:	**941967784.26**
Total: Services included in capitation:	807168891.20
Total: Services not included in capitation:	134798893.06
Total Estimated Unduplicated Participants:	**38518**
Factor D (Divide total by number of participants):	**24455.26**
Services included in capitation:	20955.63
Services not included in capitation:	3499.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration and Support Total:							
Consumer Directed Community Supports (CDCS): Community Integration and Support	☐	*decremental*	*2*	*23.35*	*100.95*	***4714.36***	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions Total:							***0.00***
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☐	*decremental*	*0*	*20.60*	*154.92*	***0.00***	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications Total:							***40903.53***
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☐	*decremental*	*13*	*20.31*	*154.92*	***40903.53***	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications Total:							***11736.74***
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle	☐	*decremental*	*4*	*18.94*	*154.92*	***11736.74***	

GRAND TOTAL:	***941967784.26***
Total: Services included in capitation:	*807168891.20*
Total: Services not included in capitation:	*134798893.06*
Total Estimated Unduplicated Participants:	***38518***
Factor D (Divide total by number of participants):	***24455.26***
Services included in capitation:	*20955.63*
Services not included in capitation:	*3499.63*
Average Length of Stay on the Waiver:	*311*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications							
Consumer Directed Community Supports (CDCS): Financial Management Services Total:							**255943.80**
Consumer Directed Community Supports (CDCS): Financial Management Services	☐	decremental	75	170.80	19.98	**255943.80**	
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services Total:							**185244.23**
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☐	decremental	30	74.27	83.14	**185244.23**	
Consumer Directed Community Supports (CDCS): Personal Assistance Total:							**1425167.78**
Consumer Directed Community Supports (CDCS): Personal Assistance	☐	decremental	88	309.48	52.33	**1425167.78**	
Consumer Directed Community Supports (CDCS): Self-direction Support Activities Total:							**0.00**
Consumer Directed Community Supports (CDCS): Self-direction Support	☐	decremental	0	144.17	19.98	**0.00**	

GRAND TOTAL:	**941967784.26**
Total: Services included in capitation:	807168891.20
Total: Services not included in capitation:	134798893.06
Total Estimated Unduplicated Participants:	**38518**
Factor D (Divide total by number of participants):	**24455.26**
Services included in capitation:	20955.63
Services not included in capitation:	3499.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Activities							
Consumer Directed Community Supports (CDCS): Support Planning Total:							***54209.74***
Consumer Directed Community Supports (CDCS): Support Planning	☐	*decremental*	*19*	*142.80*	*19.98*	***54209.74***	
Consumer Directed Community Supports (CDCS): Treatment and Training Total:							***81024.49***
Consumer Directed Community Supports (CDCS): Treatment and Training	☐	*decremental*	*7*	*114.66*	*100.95*	***81024.49***	
Customized Living Services Total:							***115431816.96***
Customized Living Services	☐	*daily*	*5056*	*153.00*	*149.22*	***115431816.96***	
Environmental Accessibility Adaptations - Home Modifications Total:							***740120.92***
Environmental Accessibility Adaptations - Home Modifications	☐	*item*	*70*	*2.06*	*5132.60*	***740120.92***	
Environmental Accessibility Adaptations – Vehicle Modifications Total:							***489.93***
Environmental Accessibility Adaptations – Vehicle Modifications	☐	*item*	*1*	*1.03*	*475.66*	***489.93***	
Family Caregiver Services Total:							***663.93***

GRAND TOTAL:	***941967784.26***
Total: Services included in capitation:	*807168891.20*
Total: Services not included in capitation:	*134798893.06*
Total Estimated Unduplicated Participants:	***38518***
Factor D (Divide total by number of participants):	***24455.26***
Services included in capitation:	*20955.63*
Services not included in capitation:	*3499.63*
Average Length of Stay on the Waiver:	*311*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Family Caregiver Services	☐	15 min	3	9.00	24.59	663.93	
Home Delivered Meals Total:							525959.52
Home Delivered Meals	☐	item	571	101.00	9.12	525959.52	
Individual Community Living Supports Total:							1260294.40
Individual Community Living Supports	☐	15 min	128	955.00	10.31	1260294.40	
Managed Care Premiums Total:							807168891.20
Managed Care Premiums	☒	month	34388	10.00	2347.24	807168891.20	
Specialized Equipment and Supplies Total:							694946.56
Specialized Equipment and Supplies	☐	item	1232	22.00	25.64	694946.56	
Transitional Services Total:							41169.24
Transitional Services	☐	item	17	42.00	57.66	41169.24	
Transportation Total:							200253.60
Transportation	☐	trip	219	6096.00	0.15	200253.60	

GRAND TOTAL:	941967784.26
Total: Services included in capitation:	807168891.20
Total: Services not included in capitation:	134798893.06
Total Estimated Unduplicated Participants:	38518
Factor D (Divide total by number of participants):	24455.26
Services included in capitation:	20955.63
Services not included in capitation:	3499.63
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**688207.84**
Adult Day Service	☐	15 min	94	1384.00	5.29	**688207.84**	
Case Management Total:							**8018010.00**
Case Management	☐	15 min	6230	45.00	28.60	**8018010.00**	
Homemaker Total:							**2673953.03**
Homemaker	☐	15 min	503	571.00	9.31	**2673953.03**	
Respite Total:							**280676.97**
Respite	☐	15 min/daily	21	1077.00	12.41	**280676.97**	
Extended Home Care Nursing Total:							**928.74**
Extended Home Care Nursing	☐	15 min	1	69.00	13.46	**928.74**	
Extended State Plan Home Health Care Services Total:							**2072.96**
Extended State Plan Home Health Care Services	☐	15 min	1	164.00	12.64	**2072.96**	
Extended State Plan Personal Care Assistance (PCA) Total:							**435015.90**
Extended State Plan Personal Care Assistance (PCA)	☐	15 min	45	1661.00	5.82	**435015.90**	
Adult Companion Services Total:							**70124.32**
Adult Companion Services	☐	15 min	34	232.00	8.89	**70124.32**	
Adult Day Service Bath Total:							**575.75**
Adult Day Service Bath	☐	bath	1	49.00	11.75	**575.75**	
Adult Foster Care Total:							**2797608.04**
Adult Foster Care	☐					**2797608.04**	

GRAND TOTAL:	**1056684238.53**
Total: Services included in capitation:	904383792.00
Total: Services not included in capitation:	152300446.53
Total Estimated Unduplicated Participants:	**40083**
Factor D (Divide total by number of participants):	**26362.40**
Services included in capitation:	22563.00
Services not included in capitation:	3799.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		daily	79	194.00	182.54		
Chore Services Total:							**162031.12**
Chore Services	☐	15 min/daily	58	331.00	8.44	**162031.12**	
Consumer Directed Community Supports (CDCS): Community Integration and Support Total:							**5198.24**
Consumer Directed Community Supports (CDCS): Community Integration and Support	☐	decremental	2	24.52	106.00	**5198.24**	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions Total:							**0.00**
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☐	decremental	0	21.64	162.67	**0.00**	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications Total:							**45106.76**
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☐	decremental	13	21.33	162.67	**45106.76**	
Consumer Directed Community Supports (CDCS): Environmental							**12942.03**

GRAND TOTAL:	**1056684238.53**
Total: Services included in capitation:	904383792.00
Total: Services not included in capitation:	152300446.53
Total Estimated Unduplicated Participants:	**40083**
Factor D (Divide total by number of participants):	**26362.40**
Services included in capitation:	22563.00
Services not included in capitation:	3799.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications-Vehicle Modifications Total:							
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☐	decremental	4	19.89	162.67	**12942.03**	
Consumer Directed Community Supports (CDCS): Financial Management Services Total:							**293560.97**
Consumer Directed Community Supports (CDCS): Financial Management Services	☐	decremental	78	179.39	20.98	**293560.97**	
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services Total:							**217928.74**
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☐	decremental	32	78.01	87.30	**217928.74**	
Consumer Directed Community Supports (CDCS): Personal Assistance Total:							**1643207.22**
Consumer Directed Community Supports (CDCS): Personal Assistance	☐	decremental	92	325.04	54.95	**1643207.22**	
Consumer Directed							**0.00**

GRAND TOTAL:	**1056684238.53**
Total: Services included in capitation:	904383792.00
Total: Services not included in capitation:	152300446.53
Total Estimated Unduplicated Participants:	**40083**
Factor D (Divide total by number of participants):	**26362.40**
Services included in capitation:	22563.00
Services not included in capitation:	3799.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Supports (CDCS): Self-direction Support Activities Total:							
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☐	decremental	0	151.42	20.98	**0.00**	
Consumer Directed Community Supports (CDCS): Support Planning Total:							**62931.61**
Consumer Directed Community Supports (CDCS): Support Planning	☐	decremental	20	149.98	20.98	**62931.61**	
Consumer Directed Community Supports (CDCS): Treatment and Training Total:							**89359.06**
Consumer Directed Community Supports (CDCS): Treatment and Training	☐	decremental	7	120.43	106.00	**89359.06**	
Customized Living Services Total:							**131011644.78**
Customized Living Services	☐	daily	5262	153.00	162.73	**131011644.78**	
Environmental Accessibility Adaptations - Home Modifications Total:							**810433.91**
Environmental Accessibility Adaptations - Home Modifications	☐	item	73	2.06	5389.24	**810433.91**	
Environmental Accessibility Adaptations –							**514.43**

GRAND TOTAL:	**1056684238.53**
Total: Services included in capitation:	904383792.00
Total: Services not included in capitation:	152300446.53
Total Estimated Unduplicated Participants:	**40083**
Factor D (Divide total by number of participants):	**26362.40**
Services included in capitation:	22563.00
Services not included in capitation:	3799.63
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications Total:							
Environmental Accessibility Adaptations – Vehicle Modifications	☐	item	1	1.03	499.45	**514.43**	
Family Caregiver Services Total:							**697.14**
Family Caregiver Services	☐	15 min	3	9.00	25.82	**697.14**	
Home Delivered Meals Total:							**574742.52**
Home Delivered Meals	☐	item	594	101.00	9.58	**574742.52**	
Individual Community Living Supports Total:							**1375572.45**
Individual Community Living Supports	☐	15 min	133	955.00	10.83	**1375572.45**	
Managed Care Premiums Total:							**904383792.00**
Managed Care Premiums	☒	month	35786	10.00	2527.20	**904383792.00**	
Specialized Equipment and Supplies Total:							**759251.68**
Specialized Equipment and Supplies	☐	item	1282	22.00	26.92	**759251.68**	
Transitional Services Total:							**45768.24**
Transitional Services	☐	item	18	42.00	60.54	**45768.24**	
Transportation Total:							**222382.08**
Transportation	☐	trip	228	6096.00	0.16	**222382.08**	

GRAND TOTAL:	**1056684238.53**
Total: Services included in capitation:	904383792.00
Total: Services not included in capitation:	152300446.53
Total Estimated Unduplicated Participants:	**40083**
Factor D (Divide total by number of participants):	**26362.40**
Services included in capitation:	22563.00
Services not included in capitation:	3799.63
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User,*

and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**754113.92**
Adult Day Service	☐	15 min	98	1384.00	5.56	**754113.92**	
Case Management Total:							**8767558.80**
Case Management	☐	15 min	6488	45.00	30.03	**8767558.80**	
Homemaker Total:							**2926215.12**
Homemaker	☐	15 min	524	571.00	9.78	**2926215.12**	
Respite Total:							**308732.82**
Respite	☐	15 min/daily	22	1077.00	13.03	**308732.82**	
Extended Home Care Nursing Total:							**974.97**
Extended Home Care Nursing	☐	15 min	1	69.00	14.13	**974.97**	
Extended State Plan Home Health Care Services Total:							**2176.28**
Extended State Plan Home Health Care Services	☐	15 min	1	164.00	13.27	**2176.28**	
Extended State Plan Personal Care Assistance (PCA) Total:							**476989.37**
Extended State Plan Personal Care Assistance (PCA)	☐	15 min	47	1661.00	6.11	**476989.37**	
Adult Companion Services Total:							**75759.60**
Adult Companion Services	☐	15 min	35	232.00	9.33	**75759.60**	
Adult Day Service Bath Total:							**604.66**

GRAND TOTAL:	**1155544084.13**
Total: Services included in capitation:	989008347.60
Total: Services not included in capitation:	166535736.53
Total Estimated Unduplicated Participants:	**41746**
Factor D (Divide total by number of participants):	**27680.35**
Services included in capitation:	23691.09
Services not included in capitation:	3989.26
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Bath	☐	bath	1	49.00	12.34	604.66	
Adult Foster Care Total:							3048927.28
Adult Foster Care	☐	daily	82	194.00	191.66	3048927.28	
Chore Services Total:							175959.60
Chore Services	☐	15 min/daily	60	331.00	8.86	175959.60	
Consumer Directed Community Supports (CDCS): Community Integration and Support Total:							5458.15
Consumer Directed Community Supports (CDCS): Community Integration and Support	☐	decremental	2	24.52	111.30	5458.15	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions Total:							0.00
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☐	decremental	0	21.64	170.80	0.00	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications Total:							51004.30
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home	☐	decremental	14	21.33	170.80	51004.30	

GRAND TOTAL:	**1155544084.13**
Total: Services included in capitation:	989008347.60
Total: Services not included in capitation:	166535736.53
Total Estimated Unduplicated Participants:	**41746**
Factor D (Divide total by number of participants):	**27680.35**
Services included in capitation:	23691.09
Services not included in capitation:	3989.26
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications							
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications Total:							***13588.85***
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☐	*decremental*	*4*	*19.89*	*170.80*	***13588.85***	
Consumer Directed Community Supports (CDCS): Financial Management Services Total:							***320108.90***
Consumer Directed Community Supports (CDCS): Financial Management Services	☐	*decremental*	*81*	*179.39*	*22.03*	***320108.90***	
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services Total:							***235963.09***
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☐	*decremental*	*33*	*78.01*	*91.66*	***235963.09***	
Consumer Directed Community Supports (CDCS): Personal Assistance Total:							***1800461.57***
Consumer Directed Community	☐	*decremental*	*96*	*325.04*	*57.70*	***1800461.57***	

GRAND TOTAL:	***1155544084.13***
Total: Services included in capitation:	*989008347.60*
Total: Services not included in capitation:	*166535736.53*
Total Estimated Unduplicated Participants:	***41746***
Factor D (Divide total by number of participants):	***27680.35***
Services included in capitation:	*23691.09*
Services not included in capitation:	*3989.26*
Average Length of Stay on the Waiver:	*311*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supports (CDCS): Personal Assistance							
Consumer Directed Community Supports (CDCS): Self-direction Support Activities Total:							**0.00**
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☐	decremental	0	151.42	22.03	**0.00**	
Consumer Directed Community Supports (CDCS): Support Planning Total:							**69385.25**
Consumer Directed Community Supports (CDCS): Support Planning	☐	decremental	21	149.98	22.03	**69385.25**	
Consumer Directed Community Supports (CDCS): Treatment and Training Total:							**93827.01**
Consumer Directed Community Supports (CDCS): Treatment and Training	☐	decremental	7	120.43	111.30	**93827.01**	
Customized Living Services Total:							**143255858.40**
Customized Living Services	☐	daily	5480	153.00	170.86	**143255858.40**	
Environmental Accessibility Adaptations - Home Modifications Total:							**885926.07**
Environmental Accessibility	☐	item				**885926.07**	

GRAND TOTAL:	**1155544084.13**
Total: Services included in capitation:	989008347.60
Total: Services not included in capitation:	166535736.53
Total Estimated Unduplicated Participants:	**41746**
Factor D (Divide total by number of participants):	**27680.35**
Services included in capitation:	23691.09
Services not included in capitation:	3989.26
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations - Home Modifications			76	2.06	5658.70		
Environmental Accessibility Adaptations – Vehicle Modifications Total:							**540.15**
Environmental Accessibility Adaptations – Vehicle Modifications	☐	item	1	1.03	524.42	**540.15**	
Family Caregiver Services Total:							**731.97**
Family Caregiver Services	☐	15 min	3	9.00	27.11	**731.97**	
Home Delivered Meals Total:							**628941.14**
Home Delivered Meals	☐	item	619	101.00	10.06	**628941.14**	
Individual Community Living Supports Total:							**1509310.65**
Individual Community Living Supports	☐	15 min	139	955.00	11.37	**1509310.65**	
Managed Care Premiums Total:							**989008347.60**
Managed Care Premiums	☒	month	37271	10.00	2653.56	**989008347.60**	
Specialized Equipment and Supplies Total:							**830289.90**
Specialized Equipment and Supplies	☐	item	1335	22.00	28.27	**830289.90**	
Transitional Services Total:							**50720.88**
Transitional Services	☐	item	19	42.00	63.56	**50720.88**	
Transportation Total:							**245607.84**
Transportation	☐	trip	237	6096.00	0.17	**245607.84**	

GRAND TOTAL:	**1155544084.13**
Total: Services included in capitation:	989008347.60
Total: Services not included in capitation:	166535736.53
Total Estimated Unduplicated Participants:	**41746**
Factor D (Divide total by number of participants):	**27680.35**
Services included in capitation:	23691.09
Services not included in capitation:	3989.26
Average Length of Stay on the Waiver:	311

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**835180.44**
Adult Day Service	☐	15 min	103	1388.45	5.84	**835180.44**	
Case Management Total:							**9678196.56**
Case Management	☐	15 min	6800	45.14	31.53	**9678196.56**	
Homemaker Total:							**3229803.67**
Homemaker	☐	15 min	549	572.84	10.27	**3229803.67**	
Respite Total:							**340204.44**
Respite	☐	15 min/daily	23	1080.46	13.69	**340204.44**	
Extended Home Care Nursing Total:							**1027.22**
Extended Home Care Nursing	☐	15 min	1	69.22	14.84	**1027.22**	
Extended State Plan Home Health Care Services Total:							**2291.90**
Extended State Plan Home Health Care Services	☐	15 min	1	164.53	13.93	**2291.90**	
Extended State Plan Personal Care Assistance (PCA) Total:							**524197.24**
Extended State Plan Personal Care Assistance (PCA)	☐	15 min	49	1666.34	6.42	**524197.24**	

GRAND TOTAL:	**1275597630.50**
Total: Services included in capitation:	1091709989.97
Total: Services not included in capitation:	183887640.54
Total Estimated Unduplicated Participants:	**43756**
Factor D (Divide total by number of participants):	**29152.52**
Services included in capitation:	24949.95
Services not included in capitation:	4202.57
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Companion Services Total:							**84395.15**
Adult Companion Services	☐	15 min	37	232.75	9.80	**84395.15**	
Adult Day Service Bath Total:							**636.62**
Adult Day Service Bath	☐	bath	1	49.16	12.95	**636.62**	
Adult Foster Care Total:							**3368385.65**
Adult Foster Care	☐	daily	86	194.62	201.25	**3368385.65**	
Chore Services Total:							**194763.15**
Chore Services	☐	15 min/daily	63	332.06	9.31	**194763.15**	
Consumer Directed Community Supports (CDCS): Community Integration and Support Total:							**5750.00**
Consumer Directed Community Supports (CDCS): Community Integration and Support	☐	decremental	2	24.60	116.87	**5750.00**	
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions Total:							**0.00**
Consumer Directed Community Supports (CDCS): Environmental Modifications and Provisions	☐	decremental	0	21.71	179.34	**0.00**	
Consumer Directed Community Supports (CDCS): Environmental Modifications- Home Modifications Total:							**57568.14**

GRAND TOTAL:	**1275597630.50**
Total: Services included in capitation:	1091709989.97
Total: Services not included in capitation:	183887640.54
Total Estimated Unduplicated Participants:	**43756**
Factor D (Divide total by number of participants):	**29152.52**
Services included in capitation:	24949.95
Services not included in capitation:	4202.57
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Directed Community Supports (CDCS): Environmental Modifications-Home Modifications	☐	decremental	15	21.40	179.34	**57568.14**	
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications Total:							**14311.33**
Consumer Directed Community Supports (CDCS): Environmental Modifications-Vehicle Modifications	☐	decremental	4	19.95	179.34	**14311.33**	
Consumer Directed Community Supports (CDCS): Financial Management Services Total:							**353830.02**
Consumer Directed Community Supports (CDCS): Financial Management Services	☐	decremental	85	179.97	23.13	**353830.02**	
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services Total:							**263638.38**
Consumer Directed Community Supports (CDCS): Individual-Directed Goods and Services	☐	decremental	35	78.26	96.25	**263638.38**	
Consumer							**1995207.75**

GRAND TOTAL:	**1275597630.50**
Total: Services included in capitation:	1091709989.97
Total: Services not included in capitation:	183887640.54
Total Estimated Unduplicated Participants:	**43756**
Factor D (Divide total by number of participants):	**29152.52**
Services included in capitation:	24949.95
Services not included in capitation:	4202.57
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed Community Supports (CDCS): Personal Assistance Total:							
Consumer Directed Community Supports (CDCS): Personal Assistance	☐	decremental	101	326.09	60.58	**1995207.75**	
Consumer Directed Community Supports (CDCS): Self-direction Support Activities Total:							**0.00**
Consumer Directed Community Supports (CDCS): Self-direction Support Activities	☐	decremental	0	151.91	23.13	**0.00**	
Consumer Directed Community Supports (CDCS): Support Planning Total:							**76563.08**
Consumer Directed Community Supports (CDCS): Support Planning	☐	decremental	22	150.46	23.13	**76563.08**	
Consumer Directed Community Supports (CDCS): Treatment and Training Total:							**98841.63**
Consumer Directed Community Supports (CDCS): Treatment and Training	☐	decremental	7	120.82	116.87	**98841.63**	
Customized Living Services Total:							**158167392.86**
Customized Living Services	☐	daily	5744	153.49	179.40	**158167392.86**	

GRAND TOTAL:	**1275597630.50**
Total: Services included in capitation:	1091709989.97
Total: Services not included in capitation:	183887640.54
Total Estimated Unduplicated Participants:	**43756**
Factor D (Divide total by number of participants):	**29152.52**
Services included in capitation:	24949.95
Services not included in capitation:	4202.57
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations - Home Modifications Total:							**983933.93**
Environmental Accessibility Adaptations - Home Modifications	☐	item	80	2.07	5941.63	**983933.93**	
Environmental Accessibility Adaptations – Vehicle Modifications Total:							**567.16**
Environmental Accessibility Adaptations – Vehicle Modifications	☐	item	1	1.03	550.64	**567.16**	
Family Caregiver Services Total:							**771.25**
Family Caregiver Services	☐	15 min	3	9.03	28.47	**771.25**	
Home Delivered Meals Total:							**694390.54**
Home Delivered Meals	☐	item	649	101.32	10.56	**694390.54**	
Individual Community Living Supports Total:							**1670145.95**
Individual Community Living Supports	☐	15 min	146	958.07	11.94	**1670145.95**	
Managed Care Premiums Total:							**1091709989.97**
Managed Care Premiums	☒	month	39065	10.03	2786.24	**1091709989.97**	
Specialized Equipment and Supplies Total:							**916397.60**
Specialized Equipment and Supplies	☐	item	1399	22.07	29.68	**916397.60**	
Transitional Services Total:							**56248.47**
Transitional Services	☐	item	20	42.14	66.74	**56248.47**	
Transportation							**273000.38**

GRAND TOTAL:	**1275597630.50**
Total: Services included in capitation:	1091709989.97
Total: Services not included in capitation:	183887640.54
Total Estimated Unduplicated Participants:	**43756**
Factor D (Divide total by number of participants):	**29152.52**
Services included in capitation:	24949.95
Services not included in capitation:	4202.57
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Total:							
Transportation	☐	*trip*	*248*	*6115.60*	*0.18*	***273000.38***	

GRAND TOTAL:	***1275597630.50***
Total: Services included in capitation:	*1091709989.97*
Total: Services not included in capitation:	*183887640.54*
Total Estimated Unduplicated Participants:	***43756***
Factor D (Divide total by number of participants):	***29152.52***
Services included in capitation:	*24949.95*
Services not included in capitation:	*4202.57*
Average Length of Stay on the Waiver:	*312*