Performance Measures

Reform: Pathways to Independence
Section 1115 Demonstration Waiver No. 11-W-00286/5
Alternative Care (2025 – 2030)

Introduction

This report includes Minnesota's performance measures for the Reform: Pathways to Independence demonstration (No. 11-W-00286/5) authorized under section 1115 of the Social Security Act. These performance measures are being submitted to the Centers for Medicare and Medicaid Services (CMS) by the Minnesota Department of Human Services (DHS) as required by item 8.4 of the current Special Terms and Conditions (STC) dated January 2, 2025, and align with the demonstration period from February 1, 2025 to January 31, 2030.

Item 8.4 of the STCs requires the state to develop performance measures for home and community-based services (HCBS) programs to address the following requirements, copied directly from the current STCs.

A. **Administrative Authority**: The state must have performance measures to demonstrate that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.

B. **Level of Care**: The state must have performance measures to demonstrate each of the following: a) that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that 1915(c)-like HCBS services may be needed in the future, and b) that the process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine initial participant level of care. While the state is required to conduct annual re-evaluations for level of care, a performance measure is not required to demonstrate compliance with this requirement.

C. **Qualified Providers**: The state must have performance measures to demonstrate each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing 1915(c)-like HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

D. **Service Plans**: The state must have performance measures to demonstrate each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of 1915(c)-like HCBS services or through other means, b) service plans are updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among 1915(c)-like HCBS services and providers.

E. **Health and Welfare**: The state must have performance measures to demonstrate each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

F. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the 1915(c)-like HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period.

The performance measures provided in this report for the Reform demonstration align with DHS' Quality Improvement Strategy submitted to CMS on April 1, 2025. The Quality Improvement Strategy and performance measures demonstrate the state's operational oversight of the Alternative Care (AC) program.

DHS requires remediation of all findings of non-compliance (i.e., deficiencies) and formal corrective action when patterns of non-compliance with demonstration standards are discovered. CMS requires remediation of measures for which compliance is at or below 85%.[1]

The state will provide data for the following three full years:

- 02/01/2025 – 01/31/2026
- 02/01/2026 – 01/31/2027
- 02/01/2027 – 01/31/2028

[1] CMS instructions "Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers" March 12, 2014. 3-cmcs-quality-memo-narrative_0.pdf (medicaid.gov)

As required in STC 8.5 (b), the state will submit a report to CMS no later than 21 months prior to the end of the approved demonstration period (April 30, 2028), including evidence on the status of the approved performance measures.

Lead Agency Review Sampling Method and Remediation Cycle

DHS conducts reviews of the functions delegated to county and tribal human service agencies, referred to as lead agency reviews, on an ongoing basis. County and tribal human service agencies are randomly selected for review each year.

Sampling Method

DHS utilizes a multi-stage sampling methodology for completing its Lead Agency Reviews which includes the use of both cluster sampling and probability sampling methods.

To conduct the Lead Agency Reviews, the state begins by randomly selecting and assigning all county and tribal human service agencies to be reviewed during a specific year of the 4-year review cycle. In an effort to ensure that all county and tribal human service agencies are reviewed on a routine basis and that an appropriate number of agencies are being looked at during each review cycle year, the state uses a cluster sampling approach by which all agencies are categorized into one of five cohorts based on the total number of participants they serve as listed below. After all agencies are organized by cohort, the state then selects agencies from each cohort. Depending on the total number of agencies within each cohort, a varying number of agencies is selected for review using a standard probability method.

- Cohort 1: 0 - 199 participants
- Cohort 2: 200 - 449 participants
- Cohort 3: 450 - 899 participants
- Cohort 4: 900 - 2,499 participants
- Cohort 5: 2,500 - 19,000 participants

After all county and tribal human services agencies have been scheduled for review, the next step is the selection of participants from each of the individual agencies. In order to ensure that as representative of a sample of participants is reviewed, all participants are selected at random following these three specific rules dependent on the total number of participants that each individual agency serves.

1. If an agency serves less than ten participants, then all participants are reviewed.
2. If an agency serves more than ten participants, then a 10% sample is selected.
3. For larger agencies generally serving more than 2,500 participants and a 10% sample is not statistically reliable, then a sample size must be individually calculated for each agency so that it reaches a 95% confidence level with a 10% margin.

Once all the selected agencies and the respective participants have been reviewed, the state releases its findings on a year-by-year basis.

Remediation Cycle

DHS requires remediation of all findings of non-compliance in the sample, and formal corrective action when patterns of non-compliance with program standards are discovered during the review. County and tribal human service agencies must formally assure DHS, generally within 60 days, that they have fully remediated all deficiencies and have brought all files reviewed as a part of the sample into compliance. Corrective actions are issued when patterns of non-compliance are found. If a corrective action has been issued, the county or tribal human service agency must develop and submit a corrective action plan within ten (10) days following receipt of the final report summarizing the review findings. Eighteen months following a review, DHS sends county and tribal human service agencies a follow-up survey. County and tribal human service agencies are asked to self-report whether their corrective actions resulted in compliant practices and describe the methods they use for monitoring. A follow-up review is required when there is a high level of non-compliance during the initial review. To verify corrective actions have been implemented and are resulting in improved compliance, the follow-up review occurs 12-14 months following the initial review and consists of reviewing another sample of cases looking specifically at the areas that received corrective action.

Appendix A – Administrative Authority

Requirement. The state demonstrates that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.

Background

Lead Agency Review. DHS monitors AC program activities delegated to county and tribal human service agencies through reviews. The reviews result in deficiencies and corrective actions issued by DHS as needed. The results reflect the number of corrective actions remediated compared to the number issued during lead agency review.

Performance Measure 1	
Percent of administrative AC requirement compliance deficiencies (identified during lead agency reviews) resolved	
Evidence	
Numerator	Number of AC requirement corrective actions resolved
Denominator	Number of AC requirement corrective actions issued
Data Source	Other: Lead Agency Review Database
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Continuously and ongoing
Sampling Approach	Other: DHS uses a multi-stage sampling methodology for the lead agency reviews. A multi-stage sample is a specific type of cluster sample and probability sample.
Responsible Party for Data	State Medicaid Agency

Aggregation and Analysis				
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Appendix B – Level of Care (LOC) Determination

Requirement. The state demonstrates each of the following: a) that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that 1915(c)-like HCBS services may be needed in the future, and b) that the process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine initial participant level of care. While the state is required to conduct annual re-evaluations for level of care, a performance measure is not required to demonstrate compliance with this requirement.

Background

MnCHOICES and MMIS. A comprehensive assessment, known as the MnCHOICES assessment, is conducted by a certified assessor with an applicant or participant to assess functional needs, financial eligibility, determine nursing facility level of care (NF LOC), and inform the development of the person-centered support plan. When an applicant contacts a county, tribal human service agency, or DHS for home and community-based services, the applicant is directed to their county or tribal human service agency intake office and an assessment visit is scheduled. All county and tribal human service agencies are required to complete the assessment within required timeframes. Assessors must be certified by DHS, and must conduct a MnCHOICES assessment and develop a person-centered support plan. Information from the MnCHOICES assessment (including NF LOC determination and assessed needs) and AC Program Eligibility Worksheet is entered into MMIS. Data from MnCHOICES and MMIS are used to monitor county and tribal human service agency compliance in completing assessment information needed for NF LOC evaluations. MnCHOICES algorithms and MMIS edits support the entry of all required assessment information and validates that the information entered meets NF LOC criteria.

Level of Care Determination: Sub-assurance a

Requirement. An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure 2				
Percent of completed initial MnCHOICES assessment results for AC sent to the applicant within 60 days of the assessment visit				
Evidence				
Numerator	Number of completed initial MnCHOICES assessment results for AC sent to the applicant within 60 days of the assessment visit			
Denominator	Number of initial AC assessments completed			
Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Performance Measure 3	
Percent of initial AC assessments completed within 20 days of request	
Evidence	
Numerator	Number of initial AC assessments completed within 20 days of request
Denominator	Number of initial AC assessments
Data Source	Other: MnCHOICES Database
Responsible Party for data	Other: County and tribal human service agencies enter data

collection/generation				
Frequency of data collection/generation	Continuously and Ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Level of Care Determination: Sub-assurance b

Requirement. The level of care of enrolled participants is reevaluated at least annually or as specified in the approved waiver.

While states are no longer required to report on this measure,[2] completion of at least annual reassessment of level of care and verification of other waiver eligibility criteria continues to be required to be completed by county and tribal human service agencies and is monitored and assured by DHS.

Level of Care Determination: Sub-assurance c

Requirement. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.

Background

MnCHOICES. The MnCHOICES assessment captures all of the fields related to determining level of care, and generates a level of care determination based on information included in the assessment through a built-in

[2] CMS instructions "Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers" (page 3) March 12, 2014. 3-cmcs-quality-memo-narrative_0.pdf (medicaid.gov)

algorithm. The data below includes all assessments and reassessments for which a nursing facility level of care determination is required for initial and continued AC program eligibility.

Performance Measure 4				
Percent of MnCHOICES assessments for AC participants completed by a certified assessor				
Evidence				
Numerator	Number of MnCHOICES assessments for AC participants completed by a certified assessor that resulted in a determination of NF LOC			
Denominator	Number of MnCHOICES assessments for AC participants completed			
Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Appendix C - Qualified Providers

Requirement. The State demonstrates each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing 1915(c)-like HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

Background

Provider Eligibility and Compliance and MMIS. To enroll as a Minnesota Health Care Programs (MHCP) provider, providers must meet professional, certification and/or licensure requirements according to state and federal laws and regulations, including HBCS waiver and section 1115 demonstration requirements. DHS' Provider Eligibility and Compliance unit (Provider Enrollment) verifies that these requirements are met before a provider is enrolled and added to the provider subsystem in MMIS and the Minnesota Provider Screening and Enrollment portal.[3] Most providers must be enrolled through Provider Enrollment. Before providers are paid they must:

1. Be enrolled as an MHCP provider;
2. Have services prior authorized by the case manager based on the participant's approved support plan; and
3. Submit service claims in MMIS in accordance with state policies.

Edits in MMIS check that these requirements are met.

Provider Enrollment conducts monthly internal audits to assess compliance with provider screening and enrollment regulations and operational procedures. Twenty percent (20%) of home and community-based waiver/AC program service provider enrollment actions are randomly selected and reviewed each month. Issues discovered through the audits are individually addressed by DHS staff. Performance measure 6 provides the data from these audits.

If a provider's license or certification expires or is revoked and the provider does not respond in a timely manner, the provider is removed from active enrollment status. Services cannot be authorized or claims paid for dates of service during which the provider is not in active enrollment status. Performance measure 5 provides the data for this monitoring to show that MHCP providers initially and continually meet required licensure or certification standards prior to furnishing AC services.

For market and receipt-based services,[4] providers are not required to enroll with DHS, but they have the option to enroll if they choose. The state directs county and tribal human service agencies to assure compliance with non-enrolled market and receipt-based services, authorize the purchase of goods and services in compliance with state and federal requirements, and to maintain payment records in a manner directed by the state.

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[3] The Minnesota Provider Screening and Enrollment portal is a secure online web-based tool that lets providers enroll and manage their MHCP enrollment records. See Minnesota Provider Screening and Enrollment (MPSE) Home.

[4] Market services are those purchased at a price typically charged on a community market basis (i.e., cleaning, home modifications). 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).

Lead Agency Review. DHS monitors program activities delegated to county and tribal human service agencies through reviews. If a county or tribal human service agency uses non-enrolled providers to meet a participant's service needs, DHS requires that the county or tribal human service agency use a state-directed procedure to verify, track and document the qualifications of those providers. The results for this measure show how many county and tribal human service agencies received corrective actions related to this required process. County and tribal human service agencies that receive corrective actions are required to implement the state-directed procedure and verify implementation.

Qualified Providers: Sub-assurance a

Requirement. 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 Measure 5				
Percent of total claims paid to new and existing MHCP providers for services provided to AC participants				
Evidence				
Numerator	Number of claims paid to new and existing MHCP providers for services provided to AC participants			
Denominator	Number of all claims paid for service provided to AC participants			
Data Source	MMIS			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Performance Measure 6				
Percent of new and existing HCBS provider applications randomly selected, reviewed and determined to meet all required standards				
Evidence				
Numerator	Number of new and existing HCBS provider applications randomly reviewed that met all required standards			
Denominator	Number of new and existing HCBS provider applications randomly reviewed			
Data Source	Other: Minnesota Health Care Program (MHCP) Quality Control Audit Record			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Monthly			
Sampling Approach	Less than 100% Review; MHCP program area random audit sample.			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Qualified Providers: Sub-assurance b

Requirement. The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure 7	
Percent of county and tribal human service agencies that use a state-directed procedure to verify, track and document the qualifications of non-enrolled providers	
Evidence	
Numerator	Number of county and tribal human service agencies that use a state-directed procedure to verify, track and document the qualifications of non-enrolled providers
Denominator	Number of county and tribal human service agencies that use non-enrolled

	providers
Data Source	Other: Lead Agency Review Database (until MnCHOICES application data is available for reporting on this measure)
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Continuously and ongoing
Sampling Approach	Other: DHS uses a multi-stage sampling methodology for the lead agency reviews. A multi-stage sample is a specific type of cluster sample and probability sample.
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency
Frequency of Data Aggregation and Analysis	Annually

State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				

State Analysis

Remediation

Quality Improvement Activities

Qualified Providers: Sub-assurance c

Requirement. The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved protocol.

Performance Measure 8	
Percent of MHCP providers that completed the required provider training	
Evidence	
Numerator	Number of MHCP providers that completed the required provider training
Denominator	Number of MHCP providers required to complete the provider training
Data Source	Other: Minnesota Provider Screening and Enrollment system
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Continuously and ongoing
Sampling Approach	100% Review
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency

Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Appendix D – Service Plans

Requirement. The State demonstrates each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of 1915(c)-like HCBS services or through other means, b) service plans are updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among 1915(c)-like HCBS services and providers.

Background

MnCHOICES. The MnCHOICES application is an integrated platform that includes both the participant assessment and support plan. When needs are identified through the assessment, they are populated in an electronic support plan to be addressed by the case manager through person-centered care planning with the participant. In order to be completed, the support plan must document goals and action steps needed to achieve those goals (or a reason for not having a goal), and address all assessed needs through AC program services or other supports. The case manager discusses with the participant the different services, providers, and supports available during the support planning process. When signing the support plan, participants are asked to confirm whether they were offered a choice of all available services, supports, and providers.

Lead Agency Review. DHS monitors AC program activities delegated to county and tribal human service agencies through reviews. The reviews include reviewing a sample of AC program case files to determine whether the required forms and documents are included in the file, and the support plan is developed in accordance with AC program policies and procedures, including that the support plan:

1. Is current, updated timely, and is updated at least annually;
2. Documents assessed health and safety issues, and participant goals;
3. Documents the participant's needs as identified in the assessment;

4. Documents the services necessary to address the participant's assessed needs;
5. Contains the appropriate signature forms indicating the participant was offered a choice between/among services and providers; and
6. Was signed by the participant.

Encumbrance reports. Encumbrance and payment reports are used to track that each person receives the services authorized. These reports link back to participants' support plans which include all services required to meet participants' needs based on their assessments. Before any services can be provided, the services must be authorized in an MMIS service agreement. Service agreements include the type, scope, amount, frequency, service date span, and rate for each service and the provider(s) who will deliver each service. A service agreement is only approved when there is a corresponding approved screening document in MMIS that identifies the applicant or participant is eligible for the program, including meeting the level of care requirements, having service needs that can be met by the program, etc. When services are provided, the provider submits a claim which is also tracked in MMIS. For a claim to be paid, the claim must correspond with the service agreement in MMIS. The service agreement and claims payments are linked to MMIS edits to assure providers only claim for services authorized. The data in performance measure 11 compares the services provided using claims data to what the participant was authorized to receive in the service agreement.

Service Plans: Sub-assurance a

Requirement. 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 Measure 9				
Percent of AC support plans that address all the participant's assessed needs and goals				
Evidence				
Numerator	Number of completed AC support plans that address all the participant's assessed needs and goals			
Denominator	Number of completed AC support plans			
Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				

02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Service Plans: Sub-assurance b

Requirement. The State monitors service plan development in accordance with its policies and procedures.

While states are no longer required to report on this measure, DHS continues to monitor and assure that service plans are developed in accordance with policies and procedures. Evaluation of compliance with completion of service plan elements using approved DHS forms and processes is part of the case file review conducted during lead agency reviews.

Service Plans: Sub-Assurance c

Requirement. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure 10				
Percent of AC participant files reviewed during the lead agency review where the support plan was updated annually				
Evidence				
Numerator	Number of AC participant files reviewed during the lead agency review where the support plan was updated annually			
Denominator	Number of AC participant files reviewed			
Data Source	Other: Lead Agency Review Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	Other: DHS uses a multi-stage sampling methodology for the lead agency reviews. A multi-stage sample is a specific type of cluster sample and probability sample.			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**

02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Service Plans: Sub-assurance d

Requirement. Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

Performance Measure 11				
Percent difference between the dollar amount authorized for AC services compared to the dollar amount claimed for services provided to AC participants				
Evidence				
Numerator	Dollar amount claimed for services provided to AC participants			
Denominator	Dollar amount authorized for AC services			
Data Source	MMIS			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Performance Measure 12				
Percent of AC participants who responded "Yes, All Paid Support Workers, Always or Almost Always" to the NCI-AD survey indicator "Percentage of people whose paid support staff do things the way they want them done"				
Evidence				
Numerator	Number of AC participants who responded "Yes, All Paid Support Workers, Always or Almost Always" to the NCI-AD survey indicator "Percentage of people whose paid support staff do things the way they want them done"			
Denominator	Number of AC participants who answered the NCI-AD survey indicator "Percentage of people whose paid support staff do things the way they want them done"			
Data Source	Other: National Core Indicators – Aging and Disabilities Survey results			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Other: Every other year			
Sampling Approach	Less than 100% Review Representative Sample Confidence interval = 90% Margin of error = 10%			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Other: Every other year			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Performance Measure 13
Percent of AC participants who responded "Yes, All Paid Support Workers, Always or Almost Always" to the NCI-AD survey indicator "Percentage of people whose paid support staff come and leave when they are supposed to"

Evidence	
Numerator	Number of AC participants who responded “Yes, All Paid Support Workers, Always or Almost Always” to the NCI-AD survey indicator “Percentage of people whose paid support staff come and leave when they are supposed to”
Denominator	Number of AC participants who answered the NCI-AD survey indicator “Percentage of people whose paid support staff come and leave when they are supposed to”
Data Source	Other: National Core Indicators – Aging and Disabilities Survey results
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Other: Every other year
Sampling Approach	Less than 100% Review Representative Sample Confidence interval = 90% Margin of error = 10%
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency
Frequency of Data Aggregation and Analysis	Other: Every other year

State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				

State Analysis

Remediation

Quality Improvement Activities

Service Plans: Sub-assurance e

Requirement. Participants are afforded choice between/among waiver services and providers.

Performance Measure 14	
Percent of completed AC support plans where the participant acknowledges being provided choice by selecting yes to the MnCHOICES assessment question “I was offered a choice of all available services, supports, and providers”	
Evidence	
Numerator	Number of completed AC support plans where the participant acknowledges being provided choice by selecting yes to the MnCHOICES assessment question “I was offered a choice of all available services, supports, and providers”
Denominator	Number of completed AC support plans

Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Appendix G: Participant Safeguards

Requirement. The State demonstrates each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

Background

Maltreatment Report Investigations. Minnesota has a comprehensive system to receive reports about and follow-up on alleged or suspected maltreatment. Reports of alleged or suspected maltreatment involving vulnerable adults, including all AC program participants, are referred to the appropriate lead investigative agency for investigation, determination, and final disposition. Aggregate data is used to evaluate potential trends or patterns and to inform actions to improve adult protection systems. The data will include county-investigated reports.

All reports that involve the death of a vulnerable adult, regardless of program participation, are referred to a medical examiner. Restrictive interventions, including restraints and seclusion, are not allowed. If they were used on AC participants, they are to be reported as suspected maltreatment.

MnCHOICES. The MnCHOICES assessment captures health screening and safety needs that are important to address to minimize participants' risk of potential maltreatment and to monitor their health needs. These health and safety needs are automatically populated on participants' individual support plans in order for the case manager to offer services or supports that could meet those needs. Health screening questions are primarily captured in the Wellness section of the MnCHOICES assessment, and supports and services to address safety needs are mainly in the Self-Preservation section of the MnCHOICES support plan. MnCHOICES data is used to monitor county and tribal human service agency compliance in completing assessment information.

Health and Welfare: Sub-assurance a

Requirement. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measure 15				
Percent of AC participants who are determined to not have been maltreated based on county or tribal human service agency investigation				
Evidence				
Numerator	Number of AC participants who are determined to not have been maltreated based on county or tribal human service agency investigation			
Denominator	Number of AC participants			
Data Source	Other: Social Services Information System, Minnesota Adult Protection Database			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				

Quality Improvement Activities

Performance Measure 16				
Percent of AC support plans where the participant was assessed to have a dependency in self-preservation, and the support plan documents services and supports offered to mitigate the person's risk				
Evidence				
Numerator	Number of AC support plans that address the participant's assessed self-preservation needs			
Denominator	Number of AC support plans completed with a self-preservation need identified			
Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Health and Welfare: Sub-assurance b

Requirement. 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 Measure 17
Percent of AC participant deaths associated with alleged maltreatment referred to the local medical examiner

for independent investigation				
Evidence				
Numerator	Number of AC deaths associated with alleged maltreatment reported to Minnesota Adult Abuse Reporting Center that were referred to the medical examiner			
Denominator	Number of AC deaths associated with alleged maltreatment reported to Minnesota Adult Abuse Reporting Center			
Data Source	Other: Social Services Information System, Minnesota Adult Protection Database			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Performance Measure 18	
Percent of reports of maltreatment of AC participants submitted to the Minnesota Adult Abuse Reporting Center and referred to a lead investigative agency according to state specified timelines	
Evidence	
Numerator	Number of allegations of maltreatment of AC participants reported to the Minnesota Adult Abuse Reporting Center and referred to a lead investigative agency within two working days of receipt of the report
Denominator	Number of allegations of maltreatment of AC participants reported to the Minnesota Adult Abuse Reporting Center
Data Source	Other: Social Services Information System, Minnesota Adult Protection Database
Responsible Party for data collection/generation	State Medicaid Agency

Frequency of data collection/generation	Continuously and ongoing
Sampling Approach	100% Review
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency
Frequency of Data Aggregation and Analysis	Annually

State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
DY15 (7/1/26 – 6/30/27)				
DY16 (7/1/27 – 6/30/28)				
DY17 (7/1/28 – 6/30/29)				

State Analysis
Remediation
Quality Improvement Activities

Health and Welfare: Sub-assurance c

Requirement. The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Background

Maltreatment Report Investigations. The AC program policy specifies that the state prohibits the use of restraints. Restrictive interventions are considered maltreatment and are reportable under Minnesota's vulnerable adult statute (626.5572, Subd. 2).

Performance Measure 19	
Percent of AC participants who were not maltreated	
Evidence	
Numerator	Number of AC participants who were not maltreated
Denominator	Number of AC participants
Data Source	Other: Social Services Information System, Minnesota Adult Protection Database
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Continuously and ongoing
Sampling Approach	100% Review
Responsible Party for Data	State Medicaid Agency

Aggregation and Analysis				
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Health and Welfare: Sub-assurance d

Requirement. 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 Measure 20				
Percent of completed MnCHOICES assessments for AC participants that have all wellbeing questions answered				
Evidence				
Numerator	Number of completed MnCHOICES assessments for AC participants that have all wellbeing questions answered			
Denominator	Number of MnCHOICES assessments completed for AC participants			
Data Source	Other: MnCHOICES Database			
Responsible Party for data collection/generation	Other: County and tribal human service agencies enter data			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				

State Analysis
Remediation
Quality Improvement Activities

Appendix I – Financial Accountability

Requirement. The State demonstrates that it has designed and implemented an adequate system for insuring financial accountability of the 1915(c)-like HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period.

Background

MMIS and MnCHOICES. Many potential claims and coding problems are averted through interactive MMIS edits, including edits related to eligibility, screening data, authorization criteria, and provider status.

For an AC program service claim to be paid, the claim must correspond with the service authorization entered in MMIS by the county or tribal human service agency. The electronic form used is referred to as a service agreement. The service agreement includes the rate, service date span, number of units, type of service, and provider for each service. A service agreement cannot be approved unless there is a corresponding approved screening document in MMIS that identifies the applicant or participant as eligible for the program, including such things as meeting the level of care requirements, having service needs that can be met by the program, etc.

The applicant or participant must be ineligible for Medicaid coverage due to their income and assets exceeding eligibility limits. Additionally, their income and/or assets must be insufficient to pay for 135 days of nursing facility care. This information is cross-checked against another subsystem in MMIS. The provider number on the claim must match the authorization and the provider's enrollment type (referred to as a category of service). The provider must also have an active provider number, and the services for which the claim is submitted must be within the parameters of the service authorization in MMIS and the limits established by DHS, including rates and units.

For example, if a provider attempts to bill using a valid claim code but is not an appropriate provider type for the service being authorized, a systems edit would post and a message would be sent to the provider describing the inconsistency. Similarly, a claim would not be paid until the identified problem is corrected. There are also edits that cross-check for eligibility for long-term care services related to improper asset transfers and related penalty periods. The prior authorization subsystem also verifies via editing that authorizations and claims utilize state-established rates for services. Rates are updated annually in MMIS and the MnCHOICES application. Once they are updated, testing is done in both systems to show that the rates were updated correctly.

Financial Accountability: Sub-assurance a

Requirement. 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 Measure 21				
Percent of AC claims properly coded and paid for services provided to AC participants for which there is corresponding prior authorization				
Evidence				
Numerator	Number of AC claims paid that have a corresponding prior authorization			
Denominator	Total number of AC claims paid			
Data Source	MMIS			
Responsible Party for data collection/generation	State Medicaid Agency			
Frequency of data collection/generation	Continuously and ongoing			
Sampling Approach	100% Review			
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency			
Frequency of Data Aggregation and Analysis	Annually			
State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				
State Analysis				
Remediation				
Quality Improvement Activities				

Financial Accountability: Sub-assurance b

Requirement. The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure 22	
Percent of AC rate changes with approved test results showing rates were updated correctly	
Evidence	
Numerator	Number of AC rate changes with approved test results showing rates were

	updated correctly
Denominator	Total number of scheduled rate changes
Data Source	MMIS Other: MnCHOICES Database
Responsible Party for data collection/generation	State Medicaid Agency
Frequency of data collection/generation	Annually
Sampling Approach	100% Review
Responsible Party for Data Aggregation and Analysis	State Medicaid Agency
Frequency of Data Aggregation and Analysis	Annually

State Data				
Year	**Sample Universe (entire population from which the sample is drawn)**	**Numerator (# compliant)**	**Denominator (sample size)**	**% Compliant (pre-remediation)**
02/01/2025 - 01/31/2026				
02/01/2026 - 01/31/2027				
02/01/2027 - 01/31/2028				

State Analysis

Remediation

Quality Improvement Activities