2013 Proposed Elderly Waiver Renewal

The application being used is a new format that requires an increased level of detail that has not been requested in the past, and includes a number of Quality Assurance measures throughout the document. This application is different from previous versions and changes are not identified within the application. CMS requires a new application to be entered online. Once entered, the format will look different; however the context remains the same. The table below summarizes the waiver policy changes and clarifications.

Section	Change
Entire Document	• Corrects statutory references, form numbers and web sites. • Updates" care plan" language to reflect "Community Support Plan".
Application: Description of the waiver	Item 2: Information was added to outline the elimination of provider contracting requirements for lead agencies as part of Minnesota's waiver structure. Information is included to describe the enhanced waiver provider qualification review process underway.
Appendix A(6)	Assessment Methods and Frequency: This item is related to methods 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. Additional information added is about how the department monitors lead agency performance through site reviews, care plan audits, sampling and data analysis, contracts, consumer surveys, and so on.
Appendix A	Quality Improvement: Performance measures are added.
Appendix B-3	The Waiver Plan is updated to reflect the projected number of individuals served.
Appendix B	Quality Improvement: Performance measures and remediation or improvement strategies related to assurances are added. Some assurances are addressed using more than one performance measure.
Appendix B-8	Access to Services by Limited English Proficient Persons: Added additional detail about translation assistance and county-based plans that outline approaches and services to provide meaningful access for all individuals applying for or receiving services.
Appendix C Participant Services	• Added new background study process as described in the Background Studies Act –MN Statutes Chapter 245C.09 • Added Mandatory Criminal Background Studies to services: (other services were added with amendments previous to this waiver submission) • CDCS • Family and Caregiver Training and Education, • Respite • Adult Companion Services

Section	Change
	• Modified the frequency of verification of provider qualifications for: • Chore • Adult Day Services Bath • Environmental Accessibility Adaptations • Respite • Home Delivered Meals • Specialized Supplies and Equipment • Transportation • Extended State Plan Private Duty Nursing • Homemaker • Transitional Services
Appendix C	Consumer Directed Community Supports (CDCS): • Added thickening agents and costs related to internet access to CDCS allowable expenditures. • Aligned general language for CDCS allowable expenditures with general waiver criteria language. • Replaced the term Flexible Case Manager with Support Planner. • Added a section for general waiver unallowable expenditures which applies to CDCS and all waiver services. • Added an allowance for accessible bathroom (additional square footage) as an exception to unallowable expenses. • Replaced the term Primary Care Utilization and Review Program with Minnesota Restricted Recipient Program. • Additions and clarifications to the provider standards for FE's.
Appendix C	Explains contract elimination as of 1/1/2014 and re-evaluation of providers
Appendix C	Added Performance Measures
Appendix C	Family and Caregiver Training and Education: • Refined service definition – define coaching, counseling, and training • Revised provider qualifications for each component of the service.
Appendix C	Environmental Accessibility Adaptations – Added new provider standards.
Appendix C	Homemaker – Corrected statute citation.
Appendix C	Adult Day Services Bath: Added the entity responsible for verification and the frequency of provider requirements for nursing homes, hospitals and medical clinics.
Appendix C-2(d)	Updated the provision of personal care by legally responsible individuals to reflect current statute.
Appendix C-2(e)	Clarified the provision of paying spouses and parents of minors to be paid under CDCS.
Appendix C-2(f)	Indicates the states transition from the current contracting practices to an enhanced provider qualification review process.
Appendix D	Participant-Centered Planning and Service Delivery: Added performance measures developed for this area of waiver management and oversight.
Appendix D-1(d)	Updated timelines for LTCC assessments and community support plan development to reflect current statute.

Section	Change
Appendix D-2(g)	Described the sampling methodology for the lead agency reviews.
Appendix E	Participant Direction of Services: Provided additional detail in all sections.
Appendix F	Participants Rights • Added additional detail concerning fair hearing information provided at the time of an application for services and when the care plan is approved. • Updated the notices that are provided to provide fair hearing information.
Appendix G	Participant Safeguards (includes critical incident responses, use of restrictive interventions, and medication management requirements: Provides additional detail for the oversight of critical incidents and events
Appendix H	Systems Improvement: Provides additional detail concerning the Waiver Quality Monitoring and Management process.
Appendix I	Financial Accountability: • Provides additional performance measures. • Indicates the use of statewide maximum unit rates for all services beginning 1/1/14.

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Minnesota Department of Human Services

Submission Date:	

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:

This is a request to renew Minnesota's Elderly Waiver, CMS control number 0025.91.R4.07. This home and community-based service waiver provides supports for approximately 22,500 people who are at risk of the level of care provided in a nursing facility.

Changes:

- Corrects statutory references, form numbers and web sites
- Additional information about how the department monitors lead agency performance through site reviews, care plan audits, sampling and data analysis and consumer surveys
- Plan updated to reflect projections of the number of individuals served
- Added new background study process
- Added mandatory background studies to additional services
- Changes and clarifications to the Consumer Directed Community Support Service (CDCS)
- Refined the service definition and provider standards for Family and Caregiver Training and Education
- Added additional provider standards for Environmental Accessibility Adaptations
- Elimination of contracts as of 1/1/14 and describes the transition and process of the enhanced waiver provider qualification review process
- Updates timelines for LTCC assessment and community support plan to reflect current statute
- Provides additional detail concerning the Waiver Quality Monitoring and Management process
- Provides additional detail for the oversight of critical incidents and events

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 waiver's 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.

State:	
Effective Date	

1. Request Information

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. Waiver Title (*optional*): Elderly Waiver (EW)

C. Type of Request *(select only one)*:

O	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
O	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
X	**Renewal (5 Years) of Waiver #**	??	
O	**Amendment to Waiver #**		

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

O	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
X	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2013

E.2 Approved Effective Date *(CMS Use):*

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)*	
	O	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:
	O	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
X	Nursing Facility *(select applicable level of care)*	
	O	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:
	O	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

X	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I			
X	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:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	X	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	X	§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:*			
☐	Not applicable			

*State Note:

- §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 service coordination by the managed care organization (MCO); (2) the obligations of the case manager are the obligations of the MCO service 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.

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 keep elderly people in their own homes or delay nursing facility admission. This is accomplished through comprehensive care planning that encourages the use of person-centered planning methods.

Objectives

Objectives for the waiver include:

- Supporting elderly people in their homes and communities and supporting informal caregivers
- Offering services to enhance self-sufficiency in the community.
- 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 American Indian tribes, including evaluating Medicaid recipients' waiver eligibility; completing needs assessments and level of care determinations; assisting in care plan development; authorizing services; and monitoring the services provided. Counties and tribes are also required to contract with waiver providers, using a standard template required by the department,- to assure that providers meet the provider standards and the needs of the enrollees' that will be served. If a MCO authorizes waiver services furnished by providers with which the MCO does not have a formal contract, the MCO will have an agreement with the county to use the waiver providers with whom the county has a contract. Exceptions to this process are governed by the contract between the MCOs and the department

The department monitors the contracting practices of lead agencies through the annual Quality Assurance Plan that lead agencies submit to the department. In addition, DHS monitor the contract practices for counties and tribes through the lead agency review process and for MCOs through routine reviews conducted by the Minnesota Department of Health. The department has an interagency agreement with the Department of Health for this function. The department provides direction and oversees all operational activities carried out by counties, managed care organizations, and tribes. Counties, managed care organizations, and tribes 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 is transitioning from its current contracting practices to an enhanced waiver provider qualification review process. County/tribe contracting will be eliminated as of 1/1/2014, and providers must be reviewed to remain enrolled as an MHCP provider. Communication plans have been developed and

have commenced. Training of local lead agencies and providers is being rolled out. Review and renewal of provider agreements with the department has begun statewide. A web based provider directory has been designed and is currently under development. New MHCP providers will be required to take training that has been developed by the department.

Service Delivery Methods

Twenty-one services are covered through the waiver. Enrollees' needs are assessed and an individualized care plan is developed. The waiver also includes an option for self-direction through the consumer-directed community supports (CDCS) service. Person-centered planning is encouraged as a best practice standard for all assessment activities and care plan development. Person-centered planning is required for enrollees who elect CDCS.

Approximately 92% of Elderly Waiver enrollees receive their Medicaid benefits through MCOs. Medical Assistance recipients age 65 and over are required to receive their Medical Assistance benefits through MCOs, with two exceptions: recipients who are required to pay a medical spenddown; and, certain people served by American Indian tribes. These recipients 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.

MSHO is available to recipients age 65 and older, who are not required to pay a medical spenddown. As described above, MSHO operates under §1915(a) and §1915(c) authority and has been available since 1997. Eight MCOs contract with the department to provide MSHO. Recipients 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 enrollees, waiver services are covered by the MCO. The MCO also provides care coordination services to all enrollees, including health risk assessment for all new enrollees 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. Enrollees may choose a care system in the same way they select a primary clinic.

MSC+ is the basic Medicaid plan for enrollees aged 65 and older. Recipients may select from MCOs that operate in their county of residence. 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 tribes and others identified under contracts between the department and tribes (e.g., a spouse living with a tribal member) may elect to be assessed for waiver services and receive waiver case management through their tribe. The tribe acts as a lead agency for these service populations, and is responsible for assessing for eligibility, development of community support plans, arranging, authorizing, and monitoring services, and contracting with providers until contracts are eliminated as noted above. . These recipients may also elect to be assessed for and receive waiver case management through their county of residence or through managed care rather than the tribe. Members of tribes are not required to enroll in managed care.

Currently, four of Minnesota's 11 federally recognized tribes have contracts with the department to provide waiver operational and administrative activities. These tribes are serving approximately 200 enrollees. The department continues to work with other tribes who are interested in contracting with the department to provide waiver operational and administrative activities to tribal community members.

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)*:

X	The waiver provides for participant direction of services. *Appendix E is required*. State Note: Refer also to the description of consumer directed community supports in Appendix C-3
O	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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 overall systems improvement 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)*:

X	Yes
○	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
X	**No**

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. S*pecify 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.

State Note: The state assures that, absent the waiver, individuals who are eligible for the waiver would be eligible for Medicaid-funded nursing facility services.

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 Improvement Act of 2004 (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) under age 21 when 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 amount, frequency and duration 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/MR.

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 §431.51, 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 throughout the application and in **Appendix H**.

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

State Note:

The department publishes a draft of the renewal application for public comment and informs Tribal Health Directors of the opportunity for comment.

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 as 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.

Additional Waiver Information and Requirements:

For purposes of this waiver plan, and unless otherwise specified, the terms "individual" and "enrollee" mean a person who is eligible for and enrolled in the waiver program. Where the waiver plan confers certain rights or obligations that the individual/enrollee (or a court of law acting on the individual's behalf) has conferred to a guardian, conservator or authorized representative, the use of the terms "individual" or "enrollee" 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 enrollee. Services included in the support plan must be necessary to meet a need identified in the enrollee's assessment and be for the sole benefit of the enrollee and must be related to the enrollee's condition.

2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Services not included in the support plan are not covered. In addition, the following goods and services are not covered:

   a) services that are provided prior to the development of the support plan;

   b) services that duplicate other services in the care plan;

   c) services that supplant natural supports;
   d) services that are not the least costly means to appropriately meet the enrollee's needs; or
   f) services for which there are other available funding sources.

   For enrollees who receive services through a MCO, the requirement that other source of payment for waiver services must be exhausted or are unavailable does not apply because the capitation paid to the MCO is exclusive of third party revenue. It is the MCO's responsibility to collect any third party reimbursement.

3. Services are only provided to Minnesota residents, and services are not covered outside of Minnesota except when: (1) the provider is located within the enrollee'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 direct care staff (that are authorized in the enrollee's care plan) provided when the enrollee is temporarily outside of Minnesota and within the United States.

   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 30 days per calendar year with the exception of emergencies. In situations in which temporary travel may exceed 30 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 thirtieth 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, enrollee health and safety assurances, etc. Travel expenses for enrollees 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 an enrollee may not be paid to provide waiver services for that enrollee. 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 enrollee's approved care plan.

7. Contact Person(s)

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable. This is a renewal of an existing waiver.

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)*:

X	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 *(name of unit) (do not complete Item A-2*):	
	X	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a):*	Aging and Adult Services Division, Continuing Care Administration
○	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. 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).*		

2. **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 Continuing Care 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:

Not applicable

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

X	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the 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 enrollees who receive services through managed care, the MCOs perform certain operation and administrative functions. Refer to Appendix A, 7. For enrollees who receive waiver assessment and case management through a tribe, the tribe 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).

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 *(check each that applies)*:

X	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *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 §§256B.092 and 256B.0915. 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*:
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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).

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 review that was submitted in 2011 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 including weekly statewide video conferencing on topics related to aging.

The department's waiver monitoring includes:

1. Lead Agency site reviews (counties and tribes)
2. Care plan audits (MCOs)
3. Care system audits (MCOs)
4. Triennial Review of MCOs
5. Quality assurance plans
6. Data Analysis
7. Fair Hearing requests
8. Managed care contracts (MCOs)
9. Consumer surveys

1. Lead Agency site reviews. The department conducts on-site lead agency reviews using an independent contractor to assist in conducting the reviews. Counties and tribes 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. See Appendix D-1, item g for a complete description of the sampling method used for this case file review.

If the department finds the county or tribe deficient in a required waiver activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan which is posted on the department website. All cases 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.

2. Care plan audits. The contracts between the department and MCOs require the MCOs to annually audit a sample of care plans for waiver enrollees. The MCO must use a protocol submitted to and approved by the department. The protocol must follow established guidelines and include reviewing required waiver case management tasks, addressing corrective actions as needed and providing audit results to 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, a sampling method developed and used by the National Commission on Quality Assurance (NCQA) can be found at http://www.ncqa.org/HEDISQualityMeasurement.aspx Click on "Publications and Products", then type in "Survey Sampling" in the keyword window.. The department's External Quality Review Organization (EQRO) will review the care plan audits according to the Triennial Review cycle

described in item 4 below. The department also reviews and approves corrective action plans related to care plan audit findings annually.

3. Care system audits. MCOs may use a "care system" model to provide care coordination for waiver enrollees. For example, an MCO may contract with an entity that provides care coordination such as, clinics, counties, and tribes. The department requires MCOs that use this model to audit the care systems that provide contracted services. The audits include care plan reviews to monitor whether care plans are comprehensive, assessments are complete, and enrollees are offered choice, as required by the waiver. The MCOs submit a summary report to the department that includes action plans to address any areas identified as needing improvement. The reports and improvement plans require the MCOs to actively monitor and respond to quality issues. The audit tools and protocols, sampling, and thresholds for corrective action plans are the same under care plan audits and care system audits. The department reviews and approves corrective action plans related to care plan audit findings.

4. Triennial Compliance Review: The Minnesota Department of Health (MDH) completes a triennial review of MCOs, with a mid-cycle review to assure corrective actions issued in the triennial review are in process or completed. The Department of Human Services (the State Medicaid Agency, DHS) receives a report after each review, with additional corrective actions issued by DHS as determined necessary. The MCOs submit evidence to DHS of completed corrective actions; MDH also confirms corrective actions at the mid-cycle review.

5. Quality assurance plans (QA Plan). Counties and tribes submit a *Quality Assurance Plan for Home and Community-Based Services* to the department as part of the preparation for on-site review. The plan parallels the structure of CMS' waiver quality assurance matrix and includes self-assessment questions concerning waiver operational and administrative activities. If the self-report is not fully compliance, the lead agency must submit a remediation plan.

The department reviews the plan and discusses with the lead agency any areas of concern as part of the technical assistance delivered during the on-site review. The department also uses the information provided in the plans to identify possible trends or new issues across lead agencies. These plans provide a source of information that complements the on-site review and care plan audit/case file review processes. The QA Plan is a self-assessment and self-monitoring tool for lead agencies. Many of the questions in the self-assessment correlate to activities that are assessed during the county site reviews.

MCOs submit Quality Assurance Plans to the department annually. 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 ECRO and/or Triennial Compliance Review.

6. Data analysis. Our MMIS data includes information about assessed needs and planned services for all enrollees. MMIS provides ongoing reports such as encumbrance and payment reports that may be used to monitor authorization patterns. MMIS information is used for a variety of quality assessment and program improvement purposes. The department monitors claims and payment information for fee-for-service enrollees and encounter data for managed care enrollees. For fee-for-service enrollees, review reports that are generated monthly and use ad hoc reports to research and analyze issues. For managed care enrollees, we perform annual utilization analysis with encounter claims data using performance measures calculated using HEDIS methodology.

7. Fair hearing requests. The department monitors fair hearing requests to identify patterns or trends that may indicate problems. We contact counties or the MCO if we are concerned about an individual appeal issue that does not appear to be consistent with department policies or procedures. When possible, these contacts are made in advance of the hearing to resolve the issue if possible before the

hearing. Managed care enrollees may also submit grievances to the MCO. This does not affect their fair hearing rights.

8. 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 that the MCOs are responsible for and the required standards. 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 in the entirety at:

http://www.dhs.state.mn.us/main/dhs16_139710

9. Consumer Surveys. The department conducted the first statewide random sample survey of enrollees in 2004 with the support of Real Choice Systems Change grant funding. Surveys were completed in 2004, 2007, and 2009. The survey is conducted in-person, and includes items related to quality of care and quality of life. Information captured through the surveys includes consumer-level feedback for assessing the effectiveness of the waiver in meeting participant needs.

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

** Contracted entity is a managed care organization. The distribution of waiver operational and administrative functions differs in some areas for services provided through MCOs as shown on the above chart. For managed care enrollees, the MCO is responsible to assess for eligibility, review waiver plans, authorize services, conduct utilization management, and determine rates. As stated above, the amounts are individualized and based on a statewide methodology. Rates for consumer-directed services may be negotiated by waiver enrollees but no more than currently published state maximum rates for similar services.

*** The waiver operational and administrative functions identified under the column titled “local non-state entity” include counties and tribes.

**** County and tribal contracts for waiver providers will be eliminated in January, 2014. See Item 2 in the Application section.

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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..

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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, over the most recent three calendar years**.** Numerator: Number of waiver requirement corrective actions resolved. Denominator: Number of waiver requirement corrective actions issued, per initial lead agency review.		
Data Source [e.g. – examples cited in IPG] **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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	
		☐ Other: Specify:	

Add another Data Source for this performance measure

Performance Measure:	Percent of administrative waiver requirement compliance deficiencies resolved, per annual care plan audit. Numerator: Number of waiver requirement corrective actions resolved, per MCO follow-up review. Denominator: Number of waiver requirement corrective actions issued, per annual MCO care plan audit.		
Data Source [e.g. – examples cited in IPG] **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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			The number of care plans audited is based on the NCQA sampling method for auditing in MCOs. The number of corrective actions reviewed is 100%.
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*	

	applies	*applies*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Performance measure (button to prompt another performance measure)

a.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 screened, authorize eligibility for 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 enrollees.

The department also has:

- A robust and comprehensive assessment and care planning process to determine eligibility for 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

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

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 tribe deficient in a required waiver activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan which is posted on the department website. All cases 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.

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

See also Appendix A-6.

b.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)*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other: Specify:	*X Annually- MCO care plan audit*
		X Continuously and Ongoing - Lead Agency Review
		☐ 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.

○	**Yes** *(complete remainder of item)*
X	**No**

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

Appendix 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 a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Select one Waiver Target Group	Target Group/Subgroup		Minimum Age	Maximum Age: Maximum Age Limit: Through age –	Maximum Age: No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	○	**Aged or Disabled or Both – General** *(check each that applies)*			
	X	Aged (age 65 and older)	65		X
	☐	Disabled (Physical) (under age 65)			
	☐	Disabled (Other) (under age 65)			
	○	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

Recipients 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 §256B.0911.

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)*:

X	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-2: Individual Cost Limit

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:

X *	**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
	○ Other *(specify)*:
X **	**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: $ _____
	The dollar amount *(select one)*:
	○ Is adjusted each year that the waiver is in effect by applying the following 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: _____ %
	○ Other – *Specify:*
	State Notes:

State:	
Effective Date	

*Applicable to enrollees 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 enrollee 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 enrollees' services within the case mix limits under fee-for-service as described below.

**Applicable to enrollees 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 enrollees a case mix level based on their assessed needs. There are 12 case mix classifications (A though L) 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 12 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 annually by any net change to home and community based provider rates authorized by the legislature.

For recipients who reside in a nursing facility for which the facility-specific case mix rate is higher than the statewide average, the individual may "convert" their specific case mix amount as their individual monthly budget limit for waiver services when additional funding (above the statewide average) is needed for community-based services. The department reviews these individual-specific amounts, referred to as conversion rates, to determine whether they are necessary based on the individual's assessed needed and proposed care plan.

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

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:
X	Other safeguard(s) *(specify)*:
	Enrollees who receive waiver services covered by fee-for-service: When there is a significant change in the enrollee's condition or circumstance (e.g., loss of a primary caregiver), the enrollee is reassessed. The reassessment results in modifications to the care 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 care plan is revised accordingly. The reassessment may also lead to revisions in the care plan without a change in case mix classification. **Enrollees who receive waiver services covered through managed care:** When there is a significant change in the enrollee's condition or circumstance (e.g., loss of a primary caregiver), the enrollee is reassessed and the care 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 care plan meets enrollee's health and safety needs.

Appendix B-3: Number of Individuals Served

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	30,952
Year 2	32,198
Year 3	33,443
Year 4 (renewal only)	34,688
Year 5 (renewal only)	35,980

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)*:

X	The State does not limit the number of participants that it serves at any point in time during a waiver year.
O	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 (renewal only)	
Year 5 (renewal only)	

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)*:

X	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

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):*

X	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:*

X	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 recipients 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 recipient is determined eligible. Enrollment capacity is managed by the department on a statewide basis.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
		Waiver Year:	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

○	§1634 State
○	SSI Criteria State
X	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

○	Yes
○	No

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		
X	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
☐	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)		
X	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 the 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.				
X	**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			
	X	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:			
		X	A special income level equal to (select one):		
			X	300% of the SSI Federal Benefit Rate (FBR)	
			○	%	of FBR, which is lower than 300% (42 CFR §435.236)
			○	$	which is lower than 300%
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
		☐	Medically needy without spenddown 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%
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

Appendix B-5: Post-Eligibility Treatment of Income

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(select one)*:

X	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*):	
	X	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). 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-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*	

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following 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:		
○	Other (specify):		
○	Not applicable *(see instructions)*		

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The following standard under 42 CFR §435.121			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:			
○	Not applicable *(see instructions)*			
iii. <u>Allowance for the family</u> *(select one)*				

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 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 allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	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)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify):			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	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 the amount of the allowance:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		

○	Not applicable *(see instructions)*

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following 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:
○	Other *(specify)*:
○	Not applicable *(see instructions)*

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 checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 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. <u>Allowance for the needs of the waiver participant</u> (*select one*):

○	The following standard included under the State plan *(select one)*	
	○	The following standard under 42 CFR §435.121:
	○	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)

	○	%	of the FBR, which is less than 300%
	○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level
	○	Other standard included under the State Plan (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
X	The following formula is used to determine the needs allowance:		
	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 enrollee's waiver services are covered by an MCO, the MCO applies the enrollee's obligation (patient obligation) only to home and community-based services received by the enrollee. The department provides each MCO with monthly data on enrollee waiver obligations. The MCO reduces its payment for an enrollee's waiver services up to the amount of the waiver obligation. Providers collect the enrollee's waiver obligation.		
○	Other (*specify):*		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	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 the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount: $	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
X	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard
X	Medically needy income standard

	State Note: Medically needy income standard for families and children.
○	The following 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:
○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

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 checked.*
○	The State does not establish reasonable limits.
X	The State establishes the following reasonable limits *(specify)*:
	• There is no deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period. • A deduction for the amount of an expense not previously used as a deduction from income. • A deduction is limited to bills incurred within three months before the month of application.

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. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
X	The following formula is used to determine the needs allowance:		
	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 enrollee's waiver services are covered by an MCO, the MCO applies the enrollee's obligation (patient obligation) only to home and community-based services received by the enrollee. The department provides each MCO with monthly data on enrollee waiver obligations. The MCO reduces its payment for an enrollee's waiver services up to the amount of the waiver obligation. Providers collect the enrollee'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:*			
X	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 section 1902(r)(1) of the Act:			
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 checked.*		
○	The State does not establish reasonable limits.		

X	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix 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 waiver 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 *(insert number):*	
	two	
ii.	**Frequency of services**. The State requires *(select one)*:	
	○	The provision of waiver services at least monthly
	X	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 enrollees receive waiver services on a monthly basis. Case managers are responsible for on-going monitoring of enrollees health and safety. An enrollee must receive case management and a formal waiver service that addresses a need identified in the enrollee'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

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 an entity under contract with the Medicaid agency. *Specify the entity*:
X	Other (*specify*):
	The department delegates responsibility for evaluations and reevaluations to lead agencies.

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 LTCC includes an assessment of needs and level of care determination.
Fee for Service:
County and tribal staff who perform LTCCs must be public health nurses or social workers, unless the department grants an exception. Counties and tribes may request an exception to the LTCC requirements to allow a registered nurse with at least one year of home care experience to perform LTCC when the availability of public health nurses is insufficient to meet the demand for LTCC evaluations.

Managed Care:
The contracts with the MCOs require that the individuals completing the LTCCs be qualified health professionals, which includes social workers, registered nurses, public health nurses, physician assistants, and physicians.

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 form 3428 or 3428A, 11/11)
- *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 form 3361).

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 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

The nursing facility level of care criteria applies to individuals who have the need for at least one of the following:

- Physical assistance to perform activities of daily living or someone to complete activities of daily living for the individual
- Physical assistance to perform instrumental activities of daily living or someone to complete instrumental activities of daily living for the individual
- Assistance with activities or instrumental activities of daily living resulting from a sensory impairment
- Extended state plan home care services to prevent or delay nursing facility admission secondary to a

complex or unstable medical need

- Home modification or equipment that will maximize independence and contribute to meeting health and safety needs
- Services or supports to access community resources or maintain social networks and relationships
- Caregiver supports to supplement and extend supports provided by informal caregivers
- Supervision, direction, cueing, or hands-on- assistance to perform activities or instrumental activities of daily living due to cognitive limitations.

DHS 3427 form, titled *LTC Screening Document* 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://www.dhs.state.mn.us/main/id_000100

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)*:

X	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:

Minnesota Statutes, §256B.0911 provides for a LTCC assessment for any person with long term or chronic care need to help identify the person's need for services and supports and to develop a care plan. The LTCC assessments include a level of care determination. The LTCC assessments are conducted upon request by or on behalf of the applicant, including through referrals from social services agencies and medical clinics. The initial assessment is conducted in person within 20 calendar days of the request using DHS Form 3428 or 3428A.

Reevaluations of level of care must be performed at least annually, in person, and using the same forms as used for the initial evaluation. Lead agency staff complete the LTCC and use DHS 3427 titled *LTC Screening Document* to summarize and document the results of the level of care assessment in MMIS for both initial and reassessments. All lead agencies, (counties, tribes and managed care organizations) must follow the same processes and utilize the same tools, including data entry into MMIS.

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
X	Other schedule (*specify*):
	And as warranted by changes in the enrollee's condition.

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

X	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

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. The screening document summarizes key information from the annual reevaluation including the level of care and is valid for a maximum of twelve months from an initial evaluation and for a maximum of twelve months from each subsequent reevaluation.
Managed Care:
The additional capitation payment for the waiver service enrollee is not forwarded to the MCO unless there is a current level of care reevaluation for the enrollee 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. The screening document summarizes key information from the annual reevaluation including the level of care and is valid for maximum of twelve months from an initial evaluation and for a maximum of twelve months 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 (hard copy) of evaluation and reevaluation records are maintained by the lead agency for a minimum of three years. 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, and both the department and lead agencies have access to them.

Quality Improvement: Level of Care

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

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

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 completed assessments that include a level of care determination, per calendar year. Numerator: Number of completed assessments that include a level of care determination, per calendar year. Denominator: Number of assessments completed, per calendar year.		
Data Source [e.g. – examples cited in IPG]] ***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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	

	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	Number and percent of people who receive a level of care determination within required timelines, per calendar year**.** Numerator: Number of requested assessments completed within required timelines, per calendar year. Denominator: Number of requested assessments, per calendar year.		
Data Source [e.g. – examples cited in IPG]] ***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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 waiver reassessments that occur within required timeframes, per calendar year**.** Numerator: Number of waiver reassessments that occur within required timelines (i.e., within 366 days), per calendar year. Denominator: Number of waiver reassessments completed, per calendar year.		
Data Source [e.g. – examples cited in IPG] **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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 screening documents entered into MMIS for EW consumers where all required fields are completed**.** Numerator: Number of waiver screening documents that are complete each year. Denominator: Number of total screening documents entered each year		
Data Source [e.g. – examples cited in IPG] 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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	

		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

a.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

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

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

b.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)*
	X State Medicaid Agency	☐ *Weekly*
	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	*X 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.

○	**Yes** *(complete remainder of item)*
X	**No**

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

State:	
Effective Date	

Appendix 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 form 4134). The pamphlet includes information about eligibility screening, service options, fair hearing rights, vulnerable adult protections, etc. For managed care enrollees, similar information is included in the MCO's certificate of coverage (COC). Managed care enrollees receive a COC each year. The department's website also provides information about service options and rights. See http://www.dhs.state.mn.us/main/Aging

Lead agency staff who conduct LTCC assessments and case managers are required to provide enrollees choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. To acknowledge that choice was offered, enrollees sign *Long Term Care Consultation Community Support Plan*, DHS form 2925 and the *Community Support Plan*, DHS form 4166.

There is also a field on the MMIS screening document that asks the case manager if the individual was given choice between waiver services and the institutional placement and choice of providers for waiver services. MMIS edits prohibit a screening document from being authorized when a case manager indicates in this field that choice was not provided or if the field is left unanswered. In addition, the enrollee's care plan form includes a signature section that asks whether the enrollee was provided choice between institutional and community-based services and among waiver services and service providers. Refer to DHS form 2925 and 4166. All forms are available at http://www.dhs.state.mn.us/main/id_000100

Lead agencies' practices are monitored through: 1) The quality plans; and, 2) Reviews of enrollees' files as part of the county 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.

Care plans and signature forms are maintained by the lead agency for three years. Electronic MMIS screening document summaries are maintained by the department for a minimum of three years.

Appendix B-8: Access to Services by Limited English Proficient 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 enrollees:

When people are assessed for waiver services they receive *Information and Signature Sheet for PAS \ EW \ AC \ CADI \ CAC \ TBI* (DHS form 2727). This form provides information in ten languages about how to obtain assistance with language translation.

Community Support Plan forms (DHS 2925 or 4166) also provide information in ten languages about how to obtain assistance with translation. *All* forms now state "if you want free help in translating this information ask your worker or call the number below for your language." This statement is provided in ten languages.

In addition, counties 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 recipients to programs and services. The department provided instructional information to counties regarding requirements related to limited English proficiency and we provide a significant amount of information available on our web site at: www.dhs.state.mn.us/id_000073

For managed care enrollees:

At the time enrollment and annually thereafter, enrollees receive a certificate of coverage from the MCO that includes all information 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 enrollees must include information in ten languages on how to obtain assistance with translation

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *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:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	X	
Homemaker	X	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	X	Adult Day Services
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	X	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
X	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Environmental Accessibility Adaptations
b.	Transportation

c.	Chore Services
d.	Adult Companion Services
e.	Family Caregiver Training and Education
f.	Adult Foster Care
g.	Customized Living
h.	Residential Care Services
i.	Home Delivered Meals
j.	Adult Day Services Bath
k.	Consumer Directed Community Supports
l.	Transitional Services
m.	Specialized Supplies and Equipment
Extended State Plan Services *(select one)*	
○	Not applicable
X	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	Extended Personal Care Assistance
b.	Extended Home Health Care Services
c.	Extended Private Duty Nursing
Supports for Participant Direction *(check each that applies))*	
X	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
X	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	X	Support Planner (included in the CDCS service)
Financial Management Services	X	Fiscal Support Entity (FE) (included in the CDCS service)

Other Supports for Participant Direction *(list each support by service title)*:	
a.	
b.	
c.	

X	As a waiver service defined in Appendix C-3 (*do not complete 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. NOTE: Pursuant to CMS-2237-IFC* this selection is no longer available for 1915(c) waivers.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not 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-2: General Service Specifications

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)*:

X	**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, and scope and time lines that apply. It also describes what constitutes a disqualification.

Positions for which background studies apply: Minnesota Statutes, Chapter 245C requires criminal and maltreatment background checks to be completed for:

- All employees: 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 to13 where there is reasonable cause.
- All individuals, including employees, contractors, volunteers, etc., regardless of setting, who provide direct contact services to people enrolled in the waiver.

Direct contact services means providing face-to-face care, support, training, supervision, counseling, consultation, or medication assistance to a person. Direct contact services always includes the following services:

- Consumer directed community supports (personal assistance, treatment and training, self- directed support, and fiscal intermediary entity services)

-Adult companion services

-Adult Day Services and Adult Day Bath
-Customized Living

-Caregiver Training and Education (if direct contact with the client)

-Residential care services

- Extended Home Health Care

- Extended Personal Care Assistance

- Extended Private Duty Nursing

- Foster Care

-Homemaker

-Respite

- Transitional Services

(b) Scope of the background studies: Background studies are completed through an on-line system through the Licensing Division of the Minnesota Department of Human Services. 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), 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, 245C.08.

(c) Process for ensuring background studies are completed: The process is described in the Department of Human Services Background Studies Act, Minnesota Statutes, Chapter, 245C.09. Providers are responsible for completing, submitting and maintaining all mandatory background study forms. 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 DHS -Provider services division and cannot bill for or be paid for their services. Provider compliance is monitored through routine licensing reviews.

Providers are responsible to maintain records of employees' background studies. Providers'· Compliance is monitored through routine licensing reviews.

Managed care enrollees: For providers in MCO networks that are not also enrolled as Minnesota Health Care Programs providers, the MCO is responsible for assuring that required background studies are conducted and only those individuals who are not disqualified through the background study are allowed to provide services.

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 MN Statute 245C because of the background check requirements in the previous paragraph for these individuals.
○	**No**. Criminal history and/or background investigations are not required.

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)*:

X	**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 Department of Human Services Licensing Division, Background Studies Unit. 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. **(b) The types of' positions for which the abuse registry screenings must be conducted** All individuals who provide direct contact services and are employed by providers who are licensed by the department or the Minnesota Department of Health **(c)The process for ensuring the mandatory screenings have been conducted** Providers are responsible to initiate and maintain records of employees' background studies. Lead Agencies or the department's licensing division review providers' compliance. When a personal care assistant is not disqualified as a result of the background study, they receive an individual specific provider number from the department's provider enrollment unit. The provider enrollment unit requires evidence of the completed background study before issuing a provider number. Personal care assistants are employed by provider agencies. In order to be paid, the provider agency must include the provider number of the agency and the provider number of the specific personal care assistance worker on the claim. For providers in MCO networks who are not also enrolled as Minnesota Health Care Programs provider, the MCO is responsible for assuring that required background studies are conducted and only those individuals who are not disqualified through the background study are allowed to provide services.

	The following state laws apply and are available upon request. Minnesota Statutes, Chapter 245C Minnesota Statutes, Section 144.057 Minnesota Statutes, Chapter 144A
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
X	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Facilities licensed to provide board and lodging	Customized Living and residential care	Five or more

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

In settings that hold a board and lodge license and who serve more than four people, the enrollee's community support plan, licensing requirements (when licensed as a home care provider), and the home care bill of rights support the individual's control of the character of the setting.

Generally, settings that are licensed to provide board and lodging have congregate living room and kitchen areas that people living in the setting may use. Most of these settings have private visiting areas and private or semi-private bedrooms and bathrooms. People living in the settings may bring in personal items, including home decorations to provide a home-like atmosphere.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type Board and Lodge	Facility Type	Facility Type	Facility Type
Admission policies	X	☐	☐	☐
Physical environment	X	☐	☐	☐
Sanitation	X	☐	☐	☐
Safety	X	☐	☐	☐
Staff : resident ratios	X	☐	☐	☐
Staff training and qualifications	X	☐	☐	☐
Staff supervision	X	☐	☐	☐
Resident rights	X	☐	☐	☐
Medication administration	X	☐	☐	☐
Use of restrictive interventions	X	☐	☐	☐
Incident reporting	X	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Provision of or arrangement for necessary health services

Board and lodge providers must be registered with the Minnesota Department of Health as a housing with services provider. The housing with services standards govern the scope of health services and monitoring that may be provided or arranged without an additional home care license. The majority of board and lodge providers who furnish waiver services elect to be concurrently licensed as a Class A, B or F home care provider, or are required to be licensed as a Class A, B, or F home care provider based on the scope of services they provide.

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.
X	**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-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 enrollee'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. (b) Authorization criteria The screening and support plan process is used to determine the enrollee'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 form 3428) and Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS form 3428D). The information from the assessment identifies whether the needs are beyond what is a typical activity that the relative would ordinarily perform or be responsible to perform. These activities may include, but are not limited to, supervision, household cleaning, and home maintenance. If determined necessary, the case manager authorizes the PCA time in the enrollee's waiver plan. (c) Payment controls Enrollees must sign PCA's 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 enrollees 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 enrollees, providers, and county 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 enrollee 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 enrollees 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 enrollees 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.

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.
X	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-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. <u>Private duty nursing (this is an extended home health care service)</u> Spouses, non-paid legal guardians, and conservators may 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 enrollee; 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 enrollee because of labor conditions, special language needs, or intermittent hours of care needed.

The individual must be a nurse licensed in Minnesota and employed by a home health or PDN agency. The individual must also complete a criminal background study in accordance with Minnesota Statutes, Chapter 245C and not be disqualified. 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, or the physician determines that the private duty nursing care provided by the spouse or legal guardian is unsafe or may potentially jeopardize the enrollee's health and safety.

Adult foster care

Counties may certify people related to the enrollee to provide foster care in accordance with Minnesota Statutes, §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

Relatives who are related by blood, marriage or adoption, and legal guardians or conservators may be paid to provide services through the CDCS service 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.

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 community support plan;
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant's community 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 parent of an adult or spouse would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document.*

The LTCC screening 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, and to identify areas

in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- spouses may not provide more than 40 hours of service in a seven-day period. For spouses, 40 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 community support plan.
- spouses may only be paid for providing supports that fall within the Personal Assistant service category
- spouses may not be reimbursed for mileage expenses.

Monitoring Requirements: These additional requirements apply to participants electing to employ a spouse for CDCS services:

- monthly reviews by the fiscal support entity 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 fiscal support entity when billing;
- at least quarterly reviews by the county on the expenditures and the health and safety status of the participant;
- face-to-face visits with the participant by the county on at least an annual basis.

All services: 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.

Other waiver services

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 enrollee's community support plan and the 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 enrollee;
- Not be otherwise responsible to provide the care or service;
- Not be an enrolled MA provider for the service being rendered;
- Be qualified to provide the service;
- 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-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○	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 providers who meet the waiver provider standards and complete a provider agreement. Providers may access information concerning enrollment on the department's web site. The web site also includes the forms that providers must submit and the provider manual that provides information concerning services, standards, billing processes, etc. The department verifies provider's qualifications at the time of enrollment. See http://www.dhs.state.mn.us/main/Business_Partners

Managed care providers
The provider network may be limited by the MCO, in accordance with §1915(b)(1) for MSC+ or in accordance with §1915(a) for MSHO, and the MCO's contract with the department.

Contracts
Until January, 2014 all providers must also have a contract with the lead agency. The department provided a standardized template for contracts with providers that lead agencies may use. Lead agencies are responsible to assure that providers meet the provider standards and the needs of the enrollees that will be served.

If a MCO authorizes waiver services furnished by providers with which the MCO does not have a formal contract, the MCO will have an agreement with the county to use the waiver providers with whom the county has a contract. Exceptions to this process are governed by the contract between the MCOs and the department.

The department monitors the contracting practices of lead agencies through the Quality Assurance Plan that lead agencies submit to the department. In addition, the department monitors the contract practices for counties and tribes through the lead agency review process and for MCOs through routine reviews conducted by the Minnesota Department of Health. The department has an interagency agreement with the Department of Health for this function.

The department is transitioning from its current contracting practices to an enhanced provider qualification review process (and periodic re-review). County/tribe contracting will be eliminated as of 1/1/2014. Providers must have an agreement with the Department of Human Services and be enrolled as an MHCP provider. Communication and training of local lead agencies and providers, and waiver provider qualification review process of providers state wide has begun. A web based provider directory has been designed and is currently under development. New MHCP providers will be required to take training that has been developed by the department. All lead agencies will utilize any qualified provider in Provider Enrollment. 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.

Tribes that contract with the department as a lead agency may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7, item

(c). A tribe that intends to implement standards for credentialing health professionals must submit the standards to the department, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The department maintains a copy of the standards and supporting evidence to enroll health professionals approved by tribes.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: **Qualified Providers**

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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[1] paid to active MHCP providers, per SFY. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per SFY. Denominator: Number of all EW claims paid for services provided to EW participants, per SFY		
Data Source [e.g. – examples cited in IPG] **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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*

	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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*	
	X State Medicaid Agency	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

[1] Includes both fee-for-service claims and managed care encounter claims.

Add another Performance measure (button to prompt another performance measure)

a.i.b Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 claims2 paid to active MHCP providers, per SFY. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per SFY. Denominator: Number of all EW claims paid for services provided to EW participants, per SFY.		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

[2] Includes both fee-for-service claims and managed care encounter claims.

MMIS	*(check each that applies)*	*applies)*	
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 claims3 paid to active MHCP providers, per SFY. Numerator: Number of EW claims paid to active MHCP providers for services provided to EW participants, per SFY. Denominator: Number of all EW claims paid for services provided to EW participants, per SFY.		
Data Source **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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Data Source for this performance measure

Add another Performance measure (button to prompt another performance measure)

a.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

[3] Includes both fee-for-service claims and managed care encounter claims.

requirements) according to state and federal laws and regulations. The Department's Provider Enrollment Unit verifies that these requirements are met before a provider is enrolled. All waiver providers must be enrolled through the Provider Enrollment Unit. Before they can provide services, bill and be reimbursed for providing waiver services, fee-for-service provider 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.

In analyzing MCO encounter claims, while MCOs can utilize non-enrolled providers, the analysis indicates that MCOs use DHS-enrolled providers for waiver services.

Non-licensed providers have had qualifications reviewed and monitored through the lead agency contract process. The department monitors the contracting practices of lead agencies through the annual Quality Assurance Plan that lead agencies submit to the department. In addition, DHS monitors the contract practices for counties and tribes through the lead agency review process and for MCOs through routine reviews conducted by the Minnesota Department of Health. The department has an interagency agreement with the Department of Health for this function. The department provides direction and oversees all operational activities carried out by counties, managed care organizations, and tribes. Counties, managed care organization, and tribes 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 is transitioning from its current lead agency contracting practices to an enhanced waiver provider qualification review process. County/tribe contracting will be eliminated as of 1/1/2014, and providers must be reviewed by the department to remain enrolled as an MHCP provider. Communication plans have been developed and have commenced. Training of local lead agencies and providers is being rolled out. Review and renewal of provider agreements with the department has begun statewide. A web based provider directory has been designed and is currently under development. New MHCP providers will be required to take training that has been developed by the department. Lead agency reviews do provide on-site monitoring of the current lead agency contracting processes, including verification of provider requirements. Certain licensed waiver providers are required to submit documentation of training to the licensing agency.

Certification. The Department certifies Support Planners and Fiscal Support Entities (FE) for Consumer Directed Community Supports service. Initial FE certification requires verification of provider standards being met and successful completion of initial review. FE recertification reviews are conducted as determined by the department.

b. Methods for Remediation/Fixing Individual Problems

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

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.

b.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)*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other: Specify:	*☐ Annually*
		X 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.

○	**Yes** *(complete remainder of item)*
X	**No**

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-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. 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).

State Notes:

- CMS' format for service and provider specifications in this Appendix includes questions to identify whether the service is "participant-directed as specified in Appendix E" or "provider managed." Minnesota's consumer-directed service cannot be accurately defined in this way. CDCS is a separate waiver service that is completely customized to meet enrollees' individualized needs and includes all services identified in the enrollee's care plan with some specific exceptions (e.g., services covered by other sources). Refer to the CDCS service description and provider qualifications.
- Waiver providers who furnish fee-for-service services must enroll with the department as a Minnesota Health Care Programs (MHCP) provider. The department verifies that providers meet the provider qualifications identified in the waiver plan at the time of enrollment.
- Tribes that contract with the department as a lead agency may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7, item (c). A tribe that intends to implement standards for credentialing health professionals must submit the standards to the department, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The department maintains a copy of the standards and supporting evidence to enroll health professionals approved by tribes.

Service Specification	
Service Title:	Case Management
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
O	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Services to assist enrollees in accessing needed waiver and other state plan services, assist individuals in appeals under Minnesota Statutes §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 care 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 enrollees' care plans. Case managers shall initiate and oversee the process of assessment and reassessment of enrollees' level of care and review their care plans at least annually, or more frequently as warranted by changes in enrollees' conditions.

Case managers shall develop the individual care plan, inform the enrollee of service options, assist in identifying potential service providers, assist in accessing services, coordinate services, evaluate and

monitor services identified in the care plan, provide enrollees with information concerning their rights, and review care plans at least annually.

The case manager or case aide shall not have a personal financial interest in the services provided to the enrollee. Duplicate payments will not be made for waiver case management services to the same enrollee by more than one provider.

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 the lead agencies that are enrolled as a medical assistance provider

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Lead Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Social Workers**,** public health nurses and/or case aides employed by lead agencies, and for MCOS, registered nurses, physicians, and physician assistants.	Public health or registered nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285		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 in a public or private social service agency. Social workers must also pass a written examination covering knowledge of counseling, interviewing and social services principles through the Minnesota Merit System or a county civil service system in Minnesota. 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 9575.1580.
Case aides employed by a lead agency			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.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
County and Tribal Agencies	The department verifies that case management activities are conducted in accordance with policies and regulations during county site reviews.	Counties or tribes are randomly selected for review. RN licenses are renewed every 2 years
MCO's	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 enrollees or waiver services, including case management.	A random sample of case files is audited annually by the MCO RN licenses are renewed every 2 years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Chore services support or assist an enrollee or his/her primary caregiver to maintain a clean, sanitary, and safe home environment. Heavy household chores such as washing floors, windows and walls, indoor and outdoor general home maintenance work , or moving or removal of large household furnishings and heavy appliances to provide safe access and egress or prevent falls may be covered.

Chore service may also include: 1) extermination and pest control; 2) customary service charges made for the delivery of grocery store products when these products represent the majority of the enrollee's total grocery needs for at least seven days, and 3) dumpster rental and refuse disposal.

Chore services shall only be covered in cases where neither the enrollee, nor anyone else in the household, is capable of performing or financially providing for them, or when the provision of chore services allows a caregiver to provide other needed supports to the enrolled person. 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 rental situations in which the lease agreement identifies the chore services as the responsibility of the landlord or in licensed settings.

If the care plan also includes homemaker services, the care 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.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals, chore service providers		Providers that meet the chore services standards.	
	Structural pest control applicators		Structural pest control applicators.	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

State:	
Effective Date	

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Providers including individuals, that meet the chore service standards			Provider qualifications necessary to meet an enrollees needs and will be identified in the community support plan
Structural Pest Control Applicators			Must meet the standards and requirements under Minnesota Statute, Chapter 18B

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Providers that meet the chore services standards.	Lead agencies	Every one to three years
Structural Pest Control Applicators.	Lead agencies	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Adult Day Service Bath
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
An enrollee may receive a bath provided by an adult day service provider. In order to receive an Adult Day Bath, and enrollee must be receiving Adult Day Services. The reason for not providing the bath in the enrollee's home must be documented.	

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.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Adult day service centers
				Adult day service programs

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Service centers	Adult day service centers must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		
Adult Day Service Programs	Adult day service programs must be licensed to provide family adult day services under Minnesota Statutes, Chapter 245A.143 and Minnesota Rules, parts 9555.9600 to 9555. 9730.		Adult day service programs must comply with Minnesota Statutes, sections 245A.01 to 245A.16.
Nursing Homes, Hospitals, Medical Clinics	Licensed under Minnesota Rules, Parts 9555.9600-9730.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Service Center	Department of Human Services – Licensing Division.	Every one to two years
Adult Day Service Program	Minnesota Department of Health	Every one to two years
Nursing Homes,	Minnesota Department of health	One to three years

Hospitals, Medical Clinics		

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Adult Day Service

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

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 community support plan. Services must be designed to meet both the health and social needs of the participants.

Adult day services must be furnished two or more hours per day on a regularly scheduled basis, for one or more days per week and include both health and social services that are designed to meet the needs of the participants. Meals provided as part of this service shall be in accordance with 42 CFR 441.310(a)(2)(ii). Services shall not be authorized for more than 12 hours in a continuous 24hour period.

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

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals may provide family adult day services.		Adult day care centers and programs	
			Nursing Facilities	
			Hospitals	
			Board and care providers	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult day care centers (also referred to as adult day services centers).	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		Providers must also meet the requirements and standards in Minnesota Statutes, Chapter 245A.01 through 245A.16, with the exception of 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.
Adult day service programs are provided in nursing homes, hospitals, and board and care settings.	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730 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 because they are exempted from the licensing requirement to provide adult day care.		The provider must also meet the requirements and standards in Minnesota Statutes, Chapter 245A.01 through 245A.16, with the exception of 245A.143.
Individuals licensed to provide family adult day (FAD) service	Must be licensed under Minnesota Statutes, §245A.143.	FADs providers must meet the standards as provided in 245A.01 to 245A.16	The service must be provided in the license holder's primary residence

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult day care centers	Minnesota Department of Human Services	Every one to two years
Adult day care programs.	Minnesota Department of Health	Every one to two years
Family adult day care.	Minnesota Department of Human Services Licensing Division	Every one to two years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Family and Caregiver Training and Education

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Family and caregiver training and education provide training, education, coaching, or counseling for caregivers who provide direct and on-going services to an enrollee. This may include a parent, spouse, children, relatives, in-laws or other informal caregivers. This service does not provide training and counseling to people who are employed by or volunteer through an organization that is paid to care for the enrollee.

Training and education include instruction about treatment regimens, disease management, direct care skills, and the use of equipment and technology to maintain the health and safety of the enrollee. It may also include education about caregiver roles, family dynamics, self-care skills and dealing with difficult behaviors, and other areas as-specified in the support plan to improve health and well-being of the caregiver and care provided for the enrollee. Training and education can include individual or group sessions.

Coaching and counseling include individualized support for caregivers of enrollees. Coaching or consulting includes an assessment of the caregiver's needs and strengths, development of a person-centered plan with goals, skills development (i.e., self-care skills, techniques for managing difficult behaviors), problem solving (i.e., family dynamics or family meetings, developing an informal support network), coaching, and ongoing support to reach established goals. Its goals are to improve caregiver health and well-being, and increase coping and self-efficacy skills to improve the quality of care provided for the enrollee. Some caregiver consultants specialize in memory care. Counseling offers professional consultation to assist caregivers in making decisions and solving problems related to their caregiving role. It includes identification of needs and preferences, development of an individualized approach and plans, family counseling, conflict resolution, and problem solving or guidance directly related to providing care to the enrollee.

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

This service pays for the costs of training offered by enrolled providers, or conference registration fees for family caregivers. Costs related to transportation, travel, meals, and lodging are not covered. If any such costs are included in the registration fee, they must be deducted. Documentation of the need for training and an outline of the training (i.e., a course syllabus, training objectives, workshop description, etc.) must be submitted to the lead agency for approval by provider or ~~by~~ the individual requesting the training. Coaching and counseling is limited to enrolled providers and pays for staff time spent with enrollees. Provider costs such as preparation time, travel, and materials are not covered. Providers will submit a service description and plan to lead agency for approval. Based on the information provided and the enrollee's needs, the case manager determines whether the service will be authorized. If the service is authorized the submitted documentation is maintained in the enrollee's file by the lead agency. The lead agency, as an enrolled Medicaid provider, will submit claims for this service to MMIS as appropriate.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Healthcare professionals		Medical equipment suppliers	
	Caregiver consultants		Care or support related organizations	
	Lead Agencies		Technical Colleges and Schools	
	Centers for Independent Living		Home Health Agencies, Clinics, Hospitals, others	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Healthcare professionals, such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists/aides, gerontologists, pharmacists, dieticians, nutritionists	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.		Providers must have 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. Physical cares requiring a specific technique for the safety of both the caregiver and enrollee must be taught by a professional specializing in such techniques, such as public health nurses, registered nurses and licensed practical nurses. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Vocational and technical colleges or schools, or individual educators such as health educators			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 lead agency that the content of the training or conference directly applies to the care and well-being of the enrollee. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Caregiver Consultants			Caregiver consultants will have completed the Minnesota Board on Aging (MBA) caregiver coaching basic training curriculum and continuing education offered by the MBA or Area Agencies on Aging.

			Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Care or Support Related Organizations, includes caregiver support professionals of nonprofit social service agencies, related agencies, or organizations; counties, area agencies on aging, and disease related organizations, such as Alzheimer's Association.	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.		Training, education, coaching and consultation will be provided by agencies and organizations who have demonstrated expertise in the topic that relates to the needs of the enrollee or the ability of the caregiver to provide care and support to the enrollee, Providers must have 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. Caregiver consultants will have completed the Minnesota Board on Aging (MBA) caregiver coaching basic training curriculum and continuing education offered by the MBA or Area Agencies on Aging Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Centers for Independent Living and Medical Equipment Suppliers.			Centers for Independent Living or medical equipment suppliers must have the ability to train the caregiver on home modifications or the use of specialized equipment that relates to the needs of the enrollee Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Providers that meet the caregiver training and education service standards.	Lead Agencies	At least annually and as needed

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	**Environmental Accessibility Adaptations**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Environmental accessibility adaptations are physical adaptations to the home or vehicle, required by the participant's community support plan that are necessary to ensure the health and safety of the participant with mobility problems, sensory deficits or behavior problems, or that enable enrollees to function with greater independence in the home. For purposes of the waiver, home means the enrollees primary place of residence. Modifications and adaptations may include the installation of ramps and 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, monitoring systems, and motion detectors. This service also covers the necessary assessments to determine the most appropriate adaptation or equipment. The service may also cover installation, maintenance and repairs of environmental modifications and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to the cost of replacement of the item.

Environmental accessibility adaptations also include modifications to vehicles that allow the enrollee to function with greater independence in the community. Modifications and adaptations include: wheelchair lifts, adapted seating, door widening, door handle replacements, wheelchair securing devices, etc. and modifications to adaptive equipment (such as adaptive furniture, adaptive positioning devices, and utensils).

If for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition); an environmental accessibility adaptation(s) that was provided may be covered through Medicaid administrative funds. Managed care organizations shall not claim Medicaid administrative expenses

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

Modifications and adaptations to the home or vehicle that are of general utility, and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, central air conditioning, major household appliances, etc. and modifications that add to the total square footage of the home are not covered.

Square footage may be added to an existing bathroom if necessary when the following criteria are met:
- The accessibility adaptation is necessary to accommodate a wheelchair.
- 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 community support plan.
- The accessibility adaptation is reasonable given the value and size of the home and is limited to materials that are the least costly and of reasonable standards

The lead agency 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.

Modifications and adaptations are not covered in congregate or shared living areas of: (1) homes that are licensed to provide foster care when the license holder does not reside in the home; and, (2) in settings that are registered as housing with services establishment.
This does not preclude coverage of modifications and adaptations to living areas that are not shared such as an enrollee's bedroom or bathroom when the space is used solely by the enrollee or the enrollee and one roommate.

Coverage is limited to modifications and adaptations to one operating vehicle and the enrollee's primary residence. The limit of one vehicle does not prohibit coverage for vehicle modifications or adaptations when the vehicle must be replaced.

Modifications and adaptations to home or vehicle or adaptive equipment are limited to a combined total of $10,000 per enrollee per waiver year. This service limit may be subject to the same percentage rate changes authorized by the Minnesota Legislature for home and community-based waiver services.

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

* (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.

nd 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) Monitoring cameras must not be installed in bathrooms; and will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department and electronic monitoring cameras must not be concealed from the participant; and
(5) Equipment that is bodily invasive, concealed cameras, and auto door or window locks are not allowed.
(6) The State plans to 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.
(7) 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 section 626.556 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 section 626.557, subdivision 12b.

(b) The agency or individual shall be monitored for compliance with the following data privacy and security provisions:

(1) The agency or individual must control access to data on participants according to the definitions of public and private data on individuals under section 13.02; classification of the data on individuals as private under section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, a

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Professionals qualified to provide the necessary modification		Lead Agencies	

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Providers that meet the standards for environmental modifications and adaptations	Must have current license or certificate, if required by Minnesota Statutes or Administrative Rules, for the services they are providing.		The provider must be qualified to perform, repair or maintain the modification as demonstrated by professional certification or references. All services shall be provided in accordance with applicable state or local building codes. The provider must have a contract or purchase agreement with the lead agency. Individuals or agencies that provide home modification assessments must be appropriately licensed or credentialed and must meet one of the following: • An Occupational Therapist that is currently registered by the American Occupational Therapy Association to perform assessment/evaluation functions and have at least 1 year of experience with home modification evaluations.

			• A certified Aging-in-Place Specialist with at least 1 year of experience with home modification evaluations • A certified Accessibility Specialist, certified through the Minnesota Department of Labor and industry with at least 1 year of experience with home modification evaluations Providers who meet the definition of residential building contractor as defined in 326B.802, subdivision 11, must be licensed as a residential contractor by the commissioner. Construction workers are exempt from licensure when the skills they perform meet the definition of "special skill" as defined in MN Statutes Chapter 326B.082, subd. 15 Individuals that provide vehicle installation services must be accredited through the National Equipment Dealer Associations Quality Assurance Program. Individuals that provide vehicle modification assessments must meet one the following: 1. Certified Driver Rehabilitation Specialist 2. Occupational Therapist with a Specialty Certification in Driving and Community Mobility 3. 5 years of full time experience in the field of driver rehabilitation 4. 4 years undergraduate degree in a health related field with a.1 year full time experience in the degree area of study b. Supervision by: i. A certified driver rehabilitation specialist OR ii. An OT 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 c. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehab Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Providers that meet the standards for environmental modifications and adaptations.	Lead Agencies	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.

X	Service is included in approved waiver. The service specifications have been modified.
O	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Respite care may be provided to enrollees 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 enrollee.

Respite care may be provided in: the enrollee's home or place of residence; a home licensed to provide foster care; a Medicare certified hospital or nursing facility; a building registered as a housing with services establishment with services delivered by a licensed home care provider; or a private home that is identified by the enrollee.

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

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 enrollee's home, enrollee'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 care plan. Enrollees who live in settings that are responsible to provide 24 hour care, supervision, or supports are not eligible for this service.

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.

Provider Specifications

Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Nurses		Home Health Agencies	
	A person selected by the enrollee		Nursing facilities	
			Foster Care Providers	
			Housing with services establishment	

State:	
Effective Date	

		Hospitals	
		Personal care provider organizations	
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐ Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
I. Providers that furnish respite care in the enrollee's home or place of residence:			
Registered or licensed practical nurses	Must be licensed under Minnesota Statutes, sections 148.171 to 148.284.		Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Nurses and home health aides employed by a Home health agency	Nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.284.		Home health agencies must have a class A license and must meet the standards under Minnesota Rules, part 9505.0290, subpart 3, B and Minnesota Rules Chapter 4668 and Minnesota Statutes, chapters: 144A.45, 144a.46, 144.461, and 144.465. Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Personal care assistants employed by personal care provider agencies or home health agencies.			Must meet the standards under Minnesota Statutes, 256B.0659 and Minnesota Rules, part 9505.0335. Home health agencies must have a class A license and must meet the standards under Minnesota Rules, part 9505.0290, subpart 3, B and Minnesota Rules Chapter 4668 and Minnesota Statutes, chapters: 144A.45, 144a.46, 144.461, and 144.465. Hospitals as defined in Minnesota Statutes, section 144.696, subdivision 3. Hospitals must be licensed under Minnesota Statutes, sections 144.50 to 144.56 Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Individuals selected by the enrollee.			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 enrollee. 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 enrollee:

			1) the provider is physically able to care for the enrollee; 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. Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
II. Providers that furnish respite care outside of the enrollee's home:			
Hospitals as defined in Minnesota Statutes, section 144.696, subdivision 3.	Hospitals must be licensed under Minnesota Statutes, sections 144.50 to 144.56.		Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Adult Foster Care	Must be licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.		Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Long –term care facilities	Must be licensed in accordance with Minnesota Statutes, Chapter 144A.		Must meet the definition under Minnesota Rules, part 9505.0175, subpart 23. Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Housing with services establishments	Must meet the standards Minnesota Statutes, chapter §144D and be licensed as a Class A or F home care provider under Minnesota Rules, parts 4668.0002 to 4668.0870.		Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies
Unlicensed caregivers selected by the enrollee			Must demonstrate to the case manager that they are able to provide, on a temporary, short term basis, the care and services need by the enrollee. In addition, out-of-home respite providers who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the enrollee: 1) the provider is physically able to care for

			the enrollee; 2) the provider has completed training identified as necessary in the care plan; 3) the provider complies with monitoring procedures as described in the care plan; and, 4) the case manager must assess whether the provider's home is appropriate to meet the needs of the enrollee. The case manager must evaluate and document whether the provider meets the standards to provide respite Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Foster Care providers	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Providers are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year
Hospitals	Minnesota Department of Health	Validation surveys are conducted on a schedule determined by CMS.
Long term care facilities	Minnesota Department of Health	Every two years by the state
Home Health Agencies	Minnesota Department of Health	Every one to three years
Registered and licensed practical nurses	Lead Agencies	Every one to three years
Personal care provider organization	Lead Agencies	Every one to three years
Housing with services establishments	Minnesota Department of Health	Annually
Individuals selected by the enrollee	Lead Agencies	Annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	**Customized Living Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select

one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Customized Living (CL) services are provided in congregate settings by an outside provider or by the management of the setting or a provider under contract with the management or the lead agency. In order for customized living services to be covered by the waiver, enrollees must have an individualized service plan based on their documented needs. This is a separate and distinct plan from the care plan developed with the case manager that includes all waiver services. Service plans that contain supervision of the enrollee must include documentation of the enrollee'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. The enrollee 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 enrollee's overall care plan. Service plans must document whether or not there is a need to for 24-hour supervision of the enrollee and whether or not 24 hour supervision is included in the CL plan. Service plans must also include documentation of the enrollee'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.

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 enrollees with arranging meetings and appointments, assisting enrollees with money management, assisting enrollees with 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 recipients 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 home care licensure
.
Providers must furnish each enrollee 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 enrollees' 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 enrollees' 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 enrollees in the customized living setting
- Have an on-going awareness of the enrollees needs and activities
- Be able to respond in-person to an enrollee within a time frame that meets the enrollee's needs and that does not exceed ten minutes

Enrollees of customized living services cannot be employed to provide customized living services in the same building in which they reside.

The lead agency must establish individualized service rates according to Minnesota Statutes §256B.0915 subd. 3(h) when contracting for customized living services that include 24 hour supervision.

The lead agency must establish individualized service rates according to Minnesota Statutes §256B.0915 subd. 3(e) 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 enrollees receiving customized living services, homemaking, and chore services are not covered as separate waiver services. For enrollees receiving services that include 24 hour supervision personal emergency response systems and home monitoring devices are not covered under supplied and equipment.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Providers with a Class A or F home care license

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certain Home Care providers	Must be licensed as a Class A or F home care provider in accordance with Minnesota Statutes, §144A.43 through §144A.47 and Minnesota Rules, parts 4668 and 4669.		Housing establishments must be registered under Minnesota Statutes §144D, "Housing with Services Registration Act" as a registered housing with services establishment. Customized living service providers that are not licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 (adult foster care), and who provide services in settings with one to five residents, must comply with Minnesota Rules, parts 9555.6205, subparts 1 to 3, parts 9555.6215, subparts 1 and 3, and parts 9555.6225, subparts 1,2,6 and 10.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Class A and F Home care providers	Minnesota Department of Health	As scheduled by Minnesota Department of Health. Providers must renew their license annually.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Residential Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Residential care services are supportive services and up to 24-hour supervision and may include: meal preparation and service; individualized home management tasks; socialization; money management; assisting enrollees with arranging meetings and appointments for medical and social services; and, coordinating or providing transportation. Residential care services may also include minimal assistance with dressing, grooming and bathing, reminding enrollees to take medications and storing medications. Residential care services are provided to enrollees that reside in residential care homes. Residential care homes are licensed as board and lodging establishments and are registered with the Minnesota Department of Health as board and lodge with special services. Service direction must be provided by the enrollee or by residential care home staff with oversight by the case manager.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Homemaker and chore services are not covered as separate services for enrollees who are receiving residential care services.	

Residential care service does not cover room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement.

Personal care assistance services provided to enrollees who receive residential care must be furnished by another provider and may not duplicate services covered in the rate paid to the residential care provider.

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Licensed board and lodge settings

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Board and lodge settings that are registered as housing with services establishments to provide specialized services.	Providers must be licensed as a board and lodging establishment and meet the standards in Minnesota Statutes, section 157.15 to 157.17. Providers must also meet standards of licensure, certification or registration where they exist either in state law or administrative rule.	Providers must be registered with the Minnesota Department of Health as providing specialized services and must meet applicable building codes.	Residential services must be provided by the management of the residential care home. Staff who provide assistance with dressing, grooming, bathing, or reminders to take medications or store medication are required to have eight hours of training and orientation by a registered nurse. If medications are distributed or stored, a registered nurse must provide supervision. Staff must possess: 1) Communication skills including the ability to read and write, and follow written and verbal instructions and converse on the telephone. 2) Experience and/or training in caring for people with functional limitations. 3) An understanding of and respect for confidentiality issues. 4) A valid state driver's license appropriate to the type of transportation provided, if providing transportation for an enrollee. 5) The ability to perform essential job functions. 6) The ability to follow the care plan, work effectively under intermittent supervision, deal with minor

			emergencies, and, work under stress in a crisis situation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Board and Lodge settings	Minnesota Department of Health	Each year providers must apply to renew their board and lodge license.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Adult Companion Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

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

Providers may assist or supervise the enrollee with tasks such as meal preparation, laundry and shopping when the tasks are incidental to the companion service, but do not perform these tasks as discrete services. Providers may complete light housekeeping tasks that are incidental to the care and supervision of the enrollee.

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

The service does not include hands-on nursing care, but may include verbal instruction or cuing.

People related to the waiver enrollee by blood, marriage, or adoption cannot be paid for providing this service

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals		Organizations that meet the provider standards	
			Senior companion programs.	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individuals			Individuals who provide 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 enrollee's care 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
Organizations			Providers must assure that individual workers have: 1. Communication skills including the ability to communicate with the enrollee(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 enrollee's care 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
Organizations that provide companion services.			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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals who meet the standard to provide companion services.	Lead agency.	At least annually.
Organizations that provide companion services.	Lead Agency	At least annually
Organizations that provide companion service under the Corporation for	Federal Corporation for National and Community Service.	Programs are monitored annually and on-site reviews conducted minimally every six years.

National and Community Service.		

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

A home delivered meal is an appropriate, nutritionally balanced meal served in the building in which the enrollee 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 enrollee's dietary requirements. Menu plans must be reviewed and approved by a licensed dietician, or licensed nutritionist.
A unit of service equals one meal. No more than one meal per day will be covered by the waiver.

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

Home delivered meals are not covered for enrollees who live in settings licensed for foster care or board and lodge.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals who meet the provider standards.		Hospitals	
			Schools	
			Any entity providing home delivered meals.	
			Restaurants	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Hospitals, schools, restaurants, and any entity providing home delivered meals, including individuals			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 parts 4626.0010 to 4626.2025. 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 Minn. Stat. 148.621 and Minnesota Rules Chapter 3250.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Hospitals, schools, restaurants, and any entity providing home delivered meals	Lead Agencies	Every one to three years
Individuals	Lead Agencies	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	Specialized Equipment and Supplies
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Specialized equipment and supplies include devices, controls, or medical 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 care plan that enable enrollees 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 enrollees, maintenance, repair of devices, and rental of equipment during periods of repair, unless covered by warranty. Training is not covered separately.

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. 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 enrollee and items that are covered by the state plan as durable medical equipment are not covered, including related assessments, repairs, and service.

Shipping and handling costs can be paid by HCBS 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 the item meets HCBS authorization criteria.

For enrollees 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 enrollees 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.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Agencies
				Pharmacies
				Medical Suppliers
				Other Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home health agencies, medical equipment providers and medical suppliers (including wheelchair and oxygen vendors).			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.
Pharmacies	Pharmacies are licensed by the Minnesota Board of Pharmacy in accordance with Minnesota Rules, parts, 6800.0100 to 6800.9954.		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.
Providers who provide supplies or equipment and have purchase agreement with the lead agency.			The lead agency determines whether the supply or equipment meets the enrollee's needs as identified in the community support plan.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home Health Agencies	Minnesota Department of Health	Every one to three years
Pharmacies	Lead Agencies	Providers are re-enrolled annually
Medical equipment providers and suppliers	Lead Agencies	Every one to three years.
Other entities	Lead Agencies	Every one to 3 years

Service Delivery Method				
	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	**Transportation**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Transportation services may be covered to enable participant to gain access to waiver and other community services, resources, and activities related to goals specified in the community 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 transportation services covered by the state plan (e.g., to medical appointments) or supplant transportation that is available at no charge or included in the rate paid to a residential or other service provider.

Provider Specifications

Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals who are not common carriers.		Lead Agency	
			Special transportation vendors.	
			Taxi and commercial companies.	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Common carriers including agency vehicles, bus, taxicab, other commercial carriers.	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.		Additional qualifications that are necessary to meet an enrollee's unique needs and preferences will be documented in the plan
Individuals who are not common carrier providers may provide transportation when they meet the enrollee's	Drivers must have a valid driver's license appropriate to the type of transportation being provided and adequate insurance		Additional qualifications that are necessary to meet an enrollee's unique needs and preferences will be documented in the community support plan.

needs and preferences in a cost-effective manner	coverage, including auto insurance as required under Minnesota Rules, part 9505.0315 and 8840.6000		
Special transportation: may be required to transport an enrollee who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.		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 l74.30.	Additional qualifications that are necessary to meet an enrollee's unique needs and preferences will be documented in the care plan.
Agencies including non-profit groups that provide transportation	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.		Additional qualifications that are necessary to meet an enrollee's unique needs and preferences will be documented in the plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Common carrier, individual drivers, special transportation providers, and other agencies.	Lead agencies are responsible to verify and monitor that providers meet the provider qualifications.	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

State:	
Effective Date	

Service Specification	
Service Title:	**Extended State Plan Private Duty Nursing**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Extended private duty nursing (PDN) are PDN 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 enrollee must receive and exhaust the PDN benefit for each month that the extended service is authorized.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Independent registered and licensed practical nurses.		Medicare certified home health agencies	
			Agencies licensed to provide Class A home care services.	
			PDN Class A licensed agency	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered nurses	Must be licensed under Minnesota Statutes, sections l48.l7l to 148.284.		
Licensed practical nurses (LPN).	Must be licensed under Minnesota Statutes, sections l48.171 to l48.284. LPNs must also have a Class A license.		LPNs must be supervised by registered nurse and may only provide care that is delegated by the registered nurse.

Home health agencies.	Must be licensed as a Class A home care provider		Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290. A nurse who provides PDN services as an employee of a home health agency must have a valid license to practice in Minnesota.
PDN Class A licensed agency.	Must be licensed as a Class A home care provider.		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Registered and licensed practical nurses.	Lead agencies.	Every one to three years
Home health agencies, include Medicare certified agencies	Minnesota Department of Health	Every one to three years
Class A private duty nurse agency.	Minnesota Department of Health	Every one to three years

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification

Service Title:	**Extended State Plan Personal Care Assistant (PCA)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.

○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Extended personal care assistant (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 enrollee must receive and exhaust the PCA benefit for each month that the extended service is authorized. The state plan rates apply. The frequency and duration of the service is determined on completion of the PCA assessment tool (DHS form 3428D).

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

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Personal care provider agencies
				Home health care agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Providers that meet the standards to provide extended PCA services.			The standards and requirements for PCA services in the state plan and under Minnesota Statutes, section 256B.0659, and Minnesota Rules, part 9505.0335, including supervision, must be met.
Medicare certified home health agencies	Must meet the standards and requirements under Minnesota Statutes, 256B.0659, subd. 21, 22, 23.	Medicare certification	The standards and requirements for PCA services in the state plan and under Minnesota Statutes, section 256B.0659, and Minnesota Rules, part 9505.0335, including supervision, must be met.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal care provider agencies.	Lead Agencies	annually
Personal care choice agencies.	Lead Agencies	annually

Home health care agencies that are Medicare certified	Minnesota Department of Health	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Title:	**Homemaker**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Homemaker services consist of general household activities (e.g. meal preparation and routine household care) provided by a trained homemaker when the individual regularly responsible for these activities is unable to manage the household activities or is temporarily absent.

Home management activities may include assistance with laundry, meal preparation, shopping for food, clothing and supplies, simple household repairs and arranging for transportation. Homemaker services also may include assistance with bathing, toileting, grooming, eating and ambulating**;** providing companionship, emotional support and social stimulation in conjunction with the completion of homemaker tasks. In addition to these services, homemakers may provide monitoring of the client's well-being while in the home, including safety.

Lead agencies may grant variances to the requirement that homemaker providers meet training requirements in Minnesota Rules, part 9565.1200 governing provisions of homemaker services, when the enrollee's support plan specifically states that the homemaker is only providing light housekeeping and is not responsible for training or monitoring the well-being of the enrollee. The provider of homemaker services must have the ability to perform the duties expected and be a cost effective alternative to certified homemaker providers.

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 enrollee resides in a licensed foster care home or supervised living facility, or receives residential care, customized living, or 24 hour customized living service.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	X	Individual. List types:	X	Agency. List the types of agencies:
	Individuals who meet the qualifications.		Agencies that meet the provider standard.	

State:	
Effective Date	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agencies.	Class A, B, C, or F home care license.	Certificate of Home Management registration.	Must meet the requirements established in Minnesota Statutes, sections 144A.43 to 144A.461 and must meet the standards defined in Minnesota Rules, 4668. And Minnesota Rules 9565.1100 to 9565.1300. The standards outlined in Minnesota Statutes, Chapter 245C concerning criminal background studies must be applied.
Individuals (not employed by an agency).		Homemakers must have a Home Management-registration and must meet the requirements established in Minnesota Statutes, sections 144A.43 to 144A.461 and individuals must meet requirements in Minnesota Rule, Parts 9565.1100 to 9565.1300	Must meet requirements in Minnesota Rule, parts 9565.1100 to 9565.1300. Lead agencies make the determination whether to grant a variance from the training requirements of a certified homemaker and whether the provider of the homemaker service is able to perform the duties assigned. The standards outlined in Minnesota Statutes, Chapter 245C concerning criminal background studies must be applied.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Agencies licensed to provide homemaking services.	Minnesota Department of Health	Every one to three years
Individuals (not employed by an agency).	Lead Agencies	Every one to three years

Service Delivery Method

Service Delivery	☐	Participant-directed as specified in Appendix	X	Provider

Method *(check each that applies)*:		E		managed

Service Specification	
Service Title:	Extended State Plan Home Health Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
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 enrollee 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.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	X	Agency. List the types of agencies:
				Home Health Care Agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Home Health Agencies	Class A license		Must be Medicare certified and meet the standards as specified under the 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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home health care agencies that are Medicare certified	Minnesota Department of Health	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Adult Foster Care
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
X	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Foster care is ongoing residential care and supportive services and includes personal care assistant services, homemaker, chore, companion services, and medication oversight (to the extent permitted under State law) provided in a licensed private home by a principal care provider. Adult foster care is furnished to enrollees who receive these services in conjunction with residing in the home.

The total number of individuals (including waiver enrollees) 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 enrollees) living in the home, who are unrelated to the principal care provider, cannot exceed five.

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

The following are not covered: Room and board; items of comfort or convenience; payments directly or indirectly to the enrollee; and, the costs of facility maintenance, upkeep and improvement.
For enrollees receiving foster care, homemaker and chore services are not covered as separate services, because these services are integral to and inherent in the provision of foster care services.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Adult foster care providers, including relatives.		Providers who are licensed to provide adult foster care.	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult foster care providers (individuals and agencies) who are unrelated to the enrollee.	Must be licensed under Minnesota Rules, parts 9555.5l05 to 9555.6265 and 2960.3000 to 2960.3230, and Minnesota Statutes, §245A.03.		Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, §256B.0919 Subdivisions 1and 2.
Adult Foster Provider who are related to the enrollee	Exempt	Must meet the requirements in Minnesota Statutes, §256b.0919 subd. 3 related to county certification.	Must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, §256B.0919 subd. 1 and 2.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult foster care providers including individuals	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Providers 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 delegated to county agencies at least once every four years to determine whether they continue to meet the certification standards.

Relative Adult Foster Care Providers	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 four years to evaluate their compliance with department policies.	Providers are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Transitional Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Community transitional support 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 144.58; adult foster care homes licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; and, nursing facilities and intermediate care facilities licensed under Minnesota Rules, part 9505.0175, subpart 23.

Examples of items and expenses that may be covered include lease and rental deposits, essential furniture, utility set up fees and deposits, basic household items, personal items, and one time pest and allergen treatment of the setting. Used items may be purchased if they are safe by reasonable standards.

Examples of supports that can be covered include personal supports to assist 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. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

The case manager determines whether the items, expenses, and supports are necessary and reasonable for the enrollee 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 using the waiver, the local agency 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.

Community transitional support services will be identified on the individual's care plan. For enrollees 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 lead agency 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.

Provider Specifications				
Provider Category(s) *(check one or both)*:	X	Individual. List types:	X	Agency. List the types of agencies:
	Providers of items and expenses		Providers of items and expenses	
	Providers of supports		Providers of supports	
			Lead Agencies	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Providers of items and expenses	Must maintain all applicable licenses, permits, registrations as required for their business.		Providers of items or to whom expenses are paid (i.e., utility companies) must have a contract or purchase agreement with the lead agency for the item or expense to be covered. All receipts or other documentation related to the item or expense covered must be maintained in the enrollee's file at the lead agency.
Providers of supports			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 –a contract with the lead agency that sets forth their responsibilities including maintaining confidentiality

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Providers of items and expenses	Lead agencies	Every one to three years
Providers of supports	Lead agencies	Every one to three years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	X	Provider managed

Service Specification	
Service Title:	Consumer Directed Community Supports
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	

○	Service is included in approved waiver. There is no change in service specifications.
X	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support enrollees. Four categories of CDCS are covered: personal assistance; treatment and training; environmental modifications and provisions; and, self-direction support activities Enrollees or their representative hire, fire, manage and direct their support workers. The enrollees or their representative may purchase assistance with these functions through a fiscal support entity (FE Personal Assistance includes a range of direct assistance provided in an enrollee's home or community. Enrollees determine the provider's qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category: Assistance with activities of daily living and incidental activities of daily living, respite care and homemaking.

Treatment and Training includes a range of services that promote the enrollee's ability to live in and participate in the community. Providers must meet the certification or licensing requirements in state law related to the service. The following are typically covered under this category: Specialized health care, Extended therapy treatment, habilitation services, day services/programs, training and education to paid or unpaid caregivers, training and education to enrollees to increase their ability to manage CDCS services.

Environmental Modifications and Provisions include supports, services and goods provided to the enrollee 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.

Self Direction Support Activities include services, supports and expenses incurred for administering or assisting the enrollee 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 community support plan, monitoring and provision of services. Support planner service is covered under this category.

FEs offer a range of supports as defined in the provider standards. The agreement between the FE and the enrollee determines who the employer of record and managing employer are. The employer of record must be identified and documented in the enrollee's community support plan. Support planners may also provide assistance with employee-related functions as defined in the provider standards. Support planners cannot be the employer of record.

Enrollees or their representatives have control over the goods and services to be provided through developing the community 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+) enrollees, by the managed care organization or its designee.

Enrollees are not eligible for CDCS if they or their representative have at any time been assigned to the Health Care Designated Providers program. People living in licensed foster care settings, settings licensed by DHS or Minnesota Department of Health (MDH), or registered as a housing with services establishment with MDH are

not eligible for CDCS.

An individual written Community Support Plan must be developed for each enrollee. The enrollee or their representative will direct the development and revision of the community support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the enrollee'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 enrollee or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The community support plan identifies:

- the goods and services that will be provided to meet the enrollee's needs identified in the assessment and be for the direct benefit of the participant;
- safeguards to reasonably maintain the enrollee's health and safety; and,
- how emergency needs of the enrollee 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 waiver shall cover only those goods and services authorized in the community support plan. Goods and services are not covered when they are provided prior to the development of the community support plan, duplicate other services in the community support plan, supplant natural supports appropriately meeting the participant's needs or are available through other funding sources. Consumer directed community supports 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.

The community support plan will specify provider qualifications including training requirements (if they exceed the provider standards). The community support plan will also specify who is responsible to assure that the qualification and training requirements are met. Criminal background study standards as outlined in Minnesota Statutes 245C, Department of Human Services Licensing Act, must be applied to determine whether a person is disqualified or not. An individual who is disqualified may not be paid under CDCS.

For recipients who are not enrolled in MSHO or MSC+, the cost of background studies is not included in the individual budget amount but will be covered as a service expense within the individual's case mix classification amount. For MSHO and MSC+ enrollees, the cost will be covered as a service expense through the health plan.

The enrollee or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the lead agency when the revision does not change or modify parameters of the support plan authorized by the case manager. If a revision results in a change or modification of the approved community support plan parameters, the enrollee or their representative will work with the lead agency to have the community support plan reviewed and re-authorized.). See also Appendix E-2-b-iv.

Enrollee Budgets.
The individual budget maximum amount is set by the state or for MSHO and MSC+ enrollees, the health plan or the health plan's design. The lead agency is responsible to review and approve final spending decisions as delineated in the enrollee's community support plan.

In a 12 month service agreement period, the enrollee'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 activities that are required and those that are flexible which are provided

through the purchase of a support planner. Required case management functions are provided by lead agencies and are not included in the enrollee's budget. Required case management functions are as follows:

- Screen and assess to determine if the individual is eligible for waiver services including level of care requirements.
- Eligibility determination and re-determination
- Provide the enrollee with information regarding HCBS alternatives to make informed choice
- Summary of assessment information and outline of required plan elements
- If the enrollee elects CDCS, provide them with their maximum budget
- Provide CDCS enrollees with resources and informational tool kits to assist them in managing the service
- Determine whether the enrollees health and safety needs are expected to be met through the care plan
- Determine whether the plan is appropriate, including that the goods and services meet the services description and provider qualifications and rates are appropriate
- Authorization of service plan and funding and changes to services and funding
- Review each enrollee's CDCS expenditures, at a minimum, within three months, six months, and twelve months of the community support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved community support plan.
- Review expenditures and the enrollee's health and safety at least once per quarter when a spouse of an enrollee is being paid through CDCS.
- Provide technical assistance
- Provide notice and terminate CDCS if there are immediate concerns regarding health and safety or miss use or abuse of public funds . The notice will include fair hearing rights and inform enrollees that their CDCS services are being suspended pending the outcome of the hearing if one is requested. The enrollees community support plan will return to other traditional waiver or state plan services pending the outcome of a hearing,
- Monitoring quality systems and performance.

See the CDCS Lead Agency Operations Manual DHS 4270 for a description of all required lead agency activity.

Support planner supports are included in the budget. Support Planner functions are as follows:

- If the enrollee elects CDCS provide more detailed information about CDCS and provider options
- Facilitate development of a person-centered community support plan
- Monitor and assist with revisions to the community support plan

- Assist in recruiting, screening, hiring, training, scheduling, monitoring and paying workers.
- Monitor the provision of services including such things as interviews or monitoring visits with the enrollee or service providers
- Provide staff training that is specific to the consumers support plan
- Community support plan must include specific tasks to be performed by a paid support planner and payment agreements

Case managers must apply the criteria for allowable expenditures) to all CDCS services, supports, and items to determine whether the service, support, or item may be authorized in the community support plan. These are as follows:

1. Must be required to meet the identified needs and outcomes in the enrollee's community support plan and to assure the health and safety of the enrollee; **AND**
2. Goods and services collectively provide a feasible alternative to an institution; **AND**
3. Be the least costly alternative that reasonably meets the enrollee's identified needs; **AND**
4. Be for the sole benefit of the enrollee.

If all the above criteria are met, goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:

- Maintain the ability of the enrollee 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 enrollee;
- 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 enrollee or the enrollee's representative notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support enrollees. 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 negotiated and included in the community 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 mitigate the enrollee's disability when they 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 enrollee's physical condition. The condition must be identified in the enrollee's care plan and monitored by a MHCP enrolled physician.
(5) Expenses related to the development and implementation of the community support plan will be included in the budget. This is referred to as flexible case management functions . This may include but is not limited to assistance in determining what will best meet the enrollee's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The enrollee chooses who will provide the service and

how much will be included in the community support plan. This support may be provided via care coordination (or case management) through the lead agency or by another entity.
(6) Costs incurred to manage the budget; advertise 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).
(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.

Goods and services that shall not be purchased within the enrollees budget are:

- Services provided to people living in licensed foster care settings, residential settings licensed by DHS or MDH, or registered as a housing with services establishment;
- Services covered by the state plan, Medicare, or other liable third parties including education, home-based schooling, and vocational services;
- Services, goods or supports provided to or benefiting persons other than the enrollee;
- Any fees incurred by the enrollee such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies, with the exception of services provided as flexible case management;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items that are not related to the assessed need/ disability;
- Home modifications that add any square footage with the exception of an accessible bathroom-the lead agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations)
- Home modifications for a residence other than the primary residence of the enrollee
- Services provided to or by enrollees, representatives, providers or caregivers that have at any time been assigned to the Minnesota Restricted Recipient Program
- 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 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;
- Costs related to internet access.

Individual Budgeting:

Lead agencies will inform the enrollee prior to the development of the community support plan of the amount that will be available to the enrollee for implementing the support plan over a one year period.

Individual Budget Methodology. Enrollees' budgets may not exceed the length of their MMIS Service Agreement span (i.e., a maximum of 365 days). If the span is less than 365 days, the budget amount will be prorated. Enrollees shall not carry forward unspent budgeted amounts from one plan year to the next. If an enrollee 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. Assessments shall be conducted by the lead agency case manager.

Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's case mix classification amount. These supports whether

included in the individual budget or not, must be identified in the community support plan. For recipients who are not enrolled in MSHO or MSC+, the enrollee's maximum budget is the published CDCS Case Mix Cap.

For MSHO and MSC+ enrollees, the individual budget is developed by the managed care organization and the MCO may use the limit established by the department. The MCO or their designee (usually the care coordinator) is responsible for the care coordination or case management functions and establishing a payment level. This includes working with the waiver enrollee to establish a budget. Waiver enrollees or their representatives have the right to select and work with providers in their managed care organizations' network. To use an out of network provider, enrollees must follow the procedures delineated in the managed care organization's Certificate of Coverage. Unless authorized by the managed care organization, the individual budget limits for MSHO and MSC+ enrollees shall not exceed the individual budget limits for recipients who are not enrolled in MSHO or MSC+.

State Agency Responsibilities. Annually, the state agency will review and analyze access and utilization data and the number and outcomes of CDCS appeals.

Qualifications and standards for direct care workers and other people or entities that provide supports:
CDCS direct care workers and other people or entities providing supports are selected by the enrollee. People or entities providing goods or services covered by CDCS must bill through the financial support entity (FE). The FE must have a written agreement with the person or entity providing goods or services, or the enrollee may submit an invoice from the person or entity providing goods and services and to the FE for payment. Providers may not be paid with CDCS funds if they have: 1) Had contract with the state, tribes, or counties discontinued due to fraud, or for MSHO or MSC+ enrollees, managed care contracts or provider agreements discontinued due to fraud; or, 2) been disqualified under the criminal background check according to the standards in Minnesota Statutes 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the community support plan (e.g. support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. This does not preclude them from payment for their work in providing community support plan development services. This provision does not apply to case managers employed by lead agencies. This provision precludes FEs or their representatives from participating in the development of a community support plan for enrollees who are purchasing FE services from them.

1) Provider Standards for Personal Assistance
Includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: assistance with activities of daily living and incidental activities of daily living, respite care, and homemaking. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the enrollee or their designee indicating how the qualifications are met.

2) Provider Standards for Treatment and Training
Includes a range of services that promote the participant's ability to live in and participate in the community. For services and supports that require the person or entity providing the service or support to be professionally licensed, credentialed, or otherwise certified to perform the service under state law, the provider must meet all applicable standards. The following service providers are typically covered in this category: therapists, physicians, nurses, and dieticians. The community support plan may identify additional qualifications that the person or provider must meet to provide the service. For services and supports that do not require professional licensing, credentialing, or certification, the community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the enrollee or their designee indicating how the qualifications are met. For waiver services defined that require licensing under Minnesota

Statutes 245.A.01 to 245A.17, the same standards apply when the service is provided through CDCS. Minnesota Statutes 245.A.01 to 17 do not apply to CDCS services that do not otherwise require licensing.

3) Provider Standards for Environmental Modifications
Include supports, services and goods provided to the enrollee to maintain a physical environment that assists the person to live in and participate in the community or are related to maintain health and well-being.

The following items are typically covered in this category: home and vehicle modifications and adaptations, supplies and equipment, assistive technology, transportation, chore services, special diets, and adaptive clothing, and costs for fitness or exercise programs furnished at health clubs and fitness centers

Home and Vehicle Modifications. 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, private vehicle, or vehicles that are owned or leased by the lead agency. Private individuals may be designated to provide transportation when they meet the enrollee's needs and preferences in a cost-effective manner. All 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 enrollee's actual and projected use of the health club or fitness center. Enrollees must periodically provide verification to the lead agency that they are using the health club or fitness center.

4) Provider Standards for Self Direction Support Activities
Includes services and supports, supports, and expenses incurred for administering or assisting the participant or their representative in administering CDCS. This category of service includes two main functions: fiscal support entity (FE) services and Support planner services

A) Fiscal Support Entities (FEs)

FEs are the CDCS Medicaid-enrolled provider for all CDCS services. Counties or tribes may enroll as a FE. FEs must provide, at a minimum, payroll assistance and must offer a range of services that allow the enrollee, to select how much autonomy they want in employing, managing, and paying for services, supports, and goods.

The FE may not in any way limit or restrict the enrollee's choice of service or support providers.
FEs must have a written agreement with the enrollee or their representative that identifies the duties and responsibilities to be performed and the related charges. The FE must provide the enrollee, on a monthly basis, and county of financial responsibility or other identified lead agency, on a quarterly basis, written summary of what CDCS services were billed including charges from the FE.

FEs must establish and make public the maximum rate(s) for their services. The rate for and scope of FE services is negotiated between the enrollee or the enrollee's representative and the FE, and included in the community support plan. FE rates must be on a fee-for-service basis other than a percentage of the enrollees' service budget and may not include set up or base rate or other similar charges. Maximum FE rates may be established by the state agency. FEs who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training or environmental modifications and provisions provided to the enrollee must disclose in writing the nature of that relationship, and must not develop the enrollee's community support plan

.
The FE must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FE must have current and adequate liability insurance and bonding, sufficient cash flow, and have on staff or by contract a certified public accountant or an individual with a baccalaureate degree in accounting. The state agency determines if these criteria and the provider standards are met through a written readiness review submitted by the FE. FE providers must pass the readiness review prior to providing services. A certificate is issued to FE providers that successfully complete the readiness review. Recertification reviews are conducted as determined by the department.

The FE 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 FE must also receive a copy of the enrollee's community support plan approved by the lead agency. Claims submitted by the FE must correspond with services, amounts, time frames, etc. as authorized in the community support plan. Each lead agency must submit to the State a statement addressing their policy of conflict of interest. Section C of the Fiscal Support Entity Recertification Review checklist provides a list of the specific requirements that such policy must contain for the FE to maintain compliance

B) Care Plan Support / Support planner services

Support planner is an optional service covered under this CDCS category .These services have been described earlier in the service definition. Enrollees select who they want to provide this service. People who are paid through CDCS to assist with the development of the enrollee's person-centered community 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 and Maltreatment of Minors Acts; provide a copy of their training certificate to the enrollee; use the community support plan template or a community support plan format that includes all of the information required to authorize CDCS; be able to coordinate their services with their case manager to assure that there is no duplication between functions; and, follow the standards developed by the department. Enrollees may require additional provider qualifications tailored to their individual needs. These will be defined in the enrollee's community support plan. The provider must provide the enrollee or the enrollee's representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

Services and supports provided by a legally responsible individual.

CDCS may be used to pay spouses of enrollees for services rendered. The only service covered is personal assistance services provided as defined in Attachment A. Spouses must meet the provider qualifications for this service.

For a spouse of an enrollee 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 enrollee's care plan;
- be provided by a spouse who meets the qualifications and training standards identified as necessary in the enrollee's community 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 attendant (PCA) services;
- NOT be an activity that the spouse would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the LTCC assessment form.

In addition to the above:

- A spouse may not provide more than 40 hours of services in a seven day period;
- The spouse must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- Enrollees must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.

(CDCS may be used to pay parents (including biological and adoptive parents) of minor participants under age 18 or spouses of participants for services rendered. Such payments may only be made under the category of personal assistance services. Parents of minors and spouses must meet the provider qualifications 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 individual community support plan;
• be provided by a spouse who meets the qualifications and training standards identified as necessary in the participant's community 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;
• NOT be an activity that the family would ordinarily perform or is responsible to perform;
• be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document.*

* The LTCC screening will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age. The LTCC screening will be used to determine whether extraordinary care is required and may be provided by a spouse. To determine if extraordinary care is required and may be provided by a parent, the LTCC screening for age appropriateness is completed.

In addition to the above:
• the parents of minor children and spouses may not provide more than 40 hours of service in a seven-day period. (For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
  • number of parents,
  • combination of parent(s) and spouse, or
  • number of children who receive CDCS;)
• the parents and spouses 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 community support plan.
• Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistance service category.

All services: 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.

<u>Monitoring Requirements</u>

These additional requirements apply to enrollees electing to employ legally responsible parents or a spouse for CDCS services:

- monthly reviews by the fiscal support agent of hours billed for care provided by a spouse or parent 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 fiscal agent when billing;
- at least quarterly reviews by the lead agency on the expenditures and the health and safety status of the enrollee;
- face-to-face visits with the enrollee by the lead agency on at least a semi-annual basis.

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

The cost of the CDCS services must be within the enrollee's individual budget. CDCS services are not available to waiver participants receiving licensed foster care or residing in a residential setting licensed by the Department of Human Services (DHS) or the Minnesota Department of Health (MDH) or registered as a housing with services establishment.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	X	Agency. List the types of agencies:
				Fiscal Support Entities (FE)

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Fiscal Support Entities (FE)		A certificate is issued to providers who successfully complete the readiness review	In addition to the provider standards listed above, providers must submit to the department and pass a readiness review prior to providing services. Each lead agency must submit to the State a statement addressing their policy of conflict of interest. Section C of the Fiscal Support Entity Recertification Review checklist provides a list of the specific requirements that such policy must contain for the FE to maintain compliance The FE must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of tax liabilities; and maintain documentation to support MA claims. The FE must have current and adequate liability insurance and

			bonding, sufficient cash flow, and have on staff or by contract a certified public accountant or an individual with a degree in accounting. The FE must have a written agreement with the person or entity providing goods or services, or the participant may submit an invoice from the person or entity providing goods and services and to the FE for payment.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Fiscal Support Entity (FE)	The state agency determines whether provider standards are met through a written readiness review submitted by the FE	Recertification reviews are conducted as determined by the department

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	X	Participant-directed as specified in Appendix E		Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

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; and, (f) how participants are notified of the amount of the limit.

X	**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*.
	Consumer Directed Community Supports (CDCS) (a) Service. Enrollees who elect CDCS are limited to an annual budget amount. (b) Basis. The methodology used to establish the individual CDCS budget amounts is included in the service description in Appendix C-3. (c) Adjustments, (d) Exceptions, (e) Safeguards. Refer to the CDCS service description in Appendix C-3. (f) Notification. The department notifies the lead agency of the individual budget amount and the lead agency informs the enrollee prior to development of the support plan. **Environmental Modifications and Adaptations** Environmental accessibility adaptations are limited to $10,000 per the enrollee's service plan year
☐	**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*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*

☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

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 *(check 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)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

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.
X	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. Lead agencies 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 public health agency may provide home care services while the social service agency is responsible for case management. Case managers are never allowed to be the direct provider of another waiver service. The lead agency may provide other services but the case manager role is separated from service provision. Each lead agency maintains a HCBS provider directory that is part of the information packet delivered to individuals at LTCC assessment and used for care planning and choice amongst

providers and services. All licensed providers are listed on the DHS and MDH websites, including county of location of the service at http://www.dhs.state.mn.us/main/id_054422 and at http://www.health.state.mn.us/divs/fpc/directory/providerselect.cfm, respectively.

Private case management organizations may not have any direct financial interest in the provision of any waiver service in an individual's service plan per MN Statute, section 256B.0915, subdivision 1a, paragraph (f); see https://www.revisor.mn.gov/statutes/256B.0915

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 begins during the long term care consultation assessment process, This includes engaging enrollees and their representatives, as appropriate, in the assessment and care planning process, and supporting enrollees 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 must be comprehensive and includes a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individual, and provides information necessary to develop a community support plan that meets the consumer's needs, using an assessment form provided by the commissioner.

The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety The product of the assessment process is a community support or care plan, as described in MN Statutes, section 256B.0911, subdivision 3a. See https://www.revisor.mn.gov/statutes/256B.0911. For eligible individuals, additional care plan requirements are found at https://www.revisor.mn.gov/statutes/256B.0915.

The care plan format published by the department and used by long term care consultant/case managers reflects person-centered planning components. Enrollees are asked to verify, by signature, if they participated in the development of and agree with the care plan, were offered choices between services, and between providers. . See more detailed care plan requirements at Mn Statute, section 245B.0915, subdivisions 6 and 8 at https://www.revisor.mn.gov/statutes/256B.0915. See also care plan forms DHS 2925 (an open-ended care planning format) and DHS 4166 (a format that can be populated with the LTCC assessment data) at http://www.dhs.state.mn.us/main/id_000100

The department's web site offers a considerable amount of information, for enrollees, and families regarding consumer-direction.. as found at http://www.dhs.state.mn.us/main/id_054696, and offers training for case managers on helping individuals understand and access consumer-directed options by providing video conference training and materials. See http://www.dhs.state.mn.us/main/id_054699# for samples of these materials. See also DHS forms 4270 (Lead Agency CDCS Operations Manual), DHS 4317 (CDCS Consumer Handbook), and

DHS 4124 (CDC Consumer Brochure).Additional person-centered planning components are required for enrollees who elect self-directed services as reflected in DHS 4166. All forms can be found at http://www.dhs.state.mn.us/main/id_000100

Managed care organizations are required under contract to provide information to all of the enrolled members about how to access HCBS, the assessment and support planning process, the HCBS provider network available, and self-directed options.

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 enrollees who have not elected consumer-directed services.

The following applies to individual enrolled in managed care who participate in the wavier and those in FFS.

(a**) who develops the plan, who participate in the process, and the timing of the plan**
The long term care consultant/ case manager works with the enrollee and others, as directed by the enrollee, to develop and finalize the community support plan. The care plan (community support plan) must be finalized, with providers selected and services authorized, within 50 days of eligibility determination for the waiver. Family members frequently participate in the care plan development. If the enrollee has a guardian or conservator, the guardian or conservator must participate in the development of the care plan.

(b) the types of assessments that are conducted to support the care plan development process, including securing information about enrollee needs, preference and goals, and health status. The LTCC assessment process is used to inform the case manager of the individual's needs, condition, goals, and preferences. Lead agencies are required to perform the LTCC within 20 calendar days of the referral or request for services. Minnesota Statute, Section 256B.0911 governing LTCC requires assessments and community support plan development for all individuals who have long term or chronic care needs, regardless of public programs eligibility. See https://www.revisor.mn.gov/statutes/256B.0911 The LTCC may result in a determination that the individual is eligible for waiver service and meets the threshold for nursing facility level of care. The LTCC and community support plan are used and developed for initial screenings and re-evaluations.

The LTCC process includes assessment of the individual'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 LTCC/case manager 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 accessibility, safety, and sanitation
- 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 form #3427).

(c) how the enrollee is informed of the services that are available under the waiver
As described in Appendix B-7, *Freedom of Choice*, the case manager is responsible to provide information to the enrollee about waiver services and providers. Information about waiver services is also available on the department's web site. Case managers also provide information to enrollees about other services that may be appropriate (e.g., community programs, housing, state plan home care services, etc.). MCO enrollees receive waiver provider network information as part of their member materials.

(d) how the plan development process ensures that the care plan addresses enrollee goals, needs (including health care needs), and preferences
The LTCC assessment is designed be a comprehensive assessment and to summarize information about needs to inform the care plan development process. Completing the community support plan and including family members in the planning process, assists the case manager in addressing the enrollee's needs, goals, and preferences. The plan includes:

- Assessed needs and how needs will be met with informal or community-wide 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 for identified needs for which the person does not want services
- The enrollee's preferences concerning services and providers
- Back up and emergency plans as needed to address identified risks

The department provides ongoing training regarding and resources to support person-centered planning that includes addressing enrollees' strengths and preferences in the care planning process, and encourages the use of person-centered planning for all care plan development. State law requires that participants receive a copy of their written community support plan, including enrollee signatures verifying their participation in the development of, and agreement with the plan.

(e) how waiver and other services are coordinated
Minnesota Statutes, section 256B.0915 governing the waiver requires case managers to assist enrollees 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 individuals in managed care, care coordination requirements for all enrolled members underlie additional case management requirements for coordination of waiver and other services. All services must be included in the 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 enrollee's community 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 enrollee's community support plan. The amount and frequency is based on the enrollee'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. Under the consumer-directed community supports service option, enrollees determine their own quality management and monitoring plan, and individuals, such as a flexible case manager, are responsible to carry out those monitoring activities.

(g) how and when the plan is updated, including when the enrollee's needs change
Community support plans are updated any time there is a significant change in the enrollee's condition or supports that may warrant a change in services. Case managers must reevaluate level of care and care plans at least annually. Case managers also meet with enrollees as identified in the enrollees' community support plans and upon request.

The following applies to enrollees who have elected consumer-directed services.
Care planning and monitoring for enrollees who have elected CDCS are described in the CDCS service description in Appendix C-3.

The state laws, waiver manual, provider manual, bulletins, and instructional materials applicable to care plan development are available upon request.

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 LTCC assessment and care planning processes, case managers are responsible to identify a variety of needs, and to identify risks associated with these needs that may affect the enrollee's health and safety. For example, the LTCC identifies areas in which the enrollee may be vulnerable by assessing the enrollee'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 community support plan. Case managers are also responsible to develop emergency and back-up plans as necessary: this includes 24 hour plans for individuals whose needs warrant them. The emergency back up plans address issues such as emergency medical care, provider no-shows, weather conditions, etc.

The community support plan as a whole must reasonably ensure the enrollee's health and safety before it is approved by the case manager. Care plan development must also reflect personal risk management strategies when an enrollee chooses to declines a service that results in a risk related to health and safety. Under person-centered approaches, an individual has the right to assume personal risk, and the case manager is responsible to help identity those remaining risks and help the individual develop personal risk management strategies to mitigate that risk. For example, adaptive equipment may be recommendation as a strategy to mitigate risk of falls. If the individual declines, the care plan must reflect how the individual 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 certain residential providers are required to develop individual risk management plans related to their services (i.e., in addition to the comprehensive community support plan and risk management plan). The provider must review the plan at least annually and update it as needed based on the enrollee's needs and changes to the environment.

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.

Case managers are required to provide enrollees choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. Case managers are also required to assist the enrollee in the community support planning process by providing information regarding service options and choice of providers. Refer to Minnesota Statutes, Section 256B.0911 and 256B.0915. 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 enrollees. The materials are approved by the department before distribution to enrollees.

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 enrollees who are served under a FFS purchasing model, key information from the written community support plan is entered into MMIS in what is referred to as a service agreement. The service agreement is enrollee-specific and includes the name and enrollment number of each service provider, type and category, 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 enrollee 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 and we review a sample of written community support plans compared to the MMIS service agreements during county site reviews.

The community support plan is more comprehensive than the service agreement. used to authorize Medicaid-funded services. The service agreement 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 care plan audit is intended to assess whether a sample of care plans have been developed in accordance with applicable policies and procedures, and reflect required care plan elements.

During the care plan audit, which is conducted for both FFS and managed care enrollees, assessment information is reviewed to assure completion of assessment content. The care plan is then reviewed to determine whether:

1)all assessed needs are addressed in the care plan (through waiver services or other strategies, such as informal caregiving)

2)there is an assessed need associated with all services included in the care plan

3)risk management strategies are included in the care 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 individual enrolled in managed care, care 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 http://www.ncqa.org/ Click on “Publications & Products”, enter the key words “survey sampling” in the search box. 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.

It is important to note that all MCOs have agreed to use the same comprehensive care plan format and data collection protocol for waiver care plan auditing. These comprehensive care 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 Waiver Management Review process samples care plans when counties and tribes are reviewed on-site. Sampling is conducted using the sampling method described here.

Sampling Method for County/Tribe 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 Cluster Sample and a probability sample. A probability sample is differentiated by the fact that every sample element in a probability has a knowable, non-zero probability of being selected.

The first step is to select the counties for review. The lead agencies are separated into three groups based on the size of their waiver population (small, medium and large). Counties are randomly selected out of each group based on the number of counties in each group. Therefore the probability of a county being selected is based on the number of counties in a group and the number of counties selected out of that group. For example, if there were fifteen counties in Group A and two were selected the probability a Group A county being selected would be .133 repeating or 2/15.

The second step is to select the individuals to be part of the review. This is a simple random sample of the waiver recipients for the selected county. A list of waiver recipients is generated from DHS administrative data. The lists are divided by waiver and from each waiver list individuals are selected. If there are less than eight individuals on a particular waiver then all recipients are selected. Otherwise, a ten percent sample is selected with a minimum of eight recipients selected. For example, if there were one hundred EW recipients, in one of the Group A counties, the probability of any individual being selected is .1 or 10/100.

These probabilities are used to calculate the weights to be used in creating state-wide estimates. An individual's sample weight is simply the inverse of the product of their probabilities. In the above example this would be 1 / (.133 * .1) or 75.12.

The actual computation of state-wide averages, confidence level s and confidence intervals are done using the Complex Samples module of SPSS.

Given this sampling methodology, not every lead agency or county will be included in any particular state-wide estimate. This is inherent to all multi-stage samples.

Three Year Rolling Averages
The State of Minnesota decided to use a three year rolling average when reporting state-wide findings. The State decided on using a rolling average due to its ability to deliver valid and reliable multi-year estimates for small domains. The use of rolling samples is common in survey research for example the American Community Survey makes use of a rolling sample.

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
X	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

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
X	Case manager
☐	Other (*specify):*

Appendix 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 care plans and assuring that enrollee health and safety needs are reasonable addressed. Monitoring generally occurs through phone contacts and visits with the enrollee and/or service providers.

Case managers must meet face-to-face with enrollees at least annually and conduct reevaluations of level of care at least annually. Community support plans are to be updated any time there is a change in the enrollee's condition or situation that warrants a reassessment (e.g., change in caregivers' capacity) in accordance with Minnesota Statutes, §256B.0915. Additional monitoring is individualized, based on the needs of the enrollee, and occurs as outlined in the community support plan.

For CDCS enrollees, the enrollee determines the mode and frequency of monitoring activity, and who is responsible to carry out these activities. The lead agency case manager is still responsible for at least annual reevaluation of level of care and assessment of care plan adequacy.

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.
X	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 Community Support plan implementation including monitoring that the health and safety needs of the enrollee, as identified in the community support plan, are addressed. There are circumstances when the county or tribe may provide case management and other waiver services. Case managers are never allowed to be the direct provider of another waiver service. The lead agency may provide other services but the case manager role is separated from service provision. See also D-1.b. Enrollee 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 tribes require that tribal agencies offer enrollees the option of accessing waiver services through an MCO (as applicable) or county.

Quality Improvement: Service Plan

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

a. Methods for Discovery: **Service Plan Assurance/Sub-assurances**

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 care plans in which issues and needs identified in the LTCC are documented. Numerator: Number of care plans with issues and needs identified. Denominator : Number of care plans audited		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
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*	Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the

			sampling method.
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of audited MCO care plans where the care plan is developed and includes services and supports to be provided. Numerator = Number of care plans developed with services and supports included. Denominator = Number of care plans audited.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	

		☐ *Other: Specify:*	

Performance Measure:	Percent of EW case files reviewed over the most recent three SFYs in which all assessed needs are documented in the support plan. Numerator: Number of EW case files reviewed over the most recent three SFYs in which all assessed needs are addressed in the support plan. Denominator: Total number of EW case files reviewed over the most recent three SFYs		
Data Source [e.g. – examples cited in IPG] **Waiver Review Research Data Base**	***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)*
	X State Medicaid Agency	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			X Other: Describe Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description of this sampling method.
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*	
	X State Medicaid Agency	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	

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

a.i.b Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 care plans where the care plan is developed and includes services and supports to be provided. Numerator = Number of care plans developed with services and supports included. Denominator = Number of care plans audited.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
Data Aggregation	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

and Analysis	***analysis*** *(check each that applies*	***analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of audited MCO care plans where care plan is completed in a timely manner and incorporates all elements of the required care plan format. Numerator: Number of care plans completed in timely manner and incorporates all elements. Denominator: Number of care plans audited		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	

	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of EW files case reviewed over the most recent three SFYs in which the support plan is signed and dates by all relevant parties (i.e., the participant or their legal representative and the case manager). Numerator: Number of case files reviewed in which support plan is signed and dated. Denominator: Number of cases reviewed.		
Data Source [e.g. – examples cited in IPG] **Waiver Review Research Data Base**	***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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description of this sampling method.
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

	analysis *(check each that applies*	***analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.c Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 care plans where care plan is updated in required timeframes. Numerator: Number of audited care plans where care plan is updated in required timeframes. Denominator: Total number of audited care plans.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling

			methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of EW case files reviewed over the most recent three SFYs that include a support plan that has been updated within required timelines .Numerator: Number of EW case files reviewed over the most recent three SFYs that include a support plan that has been updated within required timelines. Denominator: Number of EW case files reviewed over the most recent three SFYs.		
Data Source [e.g. – examples cited in IPG] **Waiver Review Research Data Base**	***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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe Multi-stage sample: Case file sampling for

			lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description of this sampling method..
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.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.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 care plans where documentation is present for monitoring of outcomes and achievement dates. Numerator: Number of audited care plans where documentation is present for monitoring of outcomes and achievement dates. Denominator: Total number of audited care plans.		
Data Source [e.g. – examples cited in IPG] 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*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			X Other: Describe
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*	Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
	X State Medicaid Agency	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	*X Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure:	Percent of audited MCO care plans where documentation in which include documentation of a follow up plan, for contact with necessary services and supports. Numerator: Number of audited care plans where documentation is present of a follow up plan, for contact with necessary services and supports. Denominator: Total number of audited care plans.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	

State:	
Effective Date	

	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of EW case files reviewed over the most recent three SFYs that showed consistency in documentation of participant needs and services across support planning functions (i.e., continuity across screening, assessment form, support plan and service agreement). Numerator: Number of EW case files reviewed over the most recent three SFYs that include a care plan that showed consistency in documentation of participant needs and services across support planning functions (i.e., continuity across screening document, assessment form, support plan and service agreement). Denominator: Number of EW case files reviewed over the most recent three SFYs.		
Data Source [e.g. – examples cited in IPG] Waiver Review Research Data Base	***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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100%*

			Review
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description of this sampling method.
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	For participants enrolled through fee-for-service (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 SFY. Numerator: Dollar amount claimed for services provided to EW participants, per SFY. Denominator: Dollar amount encumbered for services for EW participants, per SFY.		
Data Source [e.g. – examples cited in IPG] **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:	
Effective Date	

	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*X Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*☐ Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 managed care enrollees, percent of audited care plans per CY in which documentation is present indicating the enrollee was given a choice between HCBS and institutional services. Numerator: Number of care plans audited with choice indicated. Denominator: Total number of care plans audited		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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 =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	For managed care enrollees, percent of audited care plans per CY in which documentation is present indicating the enrollee was given information to enable the enrollee to choose among providers of HCBS. Numerator: Number of audited care plans per CY in which documentation is present indicating the enrollee was given information to enable the enrollee to choose among providers of HCBS.

	Denominator: Total number of audited care plans.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the sampling method
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of EW case files reviewed over the most recent three in which participant choice was documented. Numerator: Number of EW case files reviewed over the most recent three SFYs that include a care plan in which choice is documented. Denominator: Number of EW case files reviewed over the most recent three SFYs.

Data Source [e.g. – examples cited in IPG] **Waiver Review Research Data Base**	***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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description of this sampling method..
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.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

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

The department conducts on-site lead agency reviews using an independent contractor to assist in conducting the reviews. Counties and tribes 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. See Appendix D-1, item g for a complete description of the sampling method used for this case file review.

If the department finds the county or tribe deficient in a required waiver activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan which is posted on the department website. All cases 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.

The MCO care 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. The care plan audit information also provides evidence that corrective action is required as needed.

b.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)*
	X State Medicaid Agency	*☐ Weekly*

	☐ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	*X 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.

○	**Yes** *(complete remainder of item)*
X	**No**

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

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

X	**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.
X	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

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.

Enrollees have had the option to self-direct their waiver services through the Consumer – Directed Community Supports (CDCS) service since 2004. Approximately 362 enrollees in state FY12, including those who receive waiver services through managed care, elected this option for their waiver services.

CDCS allows enrollees to design an individualized set of supports to meet their needs. The service includes four categories of supports: personal assistance; treatment and training; environmental modifications and provisions; and, self-direction support activities. Enrollees choose the level of support they want to assist them in developing care plans, monitoring services, and managing budgets and payments. This model provides more opportunity to individually tailor and arrange staffing compared to allowing an enrollee to self-direct a specific waiver service. The participants or their representatives may purchase assistance with these functions through a fiscal support entity (FE). FEs offer a range of supports as defined in the provider standards. The agreement between the FE and the participant determines who the employer of record and managing employer are. The employer of record must be identified and documented in the participant's community support plan. Flexible case managers may also provide assistance with employee- related functions as defined in the provider standards. Flexible case managers shall not be the employer of record with the exception of those operating within section 305 of the Internal Revenue Code under revenue procedure 80-4 and IRS notice 2003-70 related to government entities.

Participants or their representatives have control over the goods and services to be provided through development of the community support plan, selection of vendors, verification of service delivery,

evaluation of the provision of the service, and management of the CDCS budget. The individual budget maximum amount is set by the state by case mix cap and is published annually.
The participant or their representative will direct the development and revision of the community support plan and delivery of the CDCS services. 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 allowable goods and services that will be paid through CDCS.

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 activities that are required and those that are flexible. Required case management functions are provided by lead agencies and are not included in the participant's budget. Flexible case management service is included in the budget. Services to be provided by a flexible case manager must be specified in the community support plan as designed by the consumer.

Flexible Case Management, Direct Support Functions (included in the participant's CDCS budget):
1. If the consumer elects waiver services, provide information about CDCS and provider options.
2. Facilitate the development of a person-centered community support plan.
3. Monitor and assist with revisions to the community 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 community support plan.

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 negotiated and included in the community 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 that mitigate the participant's disability when they 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. 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 community support plan and monitored by a MHCP-enrolled physician.
(5) Expenses related to the development and implementation of the community 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 community 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).

The format of this Appendix does not accommodate the unique design of the CDCS service. Please refer to Appendix C for the CDCS service description and provider standards.

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.
X	**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:*

X	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)*:

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.
X	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 or their representative have at any time been assigned to the Minnesota Restricted Recipient program. People living in licensed foster care settings, settings licensed by DHS or MDH, or registered as a housing with services establishment with MDH are not eligible for CDCS.

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

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

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.	
X	The State provides for the direction of waiver services by a representative. 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-home, face-to-face visits twice per year, and is required to conduct quarterly reviews of expenditures and services provided, and 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

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-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority

Consumer-Directed Community Supports: treatment and training	X	X
Consumer-Directed Community Supports: environmental modifications and provisions	X	X
Consumer-Directed Community Supports: personal assistance	X	X
Consumer-Directed Community Supports: self-direction support activities	X	X
	☐	☐
	☐	☐

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:*

X	**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:*	
	X	Governmental entities
	X	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.	

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

X	FMS are covered as the waiver service entitled	Consumer Directed Community Supports
	as specified in Appendix C-3. *Provide the following information:*	
○	FMS are provided as an administrative activity. *Provide the following information:*	
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	See Appendix C, Consumer Directed Community Supports: self-direction support activities. The fees are negotiated between the participant and the FE, and documented in the community support plan. The FE must have a written agreement with the recipient that identifies the duties and responsibilities to be performed and the related charges. FE rates must be established on a fee-for-service basis. Charges to an individual consumer cannot be based on a percentage of the recipient's CDCS or payroll budget, and may not include set up or base rate or other similar charges. All FEs must establish and make public the maximum rate(s) for their services. The scope of FSE services to be provided to an individual must be determined by the consumer, and documented in the person's support plan. The rate for these services is negotiated between the recipient or the recipient's representative and the FSE and is included in the Community Support Plan.	
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	These services are included in the global CDCS budget, under the category of consumer-	

	directed community supports: self-direction support activities	
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*	
	Supports furnished when the participant is the employer of direct support workers:	
	X	Assist participant in verifying support worker citizenship status
	X	Collect and process timesheets of support workers
	X	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:	
	X	Maintain a separate account for each participant's participant-directed budget
	X	Track and report participant funds, disbursements and the balance-of participant funds
	X	Process and pay invoices for goods and services approved in the service plan
	X	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
	Additional functions/activities:	
	X	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	X	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	X	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 the readiness review and certification process, the community support planning process, and the FE recertification process. Initially the State required FE recertification every 2 years, but it now occurs between 3 and 4 years, unless an earlier review is indicated.	

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)*:

X	**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: self-direction support activities, under the subcategory of flexible case management. 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 consumer 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 - Determine whether the participant's community support plan and the CDCS support plan will reasonably ensure health and safety needs are expected to be met. - Determine if the 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 community 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 parent of a minor participant or spouse of a participant). - Monitor the maintenance of financial records, and the management of the budget and services - Provide technical assistance regarding budget and fiscal records management and take corrective action if needed - Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction - Contract with FE providers and monitor FE provider's performance - 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 (flexible case management) that are included in the CDCS budget: - If the consumer elects waiver services, provide information about CDCS and provider options - Facilitate development of a person centered community support plan - Monitor and assist with revisions to the community 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 community support plan.
X	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: Consumer Directed Community Supports
☐	**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:*

k. Independent Advocacy *(select one)*.

○	**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*:
X	**No.** Arrangements have not been made for independent advocacy.

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 community 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

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

The case manager will initiate a revision of the community support plan in order to provide waiver services other than CDCS. CDCS services are not available to an individual or representative who has at any time been restricted by the Minnesota Restricted Recipient Program. Also, if a CDCS participant exits with the waiver more than once during a service plan year, the participant is ineligible for CDCS services for the remainder of that service plan year. Finally, a participant can become ineligible for CDCS services by moving to a residential setting licensed by DHS or MDH, because CDCS services are not available to residents at these sites.

In these situations, the full array of traditional waiver services is available to the participant, and the lead agency case manager is responsible for revision of the care plan and arranging for waiver

services. There are no gaps in service availability during the transition.

- Involuntary exit procedures can be used to address:
- Immediate health and safety concerns
- Maltreatment of consumers
- Suspected fraud or misuse of funds
- Inability to implement the approved support plan or comply with CDCS requirements despite reasonable efforts to provide additional technical assistance and oversight as described below.

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

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	State note: Since CDCS is available to all waiver participants as a service option, the department has not established participation goals for this service, Minnesota can report to CMS the number of participants who elect CDCS as their waiver service option. Since the amount of control as employer of record and over budget is available along a continuum rather than under an either/or model, it is not possible to assign individuals who do elect CDCS to one of these categories.	
Year 2		
Year 3		
Year 4 (renewal only)		

Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

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. *Check each that applies:*

X	**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; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:*
	The Fiscal Support Entity Serves as the co-employer
X	**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. *Check the decision making authorities that participants exercise*:

X	Recruit staff
X	Refer staff to agency for hiring (co-employer)
X	Select staff from worker registry
X	Hire staff (common law employer)
X	Verify staff qualifications
X	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Background checks are paid outside the participants CDCS budget
X	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
X	Determine staff duties consistent with the service specifications in Appendix C-3.
X	Determine staff wages and benefits subject to applicable State limits
X	Schedule staff
X	Orient and instruct-staff in duties
X	Supervise staff
X	Evaluate staff performance
X	Verify time worked by staff and approve time sheets

X	Discharge staff (common law employer)
X	Discharge staff from providing services (co-employer)
X	Other *(specify)*:
	An individual can elect to perform some or all of the activities listed. Some can be assigned by the consumer to the FE, or to a support planner.

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. *Check all that apply***:**

X	Reallocate funds among services included in the budget
X	Determine the amount paid for services within the State's established limits
X	Substitute service providers
X	Schedule the provision of services
X	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
X	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
X	Identify service providers and refer for provider enrollment
X	Authorize payment for waiver goods and services
X	Review and approve provider invoices for services rendered
X	Other *(specify):*
	An individual can elect to perform some or all of the activities listed. Some can be assigned by the consumer to the FE, or to a support planner

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. These 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 community support plan.

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.

iv. Participant Exercise of Budget Flexibility. *Select one:*

X	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:
	The person's Community Support Plan will provide the foundation for purchase and delivery of services and achievement of individually desired results. The plan must include certain characteristic elements: • A summary of assessed needs • The person's desired service outcomes or results • How the result or outcome will be achieved/how the need will be met (description of services) • What training and qualifications are required for staff • How the service will be monitored, and • The budget The individual's budget must be planned for a 12 month period and 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 back ground studies. Any service plan that is less than a year must be prorated. These elements or parameters that are defined in the Community Support Plan cannot be altered without agreement from the lead agency. If a requested or proposed revision will result in a change or modification of the approved parameters of a Community Support Plan, the consumer or their legal representative will work with the lead agency to reviewed and approve requested changes. The lead agency must respond to a request to change the approved plan within 30 days of the request submitted by the consumer. A change in the plan that requires approval and/or authorization by the lead agency cannot be implemented nor paid for until lead agency approval has been received by the consumer. The recipient or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the lead agency, when the revision does not change or modify the parameters authorized by the lead agency case manager in the Community Support Plan. For example, within the approved Community Support Plan parameters and approved budget, the recipient has the flexibility to: • Change caregivers (with the exception to deciding to pay a spouse or parent if not previously authorized) • Hire additional caregivers • Change the days or times of service • Pay a business instead of staff (e.g. the local laundry instead of personal assistant) • Grant wage increase to personal assistant up to maximum permitted • Pay one caregiver who has more experience a higher rate, etc. However, the

	caregiver(s) must meet the qualifications and training requirements that the county agency approved in the Community Support Plan
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

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 community support plan to determine if it meets the criteria in Appendix C- All goods and services to be covered by CDCS must be specified in the community 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 community 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 community support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved community support plan.
4) Review expenditures and the participant's health and safety at least once per quarter when a parent of a minor or 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 community 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 community 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' community support plan 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 under42 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 table identifies how enrollees are informed of their fair hearing rights. There are slight differences in the notification processes and documents between enrollees 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 clients. All forms are available on the departments web site at: http://www.dhs.state.mn.us/id_000100

How Information is Provided	FFS	Managed Care
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 waiver services, when a care plan is approved, and when a service is reduced, suspended or terminated. Enrollees may also submit fair hearing requests if they feel that they have not been offered free choice of provider.	X	X
Managed care enrollees: Each year during open enrollment, the department sends managed care enrollees fair hearing information. This information is also sent when there are legislative changes that may affect enrollees' services. Managed care enrollees also receive a certificate of coverage at enrollment, and annually thereafter, that includes their rights and fair hearing information.		X
All participants: Legislative information is forwarded to all participants when there are legislative changes that may affect the individual's waivered services.	X	X
All participants: The department publishes a handbook for enrollees and families, "*Older Minnesotans, Know Your Rights About Services,*" DHS form 4134. The handbook includes information about fair hearing rights and is available on the department's web site and through lead agencies.	X	X
Fee-for-service participants: Each service authorization, and all subsequent changes to services authorizations, generates a letter created by MMIS	X	

forwarded to FFS enrollees that includes information about fair hearing rights All participants: Fair hearing information is available on the department's web site at: http://www.dhs.state.mn.us/main/iid_008649	X	X

Notices Provided

The following forms are used to provide fair hearing information:

Minnesota Health Care Programs Application, DHS form 3417, 11/11. This form is used to apply for Medical Assistance and includes fair hearing rights.	X	
Notice about your Rights For People Enrolled in a Health Plan, DHS form 4173, 6/11. This notice is provided to individuals who inquire about enrolling in managed care. This notice explains enrollee rights for managed health care programs including Medical Assistance and MSHO. As mentioned above, managed care enrollees also receive a certificate of coverage at the time of enrollment, and annually thereafter, which provides information regarding enrollees' rights including fair hearing rights.		X
Ombudsman for State Managed Health Care Programs DHS form -6507 6/12 – 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.		X
Notice of Action Home and Community-Based Waiver Programs and AC, DHS form 2828, 11/10. This form is provided to enrollees when there is a denial, decrease, or termination in waiver services and to notify the recipient of the program or service of their appeal rights regarding the action(s) This form also informs clients that their benefits may continue while the appeal is under consideration.	X	
Denial, Termination and Reduction notice. MCOs are required to inform enrollees 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 enrollees.		X
Application For Title XIX Home and Community Based Waiver Services and Alternative Care Program Information and Signature Sheet, DHS form 2727 9/11. Or a county form that acknowledges the client received a notice of the right to appeal. This form also informs clients that their benefits may continue while the appeal is under consideration.	X	

State Law and Polices The department's policies and instructions regarding notice of action are available in the web-based Provider manual and the *Disability Services Program Manual/Community Based Services Manual*, in the *Appeals* section of the manual. Information regarding fair hearing notice is also in the Minnesota Health Care Programs (MHCP) Provider Manual. Refer to Minnesota Statutes, §256B.0915, subd. 4 for regulations concerning fair hearings. These manuals can be found at http://www.dhs.state.mn.us/main/Manuals	X	X

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*:

X	**Yes**. The State operates an additional dispute resolution process *(complete Item b)* Note: For individuals who are enrolled in managed care, the MCOs must provide an alternative dispute resolution process.
○	**No**. This Appendix does not apply (*do not complete Item b)*

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 individuals who are enrolled in managed care, the MCOs must provide an alternative dispute resolution process. Enrollees may request a fair hear through the department or they may file an appeal or grievance directly with their MCO. Enrollees' 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 for trends and patterns.

In addition, enrollees 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 enrollee with filing an appeal or grievance with the MCO or requesting a fair hearing through the department.

Enrollees 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-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

X	**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 *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

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 enrollees
County and tribal agencies
The Office of the Ombudsman for Older Minnesotans
The Office of the Ombudsman for Mental Health and Developmental Disabilities
The Minnesota Department of Health, Office of Health Facilities and Complaints
The Minnesota Department of Human Services, Surveillance and Integrity Review Unit
The Minnesota Department of Human Services, Licensing Division

For Managed care Enrollees
In addition to all of the above, MSHO and MSC+ enrollees may also report grievances or complaints to the Office the Ombudsman for State Managed Health Care Programs.

As discussed in response to Appendix F-2(b), MSHO and MSC+ enrollees may also file a grievance or appeal with the managed care organization. Contracts between the department and the MCO provide timelines that enrollees 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. Enrollees' 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 an enrollee reports a concern to any of the entities noted below (i.e., an enrollee may concurrently work to resolve an issue via an Ombudsman and request a fair hearing). 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 enrollee 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 Facilities and Complaints, addresses complaints and allegations concerning providers or managed care organizations that they license (e.g., home care agencies, residential care providers, etc.) to determine if an investigation is warranted. If there is an indication that an individual in is imminent jeopardy, the local common entry point for vulnerable adult maltreatment reporting may initiate immediate protective services.

The Office of Health Facilities and 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 Unit 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 findings. If an enrollee is determined to be in imminent jeopardy, action is taken as soon as possible to address the person's health and safety.

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*:

X	**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).

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, §626.557 and 626.5572 at www.revisor.mn.gov/statutes/626.557 and www.revisor.mn.gov/statutes/626.5572

Critical events or incidents required to be reported as maltreatment include, but are 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**.**

Immediate reporting is required by mandated reporters of suspected maltreatment. Reports are made to the common entry point (CEP) established as required in statute by each county to receive reports of maltreatment. The county's CEP operates on a 24-hour basis to allow for immediate mandatory reporting of 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.

Maltreatment reports are forwarded by the CEP to the lead investigative agency responsible under

statute for investigation and for protective services. Lead investigative agencies include the Department of Human Services, the Department of Health, counties, and law enforcement. If the maltreatment report identifies that the enrollee's health and safety are in immediate jeopardy, the CEP also contacts the county Adult Protection division to arrange emergency protective services.

Complete information about the role of the Common Entry Point, referral to other agencies for investigation, and policies and practice requirements for county investigations can be found at http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_139381.pdf

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.

The department provides training to counties, tribes and MCOs regarding vulnerable adult reporting, triage, and follow-up, including training for waiver case managers. The department offers an online training course on Vulnerable Adult Mandated Reporting, at http://registrations.dhs.state.mn.us/WebManRpt and publishes a vulnerable adult brochure "*Help protect people who are frail or vulnerable*" (DHS 2754). The brochure includes information about what may be considered abuse, neglect, and exploitation, and how to report concerns.

The department publishes a handbook for enrollees and families, "*Older Minnesotans, Know Your Rights About Services*," DHS form 4134. The handbook includes information about enrollees' 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. The brochures are also available through lead agencies, who provide copies during waiver screenings. All DHS forms, including consumer products, can be found at http://www.dhs.state.mn.us/main/id_000100

The Long Term Care Consultation tool assessment used to determine waiver eligibility (DHS 3428) contains assessment questions intended to help discover any risk for maltreatment the applicant maybe experiencing. An assessor 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 and Disability Linkage Lines (SLL and DLL) 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 DLL can be seen at http://www.mnaging.org/advisor/SLL.htm and at

http://www.dhs.state.mn.us/main/id_056508 respectively.

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 enrollees who receive services through a home health care agency. This includes enrollees who receive customized living services. Routine licensing reviews of providers include monitoring that enrollees are informed of their rights as required. The Home Care Bill of Rights, including copies in other languages, can be accessed at http://www.health.state.mn.us/divs/fpc/consumerinfo/0904MN_HCBOR_engreg.pdf

Foster care providers are required to complete an "Individual Residential Placement Agreement" as defined in MN Rule, 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.

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.

Incidents of suspected abuse, neglect, or exploitation are reported to the common entry point (CEP) established by each county. While the CEP is responsible to take all reports and forward to the respective investigative agency, during this process the CEP staff also screen all reports for immediate risk and make all necessary referrals. 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 two working days. The lead investigative agency provides information, upon request of the reporter, within five working days as to the disposition of the report. Each lead investigative agency evaluates reports based on prioritization guidelines. The department has made a structured decision making tool available to county lead investigative agencies to promote safety through consistent, accurate and reliable assessment of safety needs.

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.

Lead investigative agencies have 60 calendar days to complete the investigation. Lead investigative agencies cooperate with law enforcement in investigation.

The lead investigative agency is responsible to notify the proper agencies or individuals of the findings. Enrollees, who are the subject of reports, or their legal surrogate with appropriate authority, are informed of the findings of the investigation at 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. Referrals for criminal prosecution may result. 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 : http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm and DHS Licensing : http://licensinglookup.dhs.state.mn.us/

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 reporting data collection system housed within the Social Services Information System (SSIS). This system stores adult maltreatment reports for the Common Entry Point (CEP). All of Minnesota's 87 county-based CEPs receive reports of suspected Vulnerable Adult (VA) maltreatment and are required to enter their VA maltreatment reports into SSIS. This system supports county functions related to vulnerable adult report intake, report distribution to the agency responsible for investigation, 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, supplies comprehensive and timely maltreatment information to the DHS, allows the department to review maltreatment incidents statewide and analyze by waiver participation, provider and agency responsible for follow-up. Data from SSIS is drawn on a quarterly and annual basis. This allows the DHS to review data and analyze for patterns and trends including waiver specific patterns and trends that may be addressed through the department and partners in maltreatment response and prevention, or policy. 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 enrollees 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 CEP reports, and findings from county investigations. Findings from DHS Licensing investigations are expected to be incorporated into the data mart by August, 2013. DHS continues to work to finalize integration of findings from the Department of Health as well. Data from these agencies is available by DHS request until this integration is complete.

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:
http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm
and
DHS Licensing : http://licensinglookup.dhs.state.mn.us/

Lead investigative agencies provide DHS with the names of substantiated perpetrators for a registry maintained by DHS. These responses and protections from maltreatment are gathered statewide and are not county nor program dependent. DHS continues to work with investigative agencies to improve systematic integration of investigative findings for analysis in DHS' data warehouse.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

X	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or 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. See G-1-b for reporting requirements, G-1-d for review of and response to reports, and G-1-e for oversight of reporting, review and response.
○	The use of restraints or seclusion 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 or Seclusion. 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 or 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 restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

X	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. See G-1-b for reporting requirements, G-1-d for review of and response to reports, and G-1-e for oversight of reporting, review and response.
○	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-a-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-3: Medication Management and Administration

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:

X	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not 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 enrollee's community 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 care planning of whether and which provider is able to reasonably meet the medication management needs identified in the participant's community support plan. The waiver includes enrollees who receive on-going services in foster care homes, customized living, and residential care services. These providers have on-going responsibilities related to monitoring enrollees 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 enrollee. The operator's compliance with requirements related to medication management is reviewed during routine licensing visits.

Customized Living
Providers of customized living must have a Class A or F home care license issued by the Minnesota Department of Health. The home care license addresses medication set-up , administration and monitoring.

Residential Care
Providers who furnish residential care in settings where 80% of the residents are 55 or older must have a board and lodge license and be registered as housing with services establishment and be licensed as a home care provider under Class A, B or F.

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, and primary care physicians. For individuals in managed care, medication management is part of care coordination requirements for all enrollees. In addition, medication set up and administration assistive devices can be utilized for individuals who can benefit from this level of assistance.

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

In order to store and dispense medications, the foster care operator must have a written statement from the enrollee's physician, permission from the enrollee or their representative, written instructions if needed beyond the labeling instructions, and must maintain a record. The record must include: medication information; consequences if the medication is not taken as directed; adverse reactions to the medication that must be reported to the physician; instructions from the physician indicating when the physician must be notified if a medication is not taken or administered as prescribed; a notation of when a medication was started, changed, or discontinued; and a notation of any reports made to the physician.

The regulations also address medication storage, and reporting requirements to the case manager and legal representative. Additional requirements apply for medications that are administered through injection(s).

Home care agencies follow practice standards under both the Board of Nursing and home care certification requirements related to medication management.

Customized Living

Only licensed nurses, physicians, or pharmacists may set up medications. Nurses must meet training requirements to administer medications. Medication monitoring requirements differ slightly depending on the type of home care license the provider holds (Class A or F), but both require monitoring by a licensed nurse. Provider's compliance is monitored through surveys conducted by the Minnesota Department of Health.

Residential Care

Residential care providers who are licensed as a Class A, B or F home care agency must follow their home care licensure standards related to medication management. The home care Class A and F license sets standards for medication set up, reminders, administration, and record keeping. Providers who have a Class B home care license may provide medication reminders when a licensed nurse is on site in the establishment for at least four hours a week to monitor the health status of residents. Providers who have a Class B license cannot provide medication set up or administration.

Case managers are responsible to develop a community support plan that identifies and addresses the participant's health and safety needs and conduct monitoring reviews at least annually.

Physicians 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 4 or more prescriptions to treat or prevent 2 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:

- Performing or obtaining necessary assessments of the participant's health status;
- Formulating a medication treatment plan;
- Monitoring and evaluating the participant's response to therapy, including safety and effectiveness;
- Performing a comprehensive medication review to identify, resolve, and prevent medication related problems, including adverse drug events;
- Documenting the care delivered and communicating essential information to the participant's other primary care providers;
- Providing verbal education and training designed to enhance participant understanding and appropriate use of participant's medications;
- Providing information, support services, and resources designed to enhance the participant's adherence with their therapeutic regimens;
- Coordinating and integrating medication therapy management services within the broader health care management services being provided to the participant.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

X	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)* State note: This applies to providers who provide foster care, residential care, customized living and state plan home care as described above.
○	Not applicable (*do not 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).

Foster Care
Medication management for foster care providers is governed by Minnesota Rules, parts 9555.5105 to 9555.6265.

Customized Living
Providers licensed as Class A and F home care providers may administer, set up, or provide reminders to enrollees to take medications. Licensing standards govern medication management including record keeping and storage. Refer to Minnesota Statutes, §144A.43 through 144A.49 for class, Minnesota statutes §144A.4605, and Minnesota Rules 4668 and 4669.

Residential Care
Providers licensed as Class A and F home care providers may administer, set up, or provide reminders to enrollees to take medications. Licensing standards govern medication management including record keeping and storage. Refer to Minnesota Statutes, §144A.43

through 144A.47 for class, Minnesota statutes §144A.4605, and Minnesota Rules 4668 and 4669.

Providers licensed as Class B home care providers may provider medication reminders when a licensed nurse is on site in the establishment for at least four hours a week to provide monitoring the health status of residents. Providers who have a Class B license cannot provide medication set up or administration. Refer to Minnesota Statutes, §144A.43 through 144A.47 for class, Minnesota statutes §144A.4605, and Minnesota Rules 4668 and 4669.

The definition of abuse and neglect in the Vulnerable Adult Reporting Act includes mandatory reports to the common entry point in each county responsible to arrange emergency protective services and forward the report for investigation to the appropriate lead investigative agency. Mandated to be reported as maltreatment are actions that cause physical pain, injury or the failure or omission of a caregiver who has assumed responsibility to provide health care or supervision. This may include reports related to medication management issues.

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:
X	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:
	Foster Care As described above, 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. Customized Living Providers with a Class F home care license are required to keep a record of all medications that were not administered as prescribed. Residential Care Not applicable because providers do not administer medications. Home care: Medication error reporting is governed by 144. Some medication errors may also be required to be reported through the CEP as maltreatment under 626.557 if the impact of the error meets the definitions of reportable maltreatment.

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 licensing (with some review activities delegated to counties). Customized living providers are licensed by the Minnesota Department of Health

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: **Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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 managed care enrollees, percent of audited care plans per CY in which identified health and safety risks and what to do in the event of an emergency are documented. Numerator: Number of audited care plans per CY in which identified health and safety risks and what to do in the event of an emergency are documented. Denominator: Total number of audited care plans.		
Data Source [e.g. – examples cited in IPG] **Care Plan Audit Research Data Base**	***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*	*XLess than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	X Other: Specify:	*X Annually*	
	MCO	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Sampling methodology is that approved by NCQA for auditing in MCOs. See Appendix A, item 6 for a more complete description of the

			sampling method.
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Add another Data Source for this performance measure

Performance Measure:	Percent of EW case files reviewed over the most recent three SFYs in which a participant's assessed health and safety issues are documented in the support plan. Numerator: Number of EW case files reviewed over the most recent three SFYs in which a participant's assessed health and safety issues are documented in the support plan. Denominator: Total number of EW case files reviewed over the most recent three SFYs.		
Data Source [e.g. – examples cited in IPG] **Waiver Review Research Data Base**	***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)*
	X State Medicaid Agency	*☐ Weekly*	*☐ 100% Review*
	☐ Operating Agency	*☐ Monthly*	*X Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			X Other: Describe
			Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two- stage sampling plan. See Appendix A. item 6 for a more complete description

			of this sampling method.
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*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

Performance Measure:	Percent of EW participants per SFY who are not victims of substantiated maltreatment. Numerator: Number of EW participants per SFY who are not victims of substantiated maltreatment. Denominator: Number of EW participants per SFY.		
Data Source [e.g. – examples cited in IPG] **Other: Social Services Information System (DHS warehouse); DHS-Licensing investigation memoranda; MDHOHFC investigative reports .**	***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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and***	***Frequency of data aggregation and***	

	analysis *(check each that applies*	***analysis:*** *(check each that applies*	
	X State Medicaid Agency	*☐ Weekly*	
	☐ Operating Agency	*☐ Monthly*	
	☐ Sub-State Entity	*☐ Quarterly*	
	☐ Other: Specify:	*X Annually*	
		☐ Continuously and Ongoing	
		☐ Other: Specify:	

a.ii If applicable, in the textbox below provide any necessary additional information on the

Add another Performance measure (button to prompt another performance measure)

a.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

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

Maltreatment Report Investigations: Adult Protection. When a report of suspected maltreatment is received, the local intake agency determines the agency responsible to assess and investigate the alleged maltreatment (the lead investigative agency) and forwards the report for investigation, determination and final disposition. 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.

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 using an independent contractor to assist in conducting the reviews. Counties and tribes 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. See Appendix D-1, item g for a complete description of the sampling method used for this case file review.

If the department finds the county or tribe deficient in a required waiver activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan which is posted on the department website. All cases 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. 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.

b.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)*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other: Specify:	*X 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 Health and Welfare that are currently non-operational.

○	**Yes** *(complete remainder of item)*
X	**No**

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: Systems Improvement

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 QMS 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;
- 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

H.1 Systems Improvement

H.1.a.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 Continuing Care Administration's Quality Essentials Team (QET) will meet twice a year to 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. The QET is responsible for integrating performance measurement and remediation association with monitoring data, and recommendations for systems improvements strategies, when such strategies are indicated for a specific program, and/or when the Department can benefit from strategies that impact individuals served under all HCBS programs,
Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the Policy Review 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.

The DHS Continuing Care Administration's Quality Essentials Team (QET) will meet twice a year to review and analyze collected performance measure and remediation data ("monitoring data") according to the process outlined below. Problems or concerns requiring intervention beyond existing remediation processes (i.e. system .improvement) are directed to the Policy Review Team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

- 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 Review 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.

H.1.a.ii

System Improvement Activities	***Responsible Party*** *(check each that applies*	***Frequency of monitoring and analysis*** *(check each that applies*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Quality Improvement Committee	*☐ Annually*
	☐ Other: Specify:	*X Other: Specify:*
		Twice a year

H.1.b.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, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. 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 Policy Review 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 http://dashboard.dhs.state.mn.us/default.aspx
- annually providing information to DHS-CCA quality management-related stakeholder bodies; and
- mandated legislative reports.

H.1.b.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-CCA leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix I: Financial Accountability

APPENDIX 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+ enrollees 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 tribe agency in the service agreement. The service agreement is based on the enrollees' care plan and includes rates, time spans, number of units authorized, service type and category, and provider. The claim must also correspond with Medicaid and waiver eligibility files that include edits related to where the enrollee resides (living arrangement). 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 (SIRS) unit 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.

Each month enrollees 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, counties, 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.

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.

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: **Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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 managed care enrollees, percent of MCO member months for whom waiver capitation was paid based on program eligibility as identified in the screening document, per SFY		
Data Source [e.g. – examples cited in IPG]	***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)*
	X State Medicaid Agency	*☐ Weekly*	*X 100% Review*
	☐ Operating Agency	*☐ Monthly*	*☐ Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*☐ Annually*	
		X Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
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*	
	X State Medicaid Agency	*☐ Weekly*	

	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Performance Measure:	For participants enrolled through FFS, percent of EW claims paid for services provided to EW participants for which there is corresponding prior authorization, per SFY		
Data Source [e.g. – examples cited in IPG] ***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)*
	X State Medicaid Agency	☐ *Weekly*	*X 100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
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*	
	X State Medicaid Agency	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		X Continuously and Ongoing	
		☐ *Other: Specify:*	

a.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 results 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

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

No remediation is required. The criteria for financial oversight is met through MMIS edits in place that ensure compliance with the reimbursement methodology specified in the approved waiver.

b.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)*
	X State Medicaid Agency	*☐ Weekly*
	☐ Operating Agency	*☐ Monthly*
	☐ Sub-State Entity	*☐ Quarterly*
	☐ Other: Specify:	*☐ Annually*
		X 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.

○	**Yes** *(complete remainder of item)*
X	**No**

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 I-2: Rates, Billing and Claims

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 MSHO or MCS+ enrollees or enrollees who have elected the CDCS option. Managed care organizations receive capitation payments for service provided to MSHO and MSC+ enrollees. Payment rates for enrollees who elect CDCS are negotiated within an individualized budget amount.

For enrollees who are not enrolled in CDCS and who do not receive waiver services through managed care, the department sets rates for home care services and personal care assistant services. The department also sets rates for case-management services. Effective in 2009, counties, health plans and tribes must use a standardize tool developed by the department to set rates for customized living services. State law currently limits the customized living component rates and establishes maximum customized living service rates. For all other waiver services, the department sets a per-unit limit in MMIS (referred to as a rate file limit). Counties and tribes are allowed to authorize services in an amount based on the enrollee's needs as identified in their LTCC, using rates at the maximum unit rate. Beginning 1/1/2014 lead agencies will be required to use the state unit rates for services. Customized living rates will continue to be set using the customized living rate tool. If a county/tribe enters a service rate that exceeds the rate file maximum, MMIS will not allow it to be authorized. In addition, as described in Appendix B-2: "Individual Cost Limit," all waiver services must be authorized within the enrollee's case mix budget limit.

Rate changes are made by the legislature and are published in the State Register. These rates may be periodically increased or decreased legislatively.

The state laws that govern payment rates are available upon request.

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.

c. Certifying Public Expenditures *(select one)*:

○	**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 (*check each that applies*):	
	☐	**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.*)
X	**No**. State or local government agencies do not certify expenditures for waiver services. Qualifying statement: There are no certified public expenditures related to waiver services, although counties certify administrative costs related to Medicaid, which includes administration of waivers	

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 enrollee's community 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 enrollee's Medical Assistance and waiver eligibility date spans).

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.

The department and providers maintain records for a minimum of three years.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

X	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS). For MHSO and MSC+ enrollees, MCOs receive a capitation payment for services. The basic capitation amount is based on county of residence, living arrangement, Medicare status and waiver status. For enrollees who receive waiver services, the capitation includes an add-on amount for waiver services. The capitation payments are actuarially sound and approved by CMS as required by federal regulations
○	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) 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:

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*):

X	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:

X	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.
	For MSHO and MSC+ enrollees, Medicaid services that are not included in the managed care contract are covered fee-for-service and fee-for-service policies apply

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:*

X	**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.

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

X	**Yes.** State or local government providers receive payment for waiver services. 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. *Complete item I-3-e.*
	For example, county-owned hospitals and nursing facilities may provide services such as home-delivered meals or respite care. Counties/tribes provide case management and other services such as home health
○	**No**. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

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*:

X	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:

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:*

X	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.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**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.
X	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**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:
X	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

X	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.
	As explained on in the waiver description on page 6 most Medicaid enrollees who are 65 or older are required to enroll in managed care in a program called Minnesota Senior Care Plus (MSC+). As an alternative, people 65 and older who are required to enroll in managed care may elect to enroll in Minnesota Senior Heath Options (MSHO). MSHO is authorized under §1915(a) It is a voluntary managed care program that integrates Medicaid and Medicare coverage (including medications), provides comprehensive care coordination, and is available statewide. For MSHO enrollees, waiver services are covered through the managed care organization. The managed care organization is responsible to furnish state plan and waiver services based on enrollees' needs. The managed care organization is paid a capitation based on a rate cell for each enrollee.
X	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. Qualifying statement: The mandatory managed care program is MSC+
○	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

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. *Check each that applies:*

X	**Appropriation of State Tax Revenues to the State Medicaid agency** Qualifying statement: The non-federal share of most Medicaid payments, including all waiver services, is paid from an appropriation from the General Fund.
☐	**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:

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. *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:
X	**Not Applicable**. There are no local government level sources of funds utilized as the non-federal share. Qualifying statement: The non-federal share of county costs to administer waiver programs is paid from county revenues and certified as a Medicaid administrative expenditure

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:*

X	None of the specified sources of funds contribute to the non-federal share of computable waiver costs. Qualifying statement: As explained above, the non-federal share of waiver services is paid with general appropriation to the department	
○	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-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. (*Do not complete Item I-5-b*).
X	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

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:

Lead agencies establish rates for residential service. They exclude costs related to room and board in these settings.

APPENDIX 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:

○	**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:*
X	**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.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

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:*

X	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*). Qualifying statement: No co-payments are charged for waiver services.
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

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)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

X	**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

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
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 (Column 7 less Column 4)**
1							
2							
3							
4							
5							

Appendix J-2 - Derivation of Estimates

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:	Level of Care:
Year 1			
Year 2			
Year 3			
Year 4 (renewal only)			
Year 5 (renewal only)			

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-d.

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 for these estimates is as follows:

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:

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:

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:

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

○	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

ii. Estimate of Factor D – 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.

Waiver Year: Year 1						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
	☐					
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	☐					
	☐					
	☐					
	☐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
	☐					
	☐					
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	☐					
	☐					
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	☐					
	☐					
	☐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
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	☐					
	☐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
	☐					
	☐					
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	☐					
GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
Waiver Service	**Check if included in capitation**	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
	☐					
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						