1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

The services provided under the Community First Services and Supports benefit are :
(1) Personal Care Assistance
(2) Personal Emergency Response Systems (PERS)
(3) Individual Directed Goods and Services
(4) Financial Management Services

2. Concurrent Operation with Other Programs. *(Indicate whether this benefit will operate concurrently with another Medicaid authority):* ***Select one*:**

☐	**Not applicable**
☒	**Applicable**
Check the applicable authority or authorities:	
☒	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1):* BluePlus, HealthPartners, Itasca Medical Care, Medica, Prime West Health, South Country Health Alliance, UCare[1] *(b) the geographic areas served by these plans:* See map of plan choices by county https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4840-ENG *(c) the specific 1915(i) State plan HCBS furnished by these plans:* Personal Care Assistance, Personal Emergency Response Systems (PERS), Individual Directed Goods and Services and Financial Management Services. *(d) how payments are made to the health plans:* Payments are made through capitations. *(e) whether the 1915(a) contract has been submitted or previously approved:* Upon approval of this state plan amendment, Minnesota Senior Health Options (MSHO) contracts will be amended to include the revised services.

☒	**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:* The 1915(b) waiver application for Minnesota Senior Care Plus (MSC+) program will be submitted in conjunction with this 1915(i) application.		
Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§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 §1115 of the Act.** *Specify the program*:		

[1] These plans are known as Minnesota Senior Health Options (MSHO) plans with voluntary enrollment for duals. These plans will also incorporate the 1915(i) benefit.

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit- *(Select one):*

☒	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	☒	The Medical Assistance Unit *(name of unit)*:	Health Care Administration
	☐	Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)* *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
☐	The State plan HCBS benefit is operated by *(name of agency)* 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 State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approvespolicies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☑	☑
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☐	☑	☑
4 Prior authorization of State plan HCBS	☑	☐	☑	☑
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☐	☐

Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Function 1: Individual State plan HCBS enrollment:

County agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that assist individuals not enrolled in an MCO with enrolling in HCBS.

Managed care organizations (MCO) are the contracted entities that assist individuals aged 65 and over who are enrolled in managed care to enroll in HCBS.

Function 3: Review of participant service plans:

Consultation service providers are the contracted entities that conduct an initial review of service plans for all individuals electing the benefit. In supporting the person, they will review whether the plan meets assessed needs and contains only covered services.

County agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that review service plans for participants not enrolled in an MCO. The state Medicaid agency provides oversight of counties and tribal human services agencies through lead agency audits and reviews. The review process includes an audit of a representative sample of approved service plans. For more information on this process please see the section on the Process for Making Person-Centered Service Plans Subject to the Approval of the Medicaid Agency section.

Managed care organizations (MCO) are the contracted entities that review participant service plans for individuals aged 65 and over who are enrolled in managed care. The state Medicaid agency provides oversight of MCOs through audits and reviews of a representative sample of approved service plans. For more information on this process, please see the section on the Process for Making Person-Centered Service Plans Subject to the Approval of the Medicaid Agency section.

Function 4: Prior authorization of state plan HCBS:

Counties agencies and tribal human services agencies under interagency agreement with the SMA are the local non-state entities that conduct prior authorizations of HCBS for those not enrolled in an MCO.

Managed care organizations (MCO) are the contracted entities that conduct prior authorization of state plan HCBS for individuals age 65 and over who are enrolled in managed care.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations,assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The SMA retains oversight for all operational and administrative functions and ensures adherence to the regulatory requirements set forth in 42 C.F.R. § 441.730(b).

Consultation service providers are the entity contracted with the SMA that furnish supports to individuals to develop their person-centered service delivery plan (plan of care). Only these entities may provide consultation services. All individuals are advised of their right to choose any contracted consultation service provider. Consultation service providers must comply with conflict-of-interest standards as outlined in their contract and provided in federal and state law.

Agencies that provide Consultation Services may also enroll to provide Medicaid services. However, Consultation service providers are prohibited from providing any other service to any individual they serve under consultation services.

The Consultation Service provider must notify each individual in writing that it cannot provide any other service to that individual. Consultation service providers must sign an assurance statement to ensure adherence with conflict-of-interest provisions.

SMA oversight is provided through contract monitoring, training, policy direction, enrollment criteria and service plan audits as outlined in this SPA.

The SMA conducts audits annually at the Consultation service provider level as outlined in the Quality Improvement section of this SPA. Audits include a review of service delivery plans to ensure they contain required elements and ensure required conflict of interest provisions are applied.

Additional participant safeguards related to conflicts of interest include:

- conflict of interest protections outlined in state statute related to person-centered planning;
- individuals are supported in exercising free choice of provider and are provided information on the full range of 1915(i) services; and
- individuals are educated on rights and protections related to development of their person-centered plan.

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒**No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒**Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.** *(Specify for year one. Years 2-5 optional):*

Annual Period	From	To	Projected Number of Participants
Year 1	~~06~~10/01/2024	09~~5~~/30~~1~~/2025	2957
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒**Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☒ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) ofthe Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

☒	Directly by the Medicaid agency
☐	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The SMA developed and manages a comprehensive electronic assessment tool, referred to as MnCHOICES, that must be used for evaluating whether individuals meet the needs-based eligibility criteria for this benefit.

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

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

In order to make a determination regarding eligibility and reevaluation of eligibility, both of the following criteria must be evaluated:

- Financial eligibility for 1915(i); and
- Needs-based eligibility for 1915(i).

Financial eligibility determinations are made by counties and tribal human services agencies as delegates of the SMA utilizing standardized tools provided, managed and overseen by the SMA. Employees making financial eligibility determinations are county or tribal human services agency employees, titled "eligibility workers". Information regarding financial eligibility is collected and entered into the Medicaid Management Information System (MMIS).

The SMA developed and manages a comprehensive electronic assessment tool, referred to as MnCHOICES, that must be used for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria.

SMA trained and certified assessors meet with individuals to compete the tool. The information from the tool is analyzed using a set of algorithms to determine whether the person meets the eligibility criteria for this benefit.

The MnCHOICES system also includes program edits to validate financial eligibility data from the MMIS system to the MnCHOICES system. This allows the SMA to make a final eligibility determination.

The SMA maintains authority over the process and determinations cannot be overridden by an assessor. The SMA also conducts quality reviews of the data to evaluate inter-rater reliability and compliance with the requirements. There is no difference in the process for initial evaluations and reevaluations, with the following exception:

- SMA county exception for areas where the electronic component of the MnCHOICES assessment tool is not currently in use for eligibility reevaluations. County assessors in certain areas of the state may use a partially automated version of the SMA's assessment tool for gathering information for eligibility reevaluations of fee-for-service (FFS) participants. The county assessors completing these FFS reassessments must be Registered Nurses with a Public Heath certificate. They may be certified assessors, but it is not required. The county assessors enter participants' reassessment information into MMIS and programming edits apply. The SMA is permitting a limited number of counties to use the partially automated process for a transition period that is projected to be completed by September 30, 2024. Under the SMA county exception, the SMA continues to make final determinations of program eligibility through Medicaid Management Information System (MMIS) programming and other oversight activities as outlined in both the conflict of interest and QIS sections of this SPA.

4. ☒ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors:
(Specify the needs-based criteria):

These 1915(i) benefits are available to participants who require hands-on assistance, or constant supervision and cueing, to accomplish one or more activities of daily living and do not meet an institutional level of care. *Individuals whose needs meet an institutional level of care will be served under a 1915(c) waiver or the 1915(k) benefit.*

6. ☒ **Needs-based Institutional and Waiver Criteria.** (By checking this box the state assures that): There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based criteria	*NF (& NF LOC** waivers)*	*ICF/IID (& ICF IID LOC waivers)*	*Applicable Hospital* (& Hospital LOC waivers)*
Require hands-on assistance, or constant supervision and cueing, to accomplish one or more activities of daily living and do not meet an institutional level of care. *Individuals whose needs meet an institutional level of care will be served under a 1915(c) waiver or the 1915(k) benefit.*	For NF level of care, the participant must meet one of the five categories of need below: 1. Does/would live alone or be homeless without current housing type and meets one of the following criteria: a. Has had a fall resulting in a fracture within the last 12 months b. Has a sensory impairment that substantially impacts functional ability and maintenance of a community residence c. Is at risk of maltreatment or neglect by another person, or is at risk of self-neglect 2. Requires assistance and is dependent in four or more activities of daily living (ADLs)	Be unable to apply skills learned in one environment to another (i.e., cannot generalize skills to "real world" situations) Have a diagnostic determination of intellectual or developmental disability or a related condition Require a continuous program of aggressive, systemic instruction and supervision (i.e., active treatment) to participate in life activities Require a 24-hour plan of care based on need for active treatment to gain and/or maintain the highest level of self-sufficiency and life participation.	Have both predictable health needs and the potential for status changes that could lead to rapid deterioration or life-threatening episodes because of the participant's health condition Require professional nursing assessments and intervention multiple times during a 24-hour period to maintain and prevent deterioration of health status Require a 24-hour plan of care, including a back-up plan, to reasonably ensure health and safety in the community Require frequent or continuous care in a hospital.

	3. Has significant difficulty with memory, using information, daily decision-making or behavioral needs that require intervention 4. Requires assistance and is dependent on another person to complete ADLS that cannot be scheduled (toileting, transferring or positioning) or 5. Needs formal clinical monitoring at least once a day.		

**Long Term Care*
***LOC= level of care*

7. ☐ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):*

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, **and** (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services.** The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*: one or more services*
ii.	**Frequency of services.** The state requires (select one):
☒	**The provision of 1915(i) services at least monthly**
☐	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy [QIS] portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home andcommunity-based settings requirements, at the time of this submission and ongoing.

The HCBS provider does not own/control the setting in which the participant resides. Therefore, they do not meet the regulatory definition of "provider-owned or controlled" as set forth in 42 C.F.R. § 441.710(a)(1)(vi).

The HCBS provider does not have a direct or indirect financial relationship with the property owners in the settings described below. Therefore, the nature of the relationship does not affect either the care provided or the financial conditions applicable to tenants. Participants do not need to use a specific HCBS provider in order to live in the residence.

This is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports.

Although the HCBS provider does not own/control the setting, person-centered planning remains an important protection to assure that individuals have opportunities for full access to the greater community to the same degree as individuals not receiving Medicaid HCBS.

Residential setting types in which an individual may receive services under the HCBS benefit include:

1. Participants may receive services in their own home or family home.

   A participant's own home is defined as a single-family home or unit in a multi-family home (e.g. apartment) where a participant lives, and the participant or their family owns/rents and maintains control over the individual unit, demonstrated by a lease agreement (if applicable).

2. Participants may receive services in residential settings that are not controlled by the provider of HCBS. These include:
   - Settings registered by the Minnesota Department of Health (MDH) as a board and lodge establishment (e.g. hotel, VRBO, etc.)
   - Board and Lodge: The HCBS provider is a separate and distinct provider from the entity that owns/operates the board and lodge setting and/or provides services under Minn. Stat. 157.17. The entity that operates the board and lodge and/or provides services under Minn. Stat. 157.17 is not being paid to provide HCBS. This entity is registered by the MN Department of Health and can designate whether they provide special services. Individuals receiving special services in this setting would not be eligible for HCBS.

HCBS will not be provided in non-residential waiver provider-controlled settings such as day service facilities or adult day centers.

The following strategies will be used to assure ongoing compliance with home and community-based service requirements for the provision of HCBS for the types of settings described under residential setting types above:

- An individual's place of residence is verified at the time services are authorized and the counties, tribal human services agencies, and MCOs determine whether they are residing in a setting in the community in which HCBS are allowed.
- Personal Care Support workers complete required person-centered training as part of worker training and development for both the agency and budget models
- Agency providers complete initial HCBS training which includes person-centered practices, as well as service and protection related rights
- Funded as a Medicaid administrative activity under a CMS approved cost allocation plan, the Consultation Service provider assists participants with the following:
  a. Offer choices to the participant regarding the services and supports they receive (and from whom) and record the alternative home and community-based settings that were considered by the participant in their service plan
  b. Educate participants on HCBS expectations and person-centered practices and their service/protection related rights upon initial orientation and annual review
- Participants are surveyed annually on their experience with HCBS to assure person-centered practices are being followed and their rights are asserted and protected. (The SMA will use survey results to trigger remediation at an individual level when a participant's experience differs from HCBS requirements).
- Agency providers attest to compliance with home and community-based services requirements as part of new enrollment (new provider record), re-enrollment (inactive to active) or revalidation every three years (review of enrollment documents of currently active record) as a Medicaid provider.

Program-monitoring metrics are cited in the quality assurance sections later in this document that assure compliance with HCBS settings requirements.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

An assessor performs face-to-face assessments of an individual's support needs and capabilities. Assessors complete training and a certification developed by the SMA and are required to be recertified every three years.

Assessors are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate or other closely related field. They must have at least one year of home and community-based experience or be a registered nurse with at least two years of home and community-based experience with training and certification specific to assessment and consultation for long-term care services in the state.

5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The individualized, person-centered service delivery plan is developed with the active engagement by the participant/representative with support from the consultation services provider (an administrative activity in accordance with the state's CMS approved Medicaid cost allocation plan).

Consultation service providers assist the participant with understanding the benefit, planning for services, choosing a model, and then creating and implementing the participant's service delivery plan.

A consultation services provider agency must:

- Be enrolled as a provider in accordance with state Medicaid agency requirements
- Employ at least one lead staff member who meets the qualifications for the lead employee
- Have the ability to provide services statewide (either in person or remotely)
- Have an office located in Minnesota;
- Have a toll-free phone number and secure fax number;
- Have never had a lead agency contract or provider agreement discontinued due to fraud;
- Have never been disqualified under the criminal background check system; and
- complete all SMA-mandated training applicable to their roles

Consultation Service provider agencies must employ at least one lead professional staff that is required to meet at least one of the following education requirements:

- Be a Doctor of Medicine or osteopathy
- Be a registered nurse; or
- Have a bachelor's degree or higher in one ofthe following fields:
  - Occupational therapist
  - Physical therapist
  - Psychologist
  - Social worker
  - Speech-language pathologist or audiologist
  - Professional recreation staff
  - Professional dietitian
  - Have a designation as a human services professional

The lead professional staff must also have at least one year of experience working directly with people who have an intellectual disability or other developmental disability and have a degree in a discipline associated with at least one of the following fields of study:

- Human behavior (e.g., psychology,sociology, speech communication, gerontology, etc.);
- Human skill development (e.g., education,counseling, human development);
- Humans and their cultural behavior (e.g., anthropology);
- The human condition (e.g., literature, art); or
- Any other study of services related to basic human care needs (e.g., rehabilitation counseling).

Additionally, the lead professional staff must:

- Be 18 years old or older;
- Clear a background study as required under Minnesota Statutes, Chapter 245C; and
- Have a minimum of two years of full-time experience in the field of self-direction.

Staff members working directly with participants (but not as the lead professional staff of a consultation services provider) must meet the education requirements listed in the lead professional staff education section or meet the education substitution. These staff members can substitute one of the following for a bachelor's degree:

- Experience coordinating or directing services for people with disabilities or people older than age 65, including self-directed services; or
- Experience coordinating their own services.

Anyone working under the lead professional staff must also:

- be 18 years or older; and
- have a completed background study.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Participants and/or their representative are actively engaged in the development of the person-centered service delivery plan with the support of a consultation services provider. The assessor will provide needs assessment results to the consultation service provider, FMS and/or service agency, as applicable.

(a) After the needs assessment, the assessor offers the participant the choice of a consultation service provider to support the individual to develop their person-centered service delivery plan. The participant chooses a consultation service provider to provide them with information about the service models, rights and responsibilities including appeal rights, choice in providers, service policy and budget information for those who choose the budget model. The consultation service provider also provides the participant with the service delivery plan template and provides support to develop the plan as directed by the participant. The support provided by consultation services is outlined in further detail below.

Consultation Services (An Administrative Activity)

This service provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Components of this support include providing voluntary training on how to select, manage and dismiss personal care support workers.

Consultation service providers will:

- Educate the participant about service options;
- Educate the participant about choices in providers;
- Educate the participant about rights and responsibilities (including appeal rights);
- Educate the participant about the agency model and budget model;
- Assure a person-centered planning process;
- Help the participant or the participant's representative write, implement and evaluate their service delivery plan (to the extent the participant desires);
- Assist participants who have chosen the budget model with developing a budget;
- Provide the participant with a list of service agency providers (if the participant chooses the agency model) or financial management services (FMS) providers (if the participant chooses the budget model);
- Train the participant to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers including assistance as desired with development of worker training and development plans within the service delivery plan;
- Respond to participant's questions related to self-directed tasks or other concerns throughout the service delivery plan year;
- Complete a semi-annual review if their spouse or parent (if a minor) serves as their personal care support worker; and
- Revise a person-centered service delivery plan to achieve quality service outcomes.

When a participant uses the budget model, the consultation services provider will provide these additional duties:

- Monitor the participant's success in using the budget model and re-educate and/or recommend involuntary exit, if needed;
- Work with the FMS provider to provide the participant with ongoing support to serve as the employer of their personal care support workers;
- Check in with the participant to ask if they are completing employer tasks, such as:
    - Ensuring the support workers are competent to meet the participant's needs, including assistance with changes to worker training and development plan as needed;
    - Orienting and training support workers;
    - Evaluating support workers within 30 days of hire, the start of a new plan year or after a change in condition;
    - Verifying and maintaining evidence of support worker competency, including documentation;
    - Completing support worker performance reviews at least once per year; and
    - Answering the participant's questions during check-ins.

The consultation service provider will maintain and document routine communication with the participant to review
services and plan implementation. The participant has the option to request additional ongoing support from the consultation service provider when needed. This may occur when the participant chooses to change their plan or they have a change in condition that needs to be addressed in the plan. A participant using the budget model may also request support from the consultation service provider to assist with understanding their role as the employer.

Consultation service providers provide additional support if a participant is not carrying out their duties under the budget-model. The consultation service provider will develop an individualized plan to provide additional training, check-ins or other assistance to ensure the participant is completing employer tasks. The consultation service provider will document outcomes of the additional supports and training, and may recommend involuntary
exit to SMA/county, tribal human services agency, or MCO, if needed.

Additional responsibilities and expectations of consultation service providers include:

- Helping SMA/counties, tribal human services agencies, and MCO with surveys and data collection, upon request;
- Documenting complaints received for possible audit;
- Implementing policies and procedures to meet the needs of culturally diverse participants receiving services;
- Reviewing grievance policies annually;
- Sharing information from SMA/county, tribal human services agency, or MCO (e.g., policy clarifications or changes) with participants when requested by the SMA;
- Complying with all other requirements, as applicable.

(b) The participant, or their representative, is responsible for writing the service delivery plan with the support of the consultation services provider to the extent desired by the participant. The participant may choose other people who are important to supporting them (for example, to be active in their community and/or meeting their assessed needs), to participate in the service delivery plan development process. This could include the representative, family members, friends, natural supports or others.

7. Informed Choice of Providers. ***(****Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

After the needs assessment, the assessor offers the participant the choice of a consultation service provider to support the individual to develop their person-centered service delivery plan. The consultation services provider shares information on how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers. Consultation service providers will also direct participants to MinnesotaHelp.info (https://MinnesotaHelp.info) or the MCO provider network. This site contains a listing of qualified service agencies and personal care support workers. The consultation services provider will answer any questions and help perform a search of available providers.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency.

(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

The participant, or their representative, are actively engaged in the development of the service delivery plan with assistance of consultation services as requested.

For purposes of developing the service delivery plan, all participants are provided with a standardized template. In supporting the person, consultation service providers will review whether the plan meets assessed needs outlined in the assessment and contains covered services. Within 10 business days, consultation service providers then submit the service delivery plan to the county, tribal human services agency, or MCO, who is the delegate of the SMA. The service delivery plan must then be approved by the county, tribal human services agency, or MCO within 30 calendar days.

Each county, tribal human services agency, or MCO utilizes Minnesota's Medicaid Management Information System (MMIS) and MnCHOICES database systems, which incorporate rules to ensure only services and supports authorized by the SMA are approved in the plan. All plans are subject to the approval of the SMA. An individual service delivery plan will not be approved by the SMA unless the individual meets all financial eligibility criteria and needs based service criteria.

The SMA conducts annual reviews, as defined in the QIS section of this document, of all consultation service providers who retain a copy of the completed and approved service delivery plans. The review of the service delivery plan is multifaceted. The state will review no less than 8 service delivery plans from each contracted and enrolled consultation service provider agency using the 8/30 methodology as outlined in the QIS section. While conducting a review of the service delivery plan, the SMA will evaluate whether service plans:

- meet assessed needs as outlined in the needs-based assessment;
- Have been updated annually;
- Document choice of services;
- Document choice of providers;
- Document choice of setting;
- Address worker training and development; and
- Include emergency back-up plans.

In addition to reviews completed for consultation services, the following oversight of counties, tribal human services agencies, and MCOs is conducted.

The SMA provides oversight of counties and tribal human services agencies through lead agency reviews. Lead agency reviews are continuous and ongoing, with approximately 20 lead agencies reviewed each year. During lead agency reviews a representative sample of approved service plans are audited and reviewed using the above mentioned 8/30 methodology where no less than 8 approved service plans will be reviewed for compliance at each of the selected counties and tribal human service agencies.

The SMA also provides oversight of MCOs by auditing and reviewing a representative sample of approved service plans, on an annual basis, where no less than 8 approved service plans will be reviewed for compliance at each of the MCOs.

In addition, the following measures, outlined in more detail in the quality assurance section of this plan, are in place to ensure ongoing SMA oversight of service plan development:

- Contract monitoring of consultation services providers;
- Desk audits to review service delivery plans;
- Care plan audits and quality review activities of MCOs;
- Review and analysis of participant satisfaction surveys;
- Ongoing oversight of the state MMIS system;
- Ongoing oversight of the states MnCHOICES system; and
- Review and analysis of participant appeals and fair hearing outcomes.

9. Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☒	Other (*specify):*	The service delivery plan is maintained by the county, tribal human services agency, or MCO for a minimum of three years.			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Personal Care Assistance
Service Definition (Scope)*:*	

Personal care assistance provided by a personal care support worker includes assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision/cueing to accomplish the task.

Personal care assistance may also include observation and redirection to the participant for episodes of behavior that need redirection (as identified in the service delivery plan).

ADLs include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting.

IADLs include activities related to living independently in the community. Covered services include providing assistance with:

- Completing household tasks necessary to support the participant with an assessed need including meal planning, preparation and cooking, shopping for food, clothing or other essential items;
- Doing Laundry and light housecleaning;
- managing medications;
- Assistance with managing finances
- Communicating needs and preferences during covered activities ;
- Arranging for participant supports
- Attending medical appointments;
- Traveling around and accompanying the person to participate in community activities; and
- Communicating by telephone or other devices.

Health-related procedures and tasks are procedures and tasks performed by a personal care support worker that can be delegated or assigned by a health care professional licensed under Minnesota state law.

Health-related procedures and tasks includes assistance with self-administered medications, interventions for seizure disorders, range-of-motion and passive exercise, clean tracheostomy suctioning and services to a participant who uses ventilator support, or other activities within the scope of personal care assistance that meet the definition of health-related procedures or tasks.

Personal care assistance may be delivered individually (1:1) or as shared care (1:2 or 1:3).

Participants determine whether or not they wish to use shared care. Participants then work with their service agency or FMS provider to enter into a voluntary written agreement to receive shared care. This is also built into their service delivery plan. An individual's personal care hours are not impacted by choosing shared care as an option but it may have implications for their budget, allowing them to stretch their service dollars further. This is then billed as shared care by either the service agency or the FMS, depending on the model.

The acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks is also included as personal care assistance.

Personal care assistance provided by a personal care support worker as described above includes activities that allow time for skills training through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-related tasks. When an assessment shows that a person needs assistance to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs, and health-related tasks, the person will receive this support concurrently (with hands-on assistance, or constant supervision and/or cueing) to accomplish the task. This will be done as described under the personal care assistance services description.

Assistance to acquire, maintain and/or enhance skills will be specifically tied to the assessment and service delivery plan. These are a means to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement. These services are limited to supports necessary for the participant to acquire, maintain or enhance skills to independently accomplish, to the extent possible, ADLs, IADLs, and health-related tasks as described under personal care assistance services.

Personal Care Support workers provide assistance under the following conditions:

- The need for skill training or maintenance activities if identified by the assessment process and it has been documented in the authorized service delivery plan;
- The activities provided are concurrent with the performance of ADLs, IADLs and health- related tasks as described above;
- The activities are for the sole benefit of the participant and are only provided to the participant receiving services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence;
- The activities provided are consistent with the stated preferences and outcomes in the service delivery plan; and
- The support worker is competent to perform these services for participants

Personal care assistance services do not include:

- services provided by a participant's representative or paid legal guardian;
- Services that are used solely as a childcare or babysitting service;
- Services for adults that are used solely for supervision like adult companion or adult day service;
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;
- Sterile procedures;
- administering injections into veins, muscles or skin;
- Homemaker services that are not an integral part of the assessed service;
- Home maintenance or chore services;
- Home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;
- Services to other members of the participant's household;
- Services not specified as covered under medical assistance;
- Application of restraints or implementation of deprivation procedures; and
- Independently determining the medication dose or time for medications for the participant.

In the budget model, the participant is the employer of their own personal care support workers. The participant recruits, hires, trains and supervises their worker.

In the provider agency model, the participant selects an agency that serves as the support worker's employer. This means the agency recruits, hires (including workers selected by the participant, if the worker meets qualifications), trains, supervises and pays the personal care assistance worker.

Describe any limitations for the systems or mechanisms provided:
Personal care support workers are limited to providing 310 hours of care per calendar month, regardless of the number of participants being served or the number of agencies or participants employing the support worker.

- If a parent(s), stepparent(s), unpaid legal guardian(s) of a participant under age 18 or the participant's spouse works as a person's personal care support worker, they may not provide personal care assistance in excess of the following:
  - If multiple parents are support workers providing personal care assistance to their minor child or children, each parent may provide up to 40 hours of personal care assistance in any seven-day period regardless of the number of children served. The total number of hours of personal care assistance provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.
  - If only one parent is a support worker providing personal care assistance to the parent's minor child or children, the parent may provide up to 60 hours of personal care assistance in a seven-day period regardless of the number of children served.
  - If a participant's spouse is a support worker providing personal care assistance, the spouse may provide up to 60 hours of personal care assistance in a seven-day period.
  - For parents of minor children and spouses, the hour outlined above apply to the total amount of hours per family regardless of the:
    - Number of parents
    - Combination of parent(s) and spouse
    - Number of children who receive 1915(i) benefits.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☒	Medically needy *(specify limits):*
	The services under this 1915(i) benefit are limited to services not otherwise covered under the state plan, including EPSDT and must be consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Personal Care Support Workers	N/A	N/A	All support workers, regardless of delivery model must: • Complete the standardized certification training and pass the test named "Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test" • Pass a background study initiated by the provider agency/FMS provider, as required under Minnesota Statutes, Chapter 245C • Enroll with Minnesota Health Care Programs as a PCA/CFSS support worker • Be able to communicate effectively with the participant and the provider agency/FMS provider • Have the skills and ability to provide the services and supports according to the participant's service delivery plan and respond appropriately to the participant's needs The participant may establish additional support worker qualifications.
CFSS Agency Provider	N/A	N/A	An agency provider must meet the following qualifications: • Enrolled as a Medical Assistance/Minnesota Health Care Programs (MHCP) provider or enrolled in an MCO network • Meet all applicable provider standards and requirements • Comply with background study requirements under Minnesota Statutes, chapter 245C and maintain documentation of background study requests and results.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Personal Care Support Worker	State Medicaid Agency	The SMA must check the Office of Inspector General (OIG) exclusion list at enrollment and then at least monthly thereafter.
CFSS Provider Agency	State Medicaid Agency	Every 3 years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Personal Emergency Response Systems (PERS)

Service Definition (Scope)*:*

Personal emergency response systems (PERS) includes:

- Purchase of the PERS equipment, including necessary training or instruction on the use of the equipment;
- Installation (including set up and testing) and monitoring of the device; and
- Monthly fees associated with operation of device.

Personal emergency response systems does not cover:

- Equipment used to deliver Medical Assistance (MA) or other waiver services;
- Sensing and/or monitoring systems that do not require activation by the participant (see CBSM – Monitoring technology usage, https://www.dhs.state.mn.us/main/dhs16_180346, for policy about those systems);
- Supervision or monitoring of activities of daily living (ADLs) provided to meet the requirements of another service;
- Telehealth and biometric monitoring devices; and
- Video equipment

The following information must be documented in the participant's service delivery plan:

- The participant's need for a personal emergency response system;
- The type of personal emergency response equipment the participant will use
- How the personal emergency response equipment will meet the participant's assessed need; and
- Fees for equipment purchase, installation and monthly monitoring.

Reimbursement for personal emergency response systems to ensure continuity of services and supports is available for any of the following:

- Participants who live alone or who are alone for significant parts of the day;
- Participants who have no regular caregiver for extended periods of time and who would otherwise require extensive routine support and/or supervision; or
- Participants who have not identified/chosen to identify a person for their back-up support.

Whether a participant chooses the agency or budget model of service delivery, they retain full budget authority for purchase of PERS. The purchase must meet the criteria outlined above and fit within the individualized budget. The service agency or participant employer is responsible to ensure the

personal emergency response systems meet the criteria outlined. The State Medicaid Agency also has quality assurance measures in place that are outlined in other areas of this document.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Personal Emergency Response Systems	N/A	N/A	PERS vendors can be either: 1) Minnesota Health Care Programs (MHCP) enrolled vendors or providers enrolled in MCO network(s) that meet one of the following qualifications: • State medical equipment provider as defined in state statute • Pharmacy licensed by the Minnesota Board of Pharmacy • Medicare-certified home health agency The participant or the representative is responsible to verify provider qualifications under the budget model. The Department's provider enrollment unit or the counties, tribal human services agencies, and MCOs are responsible to verify

			provider qualifications under the agency model.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Personal Emergency Response Systems	State Medicaid Agency	Every 5 years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Individual Directed Goods and Services

Service Definition (Scope)*:*

Individual Directed Goods and Services are services, equipment or supplies not otherwise available through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and must:

- increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance;
- not be available through another source,
- be purchased from the participant-directed budget; and
- Not be Experimental or prohibited treatments are excluded

Individual Directed Goods and Services must be documented in the service plan.

Expenditures for goods and services must:

- Relate to a need identified in a participant's service delivery plan;
- Be priced at fair market value;
- Increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed need; and
- Fit within the annual limit of the participant's approved service allocation or budget

Examples of covered goods and services include:

- Wheelchair ramps
- Smart phone applications relevant to assisting participants with ADL/IADL needs
- Specialized devices for dressing or grooming
- Microwave
- Laundry service
- Environmental modifications

Goods that are covered under the Medicaid Durable Medical Equipment benefit would not be covered by this benefit.

Whether a participant chooses the agency or budget model of service delivery, they retain full budget authority for the purchase of Individual Directed Goods and Services. The purchase must meet the criteria outlined above and fit within the individualized budget.

When a participant uses funds to purchase individual directed goods and services, the consultation services provider will review the service delivery plan with the person. In supporting the person, they will review whether the good or service meets an assessed need outlined in the needs assessment, is a covered service and fits within the individual's budget. The consultation service provider submits the plan to the county, tribal human services agencies, or MCO, the delegate of State Medicaid Agency for approval. The state Medicaid agency provides oversight via audits and reviews of a representative sample of approved service plans. All individual directed goods and services must be purchased through the FMS provider unless the provider of the good or services is an MHCP enrolled provider, in which case the provider can bill directly for the good or service.

When a participant is choosing to use individually directed goods and services the cost for the goods and services is covered using a portion of the allocated budget.

Describe any limitations for the systems or mechanisms provided:
Individual Directed Goods and services are limited to what is covered above. Individually directed goods and services must not exceed an individual's budget allowance.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Goods and Service Providers	N/A	N/A	Entities providing individual directed goods or services must bill though the Financial Management Services provider or enrolled MHCP. All individuals/vendors that provide individual directed goods and services must have: • The capability to perform the requested work

			• The ability to successfully communicate with the participant • All the necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Goods and Service Providers	State Medicaid Agency	When goods or services are billed

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Financial Management Services (FMS)

Service Definition (Scope)*:*

Financial Management Services is a service/function that assists the family or participant to:

(a) manage and direct the disbursement of funds contained in the participant-directed budget;

(b) facilitate the employment of staff by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and,

(c) performing fiscal accounting and making expenditure reports to the participant or family and state authorities.

"Financial management services provider" means a qualified organization required for participants who use the budget model. An FMS is an enrolled provider that provides vendor fiscal/employer agent financial management services (FMS).

Participants who use the budget model must select a financial management services (FMS) provider.
The role of the FMS provider is to support the participant as they fulfill their responsibilities of being the employer of their personal care support workers. The FMS provider is responsible to:

- Collect and process timesheets of the participant's support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Separately track budget funds and expenditures for each participant
- Track and report disbursements and balances of each participant's funds
- Process and pay invoices for services in the person-centered service delivery plan

- Provide individual, periodic reports of expenditures and the status of the approved service budget to the participant or their representative and SMA, as well as the consultation service provider and county, tribal human services agency, or MCO, as applicable
- Initiate background studies for support workers
- Help the participant obtain support workers' compensation insurance
- Educate the participant on how to employ support workers
- Ensure what the participant spends their funds on follows the rules of the program and the approved service delivery plan.

Participants who use the agency-provider model and choose to purchase individual directed goods and services with their service allocation must use an FMS provider to purchase the goods and services if the provider of the goods and services is not an enrolled MHCP provider.

Participants must not be limited in their choice of FMS provider. Participants are able to choose from any provider who is contracted and enrolled with the SMA as an FMS provider.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☒ Medically needy *(specify limits):*

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Financial Management Services	N/A	Federal Certification through readiness review	The SMA contracts with all FMS providers to provide FMS services. The SMA determines if FMS providers meet the qualifications through a Request for Proposal (RFP) process at a frequency determined by the SMA. All FMS providers shall: • Enter into a contract with the SMA for provision of FMS services • Enroll as a Minnesota HealthCare Programs (MHCP) provider and meet all applicable provider standards and requirements • Comply with background study requirements under Minnesota

			Statutes, Chapter 245C and maintain documentation of background study requests and results • Successfully complete a readiness review conducted by an individual or organization that meets the qualifications required by the state • Have knowledge of and compliance with Internal Revenue Service (IRS) requirements • Provide services statewide • Meet the requirements under a collective bargaining contract.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Financial Management Services	State Medicaid Agency	Every 5 Years

Service Delivery Method. *(Check each that applies)*:

X	Participant-directed	X	Provider managed

2. ☒ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

(a) For minors, parents, stepparents, and unpaid legal guardians may be paid to provide personal care. For adults, unpaid legal guardians may be paid to provide personal care.

(b) The specific state plan HCBS service is personal care.

(c) The determination about whether provision of personal care by a responsible relative or paid legal guardian is in the best interest of the participant is made through the comprehensive person-centered service planning process.

(d) When personal care is provided by a responsible relative or paid legal guardian, the county, tribal human service agency or MCO conducts a semi-annual in-person review with the participant of their plan. In addition, quarterly spending reports must be provided to the county, tribal human service agency, MCO, or consultation service provider, respectively.

(e) All provider requirements pertaining to service payment apply to legally responsible individuals that provide personal care, including use of electronic visit verification.

(f) The person-centered assessment accounts for age appropriate dependencies and natural supports. Only services that exceed those levels are authorized. Personal care services provided by relatives, legally responsible individuals, and unpaid legal guardians may only include extraordinary care that exceeds the range of activities that the caregiver would ordinarily perform for a person of the same age without a disability or chronic illness.

Parents, stepparents, unpaid legal guardians of a participants under age 18 or the participant's spouse works as a person's personal care support worker, may not provide 1915(i) personal care assistance in excess of the following:

- If multiple parents are support workers providing personal care assistance to their minor child or children, each parent may provide up to 40 hours of personal care assistance in any seven-day period regardless of the number of children served. The total number of hours of personal care assistance regardless of the number of children served.
- If only one parent is a support worker providing personal care assistance to the parent's minor child or children, the parent may provide up to 60 hours of personal care assistance in a seven-day period regardless of the number of children served.

- If a participant's spouse is a support worker providing personal care assistance, the spouse may provide up to 60 hours of personal care assistance in a seven-day period.
- For parents of minor children and spouses, the hour outlined above apply to the total amount of hours per family regardless of the:
  - Number of parents
  - Combination of parent(s) and spouse
  - Number of children who receive personal care assistance.

Paid legal guardians are not allowed to be the support worker, whether the participant is a minor or an adult.

Services must be provided within the assessed limits. For people who receive services under the budget model, the consultation services provider and FMS will work to ensure that services are provided within the scope of the service delivery plan.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (Select one):

☐	The state does not offer opportunity for participant-direction of State plan HCBS.
☒	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
☐	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

The state of MN has long viewed personal care assistance as a mechanism for individuals to have choice and control in their care while remaining in their homes and communities. Participants are offered two choices for service delivery.

There are two service delivery models: the provider agency model and the budget model. In both models, the participant:

- Directs their own care
- Selects their worker, including their spouse or parent of a minor
- Writes their plan with assistance from the consultation services provider, as desired
- Has full budget authority and the option to purchases goods, services and personal emergency response systems
- Has access to a worker training and development budget to help personal care support workers expand their skills to support the participant's specific needs

Before choosing a model, participants choose a Consultation service provider who provides them with information about service models, rights and responsibilities (including appeal rights, choice in providers and budget information and policies). Each participant eligible for the benefit has the choice to self-direct all or part of their services, depending on the service model chosen. After benefit eligibility has been determined participants are presented with their budget. They are offered support from Consultation Services to determine how their choice in models, purchase of goods and services or personal emergency response systems would impact their budget, giving all participants full budget authority from the start. Those choosing the budget model serve as the employer of their workers and have full employer and budget authority.

The consultation service provider also provides the participant with the service delivery plan template and provides support to develop the plan as directed by the participant. Participants may use the consultation service for assistance while developing a person-centered service delivery plan and budget and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss personal care support workers. They may also return to consultation services at any time for additional supports.

In both models, participants have access to worker training and development for their personal care support workers. Worker training and development is a function that pays for the training, observation, monitoring and coaching of personal care support workers. These activities help personal care support workers expand their skills to support the participant's specific needs. The need for worker training and development is identified in the development of the service delivery plan and further needs might be identified as new workers are hired, new needs for the person emerge or additional training needs for a worker are identified. Worker training and development has a minimum annual allocation credited to each participant who receives services, which is separate from the participant's service delivery budget. Participants can request additional funds for the participant's worker training and development as needed.

In the budget model, the participant is the employer of their own personal care support workers. The participant recruits hires trains and supervises their worker. The person selects a financial management services (FMS) provider to help the person comply with applicable employment related laws. Participants will use a financial management services provider for the billing and payment of services; for ensuring accountability of funds; for management of spending and to serve as a vendor/fiscal employer agent in order to maintain compliance with employer related duties, including federal and state labor and tax regulations.

Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers and obtain other supports and individual directed goods and services as defined in the service package.

2. Limited Implementation of Participant-Direction. *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

☒	Participant direction is available in all geographic areas in which State plan HCBS are available.
☐	Participant-direction is available only to individuals who reside in the following geographic areasor political subdivisions of the state. Individuals who reside in these areas may elect self-directedservice delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affectedby this option)*:

3. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Personal Care Assistance	☒	☒
Individual Directed Goods and Services	☐	☒
Personal Emergency Response Systems	☐	☒

4. Financial Management. (*Select one)* :

☐	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
☐	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
☒	Financial Management is furnished as a Medicaid 1915(i) service

5. ☒ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

The consultation services provider is responsible to help a person change models if they choose to do so. This includes educating the person on their newly chosen model and helping update their service delivery plan, if the participant wants assistance.

If the participant is a senior enrolled in managed care, the case manager or care coordinator is responsible to update the person's service agreement or authorization if they choose to switch service delivery models.

The SMA is responsible to update the person's service agreement when they switch models.

Involuntary change
If a person who used the budget model is in the Minnesota Restricted Recipient program the person must switch to the agency-provider model.

If the participant is not meeting the requirements of the budget model such as:

- Not performing the required participant-employer activities
- Participant is knowingly committing fraud, waste, or abuse of budget fund
- Participant is repeatedly breaking HCBS rules despite corrective counseling
- Participant relocates to a non-community setting where HCBS are not permitted

In the circumstances above the consultation service provider must attempt to re-educate the person before the recommendation to remove them from the budget model.

If the person is not succeeding as a participant employer (i.e., the budget model), the consultation services provider is responsible to:

- Recommend the county, tribal human services agency, or MCO or SMA disallow the person from using the budget model, if necessary
- Help the person switch models if the SMA or the county, tribal human services agency, or MCO removes them from the budget model

The SMA is responsible to:

- Review and decide on recommendations from the consultation services provider about the person's ability to continue to successfully participate in the budget model
- Update the person's service agreement when they switch service delivery models (whether voluntarily or involuntarily)

The participant may appeal the decision to remove a person from the budget model.

Termination of services

A provider, defined as a personal care provider agency, Consultation Service provider or an FMS, must provide written notice when it intends to terminate services with a participant at least 30 calendar days before the proposed service termination is to become effective, except in cases where:

1) The participant engages in conduct that significantly alters the terms of the service delivery plan with the agency-provider;
2) The participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the personal care support worker or other agency-provider staff;
3) An emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current service delivery plan so that the agency-provider cannot safely meet the participant's needs.

When a participant initiates a request to terminate services with the agency-provider, the provider must give the participant a written acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.

The -provider must participate in a coordinated transfer of the participant to a new -provider to ensure continuity of care.

The only circumstance under which a person would be unable to continue with self-direction in the above example is if they receive a service termination notice from a provider and they have exhausted all efforts to obtain the service from another provider. In the event that they have exhausted all options, the SMA or delegate would assist the person to review other service options for meeting their needs. A termination of services from a service provider would not result in their benefit eligibility for HCBS being terminated.

Voluntary change

A participant can elect to switch service-delivery models (agency-provider model or budget model) at any time, unless they are not allowed to use the budget model (i.e., the person is on the Minnesota Restricted Recipient Program [MRRP]). The Minnesota Restricted Recipient Program is authorized by Federal regulation and was developed to improve the safety and quality of care, and to reduce the costs for Minnesota Health Care Program (MHCP) recipients who have misused or abused MHCP services.

When a person is both eligible to and considers switching models, they are responsible to:

- Identify if the service delivery model they are using is working for them
- Seek support from the provider agency or consultation services provider on their options, if necessary
- Notify their provider agency or consultation services provider if they wish to switch service delivery models
- Update their service delivery plan when they switch service delivery models

8. Opportunities for Participant-Direction

a. Participant–Employer Authority *(individual can select, manage, and dismiss State plan HCBS providers). (Select one):*

☐	The state does not offer opportunity for participant-employer authority.	
☒	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions asthe 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.
	☒	**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 andother employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority *(individual directs a budget that does not result in payment for medical assistance to the individual). (Select one):*

☐	The state does not offer opportunity for participants to direct a budget.
☒	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	A service budget amount is based on an objective assessment of the participant's personal care needs as defined under Minnesota Statute and in compliance with 42 CFR 441.560. The assessment must be conducted by an assessor according to the criteria established in Minnesota Statute. A statistical model is applied to arrive at a total dollar and service amount. Once the total benefit amount is determined, the county, tribal human services agency, or MCO develops/tailors a detailed spending plan that meets the person preferences, as established in the service plan. After the assessment is completed, the assessor will provide the participant, by mail or in person, with a written summary outlining the needs for care and options for services and supports, including the total dollar amount for services. The participant works with the consultation services provider to understand how they will use funds. If the participant is on a waiver or a senior enrolled in managed care, the participant would work with the case manager or care coordinator to finalize the service delivery plan. All plans are subject to the approval of the county, tribal human services agency, or MCO. The state Medicaid agency provides oversight through audits of a representative sample of approved service plans. Participants may use their service budget to: • Directly employ and pay qualified personal care support workers • Purchase covered individual directed goods and services • Pay for the selected financial management services • Purchase personal emergency response systems

	A person's budget is recalculated annually at reassessment. The budget also may be recalculated at any time during the year if the person has a change in need. **Approval** Service delivery plans must be reviewed by the consultation services provider and approved by the county, tribal human services agency, or MCO, the delegate of the State Medicaid Agency. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant or for a senior who is enrolled in managed care. Consultation services and worker training/development are authorized on a per diem basis and do not count against a participant's service budget. The state Medicaid agency provides oversight through audits of a representative sample of approved service plans. Participants are authorized for an initial six sessions of consultation services annually. The six sessions apply for each eligible participant, including when the participant's authorization is for less than 12 months. The participant, along with the consultation service provider, can request additional sessions. Additional sessions are approved by the SMA as requested. A separate budget is available to people who employ their own workers (i.e., CFSS agency or person/representative on budget model). This is used to pay for training, observation, monitoring and coaching of workers. These activities help workers expand their skills to support the participant's specific needs. This has been outlined as an Administrative Activity.
	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.*
	The consultation service provider works with the participant to develop a person-centered service delivery plan that recognizes risk factors and develops measures/strategies to mitigate them. Risk factors include premature depletion and underutilization of the assessed budget. Participants who choose to use the budget model will need a financial management service (FMS) provider to assist with managing their budget. The FMS will: • Review the risk mitigation plan and track expenditures accordingly • Bill and make payments for expenditures • Maintain records and provide participants with a monthly written summary of the spending for services and supports that were billed against the spending budget • Work with the participant and the consultation services provider to monitor and mitigate risk

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.
2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
3. Providers meet required qualifications.
4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
5. The SMA retains authority and responsibility for program operations and oversight.
6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Table 1a-i

Requirement	***Service plans address assessed need of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1a-i Percent of service delivery plans that document services which address participant's ADL/IADL domains of assessed need. • Numerator: Number of participant plans that document services which address ADL and IADL domains of assessed need. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans and determine if participant's assessed ADL/IADL needs have been addressed. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: *: Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) are resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1a-ii

Requirement	***Service plans address assessed need of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1a-ii Percent of participants who reported that their support worker assisted them in meeting their service goals. • Numerator: Number of participants who reported satisfaction with their support worker assisting them in meeting their goals. • Denominator: Number of survey respondents who received services.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their support worker did not adequately assist them in meeting their service goals. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1b

Requirement	***Service plans are updated annually***

Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1b Percent of participant's service delivery plans that are updated annually. • Numerator: Number of participant's whose most recent service delivery plan has been updated within a 12-month period. • Denominator: Number of participants who have a service delivery plan.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of participant's 1915(i) benefit service delivery plans to determine if they have been updated within a 12-month period Data source: Desk audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-i

Requirement	***Service plan documents choice of services and provider***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1c-i Percent of service delivery plans that document participant choice of both services and providers. • Numerator: Number of service delivery plans that document participant choice of both services and providers. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans to determine which ones documented participant choice of both services and providers. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-ii

Requirement	***Service plan documents choice of services and provider***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 1c-ii Percent of participants who reported that their consultation services provider informed them adequately of the program's person-centered practices and their service/protection related rights. • Numerator: Number of participants who reported satisfaction with their consultation services provider informing them adequately of the program's person-centered practices and their service/protection related rights. • Denominator: Number of survey respondents who received services.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their consultation services provider did not adequately inform them of the program's person-centered practices and their service/protection related rights. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 1c-iii

Requirement	***Service plan documents choice of services and provider***
Discovery	

Discovery Evidence *(Performance Measure)*	Performance Measure 1c-iii Percent of participants who reported that their support worker adequately safeguarded their service/protection related rights. • Numerator: Number of participants who reported satisfaction with their support worker adequately safeguarding their service/protection related rights. • Denominator: Number of survey respondents who provided a response during the review period.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their 1915(i) benefit support worker did not adequately safeguard their service/protection related rights. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2a

Requirement	***Eligibility requirements: An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future***
Discovery	

Discovery Evidence *(Performance Measure)*	Performance Measure 2a Percent of applicants who received a comprehensive assessment that included a determination of their medical needs. • Numerator: Number of applicants who received a functional assessment that included a determination of medical need. • Denominator: Number of applicants who applied during the benefit year.
Discovery Activity *(Source of Data & sample size)*	Upon request, all people in Minnesota are entitled to request and complete a functional assessment. They will be assessed for the needs they have at the time of assessment. The SMA reviews MMIS data to determine whether all 1915(i) benefit applicants have received an assessment that included a determination of their medical needs. Data Source: MMIS Sample Size: All 1915(i)benefit applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA is responsible to assure that every 1915(i)benefit applicant received an equitable, person-centered functional assessment that included a determination of medical need. Where this did not occur, the SMA will ensure remediation within 30 days.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2b

Requirement	***Eligibility requirements: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 2b Percent of Participants/Applicants whose 1915(i) eligibility was determined by using the functional assessment. • Numerator: Number of Participants/Applicants whose 1915(i) eligibility was determined by using the functional assessment. • Denominator: Number of Participants/Applicants.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the administration of functional assessments. Data source: MMIS Sample size: All 1915(i) benefit Participants/Applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MMIS edits direct 1915(i) benefit service/support eligibility in alignment with program requirements. For an increasing number of participants/applicants MnCHOICES drives the assessment via a series of rules-driven screens that the assessor completes in sequence. MnCHOICES determines 1915(i) benefit eligibility based on assessor responses and CFSS benefit requirements. The MnCHOICES printout directs the entry of determination data into MMIS. The SMA appeals process preserves the ability of those receiving assessments to challenge adherence to the processes/application of the instruments in making determinations. Appeals judges direct remediation of due appeals. 1915(i) benefit staff monitor trends in appeals that suggest program policies are not being properly implemented or need refining. The SMA may address the situation with clarifying technical assistance or policy refinements and other system improvements.
Frequency *(of Analysis and Aggregation)*	Annual

Table 2c

Requirement	***Eligibility requirements: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 2c • Percent of participants who were reevaluated for 1915(i) benefit eligibility annually. • Numerator: Number of participants who were reevaluated for 1915(i) benefit eligibility within a 12-month period. • Denominator: Number of participants due for reevaluation of 1915(i) benefit eligibility.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the frequency of the administration of functional assessments. Data source: Medicaid Management Information System (MMIS) Sample size: All 1915(i) benefit participants due for reevaluation of 1915(i) benefit eligibility.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA MMIS database: • Prevents the payment of 1915(i) benefit services where a recipient has not received an assessment within the previous year. • Monitors claims on a continuous basis to confirm MMIS system edit functionality. • Generates a list to counties, tribal human services agencies, and MCOs. of all participants that need a reassessment within the next 60 days. • Generates a letter to providers telling them when the service agreement for a participant they are working with ends. • Generates a letter to the participant in advance of services ending that reminds them they will need a new assessment to continue services. The Operations and Data Integrity office works with the 1915(i) benefit policy area to remediate issues in the system as they are identified.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-i

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-i Percent completion of support worker training directed by the support worker training and development plan for agency model participants. • Numerator: Number of agency model participants for whom support worker training was completed as directed by the support worker training and development plan for agency model participants. • Denominator: Number of agency model participants for whom support worker training was due to be completed.
Discovery Activity *(Source of Data & sample size)*	The SMA requires 1915(i) benefit agencies to submit annual reports on the person-centered training activity of 1915(i) benefit support workers serving agency model participants. Data source: Annual 1915(i) benefit agency provider reports Sample size: 1915(i) benefit agency model participants with current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze support worker training reports received from agency 1915(i) benefit agencies. Where it identifies that a support worker did not complete training as required in the training and development plan, it will review the agency's plan to assure that the support worker receives the training necessary to meet the participant's service needs. • Work with 1915(i) benefit agency providers to assure that the necessary support worker training occurs. • Work with consultation service providers to make any adjustments needed to • the service delivery plan, including the support worker's training and development plan.

	• Address a pattern of substandard 1915(i) benefit agency performance through the provision of technical assistance and, where needed, reassessment of the 1915(i) benefit agency's enrollment status.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-ii

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-ii Percent completion of support worker training directed by the support worker training and development plan for budget model participants. • Numerator: Number of budget model participants for whom support worker training was completed as directed by the support worker training and development plan. • Denominator: Number of budget model participants for whom support worker training was due to be completed.
Discovery Activity *(Source of Data & sample size)*	The SMA requires consultation services providers to submit annual reports on the person-centered training activity of 1915(i) benefit support workers serving budget model participants. Data source: Annual 1915(i) benefit consultation services provider reports Sample size: 1915(i) benefit budget model participants current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze support worker training reports received from consultation services providers. Where it identifies a potential support worker competency issue, it will review the participant's service plan. • Work with consultation services providers to assure that the necessary support worker training occurs and accurate documentation is maintained.

	• Address a pattern of substandard consultation services provider performance through the provision of technical assistance and, where needed, modification reassessment to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 3a-iii

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 3a-iii Percent of budget model participants served by support workers determined at performance review to adequately perform job functions. • Numerator: Number of budget model participants served by support workers determined to adequately perform job functions. • Denominator: Number of budget model participants where support worker performance was evaluated.
Discovery Activity *(Source of Data & sample size)*	The SMA directs collection of a participant 1915(i) benefit satisfaction data annually through a survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: 1915(i) benefit budget model participants who receive services/supports for at least three months under their current service plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze the 1915(i) benefit participant satisfaction data. • Conduct root-cause analysis, investigating situations where participants reported that they were dissatisfied with support worker performance. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.

Frequency *(of Analysis and Aggregation)*	Annual

Table 4a-i

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-i Percent of claims paid to providers who have attested to compliance with HCBS settings regulations. • Numerator: Number of claims paid to providers who have attested to compliance with HCBS settings regulations. • Denominator: Total number of claims paid to providers.
Discovery Activity *(Source of Data & sample size)*	As part of the provider enrollment process, the SMA reviews all 1915(i) benefit provider applications for compliance with home and community-based settings regulations which includes attestation and a pre-enrollment site visit. The SMA also maintains a series of MMIS system edits to ensure that payment is made only to qualified, HCBS settings-compliant providers authorized to provide the service(s) for which they have billed. It routinely monitors the functionality of its 1915(i) benefit qualified provider edits through comparative analysis with claims data. This assesses whether the 1915(i) benefit provider was fully qualified to deliver services on the claimed date of service delivery. Using claims data, the SMA is able to track the initial and continuous compliance of providers to deliver 1915(i) benefit services. Data source: MMIS claims and MHCP provider enrollment subsystems Sample size: Total claims paid to 1915(i) benefit providers during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA: • Verifies that providers initially and continually meet required certification and other service standards, including compliance with HCBS regulations, before being approved to deliver 1915(i) benefit services. Providers that do not meet and maintain required standards will not be authorized or paid to provide 1915(i) benefit services. • Routinely reviews claims reports to assure the ongoing functionality of system edits that prevent non-qualified providers from being approved to deliver and receive payment for 1915(i) benefit services.

Table 4a-ii

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-ii Percent of service delivery plans that document participant choice of provider and HCBS/institutional setting. • Numerator: Number of service delivery plans that document participant choice of provider and HCBS/institutional setting. • Denominator: Number of service delivery plans.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans. This includes assessment of the participant's choice of provider and choice of HCBS or institutional setting. Data source: Desk Audit, MMIS MnCHOICES data, and participant plans submitted by consultation service providers. Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; requiredtimeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 4a-iii

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 4a-iii Percent of applicants who received a comprehensive assessment, including a determination that the individual's place of residence is compliant with HCBS settings regulations. • Numerator: Number of applicants who received a comprehensive assessment, including a determination that the individual's place of residence is compliant with HCBS settings regulations. • Denominator: Number of applicants who applied during the benefit year.
Discovery Activity *(Source of Data & sample size)*	Upon request, all people in Minnesota are entitled to request and complete a functional assessment. In order to qualify for 1915(i) benefit services the assessment must determine that the individual's residence is compliant with HCBS settings regulations. The SMA reviews MMIS data to determine whether all 1915(i) benefit applicants have received an assessment that included a determination of eligibility for 1915(i) benefit services based on compliance with HCBS settings regulations. Data source: MMIS Sample size: All 1915(i) benefit applicants.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Minnesota Medicaid Management System (MMIS) edits direct 1915(i) benefit service/support eligibility in alignment with program requirements, including settings standards. For an increasing number of participants/applicants MnCHOICES drives the assessment via a series of rules-driven screens that the assessor completes in sequence. MnCHOICES determines 1915(i) benefit eligibility based on assessor responses and 1915(i) benefit requirements. The SMA is responsible to assure that every 1915(i) benefit applicant received an equitable, person-centered functional assessment that included a determination of compliance with HCBS settings regulations. Where this did not occur, the SMA will ensure remediation within 30 days.
Frequency *(of Analysis and Aggregation)*	Annual

Table 5a-i

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 5a-i Percent of all consultation services provider contract deficiencies resolved during the contract review cycle. • Numerator: Number of consultation services provider contract deficiencies resolved during the contract review cycle. • Denominator: Number of consultation services provider contract deficiencies issued during the contract review cycle.
Discovery Activity *(Source of Data & sample size)*	The SMA will assess consultation services provider performance across review of participant service delivery plan content. Review includes documentation of services to meet assessed need, updates to the service delivery plan at least annually, participant choice of both services and providers and the inclusion of an emergency back-up plan. Where the SMA identifies inadequate performance we will work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation entails submission of a formal assurance (signed by the lead professional staff) of correction of all file deficiencies within 30 days. The SMA will provide technical assistance as needed and continuously monitor provider's performance until the issue(s) are resolved. The SMA will address a pattern of sustained substandard performance through modification to the provider's contract and/or disenrollment. Data source: Consultation services provider contract performance database. Sample: All consultation services provider deficiencies identified during the contract review cycle.
Monitoring Responsibilities *(Agency or entity thatconducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 5a-ii

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 5a-ii Percent of all required data, reports, metrics requested by the SMA that was completed accurately and timely by 1915(i) providers including Consultation Service, Financial Management Services, 1915(i) provider agencies. • Numerator: Number of providers submitting required information accurately and timely • Denominator: Total number of providers
Discovery Activity *(Source of Data & sample size)*	The SMA will continually assess provider performance across provider enrollment and compliance, contract review and ongoing audits. Where the SMA identifies inadequate performance we will work with providers to achieve remediation of substandard performance within 60 days. This time period will be reduced where indicated by policy or state statute. Data source: MMIS, MnCHOICES, Desk audit, provider enrollment database. Sample: All provider deficiencies identified
Monitoring Responsibilities *(Agency or entity thatconducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA will: • Aggregate and analyze audit data. • Work with providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 6a

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 6a For participants receiving services through the Fee-for-Service model, percent of service claims paid where there was a corresponding prior authorization. • Numerator: For participants receiving services through the Fee-for-Service model, number of Service claims paid where there was a corresponding authorization in the calendar year. • Denominator: Total number of Fee-for-Service claims paid for participants.
Discovery Activity *(Source of Data & sample size)*	The SMA reviews all 1915(i) benefit service claims. Data source: MMIS Sample size: All 1915(i) benefit service claims paid using the Fee-for-Service model during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects,*	Claims without prior authorization are rejected. Many potential claims and coding problems are averted through interactive MMIS edits, including edits related to

analyzes, and aggregates remediation activities; required timeframes for remediation)	eligibility, screening data, authorization criteria and other provider status. Payment of 1915(i) benefit claims is made only after alignment of a number of records in MMIS, including all of the following: • Service was authorized in the service agreement the county, tribal human services agencies, or MCO entered into MMIS. (The service agreement includes the rate, time span, units, type of service, and provider for each service to be provided) • A screening document identifies the enrollee to whom services were delivered as 1915(i) benefit eligible • The enrollee for whom services were delivered was eligible for Medical Assistance • An active provider number on the claim matches the provider number on the service authorization and corresponds to a provider that is enrolled to deliver this service (category of service) • Services are claimed within service authorization parameters and limits If a service agreement is unable to be entered, the county, tribal human services agencies, or MCO follows up with the provider, participant or financial worker to remedy the issue. The Operations and Data Integrity office works with the 1915(i) benefit policy area to remediate issues in the system as they are identified.
Frequency *(of Analysis and Aggregation)*	Annually

Table 7a-i

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance measure 7a-i Percent of both new and existing Support Workers that completed training on (1) child protection, (2) maltreatment of vulnerable adults, and (3) responsibilities as mandated reporters. • Numerator: Number of Support Workers that completed training on (1) child protection, (2) maltreatment of vulnerable adults, and (3) responsibilities as mandated reporters. • Denominator: Total number of Supports Workers approved to deliver services.
Discovery Activity *(Source of Data & sample size)*	The SMA reviews the training received by support workers to report suspected maltreatment. Data source: Medicaid Management Information System (MMIS)

	Sample size: All 1915(i) benefit Program Supports Workers approved to deliver 1915(i) benefit services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;required timeframes for remediation)*	Minnesota has established processes for reporting abuse, neglect and exploitation of vulnerable adults and minors. The SMA requires all providers that deliver direct care services to 1915(i) benefit participants to take complete training on how to prevent, recognize and report suspected maltreatment. The SMA keeps a cataloged list of each individual worker complete with their certification number that outlines whether they have completed the training. This information stays in their provider file. Support workers are not able to be enrolled to provide services until this training is complete. The state's requirement is that reports of suspected maltreatment of an adult who is vulnerable are entered immediately into the state's Social Service Information System (SSIS) and referred to Lead Investigative Agencies within the 2 business day statutory requirement. The MAARC system and operation is tightly managed with multiple quality assurance measures in place. This includes hourly service level analysis and monitoring. The MAARC reporting system complies with statute and uses the (SSIS) and Data Warehouse to ensure timely entry, receipt, and referral of reports. Issues impacting timelines of report referral are remediated immediately upon discovery with associated plans for prevention through coaching, training or system enhancements.
Frequency *(of Analysis and Aggregation)*	Annual

Table 7a-ii

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***

Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 7a-ii Percent of reports involving participants that were submitted to the Minnesota Adult Abuse Reporting Center (MAARC) and then referred to a Lead Investigative Agency (LIA) within two working days. • Numerator: Number of reports involving participants that were submitted to the MAARC and then referred to LIA within two working days. • Denominator: Number of reports involving participants that were submitted to MAARC and then referred to LIA.
Discovery Activity *(Source of Data & sample size)*	The SMA monitors the timely response to reports of alleged maltreatment involving vulnerable adults that receive 1915(i) benefit services and supports. Data source: Social Service Information System (SSIS) Sample size: All reports of alleged maltreatment involving adults that received 1915(i) benefit services and supports during the review period.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The SMA operates the Minnesota Adult Abuse Reporting Center (MAARC). MAARC staff screen reports for immediate risks, referring all cases involving an identified safety issue to county and tribal human services agencies. MAARC immediately forwards reports containing information involving an alleged crime to law enforcement. Within two working days, the MAARC refers all reports to lead investigative agency (LIA) responsible for review and investigation of such reports. It has performance measures and a system of quality review for the MAARC. There are no required timeframes for remediation of Minnesota Adult Abuse Reporting (MAARC) performance issues. The state's requirement is that reports of suspected maltreatment of an adult who is vulnerable are entered immediately into the state's Social Service Information System (SSIS) and referred to Lead Investigative Agencies within the 2 business day statutory requirement. The MAARC system and operation is tightly managed with multiple quality assurance measures in place. This includes hourly service level analysis and monitoring. The MAARC reporting system complies with statute and uses the (SSIS) and Data Warehouse to ensure timely entry, receipt, and referral of reports. Issues impacting timelines of report referral are remediated immediately upon discovery with associated plans for prevention through coaching, training or system enhancements.

Frequency *(of Analysis and Aggregation)*	Annually

Table 7a-iii

Requirement	***The state identifies, addresses, and seeks to prevent incidentsof abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance Measure 7a-iii Percent of service delivery plans that document participant received information on how to report abuse, neglect, and exploitation. • Numerator: Number of service delivery plans that document participant received information on how to report abuse, neglect, and exploitation. • Denominator: Number of service delivery plans submitted.
Discovery Activity *(Source of Data & sample size)*	The SMA will review a representative sample, as specified below, of 1915(i) benefit service delivery plans. Data source: Desk Audit, MnCHOICES data Sample size: *Total number of all Consultation Service Provider files reviewed using 8/30 Methodology.*
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; requiredtimeframes for remediation)*	The SMA will: • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency *(of Analysis and Aggregation)*	Annual

Table 7a-iv

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.***
Discovery	
Discovery Evidence *(Performance Measure)*	Performance measure 7a-iv Percent of new providers that conduct criminal background checks on new prospective employees • Numerator: Number provider agencies applying for enrollment that performed required background studies • Denominator: Total number of agencies applying for enrollment
Discovery Activity *(Source of Data & sample size)*	SMA reviews the required application materials with every enrollment application Data source: Provider enrollment screening process Sample size: All 1915(i) providers (including 1915(i) agencies, Consultation Service providers and FMS) enrollment
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities;required timeframes for remediation)*	Applicants who do not have all required background study documentation submitted with enrollment application will not be approved for enrollment. The SMA provides the prospective provider with a request for additional information and given 30 days to respond. If the required background study information is not provided they will not continue to be screened for potential enrollment until the required information is provided.
Frequency *(of Analysis and Aggregation)*	Ongoing

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The SMA will routinely analyze 1915(i) benefit process data and the response data amassed through annual 1915(i) benefit participant surveys. 1915(i) benefit participant satisfaction data. Complimentary analysis measures the extent to which key functions assigned to program providers occurred and the extent to which they were effective in maximizing participant independence, safeguarding participant health and safety, and assisting the participant in meeting their goals.

Performance trends will identify the need for further analysis, prioritizing improvement initiatives based on analytic findings and the opportunity for targeted intervention.

2. Roles and Responsibilities

A team of SMA program and policy staff will review and analyze program operations, participant survey, performance measures, and remediation data. The team will identify opportunities for system improvements (e.g., improved training, provider standards, etc.) Policy staff will review emerging issues with the 1915(i) benefit's Implementation Council that comprises participant, provider and community representatives.

3. Frequency

The SMA will review and analyze program process and outcome data on an ongoing basis. Policy staff will meet quarterly with the 1915(i) benefit's Implementation Council to review and assess findings, contemplating program improvement initiatives where applicable.

4. Method for Evaluating Effectiveness of System Changes

When a performance finding indicates the need for intervention beyond standard remediation processes, the SMA will a rigorously identify and develop targeted improvement initiatives. The SMA will routinely monitor improvement initiatives and conduct targeted/evaluative assessment to gauge the effectiveness of the interventions it implements.