



Amendments to Minnesota's BI, CAC, CADI and DD Waiver Plans

DHS Disability Services Division

Summer/Fall 2019

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Overview of amendments

Fiscal Policy: Rates, allocations, financial management

- Identifies which services allow shared care (BI, CAC, CADI, & DD)
- Allocation of resources to lead agencies (BI, CAC, CADI & DD)
 - Updates the year-to-year percent change (BI, CAC and CADI)
 - Adds reference to statutory authority allowing DHS to transfer funding between lead agencies (BI, CAC, CADI & DD)
- Updates to rate determination method section (BI, CAC, CADI & DD)
 - Replaces references to the disability waiver rate system (DWRS) with the rate management system (RMS)
 - Adds a competitive workforce factor
 - Updates the frequency of rate inflationary adjustments
 - Removes references to residential care and supported employment services which have ended
 - Cleans up the language for consistency

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Consumer Directed Community Supports (CDCS)

- Updates to CDCS service definition (BI, CAC, CADI and DD)
 - Adds shared services language to personal assistance
 - Adds clarifying language related to direct benefit services that support caregivers
 - Aligns language regarding availability of CDCS by type of living arrangement
- Updates time limit when someone is restricted from CDCS and aligns language regarding availability of CDCS by type of living arrangement (BI, CAC, CADI and DD)
- Corrects involuntary exit language in BI, CADI and DD to align with CAC (BI, CADI and DD)
- Updates required case management function (BI, CAC, CADI and DD)
- Corrects remediation language for FMS providers and support planners (DD)
- Updates the exception to the CDCS budget methodology to align with the enhanced personal care assistance (PCA) changes from 5% to 7.5% (BI, CAC, CADI and DD)
- Updates to description of participant direction section (BI, CAC, CADI and DD)
 - Clarifies CDCS participants must use an FMS provider
 - Removes employer of record language which no longer applies
 - Adds language regarding use of one FMS provider when multiple people are using the same worker
- Removes outdated language regarding a transition plan for replacing FSE's with providers of FMS which will have expired (BI, CAC, CADI and DD)

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Home Care

- Updates verification of provider qualifications for extended personal care assistance (PCA) (BI, CAC, CADI and DD)
- Updates reference from private duty nursing (PDN) to home care nursing (HCN) (CADI)
- Updates provider qualifications for extended home care nursing (HCN) (BI, CAC, CADI and DD)

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Electronic Visit Verification (EVV)

- Adds language addressing the services required to use EVV (BI, CAC, CADI and DD)

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Case Management

- Removes written exam for the MN Merit System (BI, CAC and CADI)
- Updates “county agency” to reflect “lead agency” (BI, CAC, CADI and DD)
- Adds language addressing annual visits when the case manager is the assessor (BI, CAC, CADI and DD)

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Waiver Assessment and Support Planning

- Updates language in the following areas to reflect current practices (BI, CAC, CADI & DD)
 - Assessment (BI, CAC, CADI & DD)
 - Support planning (BI, CAC, CADI & DD)
 - Forms (BI, CAC, CADI & DD)
 - Department review of DD screening documents (DD)

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Employment and Day Services

- Adult day services and adult day services bath (BI, CAC, CADI and DD)
 - Adds language addressing colocated settings and settings on or next to institutions
 - Updates provider qualifications
- Day training and habilitation (DD)
 - Adds language addressing colocated settings and settings on or next to institutions
- Employment development, employment exploration and employment support (BI, CAC, CADI and DD)
 - Includes technical/grammatical changes
 - Clarifies ownership requirements related to employment services
 - Adds language addressing when providers can bill for indirect time
 - Adds language regarding how/where lead agencies keep documentation that VRS/IDEA funds are not available

- Prevocational services (BI, CADI and DD)
 - o Adds language addressing collocated settings and settings on or next to institutions
- Structured day (BI)
 - o Updates “maladaptive behavior” language to state “challenging behavior”
 - o Adds language addressing collocated settings and settings on or next to institutions
- Supported employment (BI, CAC, CADI and DD)
 - o Removes references to supported employment services which ended August 31, 2018
 - o Removes outdated language regarding a transition plan which has expired

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Crisis Respite and Positive Support Services

- Crisis respite services (BI, CAC, CADI and DD)
 - o Restores missing language in the crisis respite service definition (CADI)
 - o Clarifies size limits for foster care and community residential settings (BI, CAC, CADI and DD)
 - o Updates provider qualifications (BI, CAC, CADI and DD)
- Positive support services (BI, CAC, CADI and DD)
 - o Updates “maladaptive behavior” language to state “challenging behavior”
 - o Removes examples of positive support approaches
 - o Adds language addressing when providers can bill for indirect time
 - o Updates who positive support professionals and analysts can train and direct
 - o Updates provider qualifications for positive support professionals
 - o Updates provider qualifications for positive support analysts

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Other Waiver Services

- Adult companion services (BI, CAC and CADI)
 - o Corrects provider qualifications
- Caregiver living expenses (BI, CAC, CADI and DD)
 - o Updates the list of approved services (BI, CAC and CADI)
 - o Clarifies this service cannot be provided by related individuals as per federal regulations (BI, CAC, CADI and DD)
 - o Clarifies documentation requirements (BI, CAC, CADI and DD)
- Customized living (BI and CADI)
 - o Clarifies this services is for adults
- Environmental accessibility adaptations (BI, CAC, CADI and DD)
 - o Adds language allowing an assessment provider to oversee the project to ensure ADA requirements are met
 - o Clarifies when there can be an exception to modifying a primary vehicle
 - o Clarifies authorization of home modifications

- o Restores missing language addressing cameras in bedrooms of minor children (DD)
 - o Adds language requiring two comparison bids when requesting an exception to the annual limit
 - o Updates provider qualifications for home modification assessment providers
- Foster care (BI, CAC and CADI)
 - o Adds community residential setting (CRS) to the definition
- Home delivered meals (BI, CAC, CADI and DD)
 - o Updates provider qualifications
- Independent living skills (ILS) training (BI, CAC and CADI)
 - o Updates “maladaptive behavior” language to state “challenging behavior”
- Night supervision services (BI, CAC, CADI and DD)
 - o Restores missing language defining “own home” (BI and CADI)
 - o Adds language addressing what this service covers (BI, CAC, CADI and DD)
- Residential care (BI and CADI)
 - o Removes references to residential care which ended June 30, 2018
 - o Removes outdated language regarding a transition plan for residential care which has expired
- Residential habilitation (DD)
 - o Clarifies caregiver living expenses are available to providers of supported living services (SLS) for adults
 - o Clarifies where services can be provided
 - o Changes “daily staff intervention” to “daily staff support”
 - o Adds language addressing daily staff support in relation to supported living services for adults, remote support, in own home
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- Respite (BI, CAC, CADI and DD)
 - o Includes a technical change in the service definition for hospitals and nursing facilities (BI, CAC and CADI)
 - o Includes a technical change in the service definition for hospitals (DD)
 - o Clarifies unlicensed settings for adults and children (BI, CAC, CADI and DD)
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 - o Removes references to residential care which has ended (BI and CADI)
 - o Updates provider qualifications (BI, CAC, CADI and DD)
- Specialist services
 - o Adds language addressing when providers can bill for indirect time
- Transitional services (BI, CAC, CADI and DD)
 - o Corrects licensing reference for intermediate care facilities for persons with developmental disabilities
 - o Aligns “own home” definition with housing access coordination
 - o Clarifies services in customized living settings

- o Updates eligibility criteria to remove the 180-day limitation
- Transportation (BI, CAC, CADI and DD)
 - o Adds language addressing what this service covers (BI, CAC, CADI and DD)
 - o Corrects provider qualifications (BI and CADI)

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Waiver Policies

- Background studies (BI, CAC, CADI and DD)
 - o Updates list of services that require a background study
- “Direct benefit” language (BI, CAC, CADI and DD)
 - o Adds clarifying language for services that support caregivers
- Minimum age of staff (BI, CAC, CADI and DD)
 - o Adds language addressing the minimum age of staff providing waiver services
- Paying relatives (BI, CAC, CADI and DD)
 - o Updates the paying relatives, legal guardians and conservators section to provide clarity and consistency across waivers
 - o Updates language regarding CDCS and payments to relatives and parents of minors who provide foster care
- People over age 65 returning to a disability waiver (BI, CAC and CADI)
 - o Restores language allowing people over age 65 who exited due to an institutional stay, to return to a disability waiver within 180 days without Department approval
- Services covered/not covered (BI, CAC, CADI and DD)
 - o Clarifies alternative therapies are only covered under CDCS
 - o Clarifies goods and services that are not covered
- Temporary out-of-state travel (BI, CAC, CADI and DD)
 - o Clarifies language for temporary travel and local trade area
 - o Removes 30-day timeline for temporary travel
- Tribes (BI, CAC, CADI and DD)
 - o Restores language regarding tribes being under contract with the Department
- Updates eligibility groups to align with the state plan for MA-EPD (BI, CAC, CADI and DD)
- Verification of provider qualifications (BI, CAC, CADI and DD)
 - o Updates frequency of verification for all 245D licensed services
 - o Updates frequency of verification for all services where the verifying entity is the Minnesota Department of Human Services, Provider Enrollment

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Quality Assurance (QA) Measures

- Updates QA measures to correct technical errors and be consistent across waivers (BI, CAC, CADI and DD)

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Fiscal Policy: Rates, Allocations, Financial Management

- Identifies which services allow shared care (BI, CAC, CADI, & DD)
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 - Adds a competitive workforce factor
 - Updates the frequency of rate inflationary adjustments
 - Removes references to residential care and supported employment services which have ended
 - Cleans up the language for consistency

Identifies which services allow shared care (BI, CAC, CADI & DD)

BI, CAC and CADI waivers

Additional Needed Information (Optional)

Additional Waiver Information and Requirements:

For purposes of this waiver plan, and unless otherwise specified, the term “participant” means a person who is eligible for and enrolled in the waiver program. Where the waiver plan confers certain rights or obligations, the participant (or a court of law acting on the participant’s behalf) may confer those rights and obligations to a guardian, conservator or authorized representative. The use of the term “participant” does not preclude the representative from meeting those obligations or exercising those rights, to the extent of the representative’s authority.

The following are additional waiver requirements:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant’s assessment and be for the direct benefit of the participant and must be related to the participant’s disability. **[add]** Services provided are one-on-one services unless shared staffing is specified in the list below. A shared staffing rate is calculated in the Disability Waiver Rates System, and a shared staffing rate is authorized in MMIS. Shared staffing is allowed for the following services (within the same service only) at the ratio indicated:

Adult Day Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)

Structured Day (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10) (BI only)

Foster Care (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)

Prevocational Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)

Respite Services (1:1, 1:2, or 1:3)

Individualized Home Support (1:1 or 1:2)

Independent Living Skills (1:1 or 1:2)

Employment Support Services (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)

Employment Exploration Services (1:1, 1:2, 1:3, 1:4, or 1:5) [end add]

DD waiver

Additional Needed Information (Optional)

Additional Waiver Information and Requirements:

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

The following are waiver requirements:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant and must be related to the participant's disability. **[add]** Services provided are one-on-one services unless shared staffing is specified in the list below. A shared staffing rate is calculated in the Disability Waiver Rates System, and a shared staffing rate is authorized in MMIS. Shared staffing is allowed for the following services (within the same service only) at the ratio indicated:

Adult Day Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)

Day Training and Habilitation (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)

Supported Living Services (daily) (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)

Prevocational Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)

Respite Services (1:1, 1:2, or 1:3)

Employment Support Services (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)

Employment Exploration Services (1:1, 1:2, 1:3, 1:4, or 1:5) [end add]

Allocation of resources to lead agencies (BI, CAC, CADI & DD)

- **Updates the year-to-year percentage change (BI, CAC and CADI)**
- **Adds reference to statutory authority allowing DHS to transfer funding between lead agencies (BI, CAC, CADI & DD)**

BI, CAC and CADI waivers

Additional Needed Information (Optional)

ALLOCATION OF RESOURCES TO LEAD AGENCIES

The Department manages cost neutrality in the aggregate through a statewide methodology that provides an allocation to each lead agency. This section describes how the department establishes, maintains, and adjusts the lead agency allocations for fee-for-service waiver participants. The allocations do not provide funds to lead agencies, nor do they establish individual limits or caps on available services. The allocation is an aggregate "resource amount" within which lead agencies authorize waiver services. Services are authorized and paid by the state with state and federal funds.

The statewide allocation methodology includes historical costs and adjustments that are sufficient to meet participants' health and safety needs. The allocations for the Community Alternative Care (CMS control number 4128), the Brain Injury Waiver (CMS control number 4169), and Community Access for Disability Inclusion Individuals (CMS control number 0166) waivers are combined; however the Department manages waiver cost-neutrality separately for each waiver (i.e. costs are identified separately for each waiver on the annual 372 reports). Lead agencies shall not authorize services that exceed their aggregate allocation.

Service authorizations are based on participant's assessed needs that are identified through comprehensive evaluation and community support planning processes. Participants who are otherwise eligible shall not be terminated from the waiver by a lead agency for the sole purpose of the lead agency's management of its allocation.

Lead agencies must maintain written procedures and criteria that include procedures related to participant protections, community support plan development, etc. The procedures and criteria must be consistent with the waiver plan and federal regulations, including health and safety requirements and the priorities established by the department.

County and Tribe Allocations

The department establishes and adjusts allocations for each lead agency. The allocation is the maximum amount of Medical Assistance funding that shall be authorized for waiver and home care services for all participants in the aggregate who are the financial responsibility of that lead agency (financial responsibility is defined in Minnesota Statutes, Chapter 256G). Lead agencies shall not authorize Medical Assistance funding for waiver or state plan home care services in excess of its allocation. The allocation will be determined as follows:

I. Annual Allocation Amount

Annual allocations are developed using three components:

- A. The total amount of the previous year's budget, plus
- B. The full-year equivalent of additional funding provided during the previous year for serving new participants as calculated according to the methodology in paragraph II.A. below, plus
- C. Other adjustments required by state law.

II. Allocation Adjustments

- A. Within funding approved under state law, the department will add resources to the lead agency's allocation for new waiver participants.

The amount of each adjustment will be based on costs associated with the person's assessed needs with regard to:

- Level of support needed
- Presence and intensity of aggressive or destructive behaviors
- Demonstrated cost impactors including diagnosis of brain injury or mental illness

The value added for new enrollment is calculated in two steps:

- 1) Calculation of a base rate for each participant;
- 2) Adjustment to the base rate to account for cost-of-living adjustments provided under state law.

The base rate is determined using scores from 11 assessment variables. Assessment scores are used in a formula that applies coefficients to a constant to determine the base rate.

Assessment variables, coefficients, and a constant were identified through multiple regression analyses of assessment information with historical expenditures.

The following summarizes the variables, coefficients and constant used in the formula:

- Variable: Case Mix; Coefficient: 9.283; Range: A-K
- Variable: Walking; Coefficient: 2.663; Range: 0-4
- Variable: Grooming; Coefficient: 7.421; Range: 0-3
- Variable: Bed Mobility; Coefficient: 3.165; Range: 0-3
- Variable: Transfers; Coefficient: 3.008; Range: 0-4
- Variable: Behaviors 1 (BI-NF only); Coefficient: 22.462; Range: 0-4
- Variable: Behaviors 2 (BI-NF only); Coefficient: 77.495; Range: 0-4
- Variable: Behaviors 3 (CADI only); Coefficient: 22.462; Range: 0-4
- Variable: Behaviors 4 (CADI only); Coefficient: 5.494; Range: 0-4
- Variable: Behaviors 5 (CAC only); Coefficient: 5.494; Range: 0-4
- Variable: (CAC only); Coefficient: 417.016
- Variable: Constant; Coefficient: 15.218

For the case mix variable, the multipliers for the A-K range are below. If, for example, an individual's case mix level is C, multiply 9.283 by 2.66.

- Case Mix Category: A; Multiplier: 1.00
- Case Mix Category: B; Multiplier: 2.60
- Case Mix Category: C; Multiplier: 2.66
- Case Mix Category: D; Multiplier: 2.14
- Case Mix Category: E; Multiplier: 3.81
- Case Mix Category: F; Multiplier: 4.71
- Case Mix Category: G; Multiplier: 3.20
- Case Mix Category: H; Multiplier: 4.94
- Case Mix Category: I; Multiplier: 3.05
- Case Mix Category: J; Multiplier: 5.45
- Case Mix Category: K; Multiplier: 8.08

The rate from step 1 is adjusted by -2.90 to assure budget neutrality and then adjusted to account for the cumulative effect of cost-of-living adjustments approved by the legislature.

The percent change from year to year and the cumulative adjustment factors are as follows:

- Effective Date: 10/1/05; percent change 2.5199; cumulative percent change 2.5199
- Effective Date: 10/1/06; percent change 2.2533; cumulative percent change 4.832
- Effective Date: 10/1/07; percent change 2.0; cumulative percent change 6.92872
- Effective Date: 10/1/08; percent change 2.0; cumulative percent change 9.0672
- Effective Date: 7/1/09; percent change -2.58; cumulative percent change 6.2533
- Effective Date: 9/1/11; percent change -1.5; cumulative percent change 4.65950
- Effective Date: 7/1/13; percent change .5; cumulative percent change 5.18270
- Effective Date: 4/1/14; percent change 1.0; cumulative percent change 6.2345
- Effective Date: 7/1/14; percent change 5.0; cumulative percent change 11.5462
- [add]**• Effective Date: 7/1/15; percent change 1.0; cumulative percent change 12.6596 **[end add]**

Additional resources will not be provided for enrollment that exceeds funding approved under state law. Lead agencies are expected to enroll additional eligible persons to the extent service costs can be managed within the annual budget. Adjustments are not an individual budget limit or cap.

B. If a participant discontinues enrollment or becomes ineligible for waiver services, the resource amount attributable to that participant is retained by the lead agency in its budget allocation and shall be used to address increased needs of current participants, provide for future participant's needs, or serve additional waiver participants within the lead agency's current allocation.

C. The department may adjust allocations as necessary based on the relationship between the allocation and the actual waiver and home care services authorization amounts.

D. The department may adjust allocations to serve additional participants, implement changes required by law, or respond to participant moves between counties.

[add] E. The department may transfer allocations between lead agencies to assure equitable participant access across the state, as specified in Minnesota Statutes, Chapter 256B.49, subdivision 11a (c). **[end add]**

Lead Agency Allocation Management. If a lead agency's total authorizations exceed its allocation for the same time period, the department may assess a portion of the amount of authorizations that exceed the lead agency's allocation to the lead agency.

I. Participant Community Support Plans. Lead agencies are responsible to develop and modify participant community support plans based on the assessed needs and within the allocation. The community support plan will include all waiver and home care services necessary to avoid institutionalization.

II. Serving Additional Participants. Unless otherwise limited by the state, lead agencies may serve additional people within the budget allocation (e.g. without the department adjusting the allocation). If a participant exits the waiver, the lead agency may use its allocation for that participant, to add waiver participants or address the anticipated needs of current participants.

Monitoring.

The department closely monitors the allocations through a variety of means including the waiver management system, lead agency reviews, fair hearing requests, and staff contact with lead agencies.

DD waiver

Additional Needed Information (Optional)

ALLOCATION OF RESOURCES TO LEAD AGENCIES

The Department manages cost neutrality in the aggregate through a statewide methodology that provides an allocation to each lead agency. This section describes how the department establishes, maintains, and adjusts lead agency allocations for fee-for-service waiver participants. The allocations do not provide funding or money to lead agencies, nor do they establish individual limits or caps on available services. The allocation is an aggregate "resource amount" within which lead agencies authorize waiver services. Services are authorized and paid by the state with state funds.

The statewide allocation methodology includes historical costs and adjustments that are sufficient to meet the participant's health and safety needs.

Service authorizations are based on participants assessed needs that are identified through comprehensive evaluation and community support planning processes. Participants who are otherwise eligible shall not be terminated from the waiver by a lead agency for the sole purpose of the lead agency's management of its allocation.

Lead agencies must maintain written procedures and criteria that include procedures related to participant protections, community support plan development, allocation management, etc. The procedures and criteria must be consistent with the waiver plan and federal regulations, including health and safety requirements and the priorities established by the department.

Lead Agency Allocations.

The department establishes and adjusts allocations for each lead agency. The allocation is the maximum amount of Medical Assistance funding that shall be authorized for waiver and home care services for all participants in the aggregate who are the financial responsibility of that lead agency (financial responsibility is defined in Minnesota Statutes, Chapter 256G). Lead agencies shall not authorize Medical Assistance funding for waiver or state plan home care services in excess of its allocation. The allocation will be determined as follows:

There are two types of new participants that are included in the allocation; Those that lead agencies have screened and are planning to provide services; and, those that have emergency needs and require immediate services.

The resource amount added to the lead agency's allocation for each new participant (planned and emergency) is the statewide weighted average for the age bracket of each participant. The formula for statewide weighted average is described below.

The department reserves a portion of the available state funding to fund new participants who have emergency needs when the lead agency cannot adequately meet the participant's needs within its annual allocations. The participant must meet eligibility requirements described under "Department Management" below.

Lead agency allocations are calculated by multiplying each lead agency's daily weighted average by the lead agency's enrollment count. This amount is then adjusted, as applicable, for: Service intensity, legislative changes; facility closure and other agreements; and a ratio of allowable to claims to paid claims. Definitions and descriptions of each component in the calculation are described below. Recalibration and service optimizing are also defined and described below because they are integral components to the allocation methodology.

The daily budget includes the following components:

A. Daily Weighted Average. This refers to six age brackets that reflect waiver service costs including those related to place of residence. The daily weighted average is derived by:

1. Historical Analysis. The daily weighted average is determined based on analysis of each lead agency's historical expenditures related to waiver and home care services for a year. The expenditures are identified in MMIS. If expenditure data is not complete for a full year, the data is annualized to represent a full year of expenditures (the annualization calculation is a conversion to full accrual of costs for a one year period).
2. Residence and Age Factors. For each lead agency, the average daily expenditures for waiver and home care services gathered in the historical analysis are divided into categories based on residence and age. Expenditure data is sorted into eight residential settings that represent all residential options covered by the waiver. The data is then divided into six age brackets. The age brackets were determined through analysis of existing waiver participants and are the ages that significant service changes occur.

B. Recalibration. This is the process of recalculating the daily weighted averages with updated cost information. Waiver and home care claims data will be analyzed every five years based on the preceding years data. This information will be used to reset the daily weighted average amounts for each age bracket by lead agency. The recalibration was implemented in calendar year 2014 and will occur every five years thereafter.

C. Enrollment Count. The number of participants identified in the last quarter of the previous calendar year in the waiver tracking system. The enrollment count is derived from age and waiver status data in MMIS. Participant's age is defined as the age they will turn during the calendar year being calculated.

When refilling vacancies created by people who disenroll from the waiver, the lead agency shall designate which new participants replace the vacancies (this does not affect the prioritization for enrollment in the waiver). These participants will be tracked in the Waiver Management System. The number of individuals who fill vacancies may not exceed the number of people who discontinued waiver services for any year (new enrollment is not limited to lead agencies refilling vacancies).

D. Service Optimizing. Term used when lead agencies elect to serve additional participants, when no additional resource amount is added to the lead agency's allocation for the participants services until they are counted at

recalibration. Lead agencies must determine that their existing allocation is sufficient to meet the needs of additional participants.

Participants added under this provision are not counted in the enrollment count until the next scheduled recalibration and will be tracked in the Waiver Management System.

Participants for whom no resource amount is added to the allocation, are counted as waiver participants for purposes of cost-neutrality reporting and waiver enrollment (e.g., Factor C in the cost-neutrality equation).

E. Service Intensity. Accounts for changes in participant's needs or circumstances, such as loss of significant caregiver or living arrangement, or change in support needs due to medical, physical, behavioral or mental health events. The allocation will be adjusted for service intensity. An amount equal to one percent (1%) of the total statewide allocation will be used for this adjustment. The one percent is divided by the total statewide enrollment to establish a per enrollment amount. That amount is multiplied by the number of participants in each lead agency, and each lead agency's allocation is adjusted by that amount.

F. Legislative Changes. Adjustments to the lead agency's allocations required by state law. These are applied to the lead agency's total allocations as defined in the law and include provider rate changes and new enrollment. The statewide daily weighted average will be used to calculate the resource amount added to the allocations for new participants.

G. Closure and Other Agreements. This refers to agreements between a lead agency and the department related to allocation adjustments for specific and extraordinary needs such as the closure of an intermediate care facility for persons with developmentally disabilities (ICF/DD). A lead agency that initiates an ICF/DD closure or downsizing shall not receive additional resources in their allocation, beyond the daily weighted average for the participants for whom they are financially responsible.

The allocations of lead agencies that are financially responsible for individuals affected by an ICF/DD closure or downsizing, initiated by another lead agency, may be adjusted by the department (State funding to enroll individuals who are being discharged from an ICF/DD, is provided in addition to adding new individuals as described above [i.e., there are no slot limits people converting from ICFs/DD]). The adjustment is based on the negotiated costs per day of the affected participants to meet their health and safety needs, and the department's evaluation of those costs.

In the case of facility receivership or abandonment, all counties of financial responsibility of affected participants may be considered for additional funding.

The department may also adjust lead agency allocations for other agreements required to meet health and safety needs of participants.

H. Ratio of allowable claims to paid claims. This is based on the amount between the lead agency's historical allocation and paid claims. Because the allocations are based on the lead agency's previous years paid claims and those claims are historically two percent (2%) less than the allocation for that year, an adjustment is

needed. The department will add an adjustment for the ratio of allowable to paid claims ratio to each lead agency's allocation.

The amount of the ratio will be calculated each year and will be based on the difference between each lead agency's allocation and paid claims for the previous three year period (for each lead agency). The exact period is determined by the availability of data. In total, this adjustment will not exceed the statewide ratio between historical costs and allocations for all lead agencies.

Lead Agency Allocation Management. If a lead agency's total paid claims exceed its allocation for the same time period, the department may assess a portion of the amount of paid claims that exceed the lead agency's allocation to the lead agency.

I. Participant Community Support Plans. Lead agencies are responsible to develop and modify participant community support plans based on the assessed needs and within the allocation. The community support plan will include all waiver and home care services necessary to avoid institutionalization.

II. Waiver and Home Care Service Changes. The lead agency shall not spend Medical Assistance funding for waiver or State plan home care services beyond its allocation including accounting for future needs of current recipients. If a lead agency re-evaluates a support plan, it must follow Minnesota Rules, Parts 9525.0004 to 9525.0036 and instructions provided by the department. All applicable recipient notification and appeal rights apply.

III. Serving Additional Participants. Unless otherwise limited by the state, lead agencies may serve additional people within the budget allocation (e.g. without the department adjusting the allocation). If a participant exits the waiver, the lead agency may use its allocation for that participant, to add waiver participants or address the anticipated needs of current participants.

IV. County Waiver Allocation Plans. The lead agency must establish and maintain written criteria and procedures for prioritizing waiver applicants and allocating resources within the lead agency's allocation. These criteria and procedures must be submitted to the department for review initially and prior to any revision being implemented. The criteria and procedures must be available upon request.

V. Reserve Amounts. Lead agencies must have and submit to the department a plan to address changes in participant's needs including anticipated, unexpected and emergency needs, within their allocation. This plan shall be available to the public upon request.

Lead agencies may elect to establish a reasonable reserve amount to address these participants' needs. The reserve amount must be based on the lead agency's experiences, participant utilization history, and anticipated participant's needs.

~~[delete] Lead agencies may elect to establish a reasonable reserve amount to address these participant's needs. The reserve amount must be based on the lead agency's experiences, participant utilization history, and anticipated participant's needs. [end delete]~~

[add] The department may transfer allocations between lead agencies to assure equitable participant access across the state, as specified in Minnesota Statutes, Chapter 256B.092, subdivision 12 (c). **[end add]**

Department Management

A. Safety Net. The safety net is an emergency fund amount managed by the department to assure current participants service needs will be met in the event of unexpected and significant changes that cause a substantial increase in the cost of the participants services and are directly related to the changes. The department will manage lead agency eligibility for the safety net by applying a statistical analysis that compares service days and lead agency allocation. The department will publish the results of this analysis annually and the availability of the safety net for lead agencies.

When the department authorizes additional amounts to a lead agency's allocation through the safety net, the amounts are individually assigned to a participant for that participants services, and are not retained in the lead agency's allocation when the participant exits the waiver or changes county of financial responsibility.

In addition to lead agency eligibility, the participant must meet one of the following criteria:

- Sudden loss of caregiver (e.g., death, abandonment, life threatening condition with poor prognosis for recovery)
- Immediate risk of out of home placement (e.g., due to a natural or other disaster, removal from unsafe living situation, etc.)
- Immediate risk of ICF/DD placement

B. Waiver enrollment. The department manages statewide waiver enrollment (Factor C in Appendix G). When funding is available for new participants, the department allocates resources to lead agencies. The department takes into account the number of people who may be waiting to receive waiver services, how their needs are currently being met, their risk status, and available funding.

The department also reserves a portion of the available resources to fund new participants who have emergency needs when the county of financial responsibility has exhausted its available allocation (funding to participants with emergency needs is different from the safety net. The safety net applies to people who are already enrolled on the waiver.) To be eligible for an emergency allocation, the participant must meet at least one of the criteria listed above under safety net management.

The amount added to the lead agency's allocation for these participants will be the statewide weighted average for the age bracket of each new participant as described under "Lead Agency Allocations" shown above.

Monitoring. The department closely monitors the allocations through a variety of means including the waiver management system, lead agency allocation plans, lead agency reviews, fair hearing requests, and staff contact with lead agencies.

Updates to rate determination method section (BI, CAC, CADI & DD)

- Replaces references to the disability waiver rate system (DWRS) with the rate management system (RMS)
- Adds a competitive workforce factor
- Updates the frequency of rate inflationary adjustments
- Removes references to residential care and supported employment services which have ended
- Cleans up the language for consistency

BI, CAC, CADI and DD waivers

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Minnesota pays for services in 3 ways.

1. DHS sets rates for state plan services, including home care services, home care nursing & PCA services ~~[delete] except for individuals who elect to receive CDCS [end delete]~~. These rates are approved in the state plan. **[add] Personal care for participants who elect to receive CDCS are not state set rates. [end add]**

DHS establishes rates for case mgmt, ext PCA, homemaker, home-delivered meals and chore services. Case mgmt is paid at \$24.47 (BI, CAC & CADI) and \$23.19 (DD) per 15-min unit. Ext PCA is paid for 1:1, 1:2 and 1:3 ratios at \$4.35, \$3.26 and \$2.86 respectively per 15-min units. For persons eligible for 12 or more hours of daily PCA, ext PCA rates are increased by ~~[delete] 5-[end delete]~~ **[add] 7.5% [end add]** ~~[delete] effective Jul 1, 2018, [end delete]~~ when the service is provided by persons who have completed the required training. Homemaker **[add] (home mgmt & w/ADLs) [end add]** is paid at \$4.61/15-min unit, home-delivered meals are paid at \$6.53/meal, and chore services are paid at \$3.76/15 min unit. These rates are subject to COLA increases as enacted by the Legislature.

2. Market rates are used when services are purchased at the price typically charged on a market basis.

Market rate services:

- 24 hour emergency assistance
- Assistive technology (DD)
- Caregiver Living Expenses
- Crisis Respite
- Environmental Accessibility Adaptations
- Family Training and Counseling
- Homemaker (cleaning component)

- ILS therapies (BI)
- Respite (daily)
- Specialized Equipment & Supplies
- Transitional Services (expenses)
- Transportation
- Specialist Services

3. For all other waiver services, rate methods are described in MN Stat. 256B.4914 **[add]** and calculated in the rate management system (RMS) **[end add]**. Rate methods are grouped into 4 categories:

Payment for residential support services:

- Customized living (BI & CADI)
- Foster Care (BI, CAC & CADI)
- [delete]-Residential care (BI and CADI)-[end delete]**
- Residential habilitation (SLS in foster care) (DD)

Payment for day program services:

- Adult Day Service
- Adult Day Service Bath (BI, CADI & DD)
- Day Training & Habilitation (DD)
- Prevocational services
- Structured day (BI)

Payments for unit-based services with programming:

- Independent Living Skills Training (BI, CAC & CADI)
- Individualized Home Supports (BI, CAC & CADI)
- In-Home Family Supports (BI, CAC & CADI)
- Personal Support
- Positive Support
- Housing Access Coordination
- Residential habilitation (in-home family supports & SLS **[add]** own home **[end add]**) (DD only)
- [delete]-Supported Employment-[end delete]**
- Employment Exploration
- Employment Development
- Employment Support

And payments for unit-based services w/o programming:

- Night Supervision
- Respite (15-min unit)
- Adult Companion (BI, CAC & CADI)

These rate methods share many similar values, calculations and expense categories with some variations within each. Rates are determined by common calculations and factors.

Rate methods are applied statewide. Online technology is utilized to determine payment rates for all waiver services. Using individualized participant information and information collected from providers, lead agencies

enter information into ~~the rate management system~~ **RMS** ~~that~~ calculates individualized payment rates based on the person's service plan. RMS takes into consideration shared and individual staffing.

Information entered into RMS includes: shared and individual staffing hours, direct RN & LPN hours, staffing ratios, information to document variable levels of service qualification for variable levels of reimbursement in each framework, shared or individualized arrangements for unit-based services, and service hours provided through monitoring technology.

Provider related expenses include direct service wages, supervision, employee-related cost factors (required tax and benefit obligations), and client and program overhead factors (expenses related to indirect support of service delivery **unless otherwise indicated in service specific definition**). Provider related costs are multiplied by required service units to provide a rate for each waiver participant. These factors are fixed across all providers.

In all rate categories, direct staffing wage costs are the main driver of rates. A base wage index was established using MN-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook. **A competitive workforce factor multiplier is applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.** The average wages are adjusted to differentiate between shared and individual staffing. The system takes into account shared staffing, when staff are available to provide services to more than one person and individual staffing, and when direct care staff are available to solely provide support as a one-to-one interaction with a specific individual. Other personnel expenses are added to produce a provider's rate for individuals including a supervisory span of control which accounts for the number of subordinates a supervisor has during the time service is provided and an added customization rate for assisting those in need of deaf/hard of hearing support. All those provider's expenses are multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits and client programming, including transportation. Client programming costs, including transportation to provide individuals access to the community or care in their home as defined in a support plan are also considered.

Within the 4 rates categories, some fixed components, which apply to only one specific category, are added separately. These include: transportation & client programming and support for residential services, facility use factor for day services, meal & snacks for adult day.

Automatic inflationary adjustments within the model will impact the component values every ~~five~~ **two** years, beginning ~~with 7/1/17~~ **7/1/22**. COLAs (after-model rate increases) enacted by the legislature will also impact these component values prior to the implementation of the automatic inflationary adjustments (rebase) within the model. When the inflationary adjustments within the model are updated using BLS and CPI, the COLAs enacted by the legislature will be replaced by the inflationary adjustments within the model. If a legislative COLA occurs in the years between rebasing, they will add to component values prior to and until the next rebase. During the rate stabilization period described below, historical rates used to calculate the limitation will include the COLAs.

DHS maintains a document with these values at ~~https://mn.gov/dhs/assets/20171003-DWRS-components_tcm1053-316648.pdf~~ **https://mn.gov/dhs/assets/2019-DWRS-component-values_tcm1053-356458.pdf**.

For individuals who use sign language and do not hear/understand speech and require staff to be fluent signers of ASL Deaf/Hard of hearing (DHOH) customization option is available in the RMS. This customization applies to individuals who meet Long Term Care and screening criteria. Staff who are fluent in ASL must provide the service, and the staff must employ this skill in the provision of service to an individual who meets the screening criteria.

There are circumstances when an individual may have exceptional needs which cannot be met by an increase in service units in ~~[delete] DWRS [end delete]~~ [add] RMS [end add]. In these cases, lead agencies may submit an exception request to increase an individual's service rate based on the person's service plan [add], as described in Minn. Stat. 256B.4914, subd. 14 [end add]. Exception requests will be reviewed on an individual basis and approved or denied by the state. Individuals may appeal any denial of an exception request.

[add] Specific exception policies exist for the following services (see Appendix C, service definitions): environmental accessibility adaptations, CDCS, extended PCA and remote support. [end add]

~~[delete] To ensure budget neutrality across all service areas, rates generated by RMS will be multiplied by a budget neutrality factor which is unique for each service area. The factor for residential services is 1.003, for day services 1.000, for unit-based with programming 0.941 and unit-based without programming 0.796. This budget neutrality adjustment will be phased out by 12/31/18. [end delete]~~

Implementation of new ~~[delete] DWRS [end delete]~~ [add] RMS [end add] system began 1/1/14 and was completed in 1 year. All service plans were entered into the ~~[delete] DWRS [end delete]~~ [add] RMS [end add] during individual annual reviews by 12/31/14. Implementation will include a 6-year rate stabilization adjustment period, from 1/1/14 through 12/31/19, during which individual reimbursement rates will be adjusted no higher or lower than:

- 0.5% change for CY 2014
- An additional 0.5% change for 2015
- An additional 0.5% change for 2016
- An additional 1.0% change for 2017
- An additional 1.0% change for 2018
- 2018 rates remain in effect for 2019
- True rate management system framework rates beginning 1/1/20

Rate stabilization adjustments limit changes in historic unit rates for all existing authorizations and some new authorizations of framework services.

A rate stabilization adjustment is applied in the following circumstances:

- when a waiver span is renewed for an existing participant, or
- when a new day or unit-based service with a provider who was authorized to provide that service (identified by procedure code and modifier) in that county (participant's county of residence) in 12/13 is authorized, or
- when there is a change in the unit rate of an existing service agreement for residential or day services.

Rate stabilization adjustments do not apply to new service providers.

To mitigate overpayments, rate file limits are set in MMIS. While some services with state established singular rates only allow for payments at an exact, actual rate, framework and market rate services may be billed at varying rates with a rate file limit established to function as a protection in the system. Rate file limits for every

service offered under the disability waivers are based on analysis of historic unit rates in the MMIS system. These rate file limits are changed as rate adjustments occur. DHS sets rate file limits for all services, regardless of payment methodology, as found in the Long-Term Services and Supports Rate Limits document:

<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG>

Providers delivering services with rates determined under MN Stat. 256B.4914 are required to report business costs every 5 yrs. The state will analyze data for each service at the individual, provider, lead agency and state levels and provide reports which include rate re-base recommendations to the legislature on **[delete] 1/15/20** **[end delete] [add] 1/15/21 [end add]** and every 4 yrs thereafter.

DHS uses several methods to monitor waiver functions delegated to lead agencies, to ensure support plans are being met, ensure equitable access to services for participants, and to evaluate purchase. These include lead agency reviews and regionally assigned staff as outlined in Appdx A.

To monitor rate system integrity, DHS will analyze data and create 2 types of reports to ensure that lead agencies accurately enter required elements in RMS to produce correct payment rates. An analysis, conducted annually, will identify high and low outliers at the individual service level. A second, annual analysis will be conducted through random sample and will assess systems continuity by service and region and identify data trends that may indicate inconsistent RMS utilization. These reports will be issued to lead agencies for analysis and necessary correction. Regional staff will conduct follow-up and assistance to ensure appropriate remediation.

For residential supports and day program services, the licensing process under chapter 245D will involve a comparison of the staffing hours and staffing ratios used for purposes of the payment rate to the actual staffing hours and ratios in a sampling of case files, as part of ensuring that needs identified in the community support plan have been met. Where staffing hours/ratios are not sufficient to meet identified needs, remediation will occur through the licensing process as identified in chapter 245D. This process began with technical assistance visits in 07/14, with a 2-yr licensing review cycle beginning 01/15.

For residential supports and day program services, the lead agency review process will be modified to review individual needs identified in the support plan in comparison to the staffing hours/ratios identified for purposes of the payment rates. This review may be used to inform the determination in the licensing process as to whether needs identified in the support plan have been met.

Beginning 2012 and every 2 years thereafter, the state conducts a gaps analysis and reports to the Legislature on the capacity and gaps in long-term care services and supports.

All reports are available upon request.

Consumer Directed Community Supports (CDCS)

- Updates to CDCS service definition (BI, CAC, CADI and DD)
 - Adds shared services language to personal assistance
 - Adds clarifying language related to direct benefit services that support caregivers
 - Aligns language regarding availability of CDCS by type of living arrangement
- Updates time limit when someone is restricted from CDCS and aligns language regarding availability of CDCS by type of living arrangement (BI, CAC, CADI and DD)
- Corrects involuntary exit language in BI, CADI and DD to align with CAC (BI, CADI and DD)
- Updates required case management function (BI, CAC, CADI and DD)
- Corrects remediation language for FMS providers and support planners (DD)
- Updates the exception to the CDCS budget methodology to align with the enhanced personal care assistance (PCA) changes from 5% to 7.5% (BI, CAC, CADI and DD)
- Updates to description of participant direction section (BI, CAC, CADI and DD)
 - Clarifies CDCS participants must use an FMS provider
 - Removes employer of record language which no longer applies
 - Adds language regarding use of one FMS provider when multiple people are using the same worker
- Removes outdated language regarding a transition plan for replacing FSE's with providers of FMS which will have expired (BI, CAC, CADI and DD)

Updates to CDCS service definition (BI, CAC, CADI & DD)

- **Adds shared services language to personal assistance**
- **Adds clarifying language related to direct benefit services that support caregivers**
- **Aligns language regarding the availability of CDCS by type of living arrangement**

BI, CAC and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Consumer-directed community supports (CDCS): personal assistance

Service Definition (Scope):

CDCS: personal assistance is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. Personal assistance includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category:

- Assistance with activities of daily living and incidental activities of daily living
- Respite care
- Homemaking

[add] Services provided under CDCS personal assistance are provided on a one-to-one basis unless the lead agency approves the use of shared services. Shared services can only be authorized for services in the personal assistance category and within the scope of personal assistance services.

Shared services are defined as services provided simultaneously to no more than three participants by the same direct care worker. The participants must jointly develop and enter into an agreement to share services.

The need for shared services must be identified in each participant's support plan. The lead agency for each participant must authorize the use of shared services based on a determination that the shared service is appropriate to meet the assessed needs of each participant.

Participants sharing services must use the same provider of financial management services (FMS) to ensure program integrity and simplify the processing of claims. The use of one FMS provider will ensure there is no duplication of services or overlapping of worker shifts. This safeguard will also ensure that workers are receiving overtime for applicable hours worked.

A participant or the participant's representative may withdraw from participating in a shared services agreement at any time. [end add]

CDCS services are not available to waiver participants receiving licensed foster care ~~[delete] or home care services-[end delete]~~ while residing in a residential setting licensed by the Department of Human Services (DHS) or ~~[add] home care services while residing in a residential setting registered by [end add]~~ the Minnesota Department of Health (MDH) ~~[delete] or registered-[end delete]~~ as a housing with services establishment.

Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment ~~[add], related to the participant's disability, [end add]~~ and be for the direct benefit of the participant ~~[delete]-and must be related to the participant's disability and/or condition-[end delete]~~. ~~[add] Some services that support caregivers such as respite, specialist services and family training & counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support. [end add]~~

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

- a) are provided prior to the development of the community support plan;
- b) duplicate other services in the community support plan;
- c) supplant natural supports appropriately meeting the participant's needs;
- d) are not the least costly and effective means to meet the participant's needs; or
- e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

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

- Maintain the ability of the participant to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the participant;
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

CDCS cannot be used to cover:

- Services covered by the State plan, Medicare, or other liable third parties including education and vocational services
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Allowable Expenditures: Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. There are four general categories of services which may be billed:

- Personal Assistance
- Treatment and training
- Environmental modifications and provisions
- Self direction support activities

Additionally, the following goods and services may also be included in the participant's budget as long as they meet the criteria and fit into the above categories:

- Goods and services that augment State plan services or provide alternatives to waiver or state plan services
- Therapies, special diets, thickening agents, and behavioral supports not otherwise available through the State plan that mitigate the participant's disability when prescribed by a physician who is enrolled as a MHCP provider
- Expenses related to the development and implementation of the community support plan. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment and must be related to the participant's disability and/or condition.
- FMS cost incurred to manage the participant's budget
- Maintenance of vehicle modifications (i.e. wheelchair lift)
- Costs related to internet access based on criteria established by the state

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

The cost of the CDCS services must be within the participant's individual budget. See Appendix E.

[add] Shared services cannot be provided:

- To more than three participants by one worker at one time;
- When more than one worker is providing services to participants who are sharing services; or
- For a child care program licensed under chapter 245A or operated by a local school district or public school.

[end add]

Service Title:

Consumer-directed community supports (CDCS): self-direction support activities
Consumer-directed community supports (CDCS): environmental modifications and provisions
Consumer-directed community supports (CDCS): treatment and training

Service Definition (Scope):

CDCS services are not available to waiver participants receiving licensed foster care **[delete]** ~~or home care services~~ **[end delete]** while residing in a residential setting licensed by the Department of Human Services (DHS) or **[add]** home care services while residing in a residential setting registered by **[end add]** the Minnesota Department of Health (MDH) **[delete]** ~~or registered~~ **[end delete]** as a housing with services establishment.

Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment **[add]**, related to the participant's disability, **[end add]** and be for the direct benefit of the participant **[delete]** ~~and must be related to the participant's disability and/or condition~~ **[end delete]**. **[add]** Some services that support caregivers such as respite, specialist services and family training & counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support.

[end add]

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

- a) are provided prior to the development of the community support plan;
- b) duplicate other services in the community support plan;
- c) supplant natural supports appropriately meeting the participant's needs;
- d) are not the least costly and effective means to meet the participant's needs; or
- e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

CADI waiver**Appendix C-1/C-3: Participant Services – Service Specification****Service Title:**

Consumer-directed community supports (CDCS): personal assistance

Service Definition (Scope):

CDCS: personal assistance is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. Personal assistance includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category:

- Assistance with activities of daily living and incidental activities of daily living
- Respite care
- Homemaking

[add] Services provided under CDCS personal assistance are provided on a one-to-one basis unless the lead agency approves the use of shared services. Shared services can only be authorized for services in the personal assistance category and within the scope of personal assistance services.

Shared services are defined as services provided simultaneously to no more than three participants by the same direct care worker. The participants must jointly develop and enter into an agreement to share services.

The need for shared services must be identified in each participant's support plan. The lead agency for each participant must authorize the use of shared services based on a determination that the shared service is appropriate to meet the assessed needs of each participant.

Participants sharing services must use the same provider of financial management services (FMS) to ensure program integrity and simplify the processing of claims. The use of one FMS provider will ensure there is no duplication of services or overlapping of worker shifts. This safeguard will also ensure that workers are receiving overtime for applicable hours worked.

A participant or the participant's representative may withdraw from participating in a shared services agreement at any time.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or home care services while residing in a residential setting registered by the Minnesota Department of Health (MDH) or as a housing with services establishment.
[end add]

Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment **[add]**, related to the participant's disability, **[end add]** and be for the direct benefit of the participant **[delete]** and must be related to the participant's disability and/or condition **[end delete]**. **[add]** Some services that support caregivers such as respite, specialist services and family training & counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support.
[end add]

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

- a) are provided prior to the development of the community support plan;
- b) duplicate other services in the community support plan;
- c) supplant natural supports appropriately meeting the participant's needs;
- d) are not the least costly and effective means to meet the participant's needs; or

e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

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

- Maintain the ability of the participant to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the participant;
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

CDCS cannot be used to cover:

- Services covered by the State plan, Medicare, or other liable third parties including education and vocational services
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Allowable Expenditures: Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. There are four general categories of services which may be billed:

- Personal Assistance
- Treatment and training
- Environmental modifications and provisions
- Self direction support activities

Additionally, the following goods and services may also be included in the participant's budget as long as they meet the criteria and fit into the above categories:

- Goods and services that augment State plan services or provide alternatives to waiver or state plan services
- Therapies, special diets, thickening agents, and behavioral supports not otherwise available through the State plan that mitigate the participant's disability when prescribed by a physician who is enrolled as a MHCP provider
- Expenses related to the development and implementation of the community support plan. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment and must be related to the participant's disability and/or condition.
- FMS cost incurred to manage the participant's budget
- Maintenance of vehicle modifications (i.e. wheelchair lift)
- Costs related to internet access based on criteria established by the state

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

The cost of the CDCS services must be within the participant's individual budget. See Appendix E.

[add] Shared services cannot be provided:

- To more than three participants by one worker at one time;
- When more than one worker is providing services to participants who are sharing services; or

- For a child care program licensed under chapter 245A or operated by a local school district or public school.
[end add]

Service Title:

Consumer-directed community supports (CDCS): self-direction support activities
 Consumer-directed community supports (CDCS): environmental modifications and provisions
 Consumer-directed community supports (CDCS): treatment and training

Service Definition (Scope):

[add] CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or home care services while residing in a residential setting registered by the Minnesota Department of Health (MDH) as a housing with services establishment. [end add]

Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment [add], related to the participant's disability. [end add] and be for the direct benefit of the participant ~~[delete] and must be related to the participant's disability and/or condition~~[end delete]. [add] Some services that support caregivers such as respite, specialist services and family training & counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support. [end add]
2. The waiver shall cover only those goods and services authorized in the community support plan that collectively represent a feasible alternative to institutional care. Services not included in the community support plan are not covered. In addition, goods and services are not covered when they:
 - a) are provided prior to the development of the community support plan;
 - b) duplicate other services in the community support plan;
 - c) supplant natural supports appropriately meeting the participant's needs;
 - d) are not the least costly and effective means to meet the participant's needs; or
 - e) are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

Updates time limit when someone is restricted from CDCS and aligns language regarding the availability of CDCS by type of living arrangement (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Consumer-directed community supports (CDCS): personal assistance

Consumer-directed community supports (CDCS): treatment and training
Consumer-directed community supports (CDCS): environmental modifications and provisions
Consumer-directed community supports (CDCS): self-direction support activities

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

The cost of the CDCS services must be within the participant's individual budget. See Appendix E.

Unallowable Expenditures. Goods and services that shall not be purchased within the participant's budget are:

- Any fees incurred by the participant such as MHCP fees and co-pays;
- Attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items;
- Home modifications that add any square footage with the exception of the addition of square footage necessary to make a bathroom accessible. The lead agency can seek state approval to increase the square footage of a home when the increase is necessary to build or modify a wheelchair accessible bathroom. (See Environmental Accessibility Adaptations).
- Home modifications for a residence other than the primary residence of the participant or, in the event of a minor with parents not living together, the primary residences of the parents;
- CDCS services to any participant ~~[delete] or their representative who has at any time been assigned to [end delete]~~ **[add]** who is placed in [end add] the Minnesota Restricted Recipient Program **[add]** (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP. [end add]
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and copayments;
- Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance;
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs.

Appendix E: Participant Direction of Services

E-1: Overview

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

☒ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

☒ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Participants are not eligible for CDCS if they ~~[delete] or their representative have at any time been assigned to [end delete]~~ **[add]** have been placed in [end add] the Minnesota Restricted Recipient program **[add]** (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP. [end add]
People receiving licensed foster care ~~[delete] or home care services [end delete]~~ while residing in residential

settings ~~[delete]~~, settings ~~[end delete]~~ licensed by DHS or ~~[add]~~ home care services while residing in a residential setting registered by the ~~[end add]~~ MDH ~~[delete]~~, or settings registered ~~[end delete]~~ as a housing with services establishment ~~[delete]~~ with MDH ~~[end delete]~~ are not eligible for CDCS.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

☐ Waiver is designed to support only individuals who want to direct their services.

☐ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

☒ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Participants are not eligible for CDCS if they ~~[delete]~~ or their representative have at any time been assigned to ~~[end delete]~~ [add] have been placed in ~~[end add]~~ the Minnesota Restricted Recipient program [add] (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP. [end add] CDCS services are not available to waiver participants receiving licensed foster care ~~[delete]~~ or home care services ~~[end delete]~~ while residing in residential settings ~~[delete]~~, settings ~~[end delete]~~ licensed by the Department of Human Services (DHS) or ~~[add]~~ home care services while residing in a residential setting registered by ~~[end add]~~ the Minnesota Department of Health (MDH) ~~[delete]~~, or registered ~~[end delete]~~ as a housing with services establishment ~~[delete]~~ with MDH ~~[end delete]~~.

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

CDCS services are not available to an individual ~~[delete]~~ or representative who has at any time been restricted by ~~[end delete]~~ [add] who has been placed in ~~[end add]~~ the Minnesota Restricted Recipient Program [add] (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP. [end add] Also, if a CDCS participant exits with the waiver more than once during a service plan year, the participant is ineligible for CDCS services for the remainder of that service plan year. Finally, a participant can become ineligible for CDCS services if they move to and receive licensed foster care ~~[delete]~~ or home care services ~~[end delete]~~ in a residential setting licensed by DHS or ~~[add]~~ home care services while residing in a residential setting registered by the ~~[end add]~~ MDH ~~[delete]~~ or a setting registered ~~[end delete]~~ as a housing with services establishment.

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

Corrects involuntary exit language in BI, CADI and DD to align with CAC (BI, CADI and DD)

BI, CADI and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview

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

~~[delete] The case manager will initiate a revision of the community support plan in order to provide waiver services other than CDCS. [end delete]~~

[add] The lead agency case manager may initiate an involuntary exit from CDCS when:

- Health and safety concerns arise; or,
- Suspected fraud or misuse of funds are evident; or,
- A fourth occurrence from the date of CDCS authorization requiring corrective action (additional technical assistance) is encountered.

The participant may be immediately exited from CDCS and returned to traditional waiver services. [end add]

Updates required case management function (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Required Lead Agency Functions (not included in the participant's CDCS budget):

1. Screen and determine if individuals are MA eligible.
2. Screen and assess to determine if the individual is eligible for waiver services including level of care requirements.
3. Provide the applicant or participant with information regarding HCBS alternatives to make an informed choice.
4. If the applicant or participant elects CDCS, provide them with their maximum budget amount.
5. Provide CDCS participants with resources and informational tool kits to assist them in managing the service.
6. Evaluate that the participant's health and safety needs are expected to be met given the community support plan including provider training and standards.
7. Evaluate if the plan is appropriate including that the goods and services meet the service description and provider qualifications, rates appear to be appropriate, etc.
8. Review the service plan and MMIS service agreement, review rates, and set limits by service category.
9. Authorize waiver services (prior authorize the MMIS service agreement).
10. Review and authorize additional funding for environmental modifications or assistive technology exceeding \$5,000 and additional quality assurance if it is manageable within the lead agency's overall waiver allocation.
11. Manage waiver spending within the lead agency's allowable waiver allocation.

12. Monitor and evaluate the implementation of the community support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions (this includes taking action when required to address suspected or alleged abuse, neglect, or exploitation of a participant as a mandated reporter according to the Maltreatment of Minors or Vulnerable Adults acts).

13. At a minimum, review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter. Monitoring requirements are increased when the provider is the parent of a minor or spouse of a participant.

14. Monitor the ~~[delete] maintenance of financial records, and the [end delete]~~ management of the budget and services.

15. Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. **[add]** Fiscal records refers to the participant's management and recordkeeping ability to retain and submit receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider. **[end add]**

~~[delete] 14.~~ **[end delete]** **[add]** 16. **[end add]** Investigate reports related to vulnerability or misuse of public funds per jurisdiction.

~~[delete] 15.~~ **[end delete]** **[add]** 17. **[end add]** Assist the state agency in completing satisfaction measurements as requested.

~~[delete] 16.~~ **[end delete]** **[add]** 18. **[end add]** Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested.

~~[delete] 17.~~ **[end delete]** **[add]** 19. **[end add]** Have a system for participants to contact the lead agency on a 24-hour basis in the case of a service emergency or crisis.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

This section delineates and distinguishes those mandatory functions of the lead agency (required case management), and those optional functions that are covered under CDCS: self-direction support activities, under the subcategory of flexible case management.

Required Lead Agency Functions that are not included within the CDCS budget:

- Screen and determine if individuals are MA eligible
- Screen and assess to determine if the individual is eligible for waiver services including level of care requirements
- Provide the participant with information regarding HCBS alternatives to make an informed choice
- If the participant elects CDCS, provide them with their maximum budget amount
- Provide CDCS participants with resources and informational tool kits to assist them in managing the service
- Determine whether the participant's health and safety needs are expected to be met through the community support plan

- Determine if the plan is appropriate, including that the goods and services meet the service description and provider qualifications, rates are appropriate, etc.
- Review the service plan and MMIS service agreement, review rates, and set limits by service category
- Authorize waiver services (prior authorize the MMIS agreement)
- Review and authorize additional funding for environmental modifications or assistive technology exceeding \$5,000 and additional quality assurance if it is manageable within the lead agency's overall waiver allocation
- Monitor and evaluate the implementation of the community support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions. This includes taking action as a mandated reporter when required to address suspected or alleged abuse, neglect, or exploitation of a participant according to the Vulnerable Adult and Maltreatment of Minors Acts.
- At a minimum, review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter (monitoring requirements are increased when the provider is the parent of a minor participant or spouse of a participant).
- Monitor ~~[delete] the maintenance of financial records, and [end delete]~~ the management of the budget and services
- Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. **[add]** Fiscal records refers to the participant's management and recordkeeping ability to retain and submit receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider. **[end add]**
- Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction
- Assist the state agency in completing satisfaction measurements as requested
- Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested
- Have a system for participants to contact the lead agency on a 24 hour basis in the case of a service emergency or crisis.

Optional, direct support functions (support planning services) that are included in the CDCS budget:

- If the participant elects waiver services, provide information about CDCS and provider options
- Facilitate development of a person centered community support plan
- Monitor and assist with revisions to the community support plan
- Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers
- Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.)
- Monitor the provision of services including such things as interviews or monitoring visits with the participant or service providers
- Provide staff training that is specific to the participant's community support plan.

Corrects remediation language for FMS providers and support planners (DD)

DD waiver

Appendix C: Participant Services – Quality Improvement: Qualified Providers

b. Methods for Remediation/Fixing Individual Problems

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

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. When licensed providers are found to be out of compliance with applicable requirements, the licensing agency will issue a citation for each violation determined and require corrective action. Depending on the nature, severity, and/or chronicity of the violation, the licensing agency establishes the method and timeframe by which evidence of remediation must be submitted or observed. Other sanctions available include fines and conditional, suspended, and revoked licensure.

Requisite provider and staff training is reviewed and verified as a condition of licensure for most waiver service provider types.

When enrolled Financial Management Services (FMS) providers are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The FMS provider must submit evidence of remediation. Depending on the nature, severity, and/or chronicity of the violation, ~~[delete] a providers certification may be placed in probationary status, the length of certification may be shortened, or certification may be revoked.~~ **[end delete] [add]** the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;
- Limiting a provider's ability to receive payment;
- Suspending or terminating the provider's enrollment; or
- Terminating the contract with the State. **[end add]**

When a participants Support Planner is found to be out of compliance with applicable requirements, the Department may deny recertification unless/until remediation is made. Depending on the nature, severity, and/or chronicity of the violation, ~~[delete] the Department may take action up to and including:~~ **[end delete]** **[add]** certification may be revoked. **[end add]**

- ~~**[delete]** • Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;~~
- ~~Limiting a provider's ability to receive payment;~~
 - ~~Suspending or terminating the provider's enrollment; or~~
 - ~~Terminating the contract with the State.~~ **[end delete]**

Provider Enrollment. When the Departments Provider Enrollment unit identifies an enrolled provider that does not meet the applicable qualifications or standards required by the waiver, the provider is subject to monetary recovery, administrative sanctions (up to and including disenrollment), or civil or criminal action. Providers have appeal rights under Minnesota Statutes, Chapter 14.

Provider Training and Technical Assistance. Central office, provider help desk and regionally-based Department staff provide training and/or technical assistance to providers and local lead agencies upon request or when waiver requirement compliance issues are identified.

Updates the exception to the CDCS budget methodology to align with the enhanced personal care assistance (PCA) changes from 5% to 7.5% (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction

b. Participant – Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

There are circumstances when a participant may have exceptional needs which cannot be met by their CDCS budget. Exceptions to the CDCS budget methodology may be allowed under any of the following four criteria:

1. Individuals who require greater resources than are allowed in order to leave institutions or crisis settings may request to increase their CDCS budget by no more than the amount of appropriate services provided in a non-institutional setting as determined by the lead agency.
2. Individuals who require greater resources than are allowed in order to improve their employment opportunities or increase the amount of time they can work may request to increase their CDCS budget by up to 30%.
3. Individuals who require greater resources than are allowed in order to transition to, move to, or live in their own home may request to increase their CDCS budget by up to 30%.
4. Individuals who require greater resources than are allowed to develop and implement a positive support plan may request to increase their CDCS budget by up to 30%.
5. Individuals may request to increase their CDCS budget by up to ~~5%~~ **[add] 7.5% [end add]** when the following criteria are met:
 - a. The individual is eligible for 12 or more daily hours of personal care assistance
 - b. The individual's services are provided by a worker who has completed the required training.

Individuals who meet more than one criteria may request to increase their budget for each of the four exception reasons listed above. For items #2-4 above, the maximum cumulative CDCS budget adjustment amount is 30%. A person may obtain the adjustment as described in item #5 above in addition to other adjustments for which they are eligible. **[add] For item #5, this rate is subject to COLA or SEIU collective bargaining increases as enacted by the Legislature. [end add]**

Updates to description of participant direction section (BI, CAC, CADI and DD)

- Clarifies CDCS participants must use an FMS provider
- Removes employer of record language which no longer applies
- Adds language regarding use of one FMS provider when multiple people are using the same worker

BI, CAC, CADI and DD waivers

Appendix E: Participant Direction of Services

E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver, and alternatives that support participants. Four categories of CDCS are covered: personal assistance; treatment and training; environmental modifications and provisions; and self-direction support activities. Refer to Appendix C, Summary of Services Covered. Participants or their representative hire, fire, manage and direct their support workers. The participants or their representative ~~[delete] may [end delete]~~ [add] must [end add] purchase assistance with these functions through a financial management services (FMS) provider.

FMS providers offer supports as defined in the agreement between the FMS and the participant; the contract with the State; and provider enrollment standards. ~~[delete] The employer of record must be identified and documented in the participant's community support plan. [end delete]~~ Support planners may also provide assistance with employee related functions as defined in the provider standards. Support planners shall not be the employer of record.

[add] When more than one CDCS participant lives in the same household and chooses to receive services from the same worker (either shared services or 1:1 service), all participants are required to use the same FMS provider.

When it is determined there is a joint employer, all participants associated with that joint employer must use the same FMS provider. [end add]

Removes outdated language regarding a transition plan for replacing FSE's with providers of FMS which will have expired (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Attachment #1: Transition Plan

~~[delete] TRANSITION PLAN FOR REPLACEMENT OF FISCAL SUPPORT ENTITIES WITH PROVIDERS OF FINANCIAL~~

MANAGEMENT SERVICES

In March of 2016, the Department held a public meeting to announce the proposed changes to fiscal services that would affect CDCS participants. Interested participants, lead agency representatives, advocacy organizations, and fiscal support entities attended the public meeting both in-person and via the phone. After the meeting, the Department conducted an online survey to address questions about this proposed change. The questions and the Department's responses were published June 23, 2016.

On 5/2/16 and 10/17/16, the Department published requests for proposals for financial management services (FMS) providers seeking to replace the current Fiscal Support Entities. The FMS providers will hold contracts with the State of Minnesota and will be enrolled providers. Three of Minnesota's current Fiscal Support Entities did not respond to the RFP and two current Fiscal Support Entities made business decisions to discontinue providing financial management services.

Although five (5) current Fiscal Support Entities have chosen not to become providers of Financial Management Services, six (6) new organizations responded to our Request for Proposals, met the RFP requirements, and contracted with the state to become FMS providers. We can ensure adequate capacity as the number of FMS providers that will be available to participants exceeds the current number of Fiscal Support Entities.

All affected participants will be asked to choose a FMS provider and may remain with their current provider if that provider chooses to provide financial management services. Participants using the Agency with Choice and Fiscal Conduit models will need to transition to the Payroll model. The Department will transition participants from FSE to FMS providers in phases. During each phase, each affected participant will receive a formal notice from the Department describing the change from FSE to FMS providers.

Note: In order to provide the least disruptive transition to participants, Fiscal Support Entities will remain operational until all current participants have selected a FMS provider. Six months after CMS approval of this transition plan, participants who are new to the program (CDCS) must select an FMS provider.

Phase I:

- The providers who have chosen to discontinue serving participants using the Payroll and Fiscal Conduit models will notify those participants that they need to select a different provider. Participants will be offered a choice of providers.

Phase II:

- Enrollment of Financial Management Services (FMS) providers

- Once FMS providers are enrolled, the Department will notify participants using the Agency with Choice model and who are being served by an entity discontinuing services that they must choose a different provider. Participants will choose an FMS provider and transition to the Payroll model.

- Beginning six months after CMS approval of this change, new CDCS participants must select an FMS provider and use the Payroll model. Agency with Choice and Fiscal Conduit models will no longer be available to participants.

- The Department will conduct training for lead agencies.

Phase III

- ~~The Department will notify participants using the Agency with Choice model and served by an FSE that will be an FMS provider that they must choose an FMS provider. Participants using the Agency with Choice model will transition to the Payroll Model.~~
- ~~The Department will notify participants using the Fiscal Conduit model and served by an FSE that will be an FMS provider that they must choose an FMS provider. Participants using the Fiscal Conduit model will transition to the Payroll Model.~~
- ~~The Department will notify participants using the Payroll model and served by an FSE that will be an FMS provider that they must choose an FMS provider. [end delete]~~

Home Care

- Updates verification of provider qualifications for extended personal care assistance (PCA) (BI, CAC, CADI and DD)
- Updates reference from private duty nursing (PDN) to home care nursing (HCN) (CADI)
- Updates provider qualifications for extended home care nursing (HCN) (BI, CAC, CADI and DD)

Updates verification of provider qualifications for extended personal care assistance (PCA) (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Extended Personal Care Assistance

Provider Specifications:

Agency – Personal care provider agencies and personal care choice provider agencies

Verification of Provider Qualifications:

Entity Responsible for Verification:

Minnesota Department of Human Services

Frequency of Verification:

~~[delete] Annually [end delete]~~ **[add] Every three years [end add]**

Provider Specifications:

Agency – Medicare certified home health agencies

Verification of Provider Qualifications:

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services

Frequency of Verification:

~~[delete] Annually [end delete]~~ **[add] Every three years [end add]**

Updates reference from private duty nursing (PDN) to home care nursing (HCN) (CADI)

CADI waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Extended **[delete]** State Plan **[end delete]** Home Care Nursing

Provider Specifications:

Agency – Home health agencies

Provider Qualifications:

Other Standard (*specify*):

Must meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.

Nurses who provide **[delete]** PDN **[end delete]** **[add]** HCN **[end add]** services as an employee of a home health agency must have a valid license to practice in Minnesota.

Updates provider qualifications for extended home care nursing (HCN) (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Extended Home Care Nursing

Provider Specifications:

Agency – Home health agencies

Verification of Provider Qualifications:

Entity Responsible for Verification:

Minnesota Department of Health **[add]** and Minnesota Department of Human Services **[end add]**

Frequency of Verification:

Every **[delete]** one to three **[end delete]** **[add]** five **[end add]** years

Provider Specifications:

[add] Agency – Home care nursing agencies **[end add]**

Provider Qualifications:

License (*specify*):

[add] Comprehensive home care license in accordance with Minnesota Statutes, section 144A.43 through 144A.484 **[end add]**

Verification of Provider Qualifications:

Entity Responsible for Verification:

[add] Minnesota Department of Health and Minnesota Department of Human Services **[end add]**

Frequency of Verification:

[add] Every five years [end add]

Electronic Visit Verification (EVV)

Adds language addressing the services required to use EVV (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix I-1: Financial Accountability – Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Potential claims and coding problems are minimized or averted through MMIS system edits related to service authorizations, eligibility, and claims processing. For a claim to be paid, the claim must correspond with the service authorization entered by the lead agency in the form of a service agreement. The service agreement is based on the participant's community support plan and includes rates, time spans, service type, and provider. The claim must also correspond with Medicaid and waiver eligibility files that include edits for such things as living arrangement. For example, if a provider attempts to bill using a valid claim code, but is not an appropriate provider type, a systems edit will post and an electronic message would be sent describing the inconsistency. The claim would not be paid until the identified problem was corrected.

The department's surveillance and integrity review section (SIRS) is responsible for the post-payment review of provider claims paid through MMIS. This includes identifying and investigating possible Medicaid fraud. SIRS monitors claims with routine reports to identify outlier claims or unusual patterns. The SIRS unit also conducts periodic reviews of providers and responds to reported concerns. In terms of scope, SIRS reviews the information on the claim against the department policies and rules and the provider records.

Participants receive an explanation of medical benefits (EOMB) summary from the department regarding what services Medical Assistance covered on their behalf. The EOMB includes information to contact the department to report questions or concerns regarding Medical Assistance payments.

SIRS also receives reports from a hot line, lead agencies, law enforcement, third party payers, and provider staff. If an issue is identified during a SIRS investigation that may affect other providers of the same (or similar) service type, SIRS reviews the claims histories of those providers (in the same or other counties) and investigates as appropriate.

[add] Upon implementation, the following waiver services are subject to electronic visit verification (EVV) as specified in Laws of Minnesota 2019, 1st Special Session, chapter 9, article 5, section 82:

- CDCS direct support workers within the personal assistance category
- Crisis respite (in-home)
- Extended personal care assistance
- Extended home health care

- Homemaker - assistance with activities of daily living
- In-home family support
- Night supervision
- Personal support
- Respite (in-home)
- Individualized home supports (in-person). **[end add]**

Minnesota does not require independent audit of waiver providers' financial statements. Counties and the state agency are subject to the Single Audit Act. The State Auditor is responsible for conducting the audit required by the Single Audit Act.

Case Management

- Removes written exam for the MN Merit System (BI, CAC and CADI)
- Updates “county agency” to reflect “lead agency” (BI, CAC, CADI and DD)
- Adds language addressing annual visits when the case manager is the assessor (BI, CAC, CADI and DD)

Removes written exam for the MN Merit System (BI, CAC and CADI)

BI, CAC and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Case Management

Provider Specifications:

Individual – Social Workers

Provider Qualifications:

Other Standard (*specify*):

Social workers must be a graduate from an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate from an accredited four-year college with a major in any field and one year experience as a social worker/case manager/care coordinator in a public or private social service agency. **[delete]** Social workers must also pass a written examination covering knowledge of counseling, interviewing, and social science principles through the Minnesota Merit System or a county civil service system in Minnesota. **[end delete]**

[add] For lead agencies that use the Minnesota Merit System or a county civil service system, social workers must:

- Apply to the Merit System to be considered for an open social worker position and be put on an eligible employment list
- Meet the minimum qualifications of a social worker under MN Rule 9575 or the county civil service system. **[end add]**

Standards for the Minnesota Merit System are authorized under Minnesota Rules, parts 9575.0010 to 9575.1580. Authority to set personnel standards is granted to the commissioner of human services under Minnesota Statutes, section 256.012.

Updates “county agency” to reflect “lead agency” (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Case Management

Provider Specifications:

Individual – Social Workers

Individual – Registered or public health nurses

Provider Qualifications:**Other Standard (specify):**

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

Adds language addressing annual visits when the case manager is the assessor (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Case Management

Service Definition (Scope):

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

The case manager or case aide shall not have a personal financial interest in the services provided to the participant.

Case managers shall ~~initiate and oversee the process of assessment and~~ refer the participant for a MnCHOICES reassessment ~~of the participant's level of care~~ and provide the necessary information to the certified assessor. Case managers are responsible for ongoing monitoring of the provision of services included in the participant's ~~community support~~ coordinated services and supports plan. Case managers must have a minimum of two face-to-face contacts with the participant within the twelve-month period. The participant's annual reevaluation may be counted as one face-to-face contact when case management activities are performed at the time of the visit.

Case aides shall perform only administrative tasks delegated and supervised by the case manager that do not involve professional expertise or judgment (e.g., case filing, contacts to vendors to schedule services, phone contacts). Case aides shall not conduct initial assessments, reassessments, or community support plan development. Case aides must understand, respect and maintain confidentiality in regard to all details of their work.

Waiver Assessment and Support Planning

Updates language in the following areas to reflect current practices (BI, CAC, CADI & DD)

- Assessment (BI, CAC, CADI & DD)
- Support planning (BI, CAC, CADI & DD)
- Forms (BI, CAC, CADI & DD)
- Department review of DD screening documents (DD)

BI and CADI waivers

Appendix B-6: Participant Access and Eligibility – Evaluation/Revaluation of Level of Care

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

Lead agencies use assessors who have completed training and are certified. The certified assessors demonstrate best practices in assessment and support planning including the use of person-centered principals and a common set of knowledge and skills that ensure consistency and equitable access to services statewide.

Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and support planning for long-term services and supports in the state.

[delete] Long-term care consultation [end delete] [add] Multidisciplinary [end add] teams are established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

Certified assessors must be part of a multidisciplinary **[delete] long-term care consultation [end delete]** team of professionals that includes public health nurses, social workers, and other professionals as defined in Minnesota Statutes, section 256B.0911, Subd. 2b, paragraph (b). The county where the person is located at the time of the assessment is responsible for providing **[delete] long-term care consultation services [end delete] [add] a MnCHOICES comprehensive assessment [end add]** regardless of eligibility for Minnesota Health Care Programs.

CAC waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Revaluation of Level of Care

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

Lead agencies use assessors who have completed training and are certified. The certified assessors demonstrate best practices in assessment and support planning including the use of person-centered principals and a common set of knowledge and skills that ensure consistency and equitable access to services statewide.

Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and support planning for long-term services and supports in the state.

[delete] Long-term care consultation [end delete] [add] Multidisciplinary [end add] teams are established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

Certified assessors must be part of a multidisciplinary **[delete] long-term care consultation [end delete]** team of professionals that includes public health nurses, social workers, and other professionals as defined in Minnesota Statutes, section 256B.0911, Subd. 2b, paragraph (b). **[add] The county where the person is located at the time of the assessment is responsible for providing a MnCHOICES comprehensive assessment regardless of eligibility for Minnesota Health Care Programs. [end add]**

DD waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Revaluation of Level of Care

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

Certified assessors perform initial evaluations. A registered nurse must be consulted for persons who are determined to have overriding health care needs **[add] that impact the delivery of services [end add]** and are:

- Seeking admission to a nursing facility or ICF/DD; or
- accessing home and community-based services

The case manager must meet the provider qualifications to provide case management as defined in Appendix C-3 Waiver Services Specifications for case management qualifications.

Lead agencies use assessors who have completed training and are certified. The certified assessors demonstrate best practices in assessment and support planning including the use of person-centered principles and a common set of knowledge and skills that ensure consistency and equitable access to services statewide.

Certified assessors must have a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and support planning for long-term services and supports in the state.

Multidisciplinary ~~[delete] long-term care consultation [end delete]~~ teams are established by the county board of commissioners. Two or more counties may collaborate to establish a joint local consultation team or teams.

Certified assessors must be part of a multidisciplinary ~~[delete] long-term care consultation [end delete]~~ team of professionals that includes public health nurses, social workers, and other professionals as defined in Minnesota Statutes, section 256B.0911, Subd. 2b, paragraph (b). The county where the person is located at the time of the assessment is responsible for providing ~~[delete] long-term care consultation services [end delete]~~ **[add] a MnCHOICES comprehensive assessment [end add]** regardless of eligibility for Minnesota Health Care Programs.

BI waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Reevaluation of Level of Care

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

The following tools and related policies are used to determine an applicant's level of care:

- **[add] MnCHOICES assessment or [end add]** Minnesota Long Term Care Consultation Services Assessment Form (DHS form 3428 or 3428A)
- Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children under 18 (DHS form 3428C)
- ~~**[delete] • MnCHOICES assessment [end delete]**~~
- OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (DHS form 3426)
- ~~**[delete] • Nursing Facility Level of Care, Recording the Basis of Professional Determination of Need, Preadmission Screening and Community Assessment for Individuals Under 21 Years Old (DHS form 3361) [end delete]**~~
- Nursing Facility Level of Care Criteria: Determining Service Eligibility for Medical Assistance Payment of Nursing Facility Services and Home and Community-Based Programs ~~**[delete], Effective January 1, 2015 for Individuals Age 21 and Older [end delete]**~~ (DHS form 7028)
- ~~**[delete] • Brain Injury Waiver Assessment and Eligibility Determination (DHS 3471)**~~
- ~~**• Brain Injury Waiver Assessment and Eligibility Instructions/Worksheet (DHS 3471A)**~~
- ~~**• Brain Injury Waiver Eligibility and Documentation Checklist (DHS 3471B) [end delete]**~~

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

The determination includes evaluating whether the applicant is able to:

- Meet their personal care needs
- Perform household management tasks
- Communicate basic wants and needs, and ensure their own safety
- Access community resources

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

- Physical assistance or ongoing supervision to accomplish activities of daily living or someone to complete activities of daily living for the individual
- Physical assistance or ongoing supervision to accomplish instrumental activities of daily living to decrease vulnerability for self-neglect or maltreatment by another, or someone to complete instrumental activities of daily living for the individual
- Assistance with activities or instrumental activities of daily living resulting from a sensory impairment
- Extended state plan home care or other delegated health services necessary to prevent or delay nursing facility admission secondary to a complex or unstable medical need
- Home modification or equipment that will maximize independence and contribute to meeting health and safety needs
- Services or supports to access community resources or maintain social networks and relationships
- Caregiver supports to supplement and extend supports provided by informal caregivers
- Supervision, direction, cueing, or hands-on assistance to perform activities or instrumental activities of daily living due to cognitive or behavioral limitations.

~~[delete]~~ The ~~[end delete]~~ **[add]** MnCHOICES summarizes the information captured during the assessment on the LTC Screening Document (DHS-3427). If MnCHOICES is not used, the ~~[end add]~~ LTC Screening Document (DHS form 3427) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

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

CAC waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Reevaluation of Level of Care

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

The following ~~[delete]~~ forms ~~[end delete]~~ tools and related policies are used to determine an applicant's level of care:

- **[add]** MnCHOICES assessment or **[end add]** Minnesota Long Term Care Consultation Services Assessment Form (DHS-3428)
- For children: Minnesota Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children under 18 (DHS-3428C)
- ~~[delete]~~ • ~~MnCHOICES assessment~~ ~~[end delete]~~
- CAC Application / Reassessment Support Plan (DHS-3614) and corresponding instructions (DHS-3614A)

Assessment Process

An individual's initial assessment is completed using the MnCHOICES assessment tool. It is comprehensive and conducted in-person by a certified assessor.

~~[delete] The initial and annual evaluations of level of care are included in the long term care consultation (LTCC) process. The screening team is made up of at least one social worker and at least one public health nurse from the lead agency. This team is responsible to provide LTCC assessment to all persons referred. One or both persons may complete the face-to-face assessment. The team is responsible for completion of the LTC Screening Document – AC, BI, CAC, CADI, ECS, EW, MHM, MSC+, MSHO, SNBC (DHS-3427). The team participates in the LTCC to discuss all the areas of the assessment and develop the community support plan. This process also includes identifying the individual’s strengths and goals.~~

~~The social worker and nurse use information from the LTCC assessment to determine whether the person meets the hospital level of care criteria.~~ ~~[end delete]~~ The ~~[delete]~~ LTCC ~~[end delete]~~ assessment includes assessment of activities of daily living, instrumental activities of daily living, medical service needs, safety and supervision needs, and informal caregiver support. The ~~[delete]~~ case manager ~~[end delete]~~ **[add]** certified assessor ~~[end add]~~ **[add]** also uses information from medical histories, physician records, and reports from providers to further evaluate and understand the applicant’s or participant’s needs.

Because people who may be eligible for CAC are likely to have significant medical needs, ~~[delete]~~ ~~an interdisciplinary~~ ~~[end delete]~~ **[add]** a multidisciplinary ~~[end add]~~ team is generally involved in needs assessment and service planning. The team generally includes the applicant (or participant if it is a reassessment), social worker and/or nurse, **[add]** and ~~[end add]~~ family members ~~[delete]~~, and providers ~~[end delete]~~. The team participates in the ~~[delete]~~ LTCC to discuss ~~[end delete]~~ **[add]** assessment and discusses ~~[end add]~~ **[add]** all areas of ~~[delete]~~ the assessment and develop the community support plan ~~[end delete]~~ **[add]** need and when appropriate develops the CSSP ~~[end add]~~.

~~[delete]~~ ~~The~~ ~~[end delete]~~ **[add]** Initially and at each subsequent assessment, the ~~[end add]~~ applicant’s or participant’s primary physician must certify that the individual requires the level of care provided in a hospital and the level of care assessment must conclude that the individual requires the level of care provided in a hospital and be consistent with the waiver eligibility criteria (as listed in Appendix B-1(b)).

~~[delete]~~ ~~The~~ ~~[end delete]~~ **[add]** MnCHOICES summarizes the information captured during the assessment on the LTC Screening Document (DHS-3427). If MnCHOICES is not used, the ~~[end add]~~ LTC Screening Document (DHS form 3427) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

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

CADI waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Reevaluation of Level of Care

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

The following tools and related policies are used to determine an applicant’s level of care:

- **[add]** MnCHOICES assessment or **[end add]** Minnesota Long Term Care Consultation Services Assessment Form (DHS form 3428 or 3428A)

- Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children under 18 (DHS form 3428C)

[delete] • ~~MnCHOICES assessment~~ **[end delete]**

- OBRA Level I Criteria – Screening for Developmental Disabilities or Mental Illness (DHS form 3426)

[delete] • ~~Nursing Facility Level of Care, Recording the Basis of Professional Determination of Need, Pre-admission Screening and Community Assessment for Individuals Under 21 Years Old (DHS form 3361)~~ **[end delete]**

- Nursing Facility Level of Care Criteria: Determining Service Eligibility for Medical Assistance Payment of Nursing Facility Services and Home and Community-Based Programs **[delete]**, Effective January 1, 2015 for Individuals Age 21 and Older **[end delete]** (DHS form 7028)

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

The determination includes evaluating whether the applicant is able to:

- Meet their personal care needs
- Perform household management tasks
- Communicate basic wants and needs, and ensure their own safety
- Access community resources

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

- Physical assistance or ongoing supervision to accomplish activities of daily living or someone to complete activities of daily living for the individual
- Physical assistance or ongoing supervision to accomplish instrumental activities of daily living to decrease vulnerability for self-neglect or maltreatment by another, or someone to complete instrumental activities of daily living for the individual
- Assistance with activities or instrumental activities of daily living resulting from a sensory impairment
- Extended state plan home care or other delegated health services necessary to prevent or delay nursing facility admission secondary to a complex or unstable medical need
- Home modification or equipment that will maximize independence and contribute to meeting health and safety needs
- Services or supports to access community resources or maintain social networks and relationships
- Caregiver supports to supplement and extend supports provided by informal caregivers
- Supervision, direction, cueing, or hands-on- assistance to perform activities or instrumental activities of daily living due to cognitive or behavioral limitations.

[delete] The **[end delete]** **[add]** MnCHOICES summarizes the information captured during the assessment on the LTC Screening Document (DHS-3427). If MnCHOICES is not used, the **[end add]** LTC Screening Document (DHS form 3427) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

All forms can be found at: http://www.dhs.state.mn.us/main/id_000100

DD waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Reevaluation of Level of Care

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

To determine an individual's level of care, **[add]** certified assessors use MnCHOICES. If MnCHOICES is not used to complete the assessment, **[end add]** case managers may use the Case Managers Guide to Determining ICF/DD Level of Care for ICF/DD and DD Waiver Services, (DHS-4147A). The corresponding instructions, Completing the Case Managers Guide to Determining ICF/DD Level of Care, are provided in DHS-4147B. Case managers may elect to use a lead agency developed form that meets criteria established by the state or maintain other documentation concerning the level of care determination in the participants file.

The level of care criteria includes evaluating whether the individual:

[add] • **[end add]** Has a developmental disability or a related condition, and

[add] • **[end add]** Requires a 24 hour plan of care, and is unable to apply skills learned in one environment to new environments without additional training or supervision, and

[add] • **[end add]** Needs active treatment

To meet the need for active treatment the individual must be unable to:

- care for personal need, or
- perform household management tasks, or
- communicate basic wants and needs, or
- comprehend spoken language, or
- use community environments, or
- demonstrate effective social skills, or
- be employed without long-term supervision or support, or
- make decisions that require informed consent, or
- self-moderate challenging behavior

[add] MnCHOICES summarizes the information captured during the assessment on the DD Screening Document (DHS-3067). If MnCHOICES is not used, **[end add]** **[delete]** Case **[end delete]** **[add]** case **[end add]** managers use the DD Screening Document (DHS-3067) to summarize the results of the level of care assessment.

If an individual does not have a diagnosis of developmental disability but may meet the criteria for a related condition, the Related Conditions Checklist, (DHS-3848) is also required to determine if the individuals condition meets the requirements for waiver eligibility. The corresponding instructions, Instructions for the Related Conditions Checklist, are provided in form DHS-3848A.

DD waiver

Appendix B-6: Participant Access and Eligibility – Evaluation/Reevaluation of Level of Care

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

An individual's first assessment is completed using the MnCHOICES assessment tool. It is comprehensive and conducted in-person and includes reviewing diagnostic information. Generally, an assessment involves a number of individuals who are or will be involved in the participant's services. For example, this may include the participant's family or friends, a qualified developmental disability professional, the case manager, a nurse if the participant has a complex medical condition **[add]** that effects the delivery of services, **[end add]** and others the person deems appropriate.

In addition to the first assessment, reassessments are completed annually, and if there is a significant change in the participant's condition that warrants a **[delete]** ~~comprehensive review~~ **[end delete]** **[add]** new assessment **[end add]**. Lead agencies enter key summary information from the MnCHOICES assessment **[delete]** ~~or full team screenings~~ **[end delete]**, including information related to the level of care, into MMIS screening documents.

Level of care re-evaluations are conducted annually and include reviewing the participant's diagnostic information, level of care, choice of services, and community support plan.

[delete] ~~Department staff review all screening documents and level of care determinations from full team screenings when certain key fields are revised in the document. For example, when there is a change in the diagnostic code, MMIS tags the document for the department to review. If the department reviewer does not concur with the level of care determination, or other information in the screening document, the document is not approved and returned to the lead agency electronically with comments. The lead agency may provide additional information to the department for further review.~~ **[end delete]**

Minnesota Statutes, section 256B.0911 provides for an assessment for any person with long term or chronic care needs to help identify the person's need for services and supports and to develop a support plan. The assessment includes a level of care determination. The assessment is conducted upon request by or on behalf of the applicant, including through referrals from human services agencies and medical clinics. The new/initial assessment is conducted in person using **[delete]** ~~form DHS-3067 or~~ **[end delete]** a MnCHOICES assessment.

MnCHOICES is a web-based application that is comprehensive and integrates assessment and support planning for people who need long-term services and supports (LTSS) in Minnesota. MnCHOICES embraces a person-centered approach to ensure services meet each individual's strengths, goals, preferences and assessed needs. MnCHOICES is for people of all ages who have any type of disability or need for LTSS. The MnCHOICES assessment replaces the following assessment tools:

- Developmental disabilities screening
- Long-term care consultation assessment
- Personal care assistance assessment

MnCHOICES was launched for new/initial assessments in 2013. All lead agencies are now using MnCHOICES for new/initial assessments. In January 2017, MnCHOICES began implementation statewide for reassessments. We are working on a staggered timeline to ensure all reassessment will be completed in MnCHOICES. MnCHOICES will be the sole assessment tool used by Minnesota lead agencies to conduct all assessments for LTSS.

Redetermination of level of care must be performed at least annually, in person, and using **[delete]** ~~the same forms as used for the new/initial assessment~~ **[end delete]** **[add]** MnCHOICES or form DHS-3067 **[end add]**. Lead

agency staff complete the assessment and use form DHS-3067 titled DD Screening Document to summarize and document the results of the level of care assessment in MMIS for both new/initial and reassessments. All lead agencies must follow the same processes and utilize the same tools, including data entry into MMIS.

BI, CAC and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Extended Personal Care Assistance

Service Definition (Scope):

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

The amount and duration of the service is determined by the case manager **[add] or assessor [end add]** based on completion of the **[add] MnCHOICES assessment or [end add]** PCA assessment tool (DHS-3428D).

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Extended Personal Care Assistance

Service Definition (Scope):

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

The amount of and duration of the service is determined by the case manager **[add] or assessor [end add]** based on completion of the DD screening and PCA assessment tool (DHS form 3244), or a MnCHOICES assessment.

BI, CAC, CADI and DD waivers

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

State Participant-Centered Service Plan Title:

Community Support Plan **[add] and Coordinated Services and Supports Plan [end add]**

BI, CAC, and DD waivers

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

~~[delete] All references to “care plan,” “support plan,” “service plan,” and “community support plan” are references to the coordinated services and supports plan (CSSP), unless otherwise specified. [end delete]~~

[add] Community support plan (CSP)

The CSP is a written summary completed for everyone who has an assessment, regardless of whether the person is eligible for Minnesota Health Care Programs (MHCP) or chooses to receive publicly funded home and community-based or state plan services. This document provides a summary of what the assessor discovered through the assessment process and identifies next steps based on the person’s needs.

Coordinated services and supports plan (CSSP)

The CSSP is a summary of the person’s choice of supports and/or services if the person chooses to receive publicly funded home and community-based services and/or state plan services. [end add]

Person-centered planning principles are required to be used in all ~~[delete] community [end delete]~~ support plan development. This includes engaging participants and their representatives, as appropriate, in the community support planning process and supporting participants in directing the process to the extent that they choose.

The department’s web site offers a considerable amount of information and training for case managers, participants, and families regarding consumer-direction, and offers links to applicable resources.

CADI waiver

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

~~[delete] All references to “care plan,” “support plan,” “service plan,” and “community support plan” are references to the coordinated services and supports plan (CSSP), unless otherwise specified. [end delete]~~

[add] Community support plan (CSP)

The CSP is a written summary completed for everyone who has an assessment, regardless of whether the person is eligible for Minnesota Health Care Programs (MHCP) or chooses to receive publicly funded home and community-based or state plan services. This document provides a summary of what the assessor discovered through the assessment process and identifies next steps based on the person’s needs.

Coordinated services and supports plan (CSSP)

The CSSP is a summary of the person's choice of supports and/or services if the person chooses to receive publicly funded home and community-based services and/or state plan services. [end add]

Person-centered planning principles are required to be used in all ~~[delete]~~ community ~~[end delete]~~ support plan development. This includes engaging participants and their representatives, as appropriate, in the community support planning process and supporting participants in directing the process to the extent that they choose.

~~[delete]~~ The department's web site offers a considerable amount of information and training for case managers, participants, and families regarding consumer-direction, and offers links to applicable resources. Specifically, the Department offers access to:

- College of Direct Supports (provides online training)
- MinnesotaHelp.info (online directory of resources and enrolled waiver service providers)
- Disability Benefits 101 (provides tools and information about health coverage, benefits, and employment so people can plan and learn how benefits and work go together)
- Disability Linkage Line (referral and assistance service for people with disabilities)
- Veterans Linkage Line, LinkVet (referral and assistance service for veterans)

For people on the waiver, service plan development options can be found within the following waiver services:

- Case Management
- Family Training and Counseling services
- Consumer Directed Community Supports — Certified Support Planner ~~[end delete]~~

[add] The department's web site offers a considerable amount of information and training for case managers, participants, and families regarding consumer-direction, and offers links to applicable resources. [end add]

BI, CAC and CADI waivers

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For participants who have not elected consumer-directed services, the following requirements apply:

(a) Community support plan development, process and timing

~~[delete]~~ The ~~[end delete]~~ [add] Through the assessment process, the [end add] certified assessor [delete] works [end delete] [add] conducts a conversational interview [end add] with the participant and others to develop the community support plan based on the information from the assessment process. Lead agencies are required to

perform the assessment within twenty calendar days of the request for services, and the community support plan is to be developed within ~~forty~~ sixty calendar days from the in-person assessment. Generally, for minors, the family participates in the community support plan development. If a child's family elects not to participate ~~in CDCS~~, the child must have an authorized representative or guardian. All services must be authorized before they are provided.

(b) Assessments

As part of the MnCHOICES assessment (or LTCC screening process), the case manager ~~add~~ (for LTCC only) ~~or certified assessment~~ assessor ~~must assess or arrange for~~ completes an assessment of the individual's care needs, the capacity of informal caregivers, and what formal services may be required. The ~~assessment~~ assessor evaluates the person's ability to complete activities of daily living, instrumental activities of daily living, ~~the need for nursing services~~ and other areas such as the person's health, employment, housing, psychosocial, social, safety needs, etc. Assessment information may also be obtained from other sources, including medical records, clinical assessments, ~~and~~ schools , service providers and vocational rehabilitation agencies.

Once this information is collected and reviewed, ~~it is summarized~~ the MnCHOICES assessment tool summarizes the information in an MMIS LTC Screening Document (DHS-3427).

(c) Choice of services

As described in Appendix B-7, Freedom of Choice, the case manager or certified assessor is responsible to provide information to the participant about waiver services and providers. Case managers or assessors also provide information to participants about other services that may be appropriate (e.g., community programs, state plan home care services, etc.). Additionally, information about waiver services is also available on the department's web site.

(d) Addressing individual needs, goals, and preferences

Minnesota Statutes, section 256B.0911, subd. 3a(g) requires that participants receive a copy of their written community support plan ~~which~~ (CSP). The CSP is a summary document representing the findings and results of the assessment process. The CSP focuses on the following: ~~add~~

~~add~~ • ~~is developed and signed by the participant within forty calendar days of the completion of the assessment;~~

- ~~meets the assessed needs of the participant;~~
- ~~reasonably ensures the health and safety of the participant;~~
- ~~promotes independence;~~
- ~~allows for services to be provided in the most integrated settings; and,~~
- ~~provides for informed choice~~
- ~~includes a summary of assessed needs, options and choices to meet the person's needs, health and safety risks and how those risks will be addressed, referral information, and informal caregiver supports (if applicable)~~ ~~add~~

add • Information that is important to and important for the person

- The person's strengths, preferences, needs and desired outcomes
- A summary of the person's assessed needs
- Options and choices available to the person to meet the identified needs
- Health and safety risks, and how those risks might be addressed

- Referral information identified through the assessment process
- Identifies informal caregivers and their role in supporting the person
- A notice about the person's right to request a conciliation conference or appeal hearing

Minnesota Statutes, section 256B.49, subd. 15 (a) requires that participants receive a copy of their written coordinated services and supports plan (CSSP). The CSSP is developed with the person and must:

- Identify the person's long-term and short-term goals
- Identify the person's preferences for services, including his/her choices for self-directed options and goals
- Document that the person made an informed choice from all available options for providers
- Include a notice about the person's right to request a conciliation conference or appeal hearing
- Describe the person's need for services (including needs met by relatives, friends and others, as well as community services used by the general public)
- List specific services to be provided for the person, including the amount and frequency of the services, and relate the service to an assessed need, the person's preferences and available resources
- Reasonably ensure the person's health and welfare, including personal risk strategies
- Contain the authorized annual and monthly amounts for the services
- Describe the provider's responsibility to implement and make recommendations about modifying the CSSP
- Provide information that assists the provider with developing an individual service delivery plan, as required by the provider's license
- Address the person's assessed needs, his/her choices for long-term services and supports (including formal and informal services) and risk management strategies
- Be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services
- Be agreed to and signed by the person, his/her legal representative (if applicable), authorized lead agency representative and providers of HCBS services. [end add]

The coordinated services and supports plan (CSSP) is [add] developed and [end add] signed by the person, the person's guardian (if applicable), the case manager, and providers responsible for delivering services under the plan [add] within 60 days of the in-person assessment [end add]. The plan is distributed to the person, the person's guardian (if applicable), the case manager, providers responsible for delivering services under the plan, and others chosen by the person. The person designates on the CSSP all parties who will receive a copy.

The department provides ongoing training and resources regarding person-centered planning to address participant's strengths and preferences in the community support planning process, and encourages the use of person-centered planning for all [delete] community [end delete] support plan development.

Upon enrollment into the waiver, participants and their family members are advised to contact their lead agency whenever a change in needs occurs. Case managers [add] and assessors [end add] also have an affirmative obligation to assess a participant's needs when they become aware of a change in the participant's needs.

(e) Coordination

Case managers are responsible to assist with service access, and coordinate and monitor waiver services. They also make referrals for other services as appropriate.

(f) Implementation and monitoring

Case managers are responsible to monitor the ~~[delete] community support plan [end delete]~~ **[add] coordinated services and supports plan (CSSP) [end add]** and services provided. If a provider fails to carry out their responsibilities as identified in the participant's ~~[delete] community [end delete]~~ support plan or develop an individual service plan when needed, the case manager shall notify the provider and, as necessary, the ~~[delete] interdisciplinary [end delete]~~ **[add] multidisciplinary [end add]** team. If the concerns are not resolved by the provider or ~~[delete] interdisciplinary [end delete]~~ **[add] multidisciplinary [end add]** team, the case manager shall notify the participant, the appropriate licensing and certification agencies, and Disability Services Division for persistent performance concerns and patterns with non-licensed waiver service providers. The case manager shall identify other steps needed to assure that the participant receives the needed services and protections.

If a participant's health and safety are in jeopardy, action is taken immediately to address the situation. The action is dependent on the situation.

(g) ~~[delete] Community support plan [end delete]~~ **[add] Coordinated services and supports plan (CSSP) [end add]** updates

Case managers must meet with participants at least twice within the twelve-month period and certified assessors must reevaluate level of care at least annually. Case managers also meet with participants as identified in the participant's ~~[delete] community support plan [end delete]~~ **[add] CSSP [end add]** and upon request, and ~~[delete] community support plans [end delete]~~ **[add] CSSPs [end add]** are updated when there is a change in the participant's condition or supports that warrants a change in service.

For participants who have elected consumer-directed services:

Service planning and monitoring for participants who have elected the consumer directed community supports (CDCS) service is described in the CDCS service description in Appendix C-3 and in Appendix E.

The state law, waiver manual, provider manual, bulletins, and instructional materials applicable to community support plan development are available upon request.

DD waiver

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For participants who have not elected consumer-directed services, the following requirements apply:

(a) Community support plan development, process and timing

~~[delete]~~ The ~~[end delete]~~ [add] Through the assessment process, the ~~[end add]~~ certified assessor ~~[delete]~~ works ~~[end delete]~~ [add] conducts a conversational interview ~~[end add]~~ with the participant and others to develop the community support plan based on the information from the assessment process. Lead agencies are required to perform the assessment within 20 calendar days of the request for services, and the community support plan is to be developed within ~~[delete]~~ 40 ~~[end delete]~~ [add] sixty ~~[end add]~~ calendar days from the in-person assessment. Generally, for minors, the family participates in the community support plan development. If a child's family elects not to participate ~~[delete]~~ in CDS ~~[end delete]~~, the child must have an authorized representative or guardian. All services must be authorized before they are provided.

(b) Assessments

~~[delete]~~ As part of the MnCHOICES assessment or full team screening process, the case manager or certified assessor must assess or arrange for an assessment of the individual's functional skills and needs. Assessment information may also be obtained from other sources, including medical records, clinical assessments, and schools and vocational rehabilitation agencies. Minnesota Rules, part 9525.0024 requires that the assessment include the individual's preferences, functional skills, and need for services and supports. The assessment must address the following areas:

- ~~-Basic needs: income or support, money management, shelter, food, clothing, and assistive technology and adaptations~~
- ~~-Health and safety: physical and dental health, vision, hearing, medication management, mental health and emotional well-being, and ability to keep oneself safe.~~
- ~~-Social skills and interpersonal relationships~~
- ~~-Communication skills~~
- ~~-Self-care: toileting, eating, dressing, hygiene, and grooming~~
- ~~-Home living skills: clothing care, housekeeping, food preparation and cooking, shopping, daily schedule, and home maintenance~~
- ~~-Community use: transportation and mobility, leisure and recreation, and other community resources~~
- ~~-Employment/vocational skills~~
- ~~-Educational skills/cognitive abilities~~
- ~~-Legal representation~~

Once this information is collected and reviewed, it is summarized in an MMIS DD Screening Document (DHS-3067). ~~[end delete]~~

[add] As part of the MnCHOICES assessment (or DD screening process), the certified assessor or case manager (for DD screening process only) completes an assessment of the individual's care needs, the capacity of informal caregivers, and what formal services may be required. The assessor evaluates the person's ability to complete activities of daily living, instrumental activities of daily living, and other areas such as the person's health, employment, housing, psychological, social, and safety needs, etc. Assessment information may also be obtained from other sources, including medical records, clinical assessments, schools, service providers and vocational rehabilitation agencies.

MnCHOICES summarizes the information captured during the assessment on the DD Screening Document (DHS-3067). If MnCHOICES is not used, case managers use the DD Screening Document (DHS-3067) to summarize the results of the level of care assessment. ~~[end add]~~

(c) Choice of services

As described in Appendix B-7, Freedom of Choice, the case manager [add] or certified assessor ~~[end add]~~ is responsible to provide information to the participant about waiver services and providers. Case managers [add] or certified assessors ~~[end add]~~ also provide information to participants about other services that may be

appropriate (e.g., community programs, state plan home care services, etc.). Additionally, information about waiver services is also available on the department's website.

(d) Addressing individual needs, goals, and preferences

~~[delete] Minnesota Rules, part 9525.0024 requires that service plans include:~~

~~The participants preferences for services as stated by the participant or their legal representative~~

~~The participants service and support needs based on results of assessment information, including identification of needs that are currently met in whole or in part by informal caregivers or community services used by the general public~~

~~The participants long- and short-range goals~~

~~Specific supports and services, including case management services, and the amount and frequency of the services to be provided to the participant based on available resources, and the participants needs and preferences.~~

~~Specific services the participant needs that are not available and actions to be taken to obtain or develop these services~~

~~A determination of whether there is a need for an individualized service plan developed by the provider according to applicable state and federal licensing and certification standards~~

~~Identification of additional assessments to be completed or arranged by the provider after service initiation~~

~~Specific information that providers or subcontractors must submit to the case manager, the frequency with which the information must be provided when not otherwise specified in contract, service agreement, or authorization form, and providers responsibilities to implement and make recommendations regarding modifications to the participants community support plan~~

~~Notice of the right to request a conciliation conference or fair hearing under Minnesota Statutes, section 256.045~~

~~Signatures of the participant, their legal representative, and the case manager at least annually and whenever changes are made~~

~~Documentation that the plan was reviewed by a health professional if the participant has overriding medical needs that impact the delivery of services [end delete]~~

[add] Minnesota Statutes, section 256B.0911, subd. 3a(g) requires that participants receive a copy of their written community support plan (CSP). The CSP is a summary document representing the findings and results of the assessment process. The CSP focuses on the following:

- Information that is important to and important for the person
- The person's strengths, preferences, needs and desired outcomes
- A summary of the person's assessed needs
- Options and choices available to the person to meet the identified needs
- Health and safety risks, and how those risks might be addressed
- Referral information identified through the assessment process
- Identifies informal caregivers and their role in supporting the person
- A notice about the person's right to request a conciliation conference or appeal hearing

Minnesota Statutes, section 256B.092, subd. 1b requires that participants receive a copy of their written coordinated services and supports plan (CSSP). The CSSP is developed with the person and must:

- Identify the person's long-term and short-term goals
- Identify the person's preferences for services, including his/her choices for self-directed options and goals
- Document that the person made an informed choice from all available options for providers

- Include a notice about the person's right to request a conciliation conference or appeal hearing
- Describe the person's need for services (including needs met by relatives, friends and others, as well as community services used by the general public)
- List specific services to be provided for the person, including the amount and frequency of the services, and relate the service to an assessed need, the person's preferences and available resources
- Reasonably ensure the person's health and welfare, including personal risk strategies
- Contain the authorized annual and monthly amounts for the services
- Describe the provider's responsibility to implement and make recommendations about modifying the CSSP
- Provide information that assists the provider with developing an individual service delivery plan, as required by the provider's license
- Address the person's assessed needs, his/her choices for long-term services and supports (including formal and informal services) and risk management strategies
- Be reviewed by a health professional if the person has overriding medical needs that impact the delivery of services
- Be agreed to and signed by the person, his/her legal representative (if applicable), authorized lead agency representative and providers of HCBS services. [end add]

The department provides ongoing training and resources regarding person-centered planning to address participant's strengths and preferences in the community support planning process, and encourages the use of person-centered planning for all ~~[delete] community [end delete]~~ support plan development.

The coordinated services and supports plan (CSSP) is ~~[add] developed and [end add]~~ signed by the person, the person's guardian (if applicable), the case manager, and providers responsible for delivering services under the plan ~~[add] within 60 days of the in-person assessment [end add]~~. The plan is distributed to the person, the person's guardian (if applicable), the case manager, providers responsible for delivering services under the plan, and others chosen by the person. The person designates on the CSSP all parties who will receive a copy.

(e) Coordination

~~[delete] Minnesota Rules, part 9525.0024 require that the case manager assist enrollees in accessing selected housing, services, and supports through the following activities:~~
~~coordinating the application process and preplacement planning activities and visits;~~
~~assuring that financial arrangements, contracts, or provider agreements are in place;~~
~~promoting the participants access to services that fit the participants needs;~~
~~assisting the participant in securing the services identified in the community support plan, including services not currently available; and~~
~~participating with the interdisciplinary team in the development of individualized service plans that are consistent with the participants community support plan. [end delete]~~

Case managers are ~~[delete] also [end delete]~~ responsible to assist with service access, and coordinate and monitor waiver services. They also make appropriate referrals for other services as appropriate.

(f) Implementation and monitoring

~~[delete] Minnesota Rules, part 9525.0024 require that the case manager specify the frequency of monitoring and evaluation activities in the participants community support plan based on the participants needs, and other~~

factors that may affect the type, amount, or frequency of service. Case managers must conduct a monitoring visit with each participant at least twice each year. This visit must assess whether:

- services are implemented in accordance with the participants community support plan, and are directed at achieving the identified goals;
- changes to the community support plan are needed to achieve desired outcomes or meet newly identified needs, including changes resulting from the recommendations of providers;
- providers are fulfilling their responsibilities and coordinating approaches to services with other providers;
- the participants health and safety needs are met;
- the participants civil and legal rights are upheld; and
- the participant and the participants legal representative are satisfied with the services received.

If a participants health and safety are in jeopardy, action is taken immediately to address the situation. The action is dependent on the situation. **[end delete]**

Case managers are responsible to monitor the **[delete] community support plan [end delete] [add] coordinated services and supports plan (CSSP) [end add]** and services provided. If a provider fails to carry out their responsibilities as identified in the participant's **[delete] community [end delete]** support plan or develop an individualized service plan when needed, the case manager shall notify the provider and, as necessary, the **[delete] interdisciplinary [end delete] [add] multidisciplinary [end add]** team. If the concerns are not resolved by the provider or **[delete] interdisciplinary [end delete] [add] multidisciplinary [end add]** team, the case manager shall notify the participant, the appropriate licensing and certification agencies, and the Disability Services Division for persistent performance concerns and patterns with non-licensed waiver service providers. The case manager shall identify other steps needed to assure that the participant receives the needed services and protections.

[add] If a participant's health and safety are in jeopardy, action is taken immediately to address the situation. The action is dependent on the situation. [end add]

(g) **[delete] Community support plan [end delete] [add] Coordinated services and supports plan (CSSP) [end add]** updates

Case managers must meet with participants at least twice within the twelve-month period and certified assessors must reevaluate level of care at least annually. Case managers also meet with participants as identified in the participant's **[delete] community support plan [end delete] [add] CSSP [end add]** and upon request, and **[delete] community support plans [end delete] [add] CSSPs [end add]** are updated when there is a change in the participant's condition or supports that warrants a change in service.

For participants who have elected consumer-directed services:

Service planning and monitoring for participants who have elected the consumer directed community supports (CDCS) service is described in the CDCS service description in Appendix C-3.

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

BI and CADI waivers

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Through the assessment and ~~[delete] community~~~~[end delete]~~ support planning process, case managers **[add]** and assessors **[end add]** are responsible to identify issues that may affect the participant's health and safety. This includes identifying possible health and safety risks and addressing these through the community support plan. Case managers **[add]** and assessors **[end add]** are also responsible to develop emergency back-up plans included in the required assessment and reassessment forms. The emergency back-up plans address issues such as emergency medical care, provider no-shows, weather conditions, etc.

[add] In addition, Minnesota Statutes, section 245A.65, subd. 2 and chapter 245D require providers that are licensed by the department to provide waiver services to develop, document in writing, and implement individual risk management plans related to the services they provide. The plans must identify areas in which the participant is vulnerable, based on an assessment, that addresses the following:

- susceptibility to abuse, financial exploitation, and self-abuse
- the participant's health needs including: physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment
- the participant's safety needs, considering the participant's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;
- environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the participant's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment
- the participant's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion

The license holder must review the plan at least annually and update the plan as needed based on the participant's needs and changes to the environment. **[end add]**

CAC and DD waivers

Appendix D-1: Participant-Centered Planning and Service Delivery – Service Plan Development

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Through the assessment and ~~[delete] community~~~~[end delete]~~ support planning process, case managers **[add]** and assessors **[end add]** are responsible to identify issues that may affect the participant's health and safety. This includes identifying possible health and safety risks and addressing these through the community support plan. Case managers **[add]** and assessors **[end add]** are also responsible to develop emergency back-up plans included in the required assessment and reassessment forms. The emergency back-up plans address issues such as emergency medical care, provider no-shows, weather conditions, etc.

In addition, Minnesota Statutes, section 245A.65, subd. 2 and chapter 245D require providers that are licensed by the department to provide waiver services to develop, document in writing, and implement individual risk management plans related to the services they provide. The plans must identify areas in which the participant is vulnerable, based on an assessment, that addresses the following:

- susceptibility to abuse, financial exploitation, and self-abuse
- the participant's health needs including: physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment
- the participant's safety needs, considering the participant's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;
- environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the participant's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment
- the participant's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion

The license holder must review the plan at least annually and update the plan as needed based on the participant's needs and changes to the environment.

BI, CAC and CADI waivers

Appendix D-2: Participant-Centered Planning and Service Delivery – Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for monitoring the implementation of ~~[delete] community support plans [end delete]~~ **[add] coordinated services and supports plans (CSSPs) [end add]** and assuring that participants' health and safety needs are reasonably addressed. Monitoring generally occurs through phone contacts and visits with the participant and/or service providers.

Case managers must meet face-to-face with participants at least twice within the twelve-month period and certified assessors must **[add] conduct reevaluations of [end add]** level of care at least annually. Community support plans are to be updated any time there is a change in the participant's condition or situation that warrants a reassessment (e.g., change in caregiver's capacity). Additional monitoring is individualized, based on the needs of the participant, and included in the community support plan **[add] and/or CSSP [end add]**.

DD waiver

Appendix D-2: Participant-Centered Planning and Service Delivery – Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for monitoring the implementation of ~~[delete] community support plans [end delete]~~ **[add] coordinated services and supports plans (CSSPs) [end add]** and assuring that participant's health and safety needs are reasonably addressed. Monitoring generally occurs through phone contacts and visits with the participant and/or service providers.

Case managers must meet face-to-face with participants at least twice within the twelve-month period and **[add] certified assessors must [end add]** conduct reevaluations of level of care at least annually. Community support plans are to be updated any time there is a change in the participants condition or situation that warrants a reassessment (e.g., change in caregivers capacity) ~~[delete] in accordance with Minnesota Statutes, §256B.092, subd. 1e [end delete]~~. Additional monitoring is individualized, based on the needs of the participant, and included in the community support plan **[add] and/or CSSP [end add]**.

BI, CAC, CADI and DD waivers

Appendix F-1: Participant Rights – Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

How Information is Provided

Fair hearing information is provided at the time an individual applies for Medicaid, at the time an individual is screened for community-based services and when a waiver service authorization is initiated or modified in MMIS. This includes service approvals, suspensions, reductions, and terminations. Participants may also submit fair hearing requests if they feel that they have not been offered free choice of provider.

Fair hearing information is also available on the department's web site at:
http://www.dhs.state.mn.us/id_008649#

Notices Provided

The following forms are used to provide fair hearing information:

- ~~[delete] Minnesota Health Care Programs Application for Medical Assistance for Long Term Care Services (MA-LTC), DHS-3531 [end delete]~~ **[add] Minnesota Health Care Programs (MHCP) Application for Certain Populations (DHS-3876) and MHCP Renewal Form (DHS-3418) [end add]**. ~~[delete] This form is [end delete]~~ **[add] These forms are [end add]** used to apply for **[add] and renew [end add]** Medical Assistance and includes fair hearing rights.
- Long-Term Services and Supports Assessment and Program Information and Signature Sheet (DHS-2727). This form is provided at the time an individual initially applies for waiver services and upon reassessment, and indicates the person was informed of their appeal rights.

- Long-term Services and Supports Notice of Action (Assessments and Reassessments), DHS-2828A. This form is provided to participants after the initial assessment and every reassessment, and informs the person of his/her eligibility for services and any service reductions as a result of the assessment or reassessment.
- Long-Term Services and Supports Notice of Action (Service Plan), DHS-2828B. This form is provided to participants when the case manager takes an action in the support plan that results in a denial, termination or reduction of the person's services.

These forms are available on the department's web site at:

<http://mn.gov/dhs/general-public/publications-forms-resources/edocs/>

State Policies

The department's policies and instructions regarding notice of action are available in the web-based program manual, Community-Based Services Manual in the Appeals section of the manual.

Employment and Day Services

- Adult day services and adult day services bath (BI, CAC, CADI and DD)
 - Adds language addressing colocated settings and settings on or next to institutions
 - Updates provider qualifications
- Day training and habilitation (DD)
 - Adds language addressing colocated settings and settings on or next to institutions
- Employment development, employment exploration and employment support (BI, CAC, CADI and DD)
 - Includes technical/grammatical changes
 - Clarifies ownership requirements related to employment services
 - Adds language addressing when providers can bill for indirect time
 - Adds language regarding how/where lead agencies keep documentation that VRS/IDEA funds are not available
- Prevocational services (BI, CADI and DD)
 - Adds language addressing colocated settings and settings on or next to institutions
- Structured day (BI)
 - Updates “maladaptive behavior” language to state “challenging behavior”
 - Adds language addressing colocated settings and settings on or next to institutions
- Supported employment (BI, CAC, CADI and DD)
 - Removes references to supported employment services which ended August 31, 2018
 - Removes outdated language regarding a transition plan which has expired

Adult day services and adult day services bath (BI, CAC, CADI and DD)

- **Adds language addressing colocated settings and settings on or next to institutions**
- **Updates provider qualifications**

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Day Service

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

Therapies are not included in adult day services.

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

[add] Services provided in a setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. This applies to settings established after July 1, 2019.

When more than one setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants receiving services in one of the settings. This applies to settings established after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation. [end add]

BI, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Day Service Bath

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

[add] Services provided in a setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. This applies to settings established after July 1, 2019.

When more than one setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants receiving services in one of the settings. This applies to settings established after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation. [end add]

BI, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Day Service

Adult Day Service Bath

Provider Specifications:

Agency – Free-Standing Centers

Agency – Hospitals

Agency – Medical Clinics

Agency – Nursing Homes

Provider Qualifications:

Other Standard (specify):

[add] Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16, with the exception of section 245A.143. [end add]

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Day Service

Adult Day Service Bath

Provider Specifications:

Individual – Family Homes

Provider Qualifications:

Other Standard (*specify*):

[add] Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16. **[end add]**

Day training and habilitation (DD)

- **Adds language addressing colocated settings and settings on or next to institutions**

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Day Training and Habilitation

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

Day training and habilitation services are not intended to assist people with seeking, obtaining and maintaining individual job positions, group employment (e.g., work crew or enclave positions), self-employment or microenterprise businesses in the community.

After June 30, 2019, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later, community employment related services must not be provided and billed as day training and habilitation, but must be provided and billed as either employment exploration services, employment development services, employment support services or prevocational services, based on the type of services and supports provided. No new authorizations for community based employment services as part of day training and habilitation will be allowed after June 30, 2018 or 180 days following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approving community based employment services as part of day training and habilitation for a participant who has not received these services on or before June 30, 2018.

Day training and habilitation must be authorized and reimbursed on a 15-minute unit basis when employment exploration services, employment development services or employment support services are provided on the same day as day training and habilitation. Wage and benefit compensation must be compliant with all applicable federal laws and regulations as well as state statute and rules.

[add] Services provided in a setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. This applies to settings established after July 1, 2019.

When more than one setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants receiving services in one of the settings. This applies to settings established after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation. [end add]

Employment development, employment exploration and employment support (BI, CAC, CADI and DD)

- Includes technical/grammatical changes
- Clarifies ownership requirements related to employment services
- Adds language addressing when providers can bill for indirect time
- Adds language regarding how/where lead agencies keep documentation that VRS/IDEA funds are not available

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Employment Development Services

Service Definition (Scope):

Employment development services are 1:1, individualized services that actively support a person to achieve paid employment in their community. Employment development services assist people with finding paid employment, becoming self-employed or establishing microenterprise businesses in their communities.

I. Employment development services - job development services are individualized support services that assist a person to achieve competitively paid employment within a community business at either a minimum wage or a customary (industry-standard) prevailing wage and comparable level of benefits. Job Development may include the following services and supports:

1. Individualized, strengths-based assessments and employment opportunity discovery strategies (employment discovery and assessment phase ~~[delete]~~—This phase ~~[end delete]~~ should not exceed 120 days of service delivery ~~[add]~~)~~[end add]~~;
2. Comprehensive employment search assistance and support;
3. Benefit(s) review, analysis, consultation and planning to learn how public benefits will interact with employment;
4. Negotiating and finalizing terms of employment; and
5. Support assistance during new employee orientation.

II. Employment development services - self-employment/micro-enterprise development services are individualized support services that prepare and assist people to develop a self-employment or micro-enterprise business in their community. Self-employment/micro-enterprise development services may include providing support to the participant(s) that will allow them to conduct the following activities:

1. Determining the type of business that the person wants to establish;
2. Writing a business plan;
3. Finding sources of start-up financing;
4. Establishing a legal structure for the business;
5. Choosing and registering an available and marketable business name;
6. Creating a marketing and sales plan;
7. Obtaining a location and the appropriate certifications, licenses, permits and variances;
8. Purchasing all necessary insurances;
9. Developing business forms, records, bookkeeping and accounting systems; and
10. Benefit(s) review, analysis, consultation and planning

[add] Employment development providers may bill for indirect time spent working on employment search assistance and support, supporting negotiating and finalizing terms of employment, development of job applications and materials, outreach with community businesses, and benefit(s) planning including fact gathering, review and analysis. All other indirect time is accounted for in the rate framework. [end add]

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

Service Delivery (General)

- Employment development services activities involve opportunities and experiences for people to have meaningful interactions with community businesses and people without disabilities.
- Employment development services must not be used to develop group employment opportunities (e.g., work crews, job enclaves, etc.).

[add] • Employment development service providers cannot be involved as owners, partners, shareholders, operators, managing entities, employees or otherwise beneficiaries of a community business where they are providing employment development services. [end add]

Duration

- Employment development services are to occur as identified in the person's support plan. A person's use of employment development services is time-limited and not to exceed a maximum of 12 months following the initial authorization of employment development services. Subsequent uses of employment development services are based upon a person's needs and verifiable employment status changes (e.g., loss of employment, reduced employment, career change, seeking other employment, debilitating health [add] condition(s) or life [end add] event [add] (s) [end add] that hinders employment, etc.) or [add] service [end add] provider change. The need for a person to receive continued employment development services beyond 12 months shall be re-evaluated annually or more frequently as determined by the person and their support planning team.

[add] • Individualized assessment and person-centered discovery experiences should not exceed 120 days of service delivery. [end add]

Connection with other services

- A person may receive both employment development services and employment support services, if they are seeking other employment opportunities while they are currently employed.
- Employment development services can be provided when a person is also receiving day training and habilitation services (DT&H), employment exploration services, prevocational services, structured day or adult day services.

- **[add]** Employment support services, **[end add]** ~~Day~~ **[end delete]** **[add]** day **[end add]** training and habilitation (DT&H), prevocational services, structured day and adult day services must be authorized and reimbursed on a 15-minute unit basis when employment development services are provided during the same day. These services must not be provided simultaneously with **[add]** direct-time **[end add]** employment ~~exploration~~ **[end delete]** **[add]** development **[end add]** services during the same time period of the day.
- All services and supports defined as part of employment development services must be provided under employment development services, and not provided as a service of DT&H, prevocational services, structured day or adult day services.
- The employment development services rate includes in-service transportation costs. Transportation services occurring between the participant's place of residence and the site of service are **[add]** waiver transportation services, and are **[end add]** not covered as part of ~~this service~~ **[end delete]** **[add]** employment development services **[end add]**.

Self-Employment and Microenterprises

- Waiver funds cannot be used as supplemental capital to finance self-employment or microenterprise businesses.
- Service providers cannot be owners, partners, shareholders, operators, employees, independent contractors, subcontractors or otherwise a financial beneficiary of the microenterprise businesses that they are assisting, supporting and serving.
- Self-employment and microenterprise businesses are limited in size to five or fewer people.

Other Limitations

- Waiver funds cannot be used to provide vocational services in facility based or sheltered workshop settings, where the primary purpose is to produce goods and perform services.
- Waiver funds cannot be used to compensate or supplement a person's wages.
- Wage and benefit compensation must be compliant with all applicable federal laws and regulations as well as state statute and rules. The provision of employment development services does not supplant an employer's duty to provide reasonable accommodations to employees as required under Title I of the Americans with Disabilities Act, if applicable.
- Employment development services do not include services that are available under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA). **[add]** • Documentation must be maintained in the participant's file indicating this service is not available within programs funded under section 110 of the Rehabilitation Act of 1973 or IDEA. **[end add]**

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Employment Exploration Services

Service Definition (Scope):

Employment exploration services are community-based services that introduce a person to competitive employment opportunities in their community and move a person toward an informed choice about employment. Employment exploration services consist of individualized educational activities, learning opportunities, work experiences and support services that are identified in the person's support plan. Employment exploration services activities and experiences strengthen a person's knowledge, interests and

preferences about working in various competitively paid jobs in the community. Employment exploration services result in the person making an informed choice about working in competitively paid jobs in the community. Employment exploration services strategies must be person-centered and based on the person's identified and developing strengths, interests, preferences, skills and abilities.

Employment exploration services may include the following educational activities, learning opportunities and work experiences:

1. Educational visits to community businesses to learn about various employers, products, services and employment opportunities;
2. Career education activities to learn about specific types of occupations, job positions and work opportunities;
3. Ongoing educational information and counseling assistance about jobs/careers that interest the person;
4. Peer-to-peer mentoring opportunities to meet and learn from people with disabilities who are competitively employed;
5. "Job shadowing" and "try-out experiences" to learn more about the work involved in various occupational positions;
6. Individualized work experiences, including volunteer work experiences;
7. Learning about post-secondary educational opportunities that enhance employment;
8. Learning to use available community employment resources;
9. Learning to use available transportation services;
10. Performing pre-employment benefit(s) resource fact-gathering and review to learn about how employment can work together with public benefits; and
11. Preliminary assessment of the person's needs for assistive technology and other accommodations to maintain employment

[add] Employment exploration providers may bill for indirect time spent working on supports for assistive technology and/or adaptive accommodations and benefit(s) planning including fact gathering, review and analysis. All other indirect time is accounted for in the rate framework. **[end add]**

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

Service Delivery (General)

- Employment exploration services involve opportunities for people to have meaningful interactions with community businesses and people without disabilities.
- Employment exploration services are not intended to teach competency in specific job skills.
- Employment exploration services are not required or necessary for people who have already identified personal employment goals to seek competitive employment in the community.

[add] • Employment exploration service providers cannot be involved as owners, partners, shareholders, operators, managing entities, employees or otherwise beneficiaries of a community business where they are providing employment exploration services. **[end add]**

Service Delivery (Group)

Group instruction, including employment education and support groups (e.g., job clubs), are allowable and comprise only one small service element within the full complement of possible employment exploration services. For all activities provided under employment exploration services, group sizes may not exceed five people.

Duration

- Employment exploration services are to occur as identified in the person's support plan. Employment exploration services are time-limited and expected to end:
 - o When a person is interested in actively seeking competitively paid employment and starts receiving employment development services; or
 - o When a person obtains competitively paid employment; or
 - o After a maximum of 12 months following the initial authorization of employment exploration services.
- Further use of employment exploration services beyond 12 months is based upon a person's need to continue employment exploration services due to a **[add] service [end add]** provider change, debilitating health **[add] condition(s) or life [end add] event [add] (s) [end add] [delete], circumstances [end delete]** that significantly hinder **[add] s [end add]** the implementation of employment exploration services, or desire to reconsider a decision not to pursue competitive integrated employment. The need for a person to receive employment exploration services beyond 12 months shall be re-evaluated annually or more frequently as determined by the person and their support planning team.

Connection with other services

- Employment exploration services can be provided while a person is concurrently receiving **[add] group employment support services, [end add]** day training and habilitation services (DT&H), **[delete] employment development services, [end delete]** prevocational services, structured day services or adult day services.
- Individual employment support services cannot be provided when a person is receiving employment exploration services.
- **[add] Group employment support services, [end add] [delete] Day [end delete] [add] day [end add]** training and habilitation (DT&H), prevocational services, structured day and adult day services must be authorized and reimbursed on a 15-minute unit basis when employment exploration services are provided during the same day. These services must not be provided simultaneously with **[add] direct-time [end add]** employment exploration services during the same time period of the day.
- All services and supports defined as part of employment exploration services must be provided under employment exploration services, and not as a service of DT&H, prevocational services, structured day or adult day services.
- The rate for employment exploration services includes in-service transportation costs. Transportation services occurring between the **[delete] participant's [end delete] [add] person's [end add]** place of residence and the site of service are **[add] waiver transportation services and are [end add]** not covered as part of **[delete] this service [end delete] [add] employment exploration services [end add]**.

Other Limitations

- Waiver funds cannot be used to provide vocational services in facility based or sheltered workshop settings, where the primary purpose is to produce goods and perform services.
- Waiver funds cannot be used to compensate or supplement a person's wages.
- Wage and benefit compensation must comply with all applicable federal laws and regulations as well as state statute and rules. The provision of employment exploration services does not supplant an employer's duty to provide reasonable accommodations to employees as required under Title I of the Americans with Disabilities Act, if applicable.
- Employment exploration services do not include services that are available under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA). **[add] • Documentation must be maintained in the participant's file indicating this service is not available within programs funded under section 110 of the Rehabilitation Act of 1973 or IDEA. [end add]**

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Employment Support Services

Service Definition (Scope):

Employment support services are long-term, individualized services and supports that assist people with maintaining paid employment in the community. Employment support services are to occur in integrated community settings.

I. Employment support services– job support can include:

1. Job analysis and re-design;
2. Arranging adaptive accommodations and assistive technology;
3. Coaching and supporting acceptable workplace self-care, proper dress, personal hygiene and grooming;
4. Job training and coaching to strengthen and maintain necessary work skills, behaviors and co-worker relationships.
5. Providing on-the-job counseling and support, including assistance with understanding earned wages and benefits;
6. Advocacy, negotiation and liaison communication with the employer;
7. Designing and implementing set schedules of ongoing follow-up support, job coach sharing, fading and monitoring;
8. Developing and strengthening natural work supports;
9. Coordinating, training and coaching employment-specific transportation;
10. Forming skilled, job-specific, work crews and job enclaves for group employment support service arrangements; and
11. Data collection, documentation and progress reporting on a person's work performance.

A. Individual employment support services provide support to one person (at a time), working at a regular or customized, fulltime or part-time, paid job position in the community or through self-employment, with opportunities for interactions with coworkers without disabilities, customers and/or the general public.

Job coaching support provided to multiple people who are working at their own distinctive, individual job positions at different locations or dispersed locations within a community business is considered individual employment support services with a shared job coaching arrangement.

Individual employment does not include group employment jobs or center-based work.

B. Group employment support services consist of 2 to 6 people in a group, working together for the same employer. Group members are:

1. Performing work duties of a full-time or part-time job position, where the work duties involved in the job position are shared and/or subdivided across group members;
2. Experiencing opportunities for interactions with co-workers without disabilities, customers and/or the general public; and
3. Being paid.

II. Employment support services - self-employment and microenterprise businesses support can include:

1. Training, coaching and support services for assisting in the effective day-to-day operations of all aspects of the business, including marketing, sales, production, order fulfillment, customer service, business technology, bookkeeping, file record maintenance, purchasing, inventory control, financial management, accounting, timely tax reporting and legal compliance;
2. Assistance to the participant(s) in identifying other needed external business resources and services to assist with the continued development and support of the business enterprise;
3. Providing ongoing analysis and consultation to identify needed supports; and
4. Designing and implementing set schedules of ongoing, follow-up support.

[add] Employment support providers may bill for indirect time spent working on advocacy, negotiation and liaison communication with employer, development and strengthening of natural work supports, research and coordination of job-related transportation, working with employer to design and implement schedules for employment support services, formation of skilled, job-specific work crews and job enclaves, data collection, documentation and progress reports, supports for assistive technology and/or adaptive accommodations and benefit(s) planning including fact gathering, review and analysis. All other indirect time is accounted for in the rate framework. **[end add]**

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

Service Delivery (general)

- Employment support services involve opportunities and experiences for people receiving employment support services to have meaningful interactions with co-workers without disabilities and people in the community without disabilities.
- Employment support services cannot be provided in facility-based, day training and habilitation (DT&H) settings, prevocational service settings, structured day settings, or adult day service settings.

[add] • Employment support service providers cannot be involved as owners, partners, shareholders, operators, managing entities, employees or otherwise beneficiaries of a community business where they are providing employment support services. **[end add]**

- Waiver funds are restricted to funding assistive services and supports to people with disabilities working in community-based jobs, self-employment or microenterprise businesses. Waiver funding does not cover payments:
 - o Made to an employer as an incentive for participation in a person's employment support services;
 - o Passed through to subsidize a person receiving employment support services;
 - o For vocational education and training that is not directly related to a person's employment support services;
 - o For routine supervision and support rendered as a normal function of the business setting; or
 - o Used as supplemental capital to finance a self-employment or microenterprise business.

Service Delivery (microenterprise and group)

- Employment support services cannot be provided in congregate group arrangements greater than 6 people in a work crew or job enclave.
- Microenterprise businesses are restricted to 5 or fewer co-owners or partners.
- Service providers cannot be owners, partners, shareholders, operators, employees, independent contractors, subcontractors or otherwise a financial beneficiary of the microenterprise businesses that they are assisting, supporting and serving.

Connection with other Services

- A person may receive both employment development services and employment support services if they are seeking other employment opportunities while they are currently employed.

- Employment support services can be provided when a person is also receiving DT&H, prevocational services, structured day or adult day services.
- **[add]** Other allowable employment services, **[end add]** ~~Day~~ **[end delete]** **[add]** day **[end add]** training and habilitation (DT&H), prevocational services, structured day and adult day services must be authorized and reimbursed on a 15-minute unit basis when employment support services are provided during the same day. These services must not be provided simultaneously with **[add]** direct-time **[end add]** employment **[delete]** exploration **[end delete]** **[add]** support **[end add]** services during the same time period of the day.
- The employment support services rate includes in-service transportation costs. Transportation services occurring between the participant's place of residence and the site of service are **[add]** waiver transportation services and are **[end add]** not covered as part of **[delete]** this service **[end delete]** **[add]** employment support services **[end add]**.
- Individual and group forms of employment support services must be provided under employment support services, and not provided as a service of DT&H, prevocational services, structured day or adult day services.

Other Limitations

- Wage and benefit compensation must be compliant with all applicable federal laws and regulations as well as Minnesota state statutes and rules. The provision of employment support services does not supplant an employer's duty to provide reasonable accommodations to employees as required under Title I of the Americans with Disabilities Act, if applicable.
 - Employment support services do not include services that are available under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).
- [add]** • Documentation must be maintained in the participant's file indicating this service is not available within programs funded under section 110 of the Rehabilitation Act of 1973 or IDEA. **[end add]**

Prevocational services (BI, CADI and DD)

- **Adds language addressing colocated settings and settings on or next to institutions**

BI, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Prevocational Services

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

[add] Services provided in a setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. This applies to settings established after July 1, 2019.

When more than one setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants receiving services in one of the settings. This applies to settings established after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation. **[end add]**

Structured day program (BI)

- Updates “maladaptive behavior” language to state “challenging behavior”
- Adds language addressing colocated settings and settings on or next to institutions

BI waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Structured Day Program

Service Definition (*scope*):

Structured day program services are directed at the development and maintenance of community living skills for participants who may benefit from continued rehabilitation and community integration. The services must include intensive therapeutic interventions and be provided in a non-residential setting. Services will be furnished, at a minimum, two or more hours per day on a regularly scheduled basis, for one or more days per week.

Structured day program services include supervision and specific training to assist the participant in attaining his or her maximum potential. Structured day program services may include social skills training, sensory/motor development, reduction/elimination of **[delete] maladaptive [end delete] [add] challenging [end add]** behavior and services designed to assist the individual with community reintegration (teaching concepts such as attending, task completion, problem solving, safety, money management, etc.).

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

Physical, occupational, speech, and cognitive rehabilitation therapies are not covered in this service.

[add] Services provided in a setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. This applies to settings established after July 1, 2019.

When more than one setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants receiving services in one of the settings. This applies to settings established after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation. [end add]

Supported employment (BI, CAC, CADI and DD)

- Removes references to supported employment services which ended Aug. 31, 2018
- Removes outdated language regarding a transition plan which has expired

BI, CAC, CADI and DD waivers

NOTE: The intention of this amendment is to remove all references to supported employment services. The following may not be inclusive of all changes that need to be made in all four disability waiver plans.

Appendix C-1/C-3: Participant Services – Service Specification

[delete] Service Title:

Supported Employment Services

Service Definition (Scope):

~~Supported employment services consist of paid employment for participants for whom competitive employment at or above the minimum wage is unlikely without supports, and who, because of their disabilities, need intensive ongoing support to perform in a community work setting. Supported employment is conducted in a variety of community settings in which people without disabilities are employed.~~

~~Supported employment includes activities needed to sustain paid work by participants receiving waiver services, including supervision and training. When supported employment services are provided at a work site where people without disabilities are employed, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.~~

~~Supported employment services can be authorized by the case manager as part of a participant's community support plan only when:~~

- ~~1. the participant engages in paid employment in a setting or variety of settings in which people without disabilities are also employed, particularly existing businesses or industry sites;~~
- ~~2. public funds are necessary for the purpose of providing ongoing training and support services throughout the period of employment; and~~
- ~~3. the participant has the opportunity for social interactions with people who do not have disabilities and who are not paid caregivers.~~

~~Supported employment services include individualized assessment, counseling, individualized job development and placement that produce an appropriate job match, on the job training required for job performance, ongoing supervision and monitoring, long term support services to assure job retention. It also includes training in skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, use of generic transportation and mobility training.~~

~~Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation must be maintained in the file of each participant receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.~~

~~Transportation will be provided between the participant's place of residence and the site of the supported employment service, or between supported employment sites (in cases where the participant receives supported employment services in more than one place) when other forms of transportation are unavailable or inaccessible. The cost of this transportation may be included in the rate paid to providers of the appropriate type of supported employment services.~~

The hours or services per day will be based on the participant's needs and functioning. All supported employment services will be coordinated by the case manager with the participant's residential services, when applicable. Non-medical transportation services may be provided by supported employment providers to enable participants to participate in these services.

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

This service does not cover incentive payments, subsidies, or unrelated training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Vocational training that is not directly related to a participant's supported employment program.

Supported employment shall discontinue after June 30, 2019, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later.

Supported Employment will be replaced by employment exploration services, employment development services and employment support services. No new authorizations for supported employment will be allowed after June 30, 2018, or 180 days following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for Supported Employment for a participant who was not previously receiving Supported Employment before June 30, 2018.

Service Delivery Method (check each that applies):

Provider Managed

Provider Specifications:

Agency—Agencies that meet the service standards for supported employment

Individual—Individuals that meet the service standards for supported employment

Provider Qualifications

License (specify): Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies/individuals holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification

Every one to three years [end delete]

Attachment #1: Transition Plan

[delete] TRANSITION PLAN FOR EMPLOYMENT EXPLORATION, DEVELOPMENT, AND SUPPORT SERVICES

This renewal adds three employment services (employment exploration, employment development, and employment support) that will replace supported employment services and shift community-based employment activities from day training and habilitation (DT&H) services to these new services. All other services currently provided under DT&H will continue. The following transition plan addresses the implementation of these employment services.

Participants who currently receive supported employment services or community-based employment services via DT&H will not experience any loss or interruption of such services. These services will instead be authorized and billed under employment exploration services, employment development services, or employment support services as appropriate.

This transition will begin on January 1, 2018, or upon federal approval of these three employment services and the Department's completion of system updates, whichever is later. The new employment services are expected to be authorized at a person's annual reevaluation. At any annual reevaluation after June 30, 2018, or up to 180 days following federal approval of these three employment services and the Department's completion of system updates, whichever is later, case managers must transition participants from supported employment services or community-based employment services under DT&H to the new employment services. After June 30, 2019, or up to 18 months following federal approval of these three employment services and the Department's completion of system updates, whichever is later, all participants receiving employment services will have transitioned to employment exploration services, employment development services or employment support services as appropriate.

Participants receiving Day Training and Habilitations Services (DT&H), Prevocational Services, and Supported Employment Services (SES) will be notified prior to July 1, 2018 that their services will be transitioning to the new employment services at annual reviews occurring after July 1, 2018. Lead agencies will also be given guidance and instructions on communicating changes with participants. All fair hearings procedures and information, outlined in Appendix F-1, will apply to this communication.

During the transition, the Department will ensure that participants, lead agencies, service providers, and other stakeholders are informed of these changes to employment services. Prior to June 30, 2018 the Department will send a notice to all participants receiving supported employment services and/or DT&H services explaining the transition to these new employment services and how it will affect them. The Department will employ other communication methods as appropriate for participants, which may include community meetings, website updates, and e-list announcements. The Department will release guidance, training webinars, and host regional meetings to help train service professionals on the new services and prepare them for the transition. [end delete]

Crisis Respite and Positive Support Services

- Crisis respite services (BI, CAC, CADI and DD)
 - Restores missing language in the crisis respite service definition (CADI)
 - Clarifies size limits for foster care and community residential settings (BI, CAC, CADI and DD)
 - Updates provider qualifications (BI, CAC, CADI and DD)
- Positive support services (BI, CAC, CADI and DD)
 - Updates “maladaptive behavior” language to state “challenging behavior”
 - Removes examples of positive support approaches
 - Adds language addressing when providers can bill for indirect time
 - Updates who positive support professionals and analysts can train and direct
 - Updates provider qualifications for positive support professionals
 - Updates provider qualifications for positive support analysts

Updates crisis respite services (BI, CAC, CADI and DD)

- Restores missing language in the crisis respite service definition (CADI)
- Clarifies size limits for foster care and community residential settings (BI, CAC, CADI and DD)
- Updates provider qualifications (BI, CAC, CADI and DD)

CADI waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Crisis Respite

Service Definition (Scope):

Crisis-respite services are specialized services that provide short-term care and intervention to an individual due to the need for relief and support of the caregiver and protection of the participant or others living with the participant and due to the need for behavioral or medical intervention. Crisis-respite services will include the following participant specific activities:

1. Assessment to determine the precipitating factors contributing to the crisis.
2. Development of a provider intervention plan in coordination with the support planning team.
3. Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the participant specific intervention plan.
4. Development and implementation of a transition plan to aid the participant in returning home if out-of-home crisis-respite was provided.
5. On-going technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the participant.
6. Recommendations for revisions to the 24-hour plan of care (community support plan) to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the participant in the community.

[add] Crisis-respite services provide specific intervention strategies directed to enable the participant to remain in the community. These services are a necessary service component of the 24-hour plan of care that is

developed and monitored by the case manager and, as such, do not duplicate those services provided through case management. [end add]

Crisis-respite services can either be provided to the participant living in his or her home or, when necessary for the relief of the caregiver and the protection of the participant or others living in the home, in a licensed foster care home [add] or licensed community residential setting (for up to five people) [end add] developed for the purpose of providing short-term crisis intervention or in a licensed hotel. Payment for out-of-home crisis-respite will include payment for room and board costs when the service is provided in a licensed foster care facility developed for the provision of crisis-respite that is not a private residence or in a licensed hotel.

The lead agency may authorize crisis respite to be provided in a licensed hotel for up to seven days only when a licensed foster care facility providing out-of-home crisis respite is not immediately available within 50 miles of the person's home or when available openings are not appropriate for the person's needs. After seven days, the lead agency must submit documentation of continued need for crisis respite to be provided in a licensed hotel to DHS for review and approval on a weekly basis.

If a participant is going to receive crisis respite services in a licensed hotel, the crisis respite provider secures hotel lodging for the participant and sends direct care staff to the licensed hotel to provide the amount, frequency, and type of crisis respite services as identified in the intervention plan. This service does not pay for caregivers to stay in a hotel while the participant remains at home. The provider of crisis respite must pay the cost of the hotel room and meals for the participant.

The following criteria must be met for a participant to receive crisis-respite services:

1. The caregiver and service providers are not capable of providing the necessary intervention and protection of the participant or others living with the participant.
2. The crisis-respite service(s) will enable the participant to avoid institutional placement.
3. The use of out-of-home crisis-respite will not exceed 180 days except when authorized as part of a plan approved by the lead agency. To exceed the 180-day limit, the lead agency must assure and document that the service is necessary; extension will not result in the participant's inability to return home or to an alternative home in the community; and continued use of the service is a cost-effective alternative to institutionalization.
4. The individual has been screened and authorized as eligible to receive home and community-based services.

Unlike other waiver services, the crisis-respite service must be immediately available to an individual as an alternative to institutional placement. Because of this, the determination of eligibility and modifications to the community support plan must occur within five working days of receiving crisis-respite services. However, no Medicaid payment will be made if the screening process determines that the individual is not eligible for home and community-based services. The screening process is the same and uses the same instrument as used for all evaluations of eligibility for ICF/DD, nursing facility, hospital level of care or home and community-based services.

BI, CAC and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Crisis Respite

Service Definition (Scope):

Crisis-respite services are specialized services that provide short-term care and intervention to an individual due to the need for relief and support of the caregiver and protection of the participant or others living with the participant and due to the need for behavioral or medical intervention. Crisis-respite services will include the following participant specific activities:

1. Assessment to determine the precipitating factors contributing to the crisis.
2. Development of a provider intervention plan in coordination with the support planning team.
3. Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the participant specific intervention plan.
4. Development and implementation of a transition plan to aid the participant in returning home if out-of-home crisis-respite was provided.
5. On-going technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the participant.
6. Recommendations for revisions to the 24-hour plan of care (community support plan) to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the participant in the community.

Crisis-respite services provide specific intervention strategies directed to enable the participant to remain in the community. These services are a necessary service component of the 24-hour plan of care that is developed and monitored by the case manager and, as such, do not duplicate those services provided through case management.

Crisis-respite services can either be provided to the participant living in his or her home or, when necessary for the relief of the caregiver and the protection of the participant or others living in the home, in a licensed foster care home or licensed community residential setting **[add] (for up to five people) [end add]** developed for the purpose of providing short-term crisis intervention or in a licensed hotel. Payment for out-of-home crisis-respite will include payment for room and board costs when the service is provided in a licensed foster care facility developed for the provision of crisis-respite that is not a private residence or in a licensed hotel.

The lead agency may authorize crisis respite to be provided in a licensed hotel for up to seven days only when a licensed foster care facility providing out-of-home crisis respite is not immediately available within 50 miles of the person's home or when available openings are not appropriate for the person's needs. After seven days, the lead agency must submit documentation of continued need for crisis respite to be provided in a licensed hotel to DHS for review and approval on a weekly basis.

If a participant is going to receive crisis respite services in a licensed hotel, the crisis respite provider secures hotel lodging for the participant and sends direct care staff to the licensed hotel to provide the amount, frequency, and type of crisis respite services as identified in the intervention plan. This service does not pay for caregivers to stay in a hotel while the participant remains at home. The provider of crisis respite must pay the cost of the hotel room and meals for the participant.

The following criteria must be met for a participant to receive crisis-respite services:

1. The caregiver and service providers are not capable of providing the necessary intervention and protection of the participant or others living with the participant.
2. The crisis-respite service(s) will enable the participant to avoid institutional placement.
3. The use of out-of-home crisis-respite will not exceed 180 days except when authorized as part of a plan approved by the lead agency. To exceed the 180-day limit, the lead agency must assure and document that the:

service is necessary; extension will not result in the participant's inability to return home or to an alternative home in the community; and continued use of the service is a cost-effective alternative to institutionalization.

4. The individual has been screened and authorized as eligible to receive home and community-based services.

Unlike other waiver services, the crisis-respite service must be immediately available to an individual as an alternative to institutional placement. Because of this, the determination of eligibility and modifications to the community support plan must occur within five working days of receiving crisis-respite services. However, no Medicaid payment will be made if the screening process determines that the individual is not eligible for home and community-based services. The screening process is the same and uses the same instrument as used for all evaluations of eligibility for ICF/DD, nursing facility, hospital level of care or home and community-based services.

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Crisis Respite

Provider Specifications:

Agency – In-home crisis respite providers
Individual – In-home crisis respite providers
Agency – Out-of-home crisis respite providers
Individual – Out-of-home crisis respite providers

Provider Qualifications:

License (specify):

Agencies/individuals must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Other Standard (specify):

[add] Providers of crisis respite must have the specific experience, skills and qualifications required to meet the person's behavioral and or medical intervention needs that resulted in or contributed to the crisis situation as identified in the person's community support plan.

Providers who bill for crisis respite specialized staff must have staff who are either:

- Licensed, certified or credentialed, or
- Have a four-year degree and be specially trained in crisis prevention, intervention and resolution **[end add]**

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Updates positive support services (BI, CAC, CADI & DD)

- Updates “maladaptive behavior” language to state “challenging behavior”
- Removes examples of positive support approaches
- Adds language addressing when providers can bill for indirect time
- Updates who positive support professionals and analysts can train and direct
- Updates provider qualifications for positive support professionals
- Updates provider qualifications for positive support analysts

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Positive Support Services

Service Definition (Scope):

Positive support services consist of the development, implementation and monitoring of a person-centered, individually-designed proactive plan to enhance positive behavior resulting in the decrease or elimination of a participant’s severe ~~[delete] maladaptive~~ ~~(end delete)~~ challenging ~~[delete]~~ ~~(end delete)~~ behavior. Positive support services include the use of person-centered approaches incorporating a comprehensive functional behavior assessment of both positive as well as ~~[delete] maladaptive~~ ~~(end delete)~~ ~~[add] challenging~~ ~~(end add)~~ behavior, development of a positive behavior support plan or positive support transition plan to phase out the use of restrictive interventions approved for use on a temporary basis, implementation of the plan, on-going training and supervision of caregivers, including paid staff, and periodic reassessment and modification of the plan. When possible, the participant will lead the process for developing a positive behavior support plan and/or positive support transition plan. ~~[delete] Examples of positive support approaches are positive behavior support (PBS), illness management and recovery (IM&R) approaches, motivational interviewing, dialectical behavior therapy and cognitive behavior therapy.~~ ~~(end delete)~~ Three levels of qualifications and duties associated with positive support services are listed below to illustrate how functions are associated with progressive levels of authority, competency, training and experience:

1) Positive support professionals:

- Complete an individualized functional behavior assessment
- In conjunction with the person, develop a person-centered, positive-practice individualized behavior support plan and/or positive support transition plan that identifies specific proactive and, if necessary, reactive intervention strategies
- Distribute the plan(s)
- Provide on-site instructional training regarding the use of behavioral interventions
- Evaluate the effectiveness of the service and interventions
- Modify the plan(s) as necessary
- Train and supervise behavioral staff (includes positive support analyst, and positive support specialist) ~~[add]~~, direct support professionals, other paid staff, caregivers, family or other people who implement the plan

Positive support professionals may bill for indirect time spent doing preparation and finalizing assessment, development and modification of positive behavior support plans. All other indirect time is accounted for in the rate framework. [end add]

2) Positive support analysts:

- Complete an individualized functional behavior assessment
- Oversee implementation of the person-centered, positive support transition plan and/or behavior support plan
- Train and direct positive support specialist staff ~~[delete] that [end delete]~~ [add], direct support staff, other paid staff, caregivers, family or other people who [end add] implement the positive support transition plan
- Supervise data collection
- Provide feedback to and coordinate with the positive support professional

[add] Positive support analysts may bill for indirect time spent overseeing implementation of plans, designing data collection and training staff on data collection. All other indirect time is accounted for in the rate framework. [end add]

3) Positive support specialists:

- Complete an individualized functional behavior assessment
- Implement the person-centered, positive support plan and/or behavior support plan
- Collect and record behavioral data
- Communicate questions or concerns to the positive support professional or positive support analyst

[add] Positive support specialists may bill for indirect time spent implementing the plans, collecting and recording data. All other indirect time is accounted for in the rate framework. [end add]

The level of positive support service to be provided is determined by the participant's assessed needs, environmental considerations, individual choice that includes an analysis of risk and benefit, informed consent, and history.

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Positive Support Services

Provider Specifications:

Agency – Positive Support Professionals

Individual – Positive Support Professionals

Provider Qualifications:

License (*specify*):

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

~~[delete] Mental health professionals must be licensed or certified, or meet the qualification criteria listed under Minnesota Statutes, section 245.462, subd. 18. [end delete]~~

Certificate (*specify*):

~~[delete] Mental health professionals must be licensed or certified, or meet the qualification criteria listed under Minnesota Statutes, section 245.462, subd. 18. [end delete]~~

Other Standard (*specify*):

Positive support professionals must have competencies in areas related to ethical considerations, functional behavior assessment, functional analysis, measurement of behavior and interpretation of data, selecting intervention outcomes and strategies, person-centered thinking strategies, positive behavior support strategies, data collection, staff/caregiver training, support plan monitoring, treating co-occurring mental and neuro-cognitive disorders, demonstrated expertise with populations being served, and meet at least one of the following requirements:

- 1) Psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98; or
- 2) Clinical social worker licensed as an independent clinical social worker under Minnesota Statutes, chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4000 hours of post-master's supervised experience in the delivery of clinical service in the above identified competency areas; or
- 3) Physician licensed under Minnesota Statutes, chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, with demonstrated competencies in the above areas; or
- 4) Licensed professional clinical counselor licensed under Minnesota Statutes, sections 148B.50 to 148B.593 with at least 4000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the above areas; or
- 5) Person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the above areas; or
- 6) Person with a master's degree or Ph.D. in one of the behavioral sciences or related field with demonstrated expertise in positive support services, as determined by the person's case manager based on the person's needs as identified in the person's community support plan; or
- 7) Registered nurse who is licensed under Minnesota Statutes, sections 148.171 to 148.285, who has demonstrated competencies in the above identified areas; and
 - i. is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or
 - ii. has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4000 hours of post-master's supervised experience in the delivery of clinical services.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Positive Support Services

Provider Specifications:

Agency – Positive Support Analyst

Individual – Positive Support Analyst

Provider Qualifications:**License (specify):**

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Other Standard (specify):

Positive support analysts must have four years of supervised experience ~~conducting functional behavior assessments and designing, implementing, and evaluating effectiveness of positive practices behavior support strategies for~~ **[end delete] [add] working with [end add]** individuals who exhibit challenging behaviors as well as co-occurring mental disorders and neuro-cognitive disorder; and one of the following qualifications:

- 1) a baccalaureate degree, master's degree or a PhD in a social services discipline; or
- 2) the qualifications of a Mental Health Practitioner as defined in Minnesota Statutes, section 245.462, subd. 17; or
- 3) certified as a Behavior Analyst or Assistant Behavior Analyst by the Behavior Analyst Certification Board.

Additionally, positive support analysts must have:

- ten hours of instruction in functional behavior assessment and functional analysis; and
- twenty hours of instruction in the understanding of the function of behavior; and
- ten hours of instruction on design of positive practices behavior support plan; and
- twenty hours of instruction on preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, summarizing/reporting program evaluation data, analyzing program evaluation data to identify design flaws in behavioral interventions or failures in maintaining fidelity to intervention strategies, and recommending enhancements based on evaluation data; and
- eight hours of instruction on the principles of person-centered thinking; and
- clinical supervision by a positive support professional.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Other Waiver Services

- Adult companion services (BI, CAC and CADI)
 - Corrects provider qualifications
- Caregiver living expenses (BI, CAC, CADI and DD)
 - Updates the list of approved services (BI, CAC and CADI)
 - Clarifies this service cannot be provided by related individuals as per federal regulations (BI, CAC, CADI and DD)
 - Clarifies documentation requirements (BI, CAC, CADI and DD)
- Customized living (BI and CADI)
 - Clarifies this services is for adults
- Environmental accessibility adaptations (BI, CAC, CADI and DD)
 - Adds language allowing an assessment provider to oversee the project to ensure ADA requirements are met
 - Clarifies when there can be an exception to modifying a primary vehicle
 - Clarifies authorization of home modifications
 - Restores missing language addressing cameras in bedrooms of minor children (DD)
 - Adds language requiring two comparison bids when requesting an exception to the annual limit
 - Updates provider qualifications for home modification assessment providers
- Foster care (BI, CAC and CADI)
 - Adds community residential setting (CRS) to the definition
- Home delivered meals (BI, CAC, CADI and DD)
 - Updates provider qualifications
- Independent living skills (ILS) training (BI, CAC and CADI)
 - Updates “maladaptive behavior” language to state “challenging behavior”
- Night supervision services (BI, CAC, CADI and DD)
 - Restores missing language defining “own home” (BI and CADI)
 - Adds language addressing what this service covers (BI, CAC, CADI and DD)
- Residential care (BI and CADI)
 - Removes references to residential care which ended June 30, 2018
 - Removes outdated language regarding a transition plan for residential care which has expired
- Residential habilitation (DD)
 - Clarifies caregiver living expenses are available to providers of supported living services (SLS) for adults
 - Clarifies where services can be provided
 - Changes “daily staff intervention” to “daily staff support”
 - Adds language addressing daily staff support in relation to supported living services for adults, remote support, in own home
 - Adds community residential setting (CRS) where applicable
 - Updates “maladaptive behavior” language to state “challenging behavior”
- Respite (BI, CAC, CADI and DD)

- o Includes a technical change in the service definition for hospitals and nursing facilities (BI, CAC and CADI)
- o Includes a technical change in the service definition for hospitals (DD)
- o Clarifies unlicensed settings for adults and children (BI, CAC, CADI and DD)
- o Adds intermediate care facilities for persons with developmental disabilities (ICFs/DD) as an available setting for people to receive respite (DD)
- o Adds a size limitation to unlicensed settings (excluding camps) (BI, CAC, CADI and DD)
- o Removes references to residential care which has ended (BI and CADI)
- o Updates provider qualifications (BI, CAC, CADI and DD)
- Specialist services
 - o Adds language addressing when providers can bill for indirect time
- Transitional services (BI, CAC, CADI and DD)
 - o Corrects licensing reference for intermediate care facilities for persons with developmental disabilities
 - o Aligns “own home” definition with housing access coordination
 - o Clarifies services in customized living settings
 - o Updates eligibility criteria to remove the 180-day limitation
- Transportation (BI, CAC, CADI and DD)
 - o Adds language addressing what this service covers (BI, CAC, CADI and DD)
 - o Corrects provider qualifications (BI and CADI)

Adult companion (BI, CAC and CADI)

- **Corrects provider qualifications**

BI, CAC and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Companion

Provider Specifications:

Agency – Agencies that meet the standards to provide adult companion

Individual – Individuals that meet the standards to provide adult companion

Provider Qualifications:

Other Standard (*specify*):

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D.

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 **[delete]** (1) and **[end delete]** (2) must meet the requirements of: section 245D.04, subd. 1(4), subd 2 (1), (2) (3) (6) and subd. 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and

medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

Verification of Provider Qualifications:

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03, subd.2 **[delete]**-(1) and **[end delete]** (2) the lead agency

Caregiver living expenses (BI, CAC, CADI and DD)

- **Updates the list of approved services (BI, CAC and CADI)**
- **Clarifies this service cannot be provided by related individuals as per federal regulations (BI, CAC, CADI and DD)**
- **Clarifies documentation requirements (BI, CAC, CADI and DD)**

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Caregiver Living Expenses

Service Definition (Scope):

Caregiver living expenses are the portion of the rent and food that may be reasonably attributed to the live-in personal caregiver, when the live-in personal caregiver also provides one of the following approved support services: independent living skills training services; individualized home supports; adult companion services; extended personal care assistance services; **[add]** personal support services; **[end add]** or consumer directed community supports. The service must be provided to an adult participant, living in his or her own home and the live-in personal caregiver must reside in the same home. For purposes of this service, food includes three meals a day or any other full nutritional regimen. **[delete]** Refer to Appendix I-6 for the form used to determine the amount to be covered. **[end delete]** **[add]** The amount of caregiver living expenses must be documented using the Caregiver Living Expenses Worksheet (DHS-4929).

The lead agency must identify and document in the support plan the role and expectations of the caregiver outside of the approved waiver support service(s) he/she provides. **[end add]**

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

~~[delete]~~ The amount of caregiver living expenses must be documented by the lead agency. ~~[end delete]~~

Caregiver living expenses are not available in situations in which the participant lives in a home that is owned by the caregiver or a residence owned or leased by a provider of Medicaid services. This service does not cover live-in expenses of ~~[delete]~~ parents (including adoptive), spouses, ~~[end delete]~~ [add] related individuals [end add] or other legally responsible individuals. [add] Related individuals include any person who is related by blood, marriage or adoption to any degree. [end add]

Provider Specifications:

Individual – Individuals that meet the live-in caregiver standards (receipt services)

Agency – Agencies that meet the live-in caregiver standards (receipt services)

Provider Qualifications:

Other Standard (specify):

The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: independent living skills training, individualized home supports, extended personal care assistance, extended home care nursing, [add] personal support services, [end add] or consumer directed community supports. Refer to the qualifications for each of these services.

Appendix I-6: Financial Accountability – Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

☐ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

☒ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

For adult participants who reside in a setting that they own, lease, or rent, adult~~[delete]~~ relatives~~[end delete]~~ [add] live-in caregivers [end add] may be paid caregiver living expenses with the exception of ~~[delete]~~ parents (i.e., cousins, aunts/uncles, and siblings may receive caregiver living expenses)~~[end delete]~~ [add] related individuals (i.e. any person who is related by blood, marriage or adoption to any degree) or other legally responsible individuals [end add].

(a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver:

Case managers are required to document the costs of rent and food attributable to the live-in caregiver **[add]** using the Caregiver Living Expenses Worksheet (DHS-4929) **[end add]**.

(b) the method used to reimburse these costs:

Claims are paid via MMIS.

CAC waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Caregiver Living Expenses

Service Definition (Scope):

Caregiver living expenses are the portion of the rent and food that may be reasonably attributed to the live-in personal caregiver, when the live-in personal caregiver also provides one of the following approved support services: independent living skills training; individualized home supports; extended personal care assistance; extended home care nursing, **[add]** personal support services, adult companion, **[end add]** or consumer directed community supports. The service must be provided to an adult participant, living in his or her own home and the live-in personal caregiver must reside in the same home. For purposes of this service, “food” includes three meals a day or any other full nutritional regimen. The amount of caregiver living expenses must be documented using the Caregiver Living Expenses Worksheet (DHS-4929).

[add] The lead agency must identify and document in the support plan the role and expectations of the caregiver outside of the approved waiver support service(s) he/she provides. **[end add]**

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

Caregiver living expenses are not available in situations in which the participant lives in a home that is owned by the caregiver or a residence owned or leased by a provider of Medicaid services. This service does not cover live-in expenses of **[delete]** ~~parents (including adoptive), spouses,~~ **[end delete]** **[add]** related individuals **[end add]** or other legally responsible individuals. **[add]** Related individuals include any person who is related by blood, marriage or adoption to any degree. **[end add]**

Provider Specifications:

Individual – Individuals that meet the live-in caregiver standards (receipt services)

Agency – Agencies that meet the live-in caregiver standards (receipt services)

Provider Qualifications:

Other Standard (specify):

The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: independent living skills training, individualized home supports, extended personal care assistance, extended home care nursing, **[add]** personal support services, adult companion, **[end add]** or consumer directed community supports. Refer to the qualifications for each of these services.

Appendix I-6: Financial Accountability – Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

☐ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

☒ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

For adult participants who reside in a setting that they own, lease, or rent, adult live-in caregivers may be paid caregiver living expenses with the exception of ~~[delete] parent, spouses-[end delete]~~ **[add]** related individuals (i.e. any person who is related by blood, marriage or adoption to any degree) **[end add]** or other legally responsible individuals ~~[delete] (i.e., cousins, aunts/uncles, and siblings may receive caregiver living expenses)~~ **[end delete]**.

(a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver:

Case managers are required to document the costs of rent and food attributable to the live-in caregiver using the Caregiver Living Expenses Worksheet (DHS-4929).

(b) the method used to reimburse these costs:

Claims are paid via MMIS.

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Caregiver Living Expenses

Service Definition (Scope):

Caregiver living expenses are the portion of the rent and food that may be reasonably attributed to the live-in personal caregiver, when the live-in personal caregiver also provides one of the following approved support services: supported living services **[add]** for adults **[end add]** (under residential habilitation); personal support services; extended personal care assistance; or consumer directed community supports. The service must be provided to an adult participant, living in his or her own home and the live-in personal caregiver must reside in

the same home. For purposes of this service, food includes three meals a day or any other full nutritional regimen. ~~[delete] Refer to Appendix I-6 for the form used to determine the amount to be covered. [end delete]~~ **[add]** The amount of caregiver living expenses must be documented using the Caregiver Living Expenses Worksheet (DHS-4929).

The lead agency must identify and document in the support plan the role and expectations of the caregiver outside of the approved waiver support service(s) he/she provides. **[end add]**

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

~~[delete] The amount of caregiver living expenses must be documented by the lead agency. [end delete]~~

Caregiver living expenses are not available in situations in which the participant lives in a home that is owned by the caregiver or a residence owned or leased by a provider of Medicaid services. This service does not cover live-in expenses of ~~[delete] parents (including adoptive), spouses, [end delete]~~ **[add]** related individuals **[end add]** or other legally responsible individuals. **[add]** Related individuals include any person who is related by blood, marriage or adoption to any degree. **[end add]**

Provider Specifications:

Individual – Individuals that meet the live-in caregiver standards (receipt services)

Agency – Agencies that meet the live-in caregiver standards (receipt services)

Provider Qualifications:

Other Standard (*specify*):

The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: supported living services **[add]** for adults **[end add]** (under residential habilitation); personal support services; extended personal care assistance services; or consumer directed community supports. Refer to the qualifications for these services.

Appendix I-6: Financial Accountability – Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

☐ No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

☒ Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

For adult participants who reside in a setting that they own, lease, or rent, adult ~~relatives~~ **[add]** live-in caregivers **[end add]** may be paid caregiver living expenses with the exception of ~~parents (i.e., cousins, aunts/uncles, and siblings may receive caregiver living expenses)~~ **[add]** related individuals (i.e. any person who is related by blood, marriage or adoption to any degree) or other legally responsible individuals **[end add]**.

(a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver:

Case managers are required to document the costs of rent and food attributable to the live-in caregiver **[add]** using the Caregiver Living Expenses Worksheet (DHS-4929) **[end add]**.

(b) the method used to reimburse these costs:

Claims are paid via MMIS.

Customized living (BI and CADI)

- **Clarifies this service is for adults**

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Customized Living

Service Definition (Scope):

Customized living (CL) services are provided **[add]** to adults 18 years of age or older **[end add]** in congregate settings by the management of the setting or a provider under contract with the management of the setting. In order for customized living services to be covered by the waiver, participants must have an individualized service plan based on their documented needs. This is a separate and distinct plan from the community support plan developed with the case manager that includes all waiver services. Service plans that contain supervision of the participant must include documentation of the participant's specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact will occur. The participant must be given the opportunity to accept, revise, or reject the service plan and the case manager determines whether the plan is approved as part of the participant's overall community support plan. Service plans must document whether or not there is a need for 24-hr supervision of the participant and whether or not 24-hour supervision is included in the CL plan. Service plans must also include documentation of the participant's specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact will occur.

Environmental accessibility adaptations (BI, CAC, CADI and DD)

- Adds language allowing an assessment provider to oversee the project to ensure ADA requirements are met
- Clarifies when there can be an exception to modifying a primary vehicle
- Clarifies authorization of home modifications
- Restores missing language addressing cameras in bedrooms of minor children (DD)
- Adds language requiring two comparison bids when requesting an exception to the annual limit
- Updates provider qualifications for home modification assessment providers

BI, CAC, CADI and DD waivers

Service Title:

Environmental Accessibility Adaptations

Service Definition (Scope):

Environmental accessibility adaptations are physical adaptations to the participant's home or primary vehicle, required by the participant's community support plan that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence. Examples of adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies, or monitoring or surveillance systems* including cameras, motion detectors, GPS trackers, home security systems, and door and window alarms. The service also covers the necessary assessments to determine the most appropriate adaptation or equipment **[add]**, and oversight of the project by an assessment provider to assure ADA requirements are met **[end add]**. The service may also cover installation, maintenance and repairs of environmental modifications and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

For purposes of the waiver, home refers to the participant's primary place of residence (i.e., not vacation homes) **[add]** and vehicle refers to the participant's primary vehicle **[end add]**. Exceptions to the requirement that home **[add]** and vehicle **[end add]** modifications be limited to the participant's primary place of residence **[add]** or primary vehicle **[end add]**, may be authorized by the case manager when the following criteria are met and documented in the participant's community support plan. The accessibility adaptation:

- 1) will enable active involvement of the participant **[add]** in the community and/or **[end add]** with family members; and
- 2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and,
- 3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

[add] To ensure integrity of modification projects, lead agencies may authorize home modifications on multiple lines:

- Line 1: Materials and permits
- Line 2: Down payment

• Line 3: Completion and inspection, or final payment **[end add]**

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

* (a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:

(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and

(2) the Minnesota Government Data Practices Act as codified in Minnesota Statutes, chapter 13.

(b) The agency or individual shall be monitored for compliance as follows:

(1) the agency or individual must control access to data on participants according to the definitions of public and private data on individuals under Minnesota Statutes, section 13.02; classification of the data on individuals as private under Minnesota Statutes, section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to Minnesota Statutes, section 13.05, in which the agency or individual is assigned the duties of a government entity;

(2) the agency or individual must provide each participant with a notice that meets the requirements under Minnesota Statutes, section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;

(3) In accordance with Minnesota Statutes, section 245A.11, Subd. 7a(f)(5) “a resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring.” If an existing resident does not consent to electronic monitoring, the application for an alternative overnight technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant’s needs are met by alternative means.

(4) The use of environmental accessibility adaptations for monitoring technology requires a process for obtaining and maintaining informed consent. To ensure informed consent, the case manager and the participant or legal guardian must collaborate and determine:

a) how the monitoring technology will be used;

b) how their needs will be met if they choose not to use monitoring technology;

c) possible risks created by the use of the technology;

d) who will have access to the data collected and how their personal information will be protected; and

e) their right to refuse, stop, or suspend the use of monitoring technology at any time.

(5) The participant’s community support plan must describe how the use of monitoring technology:

a) is the least restrictive option and the person’s preferred method to meet an assessed need;

b) achieves an identified goal or outcome; and

c) addresses health, potential individual risks and safety planning.

- (6) Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.
- (7) cameras used for electronic monitoring must not be installed in bathrooms;
- (8) cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Department approval is not required when parents are monitoring minor children living in their home using cameras in bedrooms for purposes of health and safety. Electronic monitoring cameras must not be concealed from the participant;
- (9) equipment that is bodily invasive, auto door or window locks, and concealed cameras are not allowed;
- (10) the state must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs; and
- (11) electronic video and audio recordings of participants shall be stored for five days unless: (i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under Minnesota Statutes, sections 626.556 or 626.557 or a crime under Minnesota Statutes, chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section Minnesota Statutes, 626.557, subdivision 12b.

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

Environmental Accessibility Adaptations are limited to a maximum of \$40,000 per year per waiver participant. A case manager may request an exception to the annual limit of \$40,000 from the commissioner. Approval of an exception will allow an additional \$40,000 to be authorized from the person's service allotment for the following year for a maximum of \$80,000 for a two-year time period. Exceptions over \$40,000 may be approved when **[add]** at least two comparison bids are received and **[end add]**:

- a. modification(s) are cost effective and necessary during the current year for the person to live in the most integrated community setting; and
- b. other options have been explored and will not provide the person reasonable access to community integration and functional use of the house.

DD waiver

Service Definition (Scope):

(8) Cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department **[add]**. Department approval is not required when parents are monitoring minor children living in their home using cameras in bedrooms for purposes of health and safety. **[end add]** Electronic monitoring cameras must not be concealed from the participant;

BI, CAC, CADI and DD waivers

Provider Specifications:

Individual – Environmental Accessibility Adaptations/Home Modification Assessments

Agency – Environmental Accessibility Adaptations/Home Modification Assessments

Provider Qualifications:

Other Standard (specify):

Individuals that provide home modification assessments meet one of the following:

- An Occupational Therapist that is currently registered by the American Occupational Therapy Association to perform assessment functions and have at least 1 year of experience with home modification evaluations

[add] • A Physical Therapist that is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must be registered under Minnesota Statutes, section 148.70. **[end add]**

- A Certified Aging-in-Place Specialist with at least 1 year of experience with home modification assessments
- A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry with at least 1 year of experience with home modification assessments

Foster care (BI, CAC and CADI)

- **Adds community residential setting (CRS) to the definition**

BI, CAC and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Adult Foster Care

Service Definition (Scope):

Adult foster care is ongoing residential care and supportive services and includes personal care assistance services, homemaker, chore, behavioral aide services, companion services, and medication oversight (to the extent permitted under State law) provided in a licensed home **[add]** or community residential setting (CRS) **[end add]**.

Home delivered meals (BI, CAC, CADI and DD)

- **Updates provider qualifications**

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Home Delivered Meals

Provider Specifications:

Agency – Hospitals, schools, restaurants, or other entities that meet the provider standards

Individual – Hospitals, schools, restaurants, or other entities that meet the provider standards

Provider Qualifications:**Other Standard (specify):**

Providers must comply with all state and local health regulations and ordinances related to food preparation, and handling and serving of food as defined under Minnesota Rules, parts 4626.0010 to 4626.2025. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures.

[add] Licensed dietitians and nutritionists must meet requirements as specified in Minnesota Statutes, 148.621 and Minnesota Rules, chapter 3250. **[end add]**

Independent living skills (ILS) training (BI, CAC and CADI)

- Updates “maladaptive behavior” language to state “challenging behavior”

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Independent Living Skills (ILS) Training

Service Definition (Scope):

Independent Living Skills (ILS) Training services are directed toward the acquisition, retention, maintenance and improvement of a participant’s community living skills. ILS Training Services are designed to address identified skill development needs of the participant. ILS Training Services may be provided in the participant’s home or surrounding community settings used by the general public.

ILS Training Services are staff-intensive, instructional services, whereby a participant receives direct training from a staff person on specifically needed community skills.

ILS Training Services may include, but are not limited to, training in such areas as: self-care, sensory-motor development, communication, interpersonal skills, reduction or elimination of **[delete] maladaptive [end delete]** **[add] challenging [end add]** behavior, community living, and community mobility skills.

Assistance and supervision may occur during the course of providing ILS Training Services, but, assistance and supervision should not be the entirety of provided ILS Training Services.

There must be clear documentation of service needs and outcomes that are identified in the community support plan, as well as regular written reviews of progress and periodic written reports.

Night supervision services (BI, CAC, CADI and DD)

- Restores missing language defining “own home” (BI and CADI)
- Adds language addressing what this service covers (BI, CAC, CADI and DD)

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Night Supervision Services

Service Definition (Scope):

Night supervision services provide **[add]** awake **[end add]** overnight assistance and **[delete]** ~~monitoring~~ **[end delete]** **[add]** supervision **[end add]** of the participant in his or her own home for a period of no more than 12 hours in a 24-hour period. **[add]** For this service, “own home” is defined as a home that is not licensed or operated by another entity. **[end add]**

Night supervision includes carrying out the participant’s positive behavior support plan and/or positive support transition plan when applicable, reinforcing other skill development supports, and assisting with **[add]** activities of daily living and **[end add]** instrumental activities of daily living.

CAC and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Night Supervision Services

Service Definition (Scope):

Night supervision services provide **[add]** awake **[end add]** overnight assistance and **[delete]** ~~monitoring~~ **[end delete]** **[add]** supervision **[end add]** of the participant in his or her own home for a period of no more than 12 hours in a 24-hour period. For this service, “own home” is defined as a home that is not licensed or operated by another entity.

Night supervision includes carrying out the participant’s positive behavior support plan and/or positive support transition plan when applicable, reinforcing other skill development supports, and assisting with **[add]** activities of daily living and **[end add]** instrumental activities of daily living.

Residential care (BI and CADI)

- Removes references to residential care which ended June 30, 2018
- Removes outdated language regarding a transition plan for residential care which has expired

BI and CADI waivers

NOTE: The intention of this amendment is to remove all references to residential care. The following may not be inclusive of all changes that need to be made in all four disability waiver plans.

Appendix C-1/C-3: Participant Services – Service Specification

[delete] Service Title:

~~Residential Care~~

Service Definition (Scope):

~~Residential care services are supportive services and up to 24-hour supervision and may include: meal preparation, individualized home management tasks, socialization, money management, assisting participants with arranging meetings and appointments for medical and social services, and coordinating or providing transportation.~~

~~Residential care services may also include, minimal assistance with dressing, grooming and bathing, reminding participants to take medications and storing medications in accordance with Minnesota Statutes, section 157.17.~~

~~Residential care services are provided to participants who reside in a residential care home. Residential care homes are licensed as board and lodging establishments and are registered with the Minnesota Department of Health as board and lodge with specialized services.~~

~~Service direction must be provided by the participant or by residential care home staff with oversight by the case manager.~~

~~The total number of individuals living in the setting shall not exceed four except when authorized by the commissioner. The commissioner may authorize services provided in settings serving up to five individuals, living in the setting who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert an individual's placement in a regional treatment center or nursing facility and the following criteria are met. This exception for services delivered in a site with more than four individuals shall not exceed two years. For purposes of this provision, emergency situations are defined as:~~

- ~~• An unexpected loss of an essential caregiver~~
- ~~• A sudden loss of housing due to closure~~
- ~~• Loss of services or housing due to a natural disaster~~
- ~~• Necessary to place siblings together~~

~~This limit does not apply to settings that have continuously provided this service to a waiver participant prior to July 1, 2000. Provided means that this was an approved service for a participant in the setting on or prior to July 1, 2000. This size restriction does not apply to people who are 55 years of age or older.~~

~~The residential care service shall discontinue by June 30, 2018. The Department will work with lead agencies to begin the transition process for people to complete person centered planning to determine alternative waiver supports that are more tailored to individual needs, such as homemaker, chore transportation and other services. No new authorizations for residential care services will be allowed starting July 1, 2017. A new authorization means approval for residential care services for a participant who was not receiving care services on June 30, 2017.~~

~~From July 1, 2017 to June 30, 2018, the commissioner may approve a new authorization for residential care services for a participant who is being discharged from an institutional setting (e.g. nursing facility, hospital, ICF/DD, or IMD) or short term crisis or stabilization program, and was receiving residential care services immediately prior to entering the institutional setting, crisis or stabilization program.~~

~~The commissioner may approve an adjustment to a participant's rate to assure continuity of services while transitioning to alternative services.~~

~~Transition Plan for Elimination of Residential Care: Beginning in July 2015, the Department conducted a comprehensive outreach effort to providers and lead agencies detailing the discontinuation of residential care. Specifically, the Department sent fact sheets to stakeholders and hosted two webinars for providers and lead agencies on July 15 and September 14, 2015. The webinars explained the decision to discontinue residential care and discuss transition options for providers and people receiving the service. Providers were also contacted~~

between January through February 2016 via telephone to discuss the planned discontinuation of the service and business-related options for the providers. The Department plans to continue outreach efforts by conducting a series of trainings in the fall of 2016 and beginning of 2017 to support case managers in developing a person-centered transition plan with participants affected by the discontinuation of residential care.

Case managers will contact participants affected by the discontinuation of residential care. Case managers and care coordinators will use the “Person-Centered, Informed Choice & Transition Protocol” to develop transition plans for participants transitioning from residential care to alternative waiver services and settings. Specifically, the transition protocol will address the participant’s choices and preferences while assuring the participant’s health and welfare.

Each affected participant will receive a formal notice regarding the termination of residential care at least thirty days in advance. Providers also will communicate to participants that the service will terminate on June 30, 2018. Case managers and care coordinators are responsible for developing a community support plan for the participant, which includes a component addressing the participant’s health and safety needs. During the transition period, case managers and care coordinators will update the community support plan to reflect how a person’s health and safety will be ensured. Case managers and care coordinators are responsible for monitoring the implementation of the community support plans as well as assuring the health and safety of the person.

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

Homemaker, chore, and respite services are not covered as separate services for participants who are receiving residential care services.

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

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

Services provided in a living setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the living setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. When more than one living setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants living in one of the settings.

Service Delivery Method (check each that applies):

Provider Managed

Provider Specifications:

Agency—Board and lodge settings that are registered as housing with services establishments to provide specialized services

Provider Qualifications

License (specify):

Providers must be licensed as a board and lodging establishment and meet the standards in Minnesota Statutes, section 157.15 to 157.17

Providers must also meet standards of licensure, certification or registration where they exist either in state law or administrative rule

Certificate (specify):

Providers must be registered with the Minnesota Department of Health as providing specialized services and must meet applicable building codes.

Other Standard (specify):

Residential services must be provided by the management of the residential care home.

~~Staff who provide assistance with dressing, grooming, bathing, or reminders to take medications or store medication are required to have eight hours of training and orientation by a registered nurse. If medications are distributed or stored, a registered nurse must provide supervision.~~

~~Staff must possess:~~

- ~~(1) communication skills including the ability to read and write, follow written and verbal instructions, and converse on the telephone;~~
- ~~(2) experience and/or training in caring for participants with functional limitations;~~
- ~~(3) the ability to perform essential job functions;~~
- ~~(4) the ability to follow the community support plan, work effectively under intermittent supervision, to deal with minor emergencies, and work under stress in a crisis situation;~~
- ~~(5) understanding and respect regarding maintaining confidentiality; and,~~
- ~~(6) a valid Minnesota driver's license and insurance coverage in accordance with state requirements, if they provide transportation to waiver participants.~~

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification

Every one to three years. ~~[end delete]~~

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Homemaker

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

This service is not covered when the participant resides in a licensed foster care home ~~[delete]~~, or if they are receiving residential care services ~~[end delete]~~.

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Individualized Home Supports

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

- For participants receiving individualized home supports, the following services are not covered: adult foster care, customized living, ~~[add]~~ and ~~[end add]~~ independent living skills (ILS) training ~~[delete]~~, and residential care ~~[end delete]~~.

BI and CADI waivers

Attachment #1: Transition Plan

~~[delete] Transition Plan for Elimination of Residential Care: Beginning in July 2015, the Department conducted a comprehensive outreach effort to providers and lead agencies detailing the discontinuation of residential care. Specifically, the Department sent fact sheets to stakeholders and hosted two webinars for providers and lead agencies on July 15 and September 14, 2015. The webinars explained the decision to discontinue residential care and discuss transition options for providers and people receiving the service. Providers were also contacted between January through February 2016 via telephone to discuss the planned discontinuation of the service and business-related options for the providers. The Department plans to continue outreach efforts by conducting a series of trainings in the fall of 2016 and beginning of 2017 to support case managers in developing a person-centered transition plan with participants affected by the discontinuation of residential care. Case managers will contact participants affected by the discontinuation of residential care. Case managers and care coordinators will use the “Person-Centered, Informed Choice & Transition Protocol” to develop transition plans for participants transitioning from residential care to alternative waiver services and settings. Specifically, the transition protocol will address the participant’s choices and preferences while assuring the participant’s health and welfare. Each affected participant will receive a formal notice regarding the termination of residential care at least thirty days in advance. Providers also will communicate to participants that the service will terminate on June 30, 2018. Case managers and care coordinators are responsible for developing a community support plan for the participant, which includes a component addressing the participant’s health and safety needs. During the transition period, case managers and care coordinators will update the community support plan to reflect how a person’s health and safety will be ensured. Case managers and care coordinators are responsible for monitoring the implementation of the community support plans as well as assuring the health and safety of the person.~~

~~[end delete]~~

Residential habilitation (DD)

- Clarifies caregiver living expenses are available to providers of supported living services (SLS) for adults
- Clarifies where services can be provided
- Changes “daily staff intervention” to “daily staff support”
- Adds language addressing daily staff support in relation to supported living services for adults, remote support, in own home
- Adds community residential setting (CRS) where applicable
- Updates “maladaptive behavior” language to state “challenging behavior”

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Residential Habilitation

Service Definition (Scope):

Residential habilitation services are provided to participants who live in their own homes or a supported living environment. Three types of residential habilitation are covered (1) in-home family support services, (2) supported living services for children, and (3) supportive living services for adults.

Residential habilitation services consist of assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the participant to reside in a non-institutional setting. Payments for residential habilitation do not include room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility that are required to assure the health and safety of participants, or to meet the requirements of the applicable life safety code.

Residential habilitation may be provided outside of the participant's home in community settings when the service is related to the habilitation needs of the participant and provided in settings that are used by the general public.

Caregiver living expenses are available to providers of residential habilitation ~~in home family support, and~~ supported living services for adults ~~and children~~ services as specified in this Appendix.

1. In-Home Family Support Services. These are habilitation services provided to participants and their families, including extended family members, to enable the participant to remain in or return to their family's home. In-home family support services include training of the participant, and training of the family to increase their capabilities to care for and maintain the participant in their family's home.

2. Supported Living Services for Children. These are habilitation services provided to children and adolescents who require daily staff ~~intervention~~ support due to severe behavior problems, medical conditions, physical deficits, and/or lack of adequate survival skills that result in a family's inability to maintain the child or adolescent in the family home. Services may be delivered in a setting licensed as child foster care ~~will be provided outside of the biological or adoptive homes in family style settings in the community and~~ that serve four or fewer people, or a supervised living facility.

3. Supported Living Services for Adults. These are services provided to adults who require daily staff ~~intervention~~ support due to behavior problems, medical conditions, physical deficits, and/or lack of adequate survival skills.

4. Supported Living Services for Adults, Remote Support, in own home.

Remote support is real-time, two-way communication between the provider and the participant. Face-to-face in-person service delivery will be scheduled at least on a weekly basis. The service meets intermittent or unscheduled needs for support when a participant needs it to live and work in the most integrated setting, supplementing direct face-to-face service delivery of supported living services for adults who live in their own home. Remote support is limited to assistance with coordination of community living activities, check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of Supported Living Services for Adults in their own home. Remote support may be utilized when it is chosen by the participant as a method of service delivery to achieve an identified goal(s) and meet assessed need(s). To meet the real-time, two-way exchange definition, remote support includes the following methods: telephone, secure video conferencing, and written electronic messaging excluding e-mail and facsimile. All transmitted electronic written messages must be retrievable for review. Providers must document the staff who delivered services, the date of service, the start and end time of service delivery, length of time of service delivery, method of contact,

and place of service (i.e. office or community) when remote support contact is made. Supported Living Services for Adults, Remote Support in own home service delivery can be authorized as a 15-minute unit at a 1:1 staff-to-participant ratio.

The definition of daily staff ~~intervention~~ support for supportive living services for children and adults means direct care or professional staff providing on-site supervision, training or assistance to a participant in the following areas: self-care, sensory/motor development, interpersonal skills, communication, reduction/elimination of ~~maladaptive~~ challenging behavior, community living and mobility, health care, leisure and recreation, money management and household chores.

[add] For adults receiving supported living services, daily staff support can include direct care or professional staff providing Supported Living Services for Adults, Remote Support, in own home when it meets the remote support policy regarding face-to-face service delivery. **[end add]**

Residential habilitation services will be provided in the participants home **[add]** , **[end add]** ~~or~~ **[end delete]** **[add]** a setting licensed as **[end add]** adult foster ~~homes~~ **[end delete]** **[add]** care for up to four people, a community residential setting (CRS) **[end add]** for up to four people **[add]**, or a supervised living facility **[end add]**. Under certain conditions as specified by Minnesota Statute 252.28, subd. 3, item d and Rule 9525.1860 subpart 6, item D, services may be provided for up to six adults in homes licensed to provide foster care. The commissioner may also authorize services provided in settings that have received authority under Minnesota Statutes, section 245A.11, subd. 2a, paragraph (f) for a fifth bed.

In accordance with Minnesota Statutes, 256B.092, subd. 4d, certain individuals related to the participant may be determined by the lead agency to meet the qualifications to provide supported living services for adults in lieu of the provider being licensed to provide foster care. In these situations, the provider must: 1) reside with the participant; 2) be the primary caregiver; and, 3) meet the provider qualifications, including those in Minnesota Statutes, 256B.092, subd. 4d. The provider shall not be the legal guardian or conservator of the participant nor be responsible to otherwise provide the care or services.

For purposes of residential habilitation, the participants **[add]** own **[end add]** home means a living setting that is not owned or leased by the provider of services and is under the control of the participant. Individuals related to the participant has the meaning defined in Minnesota Statutes 245A.02, subd. 13.

Habilitation services does not include special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401) that otherwise are available through a local educational agency or vocational service funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730) as amended. A finding that such services are not otherwise available through a program funded under Section 110 of the Rehabilitation Act of 1973 must be based on written documentation that the individual; (1) is not considered an appropriate referral to the Vocational Rehabilitation Services unit because the individual satisfies one or more of the Screen-Out Criteria, or presents an unfavorable Applicant Profile as described in Section 26520.025 of the Social Security Administration Program Operations Manual System; or (2) has been referred to the Vocational Rehabilitation Services unit, but was found to be ineligible for vocational services under Section 110 of rehabilitation Act; or (3) has been a recipient of section 110 services provided by the Vocational Rehabilitation Services unit, but is no longer eligible for such services; or (4) is a current client of the Vocational Rehabilitation Services unit, but the activities that are provided under the definition of supported employment services are not typically available as Section 110.

Habilitation services are directed toward increasing and maintaining physical, intellectual, emotional, and social functioning and assist participants in acquiring, retaining and improve the skills necessary to reside successfully in the community.

Respite (BI, CAC, CADI and DD)

- Includes a technical change in the service definition for hospitals and nursing facilities (BI, CAC and CADI)
- Includes a technical change in the service definition for hospitals (DD)
- Clarifies unlicensed settings for adults and children (BI, CAC, CADI and DD)
- Adds intermediate care facilities for persons with developmental disabilities (ICFs/DD) as an available setting for people to receive respite (DD)
- Adds a size limitation to unlicensed settings (excluding camps) (BI, CAC, CADI and DD)
- Removes references to residential care which has ended (BI and CADI)
- Updates provider qualifications (BI, CAC, CADI and DD)

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Service Definition (Scope):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as the owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of the home settings:

[add] • [end add] Foster care home or community residential setting

[add] • [end add] Residential hospice facilities defined under Minnesota Statutes, section 144A.75, subd. 13(a)(1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6(2)

[add] • [end add] [delete] Medicaid [end delete] [add] Medicare [end add] certified hospital

[add] • [end add] [delete] Medicaid [end delete] [add] Medicare [end add] certified nursing facility

[add] • Certified camps [end add]

[add] • [end add] Unlicensed settings **[add]** for adults 18 years of age or older **[end add]** where agency and individual providers must be licensed under Minnesota Statutes, Chapter 245D **[add]** or meet the exclusion requirements **[end add]**

[add] • Unlicensed settings for children younger than age 18 where individual providers are related to the person and must be licensed under Minnesota Statutes, Chapter 245D or meet the exclusion requirements. [end add]

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

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

Respite care is not available to participants living in settings where Customized Living, ~~[delete] Residential Care,~~ ~~[end delete]~~ or shift staff foster care is provided, with the exception of community emergencies or disasters.

Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, unless the provider has received a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

Respite care provided in facilities licensed under Minnesota Statutes, section 144A.75 subd. 13(a)(1) is limited to serving a maximum of 8 people.

~~[add] Respite care provided in unlicensed settings for adults 18 years of age or older is limited to serving a maximum of six people. This limitation does not apply to camps. [end add]~~

Respite care is limited to 30 consecutive days per respite occurrence when provided 24 hours a day.

CAC waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Service Definition (Scope):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as an owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:

- Foster care home or community residential setting
- Residential hospice facilities defined under Minnesota Statutes, section 144A.75 subd. 13(a)(1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6(2)

- ~~Medicaid~~ **[add]** Medicare **[end add]** certified hospital
- ~~Medicaid~~ **[add]** Medicare **[end add]** certified nursing facility
- [add]** • Certified camps **[end add]**
- Unlicensed settings **[add]** for adults 18 years of age or older **[end add]** where agency and individual providers must be licensed under Minnesota Statutes, chapter 245D **[add]** or meet the exclusion requirements **[end add]**
- [add]** • Unlicensed settings for children younger than age 18 where individual providers are related to the person and must be licensed under Minnesota Statutes, Chapter 245D or meet the exclusion requirements. **[end add]**

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

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

Respite care is not available to participants living in settings where shift staff foster care is provided, with the exception of community emergencies or disasters.

Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, unless the provider has received a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

Respite care provided in facilities licensed under Minnesota Statutes, section 144A.75 subd. 13(a)(1) is limited to serving a maximum of eight people.

[add] Respite care provided in unlicensed settings for adults 18 years of age or older is limited to serving a maximum of six people. This limitation does not apply to camps. **[end add]**

Respite care is limited to 30 consecutive days per respite occurrence when provided 24 hours a day.

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Service Definition (Scope):

Respite care services are short-term services provided to a participant due to the absence or need for relief of the family member(s) or primary caregiver, normally providing the care. In order to be considered a primary

caregiver, the person must be principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and must be named as an owner or lessee of the primary residence.

Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:

- Foster care home or community residential setting
- Residential hospice facilities defined under Minnesota Statutes, section 144A.75, subd. 13 (a)(1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6(2)
- ~~[delete] Medicaid [end delete]~~ [add] Medicare [end add] certified hospitals
- [add] - Intermediate care facilities for persons with developmental disabilities (ICFs/DD)
- Certified camps [end add]
- Unlicensed settings [add] for adults 18 years of age or older [end add] where agency and individual providers must be licensed under Minnesota Statutes, chapter 245D [add] or meet the exclusion requirements [end add]
- Unlicensed settings for children [add] younger than age 18 [end add] where individual providers are related to the person and must be licensed under Minnesota Statutes, Chapter 245D or meet the exclusion requirements.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in one of the licensed out-of-home settings listed above.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out-of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. Other limitations on this service may be waived by the commissioner, as necessary, in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

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

Respite care provided in homes licensed to provide foster care is limited to serving a maximum of four people, including the participants who are receiving respite care, unless the provider has received a variance to allow for the use of a fifth bed for respite under Minnesota Statutes, section 245A.11, Subd. 2a, paragraph (e).

Respite care provided in facilities licensed under Minnesota Statutes, section 144A.75 subd. 13(a)(1) is limited to serving a maximum of eight people.

Respite care is not available to participants living in settings that are not the primary residence of the license holder, with the exception of community emergencies or disasters.

[add] Respite care provided in unlicensed settings for adults 18 years of age or older is limited to serving a maximum of six people. This limitation does not apply to camps. [end add]

Respite care is limited to 30 consecutive days per respite occurrence when provided 24 hours a day.

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Provider Specifications:

Agency – Agencies that meet the respite service standards

Provider Qualifications:**Other Standard (specify):**

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute, Chapter 245D.

[add] Adults 18 years of age or older: **[end add]** Agencies that are excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

If the service is furnished in an unlicensed setting **[add] for adults 18 years of age or older, [end add]** the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Provider Specifications:

Individual – Individuals that meet the respite service standards

Provider Qualifications:**Other Standard (specify):**

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute, Chapter 245D.

[add] Adults 18 years of age or older: Unrelated [end add] individuals that are excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 **[delete] (1) and [end delete]** (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

[add] Adults and children: Related individuals that are excluded from licensure under Minnesota Statutes, 245A.03, subd. 2 (1) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding service recipient rights; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited

and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards. [end add]

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

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Provider Specifications:

Agency – Long Term Care Facilities (also referred to as nursing facilities)

Agency – Hospitals as defined in Minnesota Statutes, section 144.696, subd. 3

Provider Qualifications:

Certificate (*specify*):

[add] Medicare Certification [end add]

CAC waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Provider Specifications:

Agency – Hospitals as defined in Minnesota Statutes, section 144.696, subd. 3

Provider Qualifications:

Certificate (*specify*):

[add] Medicare Certification [end add]

Provider Specifications:

[add] Agency – Long Term Care Facilities (also referred to as nursing facilities) [end add]

Provider Qualifications:

License (*specify*):

[add] Must be licensed in accordance with MN Statute 144A and must meet the definition under MN Rules, part 9505.0175, subp. 23. **[end add]**

Certificate *(specify)*:

[add] Medicare Certification **[end add]**

Verification of Provider Qualifications:

Entity Responsible for Verification:

[add] Minnesota Department of Health **[end add]**

Frequency of Verification:

[add] Long term care facilities are reviewed every two years by the state and receive federal certification annually. **[end add]**

DD waiver

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Respite

Provider Specifications:

Agency – Hospitals as defined in Minnesota Statutes, section 144.696, subd. 3

Provider Qualifications:

Certificate *(specify)*:

[add] Medicare Certification **[end add]**

[add] Provider Specifications:

Agency – Intermediate care facilities for persons with developmental disabilities (ICFs/DD)

Provider Qualifications:

License *(specify)*:

Provider must be licensed under Minnesota Statutes, chapter 245D.

Intermediate care facilities for persons with developmental disabilities (ICFs/DD) as defined under Minnesota Rules, part 9525.1800, subp. 18 and licensed under Minnesota Statutes, section 252.28

Verification of Provider Qualifications:

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years **[end add]**

Specialist services (BI, CAC, CADI & DD)

- Adds language addressing when providers can bill for indirect time

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Specialized Equipment and Supplies

Service Definition (Scope):

Specialist services include assessments, program development, training and supervision of staff and caregivers, monitoring of specific program implementation and evaluation of service outcomes identified in the community support plan. This service is designed to promote competency of staff and caregivers.

To be eligible for this service, a participant must have documented needs in the areas of:

- augmentative communication,
- personal health care,
- mental health symptom support to strengthen effective emotional and behavioral functioning, and manage harmful symptom expression and endangering conduct,
- functional motor skills,
- community safety training and support,
- social skills,
- leisure and recreational skills, or
- independent living skills.

Behavior and mental health symptom support can occur when not covered within the scope of Positive Support Services.

Specialist services include services that exceed the scope and duration of available services, including state plan and extended state plan services. Services must not duplicate other services that are provided to the participant, and must be cost-effective and necessary to meet the needs of the participant.

[add] Specialist Services providers may bill for indirect time for preparation and finalizing assessments, evaluation of service outcomes, monitoring specific program implementation, program development, and training and supervision of staff and caregivers. All other indirect time is accounted for in the rate. **[end add]**

Transitional services (BI, CAC, CADI & DD)

- **Corrects** licensing reference for intermediate care facilities for persons with developmental disabilities
- **Aligns** “own home” definition with housing access coordination
- **Clarifies** services in customized living settings
- **Updates** eligibility criteria to remove the 180-day limitation

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Transitional Services

Service Definition (Scope):

Transitional services covers goods, housing related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following settings:

- unlicensed settings;
- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.586;
- adult foster care homes licensed under Minnesota Rules, parts 9555.5050 to 9555.6265;
- family and group child foster care licensed under Minnesota Rules, parts 9560.0500 to 9560.0670;
- nursing facilities licensed under Minnesota Statutes, Chapter 144A;
- intermediate care facilities for persons with developmental disabilities (ICF/DD’s) licensed under Minnesota Statutes, ~~Chapter 144A~~ **[end delete]** **[add]** section 252.28 **[end add]**;
- intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
- Institutions for Mental Diseases (IMD);
- Housing with services establishments as defined in Minnesota Statutes, Chapter 144D.

For purposes of this service, **[add]** own **[end add]** home means a setting that a participant owns, rents, or leases that is not operated, owned or leased by a provider of services or supports **[add]**, and the person has full control of their housing and full choice of service providers. For a participant who moves into a home where customized living services are available, transitional services are covered when the participant will reside in a self-contained living unit (e.g. apartment) with a bathroom, kitchen (or kitchenette), and sleeping area.

Transitional services are covered when the home does not include the provision of these items or services when they are inherent to the service being provided. **[end add]**

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore or homemaker services, environmental accessibility adaptations, and specialized equipment and supplies).

Durable household goods include but are not limited to:

- Living room, dining room, and bedroom furniture
- Kitchen equipment and tableware
- Lamps

Moving expenses include but are not limited to:

- Moving vehicle rental
- Packing and unpacking

Rent and mortgage payments; food and clothing; and recreational and diversionary items are not covered. Recreational and diversionary items include but are not limited to computers, VCRs, DVD players, televisions, cable television access, etc.

Eligibility:

Transitional services are not covered unless all of the following requirements are met:

- 1) There is no other funding source available for transitional services.
- 2) The participant is at least 18 years of age.
- 3) The participant is moving to a setting in which these items and expenses are not normally furnished.
- 4) The lead agency determines that the participant will be eligible for and reasonably expected to enroll in the waiver within 180 days. This includes a determination by the lead agency that sufficient resources are available to meet the participant's needs.

~~[delete] 5) The lead agency reasonably expects the participant to remain enrolled in the waiver for no less than 180 days after moving from the licensed setting. [end delete]~~

Authorization and Billing

Transitional services must be reasonable and necessary as determined by the case manager. The case manager determines whether transitional services will be authorized. If authorized, the case manager must clearly define in the participant's community support plan what will be covered to assure that there is no duplication with other waiver or state plan services. Transitional services must be provided prior to or within 45 days of the participant's move from the licensed setting. Waiver services may only be billed after the individual is enrolled in the waiver.

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

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

Transitional services are limited to a maximum of \$3000 per transition and one transition in a three year period. One-time household supplies are limited to a maximum of \$300 (of the \$3000). The cost of essential furniture may not exceed \$1000 (of the \$3000).

[add] For a participant who moves into a home where customized living services are available, transitional services are not covered when the participant's living unit does not contain a bathroom, kitchen (or kitchenette), and sleeping area. [end add]

Transportation (BI, CAC, CADI & DD)

- **Adds language addressing what this service covers (BI, CAC, CADI and DD)**
- **Corrects provider qualifications (BI and CADI)**

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

Service Title:

Transportation

Service Definition (Scope):

Transportation is covered in order to enable participants to gain access to waiver and other community services, activities **[add]** , **[end add]** ~~and~~ resources, **[add]** and employment as **[end add]** specified in the community support plan. Whenever possible, family, neighbors, friends, or community agencies who are able to provide this service without charge will be utilized.

BI and CADI waivers

Appendix C-1/C-3: Participant Services – Service Specification**Service Title:**

Transportation

Provider Specifications:

Individual – Special transportation may be required to transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.

Provider Qualifications:**License (specify):**

[add] Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B. **[end add]**

Certificate (specify):

Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.315.

Other Standard (specify):

[add] Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's community support plan. **[end add]**

Waiver Policies

- Background studies (BI, CAC, CADI and DD)
 - Updates list of services that require a background study
- “Direct benefit” language (BI, CAC, CADI and DD)
 - Adds clarifying language for services that support caregivers
- Minimum age of staff (BI, CAC, CADI and DD)
 - Adds language addressing the minimum age of staff providing waiver services
- Paying relatives (BI, CAC, CADI and DD)
 - Updates the paying relatives, legal guardians and conservators section to provide clarity and consistency across waivers
 - Updates language regarding CDCS and payments to relatives and parents of minors who provide foster care
- People over age 65 returning to a disability waiver (BI, CAC and CADI)
 - Restores language allowing people over age 65 who exited due to an institutional stay, to return to a disability waiver within 180 days without Department approval
- Services covered/not covered (BI, CAC, CADI and DD)
 - Clarifies alternative therapies are only covered under CDCS
 - Clarifies goods and services that are not covered
- Temporary out-of-state travel (BI, CAC, CADI and DD)
 - Clarifies language for temporary travel and local trade area
 - Removes 30-day timeline for temporary travel
- Tribes (BI, CAC, CADI and DD)
 - Restores language regarding tribes being under contract with the Department
- Updates eligibility groups to align with the state plan for MA-EPD (BI, CAC, CADI and DD)
- Verification of provider qualifications (BI, CAC, CADI and DD)
 - Updates frequency of verification for all 245D licensed services
 - Updates frequency of verification for all services where the verifying entity is the Minnesota Department of Human Services, Provider Enrollment

Background studies (BI, CAC, CADI and DD)

- **Updates list of services that require a background study**

BI waiver

Appendix C-2: Participant Services – General Service Specifications

a. Criminal History and/or Background Investigations.

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

24-hr Emergency Assistance (for face-to-face assistance)
 Adult Companion Services
 Adult Day Service
 Adult Day Service Bath
 Adult Foster Care
 Child Foster Care
 Consumer Directed Community Supports (personal assistance, treatment and training, self-directed support, and fiscal intermediary entity services)
 Crisis Respite
 Customized Living
[add] Employment Exploration
Employment Development
Employment Support **[end add]**
 Extended Home Health Care Services
 Extended Personal Care Assistance
 Extended Home Care Nursing
 Family Training and Counseling (for direct contact in the home)
 Homemaker
 Housing Access Coordination
 In-Home Family Supports
 Individualized Home Supports
 Independent Living Skills (ILS) Training
 Independent Living Skills (ILS) Therapies
 Night Supervision Services
 Personal Supports
 Positive Support Services
 Prevocational Services
~~**[delete]** Residential Care Services **[end delete]**~~
 Respite
 Specialist Services
 Structured Day Program
~~**[delete]** Supported Employment Services **[end delete]**~~

If the provider of Adult Companion services is a National and Community Services Senior Companion Program grantee, they are exempt from background study requirements of Minnesota Statutes, Chapter 245C. Grantees must meet the criminal history standards of the Corporation for National and Community Service Senior Companion Program, which includes:

1. A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW);
2. A statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and,
3. A fingerprint-based FBI criminal history repository check.

CAC waiver

Appendix C-2: Participant Services – General Service Specifications

a. Criminal History and/or Background Investigations.

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

- 24-hour emergency assistance (for face-to-face contact and assistance)

[add] - Adult Companion Services [end add]

- Adult Foster Care

- Adult day service

- Child foster care

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

- Crisis respite

[add] - Employment Exploration

- Employment Development

- Employment Support **[end add]**

- Extended Home Health Care

- Extended Personal Care Assistance

- Extended Home Care Nursing

- Family Training and Counseling (for direct contact in the home)

- Homemaker

- Individualized home supports

- In-home family supports

- Housing access coordination

- Independent living skills (ILS) training

- Night supervision

- Personal supports

- Positive support service

- Respite

- Specialist services

[delete]-Supported employment [end delete]

[add] If the provider of Adult Companion services is a National and Community Services Senior Companion Program grantee, they are exempt from background study requirements of Minnesota Statutes, Chapter 245C. Grantees must meet the criminal history standards of the Corporation for National and Community Service Senior Companion Program, which includes:

1. A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW);

2. A statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and,

3. A fingerprint-based FBI criminal history repository check. [end add]

CADI waiver

Appendix C-2: Participant Services – General Service Specifications

a. Criminal History and/or Background Investigations.

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

- 24-Hour Emergency Assistance (for face-to-face contact and assistance)
- Adult companion services
- Adult day service
- Adult day service bath
- Adult foster care
- Child foster care
- Consumer-directed community supports (personal assistance, treatment and training, self-directed support, and fiscal intermediary entity services)
- Customized living
- Crisis respite
- [add]** - Employment Exploration
- Employment Development
- Employment Support **[end add]**
- Extended Home Health Care Services
- Extended Personal Care Assistance
- Extended Home Care Nursing
- Family Training and Counseling (for direct contact in the home)
- Homemaker services
- Housing Access Coordination
- In-home family supports
- Independent living skills (ILS) training
- [add]** - Individualized home supports **[end add]**
- Night supervision services
- Prevocational services
- Personal supports
- Positive support services
- ~~**[delete]** - Residential care services **[end delete]**~~
- Respite
- Specialist services
- ~~**[delete]** - Supported employment services **[end delete]**~~

If the provider of Adult Companion services is a National and Community Services Senior Companion Program grantee, they are exempt from background study requirements of Minnesota Statutes, Chapter 245C. Grantees must meet the criminal history standards of the Corporation for National and Community Service Senior Companion Program, which includes:

1. A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW);
2. A statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and,
3. A fingerprint-based FBI criminal history repository check.

DD waiver

Appendix C-2: Participant Services – General Service Specifications

a. Criminal History and/or Background Investigations.

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

- 24-hr Emergency Assistance (for assistance involving direct contact)
- Adult Day Service
- Adult Day Service Bath
- Assistive Technology
- Consumer Directed Community Supports (e.g., personal assistance, treatment and training, self-directed support, and fiscal intermediary entity services)
- Crisis Respite
- Day Training & Habilitation
- [add]** - Employment Exploration
- Employment Development
- Employment Support **[end add]**
- Extended Personal Care Assistance
- Family Training and Counseling (for direct contact in the home)
- Homemaker
- Housing Access Coordination
- Night Supervision
- Personal Support
- Positive Support Service
- Prevocational Services
- Residential Habilitation
- Respite
- Specialist Services
- ~~**[delete]** - Supported Employment Services **[end delete]**~~

“Direct benefit” language (BI, CAC, CADI and DD)

- **Adds clarifying language for services that support caregivers**

BI, CAC, CADI and DD waivers

Additional Needed Information (Optional)

The following are additional waiver requirements:

1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant’s assessment **[add]**, related to the participant’s disability, **[end add]** and be for the direct benefit of the participant ~~**[delete]**~~ and must be related to the participant’s disability **[end delete]**. **[add]** Some services that support caregivers such as respite, specialist services and family training & counseling are considered to directly benefit the participant if they are chosen by the participant and the participant benefits from the caregiver support. **[end add]**

Minimum age of staff (BI, CAC, CADI and DD)

- Adds language addressing the minimum age of staff providing waiver services

BI, CAC, CADI and DD waivers

Additional Needed Information (Optional)

The following are additional waiver requirements:

[add] 5. With the exception of CDCS and chore, enrolled individual providers must be 18 years of age or older. This does not limit persons who are 16-17 from working for an agency when in compliance with federal or state labor laws. **[end add]**

Paying relatives (BI, CAC, CADI and DD)

- Updates the paying relatives, legal guardians and conservators section to provide clarity and consistency across waivers
- Updates language regarding CDCS and payments to relatives and parents of minors who also provide foster care

BI and CADI waiver

Appendix C-2: Participant Services – General Service Specifications

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- ☐ The State does not make payment to relatives/legal guardians for furnishing waiver services.
- ☒ The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

[add] NOTE: Unless otherwise specified, all references to “parents” in this section include both biological and adoptive parents, step parents, legal guardians of minors, and other legally responsible individuals. **[end add]**

[delete] ~~Extended Home Care Nursing:~~ **[end delete]** **[add]** EXTENDED HOME CARE NURSING: **[end add]**

Spouses, non-paid legal guardians, family foster parents (not corporate foster parents) and parents of minor children may receive a hardship waiver to be paid to provide extraordinary services that require specialized nursing skills when the following criteria are met:

- The service is not legally required of the parent, spouse, or legal guardian;
- The service is necessary to prevent hospitalization of the participant; and
- One of the following hardship criteria are met:
 - (i) the parent, spouse, or legal guardian resigns from a part-time or full-time job to provide the service; or
 - (ii) the parent, spouse, or legal guardian goes from a full-time to a part-time job with less compensation to provide the service; or
 - (iii) the parent, spouse, or legal guardian takes a leave of absence without pay to provide the service; or
 - (iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or legal guardian is needed in order to meet the medical needs of the participant.

The home care nursing hardship waiver is not available when a participant is using consumer directed community supports.

The spouse, non-paid legal guardian, family foster parent or parent of a minor must be a nurse licensed in Minnesota and pass a criminal background study in accordance with Minnesota Statutes, Chapter 245C. Individuals must have a current RN or LPN license with the State of Minnesota and be employed by a home health care agency. The service cannot be used in lieu of nursing services covered under and available through liable third-party payers nor does it negate the individual's responsibilities as a primary caregiver or to provide emergency backup without payment.

The number of hours shall not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. The service shall not be covered if the home health agency, the case manager, or the physician determines that the home care nursing care provided by the spouse, legal guardian, or parent of a minor is unsafe.

[delete] ~~Waiver services, other than CDCS and home care nursing, provided to adults:~~

~~Legal guardians and conservators may be paid to provide waiver services to adults only if they meet all of the following criteria. The service must be included in the participant's community support plan and the guardian or conservator must:~~

- ~~• Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, be the guardian or conservator for only one participant or more than one participant if they are siblings;~~
- ~~• Not be otherwise responsible to provide the care or service;~~
- ~~• Be qualified to provide the service;~~
- ~~• Be employed by a provider to furnish the service; and~~
- ~~• Not be an enrolled MA provider for the service being rendered.~~

~~Consumer Directed Community Support (CDCS) services provided to adults and minors: [end delete] [add]~~

CONSUMER-DIRECTED COMMUNITY SUPPORT (CDCS) SERVICES PROVIDED TO ADULTS AND MINORS: [end add]

- Relatives **[delete]** ; **[end delete]** and legal guardians or conservators who are related by blood, marriage or adoption may be paid to provide services to adults and children through the CDCS service under the category of personal assistance. **[delete]** ~~Relatives of adults may be paid to provide home care nursing when:~~
~~–the relative is qualified to provide the service;~~

~~home care nursing is provided under State Plan home care nursing services (not under the CDCS personal assistance category); and~~

~~home care nursing is within the participant's CDCS budget. [end delete]~~

- Individuals who are not related by blood, marriage, or adoption whose guardianship or conservatorship responsibilities are limited to one participant, or to participants who are siblings may be paid to provide services to adults and children through CDCS under the category of personal assistance.

~~[delete] • [end delete]~~

Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.

[add] Relatives of adults may be paid to provide home care nursing when:

- the relative is qualified to provide the service;

- home care nursing is provided under State Plan home care nursing services (not under the CDCS personal assistance category); and

- home care nursing is within the participant's CDCS budget. [end add]

~~[delete] Services and supports provided by parents, spouses, and legally responsible individuals.~~

~~NOTE: All references to “parents” in this section include both biological and adoptive parents, step parents, legal guardians of minors, and legally responsible individuals. [end delete]~~

[add] CDCS services and supports provided by parents of minors, spouses, and legally responsible individuals:
[end add]

CDCS may be used to pay parents of minor participants under age 18 or spouses of participants for services rendered. Such payments may only be made under the category of personal assistance services as defined in Appendix C-1/C-3. Parents of minors and spouses must meet the provider qualifications for this service.

For a participant’s spouse or parent of a minor participant to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

- meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;
- be a service/support that is specified in the participant’s community support plan;
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant’s community support plan;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;
- be related to the participant’s disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document **[add]** or MnCHOICES assessment [end add].*

* The LTCC screening~~[add]~~ or MnCHOICES assessment ~~[end add]~~ will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- the parents (as defined above) of minor children and spouses may not provide more than 40 hours of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
 - number of parents (as defined above),
 - combination of parent(s) of minors and spouse, or
 - number of children who receive CDCS.
- The parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver.
- Married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.
- Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistance service category.
- Parents of minors and spouses may not be reimbursed for mileage expenses.

CDCS service is allowable for minor participants under age 18 who reside in, but do not receive residential services in a licensed residential setting with the following conditions:

- Parents of minor participants under age 18 who receive payment to ~~[add] provide [end add]~~ care ~~[delete] for~~ ~~[end delete]~~ ~~[add] to [end add]~~ non-relatives in the licensed residential setting ~~[add] that is not a pre-adoptive setting [end add]~~ cannot be a paid provider of personal assistance for their ~~[add] own [end add]~~ biological/adoptive minor child~~[add](ren)[end add]~~.
- Parents of minor participants under age 18 who receive payment to ~~[add] provide [end add]~~ care ~~[add] in the licensed residential setting to [end add] [delete] for [end delete]~~ relative children ~~[add] (including pre-kinship settings) [end add] [delete] in the licensed residential setting [end delete]~~ can be a paid provider of personal assistance for their ~~[add] own [end add]~~ biological/adoptive minor child~~[add](ren)[end add]~~ up to 25 hours per week.
- ~~[add] • Parents of minor participants under age 18 who receive payment to provide care in the licensed residential setting to non-relative children in a pre-adoptive setting can be a paid provider of personal assistance for their own biological/adoptive minor child(ren) up to 25 hours per week. [end add]~~

Monitoring Requirements ~~[add] for CDCS [end add]~~:

These additional requirements apply to participants electing to employ parents of minors, legal guardians, or a spouse for CDCS services:

- monthly reviews by the fiscal support entity of hours billed for family provided care and the total amounts billed for all goods and services during the month;

- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal support entity when billing;
- at least quarterly reviews by the lead agency on the expenditures and the health and safety status of the participant;
- face-to-face visits with the participant by the lead agency on at least a semi-annual basis.

[add] WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO ADULTS:

Related individuals cannot provide adult companion services, caregiver living expenses, or case management.

Primary caregivers, including related individuals, guardians and conservators, cannot be paid to provide a service intended to provide relief or support for themselves. This includes chore services, homemaker and respite.

For all other waiver services, relatives, legal guardians and conservators may be paid to provide waiver services to adults only if they meet all of the following criteria. The service must be included in the participant's community support plan and the relative, guardian or conservator must:

- Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, be the guardian or conservator for only one participant or more than one participant if they are siblings;
- Not be otherwise responsible to provide the care or service;
- Be qualified to provide the service;
- Be employed by a provider to furnish the service; and
- Not be an enrolled MA provider for the service being rendered or a controlling entity of an enrolled Medicaid provider where the person gains financially.

WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO MINORS:

Parents, legal guardians and conservators of minors who are related by blood, marriage, or adoption, shall not be paid to provide waiver services, with the exception of parents providing CDCS and the HCN hardship waiver as described above. [end add]

[delete] All services: [end delete] [add] ALL WAIVER SERVICES: [end add]

Professional guardians and conservators shall not be paid to provide waiver services. This does not preclude non-professional guardians and conservators who meet the criteria in this section from being paid to provide waiver services as an employee of an enrolled provider.

CAC waiver

Appendix C-2: Participant Services – General Service Specifications

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- The State does not make payment to relatives/legal guardians for furnishing waiver services.
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

[add] NOTE: Unless otherwise specified, all references to “parents” in this section include both biological and adoptive parents, step parents, legal guardians of minors, and other legally responsible individuals. **[end add]**

[delete] ~~Extended Home Care Nursing:~~ **[end delete]** **[add]** EXTENDED HOME CARE NURSING: **[end add]**

Spouses, non-paid legal guardians, family foster parents (not corporate foster parents) and parents of minor children may receive a hardship waiver to be paid to provide extraordinary services that require specialized nursing skills when the following criteria are met:

- The service is not legally required of the parent, spouse, or legal guardian;
- The service is necessary to prevent hospitalization of the participant; and
- One of the following hardship criteria are met:
 - (i) the parent, spouse, or non-paid legal guardian resigns from a part-time or full-time job to provide the service; or
 - (ii) the parent, spouse, or non-paid legal guardian goes from a full-time to a part-time job with less compensation to provide the service; or
 - (iii) the parent, spouse, or non-paid legal guardian takes a leave of absence without pay to provide the service; or
 - (iv) because of labor conditions, special language needs, or intermittent hours of care needed, the parent, spouse, or non-paid legal guardian is needed in order to meet the medical needs of the recipient.

The home care nursing hardship waiver is not available when a participant is using consumer directed community supports.

The spouse, non-paid legal guardian, family foster parent or parent of a minor must be a nurse licensed in Minnesota and pass a criminal background study in accordance with Minnesota Statutes, Chapter 245C. Individuals must have a current RN or LPN license with the State of Minnesota and be employed by a home health care agency. The service cannot be used in lieu of nursing services covered under and available through liable third-party payers nor does it negate the individual’s responsibilities as a primary caregiver or to provide emergency backup without payment.

The number of hours shall not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. The service shall not be covered if the home health agency, case manager, or physician determines that the home care nursing care provided by the spouse, legal guardian, or parent of a minor is unsafe.

[add] CONSUMER-DIRECTED COMMUNITY SUPPORT (CDCS) SERVICE PROVIDED TO ADULTS AND MINORS:

- Relatives and legal guardians or conservators who are related by blood, marriage or adoption may be paid to provide services to adults and children through the CDCS service under the category of personal assistance.
- Individuals who are not related by blood, marriage, or adoption whose guardianship or conservatorship responsibilities are limited to one participant, or to participants who are siblings may be paid to provide services to adults and children through CDCS under the category of personal assistance.

Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.

Relatives of adults may be paid to provide home care nursing when:

- o the relative is qualified to provide the service;
- o home care nursing is provided under State Plan home care nursing services (not under the CDCS personal assistance category); and
- o home care nursing is within the participant's CDCS budget.

CDCS services and supports provided by parents of minors, spouses, and other legally responsible individuals:

CDCS may be used to pay parents of minor participants under age 18 or spouses of participants for services rendered. Such payments may only be made under the category of personal assistance services as defined in Appendix C-1/C-3. Parents of minors and spouses must meet the provider qualifications for this service.

For a participant's spouse or parent of a minor participant to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

- meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;
- be a service/support that is specified in the participant's community support plan;
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant's community support plan;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;
- be related to the participant's disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document or MnCHOICES assessment.*

* The LTCC screening or MnCHOICES assessment will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- the parents (as defined above) of minor children and spouses may not provide more than 40 hours of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
 - o number of parents (as defined above),
 - o combination of parent(s) of minors and spouse, or
 - o number of children who receive CDCS;
- the parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.
- Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistant service category
- Parents of minors and spouses may not be reimbursed for mileage expenses.

CDCS service is allowable for minor participants under age 18 who reside in, but do not receive residential services in a licensed residential setting with the following conditions:

- Parents of minor participants under age 18 who receive payment to provide care to non-relatives in the licensed residential setting that is not a pre-adoptive setting cannot be a paid provider of personal assistance for their own biological/adoptive minor child(ren).
- Parents of minor participants under age 18 who receive payment to provide care in the licensed residential setting to relative children (including pre-kinship settings) can be a paid provider of personal assistance for their own biological/adoptive minor child(ren) up to 25 hours per week.
- Parents of minor participants under age 18 who receive payment to provide care in the licensed residential setting to non-relative children in a pre-adoptive setting can be a paid provider of personal assistance for their own biological/adoptive minor child(ren) up to 25 hours per week.

Monitoring Requirements for CDCS:

These additional requirements apply to participants electing to employ parents of minors, legal guardians, or a spouse for CDCS services:

- monthly reviews by the fiscal support entity of hours billed for family provided care and the total amounts billed for all goods and services during the month;
- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal support entity when billing;
- at least quarterly reviews by the lead agency on the expenditures and the health and safety status of the participant;
- face-to-face visits with the participant by the lead agency on at least a semi-annual basis. [end add]

[delete] Waiver services, other than CDCS and extended home care nursing, provided to adults: [end delete]

[add] WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO ADULTS:

Related individuals cannot provide adult companion services, caregiver living expenses, or case management.

Primary caregivers, including related individuals, guardians and conservators, cannot be paid to provide a service intended to provide relief or support for themselves. This includes chore services, homemaker and respite. **[end add]**

[add] For all other waiver services, relatives, **[end add] [delete]** ~~Legal~~ **[end delete] [add]** legal **[end add]** guardians and conservators may be paid to provide waiver services to adults only if they meet all of the following criteria. The service must be included in the participant's community support plan and the **[add]** relative, **[end add]** guardian or conservator must:

- Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, be the guardian or conservator for only one participant or more than one participant if they are siblings;
- Not be otherwise responsible to provide the care or service;
- Be qualified to provide the service;
- Be employed by a provider to furnish the service; and
- Not be an enrolled MA provider for the service being rendered **[add]** or a controlling entity of an enrolled Medicaid provider where the person gains financially. **[end add]**

[delete] ~~Consumer Directed Community Support (CDCS) service provided to adults and minors:~~

- ~~• Relatives, and legal guardians or conservators who are related by blood, marriage or adoption may be paid to provide services to adults and children through the CDCS service under the category of personal assistance. Relatives of adults may be paid to provide home care nursing when:
 - o the relative is qualified to provide the service;
 - o home care nursing is provided under State Plan home care nursing services (not under the CDCS personal assistance category); and
 - o home care nursing is within the participant's CDCS budget.~~
- ~~• Individuals who are not related by blood, marriage, or adoption whose guardianship or conservatorship responsibilities are limited to one participant, or to participants who are siblings may be paid to provide services to adults and children through CDCS under the category of personal assistance.~~
- ~~• Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.~~

~~Services and supports provided by parents, spouses, and other legally responsible individuals:~~

~~NOTE: All references to "parents" in this section include both biological and adoptive parents, step parents, legal guardians of minors, and other legally responsible individuals.~~

~~CDCS may be used to pay parents of minor participants under age 18 or spouses of participants for services rendered. Such payments may only be made under the category of personal assistance services as defined in Appendix C-1/C-3. Parents of minors and spouses must meet the provider qualifications for this service.~~

~~For a participant's spouse or parent of a minor participant to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:~~

- ~~• meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;~~
- ~~• be a service/support that is specified in the participant's community support plan;~~
- ~~• be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant's community support plan;~~

- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;
 - be related to the participant's disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform;
 - be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document.*
- * The LTCC screening will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- the parents (as defined above) of minor children and spouses may not provide more than 40 hours of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
 - o number of parents (as defined above);
 - o combination of parent(s) of minors and spouse, or
 - o number of children who receive CDCS;
- the parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.
- Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistant service category
- Parents of minors and spouses may not be reimbursed for mileage expenses.

CDCS service is allowable for minor participants under age 18 who reside in, but do not receive residential services in a licensed residential setting with the following conditions:

- Parents of minor participants under age 18 who receive payment to care for non-relatives in the licensed residential setting cannot be a paid provider of personal assistance for their biological/adoptive minor child.
- Parents of minor participants under age 18 who receive payment to care for relative children in the licensed residential setting can be a paid provider of personal assistance for their biological/adoptive minor child up to 25 hours per week.

Monitoring Requirements:

These additional requirements apply to participants electing to employ parents of minors, legal guardians, or a spouse for CDCS services:

- monthly reviews by the fiscal support entity of hours billed for family provided care and the total amounts billed for all goods and services during the month;
- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal support entity when billing;
- at least quarterly reviews by the lead agency on the expenditures and the health and safety status of the participant;

~~• face-to-face visits with the participant by the lead agency on at least a semi-annual basis. [end delete]~~

[add] WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO MINORS:

Parents, legal guardians and conservators of minors who are related by blood, marriage, or adoption, shall not be paid to provide waiver services, with the exception of parents providing CDCS and the HCN hardship waiver as described above. [end add]

[delete] ~~All services:-~~**[end delete]** **[add]** ALL WAIVER SERVICES:-**[end add]**

Professional guardians and conservators shall not be paid to provide waiver services. This does not preclude nonprofessional guardians and conservators who meet the criteria in this section from being paid to provide waiver services as an employee of an enrolled provider.

DD waiver

Appendix C-2: Participant Services – General Service Specifications

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:

- ☐ The State does not make payment to relatives/legal guardians for furnishing waiver services.
- ☒ The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

[add] NOTE: Unless otherwise specified, all references to “parents” in this section include both biological and adoptive parents, step parents, legal guardians of minors, and other legally responsible individuals. [end add]

[delete] ~~Waiver services, other than CDCS, provided to adults~~

~~Legal guardians and conservators may be paid to provide waiver services to adults only if they meet all of the following criteria. The service must be included in the participants community support plan and the guardian or conservator must:~~

~~Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, be the guardian or conservator for only one participant or more than one participant if they are siblings;~~

~~Not be otherwise responsible to provide the care or service;~~

~~Be qualified to provide the service;~~

~~Be employed by a provider to furnish the service; and~~

~~Not be an enrolled MA provider for the service being rendered.~~

~~Consumer Directed Community Supports (CDCS) provided to adults and minors.~~ **[end delete] [add] CONSUMER DIRECTED COMMUNITY SUPPORT (CDCS) SERVICE PROVIDED TO ADULTS AND MINORS: [end add]**

[add] • [end add] Relatives ~~[delete]~~ **[end delete]** and legal guardians or conservators who are related by blood, marriage or adoption may be paid to provide services to adults and children through the CDCS service under the category of personal assistance.

[add] • [end add] Individuals who are not related by blood, marriage, or adoption whose guardianship or conservatorship responsibilities are limited to one participant, or to participants who are siblings, may be paid to provide services to adults and children through CDCS under the category of personal assistance.

Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.

[add] Relatives of adults may be paid to provide home care nursing when:

o the relative is qualified to provide the service;

o home care nursing is provided under State Plan home care nursing services (not under the CDCS personal assistance category); and

o home care nursing is within the participant's CDCS budget. **[end add]**

~~**[delete]** Services and supports provided by parents, spouses, and other legally responsible individuals.~~

~~NOTE: All references to parents in this section include both biological and adoptive parents, step parents, legal guardians of minors, and legally responsible individuals.~~ **[end delete]**

[add] CDCS services and supports provided by parents of minors, spouses, and other legally responsible individuals: **[end add]**

CDCS may be used to pay parents of minor participants under age 18 or spouses of participants for services rendered. Such payments may only be made under the category of personal assistance services as defined in Appendix C-1/C-3. Parents of minors and spouses must meet the provider qualifications for this service.

For a participant's spouse or parent of a minor participant to be paid under CDCS, the service or support must meet all of the following authorization criteria and monitoring provisions. The service must:

[add] • [end add] meet the definition of a service/support as outlined in the federal waiver plan and the criteria for allowable expenditures under the CDCS definition;

[add] • [end add] be a service/support that is specified in the participants community support plan;

[add] • [end add] be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participants community support plan;

[add] • [end add] be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;

[add] • [end add] be related to the participant's disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform;

[add] • [end add] be necessary to meet at least one identified dependency in activities of daily living as assessed using the DD Screening Document.*

* The DD screening document (DHS-3067) ~~[delete] and the Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children Under 18 (DHS-3428C) [end delete]~~ or the MnCHOICES assessment will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

~~[add] • [end add]~~ the parents (as defined above) of minor children and spouses may not provide more than 40 hours of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:

~~[add] o [end add]~~ number of parents,

~~[add] o [end add]~~ combination of parent(s) of minors and spouse, or

~~[add] o [end add]~~ number of children who receive CDCS;

~~[add] • [end add]~~ the parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;

~~[add] • [end add]~~ married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the community support plan.

~~[add] • [end add]~~ Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistance service category

~~[add] • [end add]~~ Parents of minors and spouses may not be reimbursed for mileage expenses.

CDCS service is allowable for minor participants under age 18 who reside in, but do not receive residential services in a licensed residential setting with the following conditions:

- Parents of minor participants under age 18 who receive payment to ~~[add] provide [end add] care [delete] for [end delete]-[add] to [end add] non-relatives in the licensed residential setting [add] that is not a pre-adoptive setting [end add] cannot be a paid provider of personal assistance for their [add] own [end add] biological/adoptive minor child[add](ren)[end add].~~

- Parents of minor participants under age 18 who receive payment to ~~[add] provide [end add] care [add] in the licensed residential setting [end add] [delete] for [end delete] [add] to [end add] relative children [add] (including pre-kinship settings) [end add] [delete] in the licensed residential setting [end delete] can be a paid provider of personal assistance for their [add] own [end add] biological/adoptive minor child[add](ren)[end add] up to 25 hours per week.~~

~~[add] • Parents of minor participants under age 18 who receive payment to provide care in the licensed residential setting to non-relative children in a pre-adoptive setting can be a paid provider of personal assistance for their own biological/adoptive minor child(ren) up to 25 hours per week. [end add]~~

Monitoring Requirements ~~[add] for CDCS [end add]~~:

These additional requirements apply to participants electing to employ parents of minors, legal guardians, or a spouse for CDCS services:

- monthly reviews by the fiscal support entity of hours billed for family provided care and the total amounts billed for all goods and services during the month;

- planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the fiscal support entity when billing;
- at least quarterly reviews by the lead agency on the expenditures and the health and safety status of the participant;
- face-to-face visits with the participant by the lead agency on at least a semi-annual basis.

[add] WAIVER SERVICES, OTHER THAN CDCS, PROVIDED TO ADULTS:

Related individuals cannot provide adult companion services, caregiver living expenses, or case management.

Primary caregivers, including related individuals, guardians and conservators, cannot be paid to provide a service intended to provide relief or support for themselves. This includes chore services, homemaker and respite.

For all other waiver services, relatives, legal guardians and conservators may be paid to provide waiver services to adults only if they meet all of the following criteria. The service must be included in the participant's community support plan and the relative, guardian or conservator must:

- Be related by blood, marriage, or adoption, or if not related by blood, marriage, or adoption, be the guardian or conservator for only one participant or more than one participant if they are siblings;
- Not be otherwise responsible to provide the care or service;
- Be qualified to provide the service;
- Be employed by a provider to furnish the service; and
- Not be an enrolled MA provider for the service being rendered or a controlling entity of an enrolled Medicaid provider where the person gains financially. [end add]

WAIVER SERVICES, OTHER THAN CDCS **[delete]** AND EXTENDED HOME CARE NURSING **[end delete]**, PROVIDED TO MINORS:

[add] Parents, [end add] [delete] Legal [end delete] [add] legal [end add] guardians and conservators of minors who are related by blood, marriage, or adoption, shall not be paid to provide waiver services, with the exception of parents providing CDCS as described above.

[delete] All services: [end delete] [add] ALL WAIVER SERVICES: [end add]

Professional guardians and conservators shall not be paid to provide waiver services. This does not preclude non-professional guardians and conservators who meet the criteria in this section from being paid to provide waiver services as an employee of an enrolled provider.

[delete] Waiver services, other than CDCS, provided to minors Legal guardians and conservators of minors who are related by blood, marriage, or adoption, shall not be paid to provide waiver services, with the exception of parents providing CDCS as described above. [end delete]

People over age 65 returning to a disability waiver (BI, CAC and CADI)

- Restores language allowing people over age 65 who exited due to an institutional stay, to return to a disability waiver within 180 days without Department approval

BI, CAC and CADI waivers

Appendix B-1: Participant Access and Eligibility – Specification of the Waiver Target Group(s)

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

☐ Not applicable. There is no maximum age limit

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

Specify:

Participants enrolled in the waiver prior to age 65 may remain after age 65. People who are 65 at the time of the initial waiver application are not eligible. A person who was enrolled on a disability waiver prior to the age of 65 may reopen to a disability waiver after the age of 65 years if **[add]** the person exited the waiver for institutional care and is returning to a disability waiver within 180 days from the date of being exited OR the person meets all of the following: **[end add]**

- they meet the eligibility requirements for the waiver;
- the Elderly Waiver does not or no longer meets their needs; and
- they receive approval from the Department.

Services covered/not covered (BI, CAC, CADI and DD)

- Clarifies alternative therapies are only covered under CDCS
- Clarifies goods and services that are not covered

BI, CAC, CADI and DD waivers

Additional Needed Information (Optional)

The following are additional waiver requirements:

2. The waiver shall cover only those goods and services authorized in the community support plan that collectively represent a feasible alternative to institutional care. **[delete]** ~~Services not included in the community support plan are not covered~~**[end delete]** **[add]** Alternative therapies are only covered under the service of consumer directed community supports (CDCS), and educational expenses are not covered under the waiver **[end add]**. In addition, goods and services are not covered when they:

- a) are provided prior to the development of the community support plan;
- [add]** b) are not included in the community support plan;
- c) are recreational or diversionary in nature; **[end add]**
- [delete]** ~~b)-~~**[end delete]** **[add]** d) duplicate other services in the community support plan; **[end add]**

~~[delete] e)~~~~[end delete]~~ **[add] e)** ~~[end add]~~ supplant natural supports appropriately meeting the participant's needs;

~~[delete] f)~~~~[end delete]~~ **[add] f)** ~~[end add]~~ are not the least costly and effective means to meet the participant's needs; or

~~[delete] g)~~~~[end delete]~~ **[add] g)** ~~[end add]~~ are available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.

Temporary out-of-state travel (BI, CAC, CADI and DD)

- **Clarifies language for temporary travel and local trade area**
- **Removes 30-day timeline for temporary travel**

BI, CAC, CADI and DD waivers

Additional Needed Information (Optional)

The following are additional waiver requirements:

3. ~~[delete]~~ Services are only provided to Minnesota residents, and services are not covered outside of Minnesota except when:

a) the provider is located within the participant's local trade area in North Dakota, South Dakota, Iowa, or Wisconsin and the service is provided in accordance with state and federal laws and regulations; or

b) the services provided are direct care staff services (that are authorized in the participant's community support plan) provided when the participant is temporarily outside of Minnesota and within the United States. Direct care staff services are defined as extended personal care assistance, extended home care nursing, foster care services, and a CDCS worker that provides ADL assistance under the category of Personal Assistance.

The local trade area is defined in Minnesota Rules, Part 9505.0175, subp. 22, as the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services. Temporary travel is defined as a maximum of 30 days per calendar year with the exception of emergencies. In situations in which temporary travel may exceed 30 days due to an emergency (e.g., cancelled flights by airlines, family emergencies, etc.), the case manager must be notified as soon as possible prior to the thirtieth day. The case manager determines whether the situation constitutes an emergency and whether additional waiver services will be authorized. All waiver plan requirements continue to apply to services provided outside of Minnesota including, prior authorization, provider standards, participant health and safety assurances, etc. Travel expenses for participants and their companions (including paid or non-paid caregivers), such as airline tickets, mileage, lodging, meals, entertainments, etc. are not covered. ~~[end delete]~~

[add] OUT-OF-STATE TEMPORARY TRAVEL / POST-SECONDARY SCHOOL:

Services are only provided to participants who maintain enrollment in Minnesota Medicaid and maintain a permanent residence in Minnesota. Services are not covered outside of the United States, and are only covered outside of Minnesota when the participant is either traveling temporarily out-of-state or attending an out-of-state post-secondary school.

Services are limited to direct care staff services authorized in the participant's community support plan. Direct care staff services are defined as extended personal care assistance, extended home care nursing, foster care services, and a CDCS worker that provides ADL assistance under the category of Personal Assistance.

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

LOCAL TRADE AREA / USE OF PROVIDERS FROM A BORDERING STATE:

A participant who resides in Minnesota may need to use a provider who is in the participant's local trade area of North Dakota, South Dakota, Iowa or Wisconsin. The services must be provided in accordance with state and federal laws and regulations. The local trade area is defined in Minnesota Rules, Part 9505.0175, subp. 22, as the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services. [end add]

Tribes (BI, CAC, CADI and DD)

- **Restores language regarding tribes being under contract with the Department**

BI, CAC, CADI and DD waivers

Appendix C-2: Participant Services – General Service Specifications

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Federally recognized tribes **[add]** under contract with the Department [end add] may establish alternative provider qualifications for waiver services in accordance with Minnesota Statutes, §256B.02 subd. 7, item (c). A tribe that intends to implement standards for credentialing health professionals must submit the standards to the department, along with evidence of meeting, exceeding, or being exempt from corresponding state standards. The department maintains a copy of the standards and supporting evidence to enroll health professionals approved by tribes. If the tribe also requests the ability to obtain a license under the alternative licensing standards, they must establish separation of authority from the tribal licensing agency and the provider agency to mitigate potential conflicts of interests.

Updates eligibility groups to align with the state plan for MA-EPD (BI, CAC, CADI and DD)

BI, CAC, CADI and DD waivers

Appendix B-4: Participant Access and Eligibility – Eligibility Groups Served in the Waiver

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

[delete] ☐ [end delete] [add] ☒ [end add] Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

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

Verification of provider qualifications (BI, CAC, CADI and DD)

- Updates frequency of verification for all 245D licensed services
- Updates frequency of verification for all services where the verifying entity is the Minnesota Department of Human Services, Provider Enrollment

BI, CAC, CADI and DD waivers

Appendix C-1/C-3: Participant Services – Service Specification

For the following services where a 245D license is required:

- 24-Hour Emergency Assistance (non-equipment)
- Adult Companion
- Adult Foster Care
- Child Foster Care
- Crisis Respite
- Day Training and Habilitation
- Employment Development Services
- Employment Exploration Services
- Employment Support Services
- Homemaker (home management services and assistance with activities of daily living)
- In-Home Family Supports
- Independent Living Skills (ILS) Training Services
- Individualized Home Supports
- Night Supervision Services
- Personal Support Services
- Positive Support Services
- Prevocational Services
- Residential Habilitation
- Respite
- Specialist Services
- Structured Day Program

Updates the following verification of provider qualification:

Frequency of Verification:

~~[delete] Every one to three years [end delete]~~ **[add]** Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of violations of law or rule. **[end add]**

For the following services where the verifying entity is the Minnesota Department of Human Services, Provider Enrollment:

- 24-hour emergency assistance (equipment)
- Adult day service
- Adult day service bath
- Caregiver living expenses
- Chore service
- Employment Development Services
- Employment Exploration Services
- Employment Support Services
- Environmental accessibility adaptations
- Family training and counseling
- Home delivered meals
- Homemaker (cleaning services)
- Housing access coordination
- Respite
- Specialized supplies and equipment
- Transitional services
- Transportation

Updates the following verification of provider qualification:

Frequency of Verification:

~~[delete] Annually [end delete]~~ **[add]** Every five years **[end add]**

Frequency of Verification:

~~[delete] Every two years [end delete]~~ **[add]** Every five years **[end add]**

Quality Assurance (QA) Measures

Updates QA measures to correct technical errors and be consistent across waivers (BI, CAC, CADI and DD)

BI and CADI waivers

Additional Needed Information (Optional)

Additional Waiver Information and Requirements:

5. Context for Quality Improvement, health and welfare performance measure:

Minnesota establishes **[add]** requirements regarding **[end add]** person-centered participant health **[delete]** requirements **[end delete]** for case managers and providers licensed to deliver home-and-community based services. Minnesota Statute §256B.49 **[delete]** and §256B.092 direct **[end delete]** **[add]** directs **[end add]** that participants of home and community-based services be provided a community support plan that reasonably ensures a participant's health. Minnesota Statute §245D.05 **[delete]** additionally **[end delete]** directs the licensed provider to meet service needs in the community support plan, "consistent with **[add]** the **[end add]** person's health needs."

The department monitors basic health care service access on a waiver population basis. It tracks waiver population performance on two nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS) measures **[add]**: <http://www.ncqa.org/HEDISQualityMeasurement.aspx> **[end add]**.

HEDIS performance allows for the rigorous, standardized measurement of health care received. Both the department and CMS monitor HEDIS performance in Medical Assistance populations. (Examples include the Adult Core Set (as required by the Affordable Care Act, Section 1139,) the Child Core Set (as required by the Children's Health Insurance Program Reauthorization Act of 2009) and the Quality of Care External Quality Review (42 C.F.R. § **[delete]** 438.64 **[end delete]** **[add]** 438.310 – 438.70 **[end add]**.) **[delete]** Adult Core Set Link: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html> Child Core Set Link: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html> Quality of Care External Quality Review Link: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html> **[end delete]** The department monitors waiver population access to primary health care using two validated HEDIS measures.

CAC waiver

Additional Needed Information (Optional)

Additional Waiver Information and Requirements:

5. Context for Quality Improvement, health and welfare performance measure:

Minnesota establishes requirements regarding person-centered participant health for case managers and providers licensed to deliver home-and-community based services. Minnesota Statutes, ~~§256B.092~~ **[add] §256B.49** **[end add]** directs that participants of home and community-based services be provided a community support plan that reasonably ensures a participant's health. Minnesota Statute §245D.05 directs the licensed provider to meet service needs in the community support plan "consistent with **[add] the** **[end add]** person's health needs."

The department monitors basic health care service access on a waiver population basis. It tracks waiver population performance on two nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS) measures: <http://www.ncqa.org/HEDISQualityMeasurement.aspx>

HEDIS performance allows for the rigorous, standardized measurement of health care received. Both the department and CMS monitor HEDIS performance in Medical Assistance populations. (Examples include the Adult Core Set (as required by the Affordable Care Act, Section 1139), the Child Core Set (as required by the Children's Health Insurance Program Reauthorization Act of 2009) and the Quality of Care External Quality Review (42 C.F.R. § ~~438.64~~ **[add] 438.310 – 438.70** **[end add]**.) The department monitors waiver population access to primary health care using two validated HEDIS measures.

DD waiver

Additional Needed Information (Optional)

Additional Waiver Information and Requirements:

5. Context for Quality Improvement, health and welfare performance measure:

Minnesota establishes **[add] requirements regarding** **[end add]** person-centered participant health ~~requirements~~ **[end delete]** for case managers and providers licensed to deliver home-and-community based services. Minnesota Statutes, §256B.092 directs that participants of home and community-based services be provided a community support plan that reasonably ensures a participant's health. Minnesota Statute §245D.05 ~~additionally~~ **[end delete]** directs the licensed provider to meet service needs in the community support plan, "consistent with **[add] the** **[end add]** person's health needs."

The department monitors basic health care service access on a waiver population basis. It tracks waiver population performance on two nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS) measures **[add]:** <http://www.ncqa.org/HEDISQualityMeasurement.aspx> **[end add]**.

HEDIS performance allows for the rigorous, standardized measurement of health care received. Both the department and CMS monitor HEDIS performance in Medical Assistance populations. (Examples include the Adult Core Set (as required by the Affordable Care Act, Section 1139,) the Child Core Set (as required by the Children's Health Insurance Program Reauthorization Act of 2009) and the Quality of Care External Quality Review (42 C.F.R. § ~~438.64~~ **[add] 438.310 – 438.70** **[end add]**.) ~~Adult Core Set Link: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html> Child Core Set Link: <https://www.medicaid.gov/medicaid/quality-of>~~

~~care/performance-measurement/child-core-set/index.html~~ Quality of Care External Quality Review Link:
~~http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html~~ **[end delete]** The department monitors access to primary health care using two validated HEDIS measures.

CAC waiver

Appendix A: Waiver Administration and Operation, Quality Improvement: Administrative Authority of the Single State Medicaid Agency

- a. Methods for Discovery: Administrative Authority
- i. Performance Measures

Performance Measure 1:

Percent of all CAC administrative compliance deficiencies resolved, over the most recent lead agency review cycle. Numerator: Number of CAC administrative compliance deficiencies resolved, per most recent lead agency review cycle. Denominator: Number of CAC administrative compliance deficiencies issued **[delete]** issued **[end delete]**, per most recent lead agency review.

Performance Measure 2:

Percent of all CAC corrective actions issued that were resolved over the most recent lead agency review cycle. Numerator: Number of CAC corrective actions resolved, per the most recent lead agency review cycle. Denominator: Number of CAC corrective actions issued, per most recent lead agency review cycle.

Data Aggregation and Analysis – Frequency of data aggregation and analysis:

[add] ☒ Annually **[end add]**

☒ Other: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Appendix B: Evaluation/Reevaluation of Level of Care, Quality Improvement: Level of Care

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances
- i. Sub-Assurances:
 - a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure 2:

Percent of **[delete]** new **[end delete]** CAC participants **[add]** (new applicants) **[end add]** who received a level of care determination within required timelines, per calendar year. Numerator: Number of new CAC participant assessments completed within 20 calendar days. Denominator: Number of new CAC participant assessments, per calendar year

Appendix C: Participant Services, Quality Improvement: Qualified Providers

- a. Methods for Discovery: Qualified Providers
- i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measure 1:

Percent of total CAC claims paid to active ~~[add]~~ MHCP ~~[end add]~~ providers, per calendar year.

Numerator: Dollar amount of CAC claims paid to active MHCP providers, per calendar year.

Denominator: Dollar amount of all CAC claims paid, per calendar year.

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

Performance Measure 3:

Percent of non-enrolled providers appropriately determined as ~~[delete]~~ providers ~~[end delete]~~ ~~[add]~~ qualified ~~[end add]~~ by lead agencies to deliver non-receipt services (e.g. chore, cleaning, home modification) to CAC participants. Numerator: Number of providers appropriately determined as qualified by lead agencies to deliver non-receipt services. Denominator: Number of providers approved by lead agencies to deliver non-receipt ~~[add]~~ CAC ~~[end add]~~ services.

Appendix D: Participant-Centered Planning and Service Delivery, Quality Improvement: Service Plan

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

i. Sub-Assurances:

d. Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measure 1:

Percent difference between the dollar amount encumbered for CAC services compared to the dollar amount claimed for CAC services provided to participants, per calendar year. Numerator: Dollar amount ~~[delete]~~ encumbered for CAC services ~~[end delete]~~ ~~[add]~~ claimed for CAC services provided to participants, ~~[end add]~~ per calendar year. Denominator: Dollar amount ~~[delete]~~ claimed for CAC services ~~[end delete]~~ ~~[add]~~ encumbered for CAC services, ~~[end add]~~ per calendar year.

Performance Measure 2:

Percent of CAC ~~[delete]~~ case ~~[end delete]~~ ~~[add]~~ participant ~~[end add]~~ files reviewed ~~[delete]~~ over the most recent three years ~~[end delete]~~ ~~[add]~~ during the current lead agency review cycle ~~[end add]~~ in which the support plan is signed and dated by and disseminated to all relevant parties as required ~~[delete]~~ under the regulation ~~[end delete]~~. Numerator: Number of CAC case files reviewed in which the support plan is signed and dated and disseminated ~~[add]~~ to all relevant parties ~~[end add]~~. Denominator: Number of CAC case files reviewed during the current review cycle.

Appendix G: Participant Services, Quality Improvement: Health and Welfare

a. Methods for Discovery: Health and Welfare

i. Sub-Assurances:

a. Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measure 1:

Percent of CAC participants who were not victims of maltreatment, per calendar year. Numerator: Number of CAC participants who were not victims of county-substantiated maltreatment while on the CAC waiver, per calendar year. Denominator: Number of CAC participants per calendar year.

Data Source:

Other: Minnesota Adult Protection Database and Minnesota Child Protection Database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 4:

Percent of CAC **[delete]** ~~waiver~~ **[end delete]** adult deaths associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per calendar year. Numerator: Number of CAC **[delete]** ~~waiver~~ **[end delete]** adult deaths associated with alleged maltreatment reported to MAARC that were referred to the ME. Denominator: Number of CAC **[delete]** ~~waiver~~ **[end delete]** adult deaths associated with alleged maltreatment reported to MAARC.

Data Source:

Other: **[delete]** ~~Social Service Information System (SSIS):~~ **[end delete]** Minnesota Adult Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 5:

Percent **[add]** of CAC waiver minors who did not experience death as a result of **[end add]** ~~maltreatment~~ **[delete]** ~~reports involving the death of a CAC waiver minor where counties determined death was not a result of maltreatment~~ **[end delete]**, per calendar yr. Numerator: Number of **[delete]** ~~maltreatment reports involving the death of a CAC minor that counties did not assign a death severity code~~ **[end delete]** **[add]** CAC minors determined not to have experienced death as a result of county-substantiated maltreatment **[end add]**. Denominator: Number of **[delete]** ~~county-substantiated maltreatment reports involving the death of a minor~~ **[end delete]** **[add]** minors enrolled **[end add]** on the CAC waiver **[add]**, per calendar yr. **[end add]**

Data Source:

Other: **[delete]** ~~Social Service Information System (SSIS):~~ **[end delete]** Minnesota Child Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

b. Sub-Assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure 1:

Percent of reports of maltreatment of CAC adults submitted to MAARC and referred to a lead investigative agency (LIA) in a timely manner, per calendar year. Numerator: Number of allegations of maltreatment of CAC adults reported to MAARC and referred to a LIA within two working days. Denominator: Number of allegations of maltreatment of CAC adults reported to MAARC, per year.

Data Source:

Other: **[delete]** ~~Social Service Information System (SSIS):~~ **[end delete]** Minnesota Adult Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 2:

Percent CAC participants who did not have a determination of substantiated maltreatment within 12 mos. of a substantiated maltreatment determination in the reporting yr. Numerator: Number of CAC

participants who did not have a determination of substantiated maltreatment within 12 mos. following a determination in the reporting year. Denominator: Number of CAC participants in the reporting year.

Data Source:

Other: Minnesota Adult Protection database and Minnesota Child Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

d. Sub-Assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measure 1:

Percent of CAC participants who had a health care visit or received home care nursing, per calendar year. Numerator: Number of adult participants meeting HEDIS adult AAP or received home care nursing & number of child participants **[add]** ≥1yr **[end add]** meeting HEDIS child/adolescent CAP or received home care nursing. Denominator: Number of CAC participants, per calendar year.

Appendix I: Financial Accountability, Quality Improvement: Financial Accountability

a. Methods for Discovery: Financial Accountability Assurance

i. Sub-Assurances:

a. Sub-Assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure 2:

Percent of CAC claims paid that align to **[delete]** Disability Waiver Rates System (DWRS) **[end delete]** **[add]** Rate Management System (RMS) **[end add]** records, per calendar year. Numerator: Dollar amount of CAC claims paid for services with agreement lines matching the **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** record, per calendar year. Denominator: Dollar amount of CAC claims paid for services with agreement lines requiring a **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** record, per calendar year.

Data Source:

Other: **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** and MMIS

b. Sub-Assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure 1:

Percent of CAC service authorizations that align to **[delete]** Disability Waiver Rates System (DWRS) **[end delete]** **[add]** Rate Management System (RMS) **[end add]** records, per calendar year. Numerator: Dollar amount of authorized CAC service agreement lines that have a matching **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** record, per calendar year. Denominator: Dollar amount of authorized CAC service agreement lines requiring a **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** record, per calendar year.

Data Source:

Other: **[delete]** DWRS **[end delete]** **[add]** RMS **[end add]** and MMIS

DD waiver

Appendix B: Evaluation/Reevaluation of Level of Care, Quality Improvement: Level of Care

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

i. Sub-Assurances:

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

Performance Measure 2:

Percent of ~~[delete]~~ new ~~[end delete]~~ DD waiver participants ~~[add]~~ (new applicants) ~~[end add]~~ who received a level of care determination within required timelines, per calendar year. Numerator: Number of new DD waiver participants who completed their initial assessment within required timelines, per calendar year. Denominator: Number of new DD waiver participants, per calendar year

Appendix C: Participant Services, Quality Improvement: Qualified Providers

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measure 1:

Percent of total DD waiver claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of DD waiver claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all DD waiver claims paid, per calendar year.

Data Source – Frequency of data collection/generation:

~~[delete]~~ ☒ ~~Annually~~ ~~[end delete]~~

☒ Continuously on Ongoing

Data Aggregation and Analysis – Frequency of data aggregation and analysis:

~~[delete]~~ ☒ ~~Annually~~ ~~[end delete]~~

~~[add]~~ ☒ Continuously and Ongoing ~~[end add]~~

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

Performance Measure 3:

Percent of non-enrolled providers appropriately determined as qualified by lead agencies to deliver non-receipt services (e.g. chore, cleaning, home modification) to DD waiver participants. Numerator: Number of providers appropriately determined as qualified by lead agencies to deliver non-receipt services. Denominator: Number of providers approved by lead agencies to deliver non-receipt services.

Data Source – Frequency of data collection/generation:

~~[delete]~~ ☒ ~~Continuously on Ongoing~~ ~~[end delete]~~

☒ Other: Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a three year cycle.

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure 1:

Percent of total DD waiver claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of DD waiver claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all DD waiver claims paid, per calendar year.

Data Aggregation and Analysis – Frequency of data aggregation and analysis:

[delete] ☒ ~~Annually~~ **[end delete]**

☒ Continuously and Ongoing

Appendix D: Participant-Centered Planning and Service Delivery, Quality Improvement: Service Plan

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

i. Sub-Assurances:

a. Sub-Assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measure 1:

Percent of DD waiver participant files reviewed during the current lead agency review cycle where the community support plan documents services to address all (100%) domains of assessed need.

Numerator: Number of DD files reviewed where the support plan documents services to address all domains of assessed needs. Denominator: Number of DD participant files reviewed during the current review cycle.

Data Source – Frequency of data collection/generation:

☒ Continuously on Ongoing

[delete] ☒ ~~Other: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.~~ **[end delete]**

Performance Measure 2:

Percent of DD waiver **[delete]** ~~waiver~~ **[end delete]** participant files reviewed during the current lead agency review cycle where the community support plan documents all (100%) domains of assessed need. Numerator: Number of DD waiver participant files reviewed where the support plan documents all domains of assessed need. Denominator: Number of DD waiver participant files reviewed during the current review cycle.

d. Sub-Assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measure 1:

Percent difference between the dollar amount encumbered for DD waiver services compared to the dollar amount claimed for DD waiver services provided to participants, per calendar year. Numerator: Dollar amount **[delete]** ~~encumbered for DD waiver services~~ **[end delete]** **[add]** claimed for DD waiver services provided to participants, **[end add]** per calendar year. Denominator: Dollar amount **[delete]** ~~claimed for DD waiver services provided to participants~~ **[end delete]** **[add]** encumbered for DD waiver services, **[end add]** per calendar year.

Performance Measure 2:

Percent of DD waiver **[delete]** ~~case~~ **[end delete]** **[add]** participant **[end add]** files reviewed **[delete]** ~~over the most recent three years~~ **[end delete]** **[add]** during the current lead agency review cycle **[end add]** in which the support plan is signed and dated by and disseminated to all relevant parties as required

~~[delete]~~ under the regulation ~~[end delete]~~. Numerator: Number of DD waiver case files reviewed in which the support plan is signed and dated and disseminated **[add]** to all relevant parties **[end add]**. Denominator: Number of DD waiver case files reviewed during the current review cycle.

e. Sub-Assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measure 1:

Percent of DD waiver participant files reviewed during the current lead agency review cycle in which participant choice between/among waiver services and providers was documented. Numerator: Number of DD waiver participant files reviewed during current review cycle in which participant choice was documented. Denominator: Number of DD waiver participant files reviewed during current review cycle.

Data Source – Sampling Approach:

☒ Less than 100% Review

[add] ☒ Other: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan. **[end add]**

Data Aggregation and Analysis – Frequency of data aggregation and analysis:

~~[delete]~~ ☒ Annually ~~[end delete]~~

☒ Continuously and Ongoing

☒ Other: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Appendix G: Participant Services, Quality Improvement: Health and Welfare

a. Methods for Discovery: Health and Welfare

i. Sub-Assurances:

a. Sub-Assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Performance Measure 1:

Percent of DD waiver participants who were not victims of maltreatment, per calendar year. Numerator: Number of DD waiver participants who were not victims of county-substantiated maltreatment while on the DD waiver, per calendar year. Denominator: Number of DD waiver participants per calendar year.

Data Source:

Other: Minnesota Adult Protection Database and Minnesota Child Protection Database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 2:

Percent of DD waiver participant files reviewed during the current lead agency review cycle where the community support plan documents assessed health and safety issues Numerator: Number of DD waiver participant files reviewed where the support plan documents assessed health and safety issues Denominator: Number of DD waiver participant files reviewed during the current lead agency review cycle.

Data Aggregation and Analysis – Frequency of data aggregation and analysis:

~~[delete]~~ ☒ Annually ~~[end delete]~~

[add] ☒ Continuously and Ongoing **[end add]**

☒ Other: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure 4:

Percent of DD waiver adult deaths associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per calendar year. Numerator: Number of DD waiver adult deaths associated with alleged maltreatment reported to MAARC that were referred to the ME. Denominator: Number of DD waiver adult deaths associated with alleged maltreatment reported to MAARC.

Data Source:

Other: ~~Other: [delete] Social Service Information System (SSIS): [end delete]~~ Minnesota Adult Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 5:

Percent **[add]** of DD waiver minors who did not experience death as a result of [end add] maltreatment [delete] reports involving the death of a DD waiver minor where counties determined death was not a result of maltreatment, per calendar yr [end delete]. Numerator: Number of ~~Number of [delete] maltreatment reports involving the death of a DD waiver minor that counties did not assign a death severity code [end delete]~~ **[add]** DD minor participants determined not to have experienced death as a result of county-substantiated maltreatment [end add]. Denominator: Number of ~~Number of [delete] county-substantiated maltreatment reports involving the death of a minor [end delete]~~ **[add]** minors enrolled [end add] on the DD waiver **[add]**, per calendar yr. [end add]

Data Source:

Other: ~~Other: [delete] Social Service Information System (SSIS): [end delete]~~ Minnesota Child Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

b. Sub-Assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure 1:

Percent of reports of maltreatment of DD waiver adults submitted to MAARC and referred to a lead investigative agency (LIA) in a timely manner, per calendar year. Numerator: Number of allegations of maltreatment of DD waiver adults reported to MAARC and referred to a LIA within two working days. Denominator: Number of allegations of maltreatment of DD waiver adults reported to MAARC, per year.

Data Source:

Other: ~~Other: [delete] Social Service Information System (SSIS): [end delete]~~ Minnesota Adult Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

Performance Measure 2:

Percent DD waiver participants who did not have a determination of substantiated maltreatment within 12 mos. of a substantiated maltreatment determination in the reporting yr. Numerator: # DD waiver participants who did not have a determination of substantiated maltreatment within 12 mos. following a determination in the reporting yr. Denominator: # of DD waiver participants in the reporting yr

Data Source:

Other: Minnesota Adult Protection database and Minnesota Child Protection database **[add]** (Social Service Information System [SSIS]) **[end add]**

d. Sub-Assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Performance Measure 1:

Percent of DD participants who had a health care visit, per calendar year. Numerator: Number of adult participants meeting HEDIS adult AAP* and number of child participants meeting HEDIS child/adolescent CAP**. Denominator: Number of DD participants **[add] ≥1yr, [end add]** per calendar year. *AAP – Adults' Access to Preventative/Ambulatory Health Services **CAP – Children and Adolescents' Access to Primary Care

Appendix I: Financial Accountability, Quality Improvement: Financial Accountability

a. Methods for Discovery: Financial Accountability Assurance

i. Sub-Assurances:

a. Sub-Assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure 2:

Percent of DD waiver claims paid that align to **[delete] Disability Waiver Rates System (DWRS) [end delete] [add] Rate Management System (RMS) [end add]** records, per calendar year. Numerator: Dollar amount of DD waiver claims paid for services with agreement lines matching the **[delete] DWRS [end delete] [add] RMS [end add]** record, per calendar year. Denominator: Dollar amount of DD waiver claims paid for services with agreement lines requiring a **[delete] DWRS [end delete] [add] RMS [end add]** record, per calendar year.

Data Source:

Other: **[delete] DWRS [end delete] [add] RMS [end add]** and MMIS

b. Sub-Assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure 1:

Percent of DD waiver service authorizations that align to **[delete] Disability Waiver Rates System (DWRS) [end delete] [add] Rate Management System (RMS) [end add]** records, per calendar year. Numerator: Dollar amount of authorized DD waiver service agreement lines that have a matching **[delete] DWRS [end delete] [add] RMS [end add]** record, per calendar year. Denominator: Dollar amount of authorized DD waiver service agreement lines requiring a **[delete] DWRS [end delete] [add] RMS [end add]** record, per calendar year.

Data Source:

Other: **[delete] DWRS [end delete] [add] RMS [end add]** and MMIS

BI and CADI waivers

Appendix H-1: Quality Improvement Strategy – Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process

The DHS ~~[delete] Continuing Care for Older Adults and Community Supports Administrations [end delete]~~

Quality Essentials Team (QET) will ~~[delete] meet twice a year to [end delete]~~ review and analyze ~~[delete] collected [end delete]~~ performance ~~[delete] measure [end delete]~~ and remediation data (monitoring data) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate Policy Review Team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)

Performance Measure and Remediation (monitoring) data

Analysis (QET)

1. Is there a problem (single instance or trend) indicated by the monitoring data?
If yes – test data (step 2).
If no – return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
If yes – Identify what type of problem is indicated (i.e., policy, process, and/or “bad actor”).
If no – return to monitoring.
3. Do existing remediation processes address the identified problem?
If yes – remediate and return to monitoring.
If no – enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (Policy Review Team & QET)

Policy Analysis Realm

1. Can the problem’s cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven policy alternatives.
If no – develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select “best” policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm

1. Is the problem an internal (DHS) or external process issue?
- 2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven internal process alternatives.
If no – develop theory driven internal process alternatives.
- 2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven external process alternatives.
If no – develop theory driven external process alternatives.
3. Test process alternative(s).
4. Select “best” process alternative.

5. Enact new process(es) and return to monitoring.

DD waiver

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process

The DHS ~~[delete] Continuing Care for Older Adults and Community Supports Administrations [end delete]~~ Quality Essentials Team (QET) will review and analyze performance and remediation data (monitoring data) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate Policy Review Team (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)

Performance Measure and Remediation (monitoring) data

Analysis (QET)

1. Is there a problem (single instance or trend) indicated by the monitoring data?
If yes – test data (step 2).
If no – return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
If yes – Identify what type of problem is indicated (i.e., policy, process, and/or “bad actor”).
If no – return to monitoring.
3. Do existing remediation processes address the identified problem?
If yes – remediate and return to monitoring.
If no – enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement (Policy Review Team & QET)

Policy Analysis Realm

1. Can the problem’s cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven policy alternatives.
If no – develop theory driven policy alternatives.
2. Test policy alternative(s).
3. Select “best” policy alternative.
4. Enact new policy and return to monitoring.

Process Analysis Realm

1. Is the problem an internal (DHS) or external process issue?
- 2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
If yes – develop data driven internal process alternatives.

If no – develop theory driven internal process alternatives.

2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?

If yes – develop data driven external process alternatives.

If no – develop theory driven external process alternatives.

3. Test process alternative(s).

4. Select “best” process alternative.

5. Enact new process(es) and return to monitoring.