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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Community Access for Disability Inclusion (CADI)

C. Waiver Number:MN.0166
Original Base Waiver Number: MN.0166.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
06/01/22
Approved Effective Date of Waiver being Amended: 10/01/20

2. Purpose(s) of Amendment

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

This amendment makes the following changes:

Additional Needed Information
- Corrects policy around shared staffing for a complete accounting of services with shared staffing
- Adds limitation that utilities are not covered under the waiver to align with federal code
- Adds extended community first services and supports as a direct care staff service available when people are traveling out of state

Attachment #1
- Adds plan to transition people from extended personal care assistance services to extended community first services and supports
- Adds plan to transition people from the current four CDCS categories to the new eight CDCS categories

Home Care Services
- Adds Extended Community First Services and Supports

Fiscal Policy: Rates, Allocations, Financial Management
- Changes chore services from a DHS established rate to a market rate
- Updates PCA rates to reflect revised PCA rate framework
- Changes the number of hours to access the enhanced rate for extended PCA
- Adds extended CFSS where relevant and adds rates for extended CFSS
- Adds shared staffing ratios for extended state plan services
- Updates the automatic inflationary adjustments schedule
- Updates the link to the component value document

MnCHOICES: Waiver Eligibility, Assessment and Support Planning
- Removes “in person” requirement for annual reassessment and allows for remote reassessments

Consumer Directed Community Supports
- Unbundles, or splits up, the four categories of services at the direction of the Centers for Medicare/Medicaid services into eight total categories: CDCS: Financial Management Services, CDCS: Support Planning, CDCS: Environmental modifications – home modifications, CDCS: Environmental modifications – vehicle modifications, CDCS: Individual-directed goods and services, CDCS: Personal Assistance, CDCS: Treatment and training, and CDCS: community integration and support
  - Splits up the category of CDCS: self-direction support activities into two new categories of CDCS: Financial Management Services and CDCS: Support Planning
  - Splits up the category of CDCS: Environmental Modifications and Provisions into three new categories of CDCS: Environmental modifications – home modifications, CDCS: Environmental modifications – vehicle modifications and CDCS: Individual-directed goods and services
  - Moves the relevant pieces of the category of CDCS: Personal Assistance into two new categories CDCS: Individual-directed goods and services and CDCS: community integration and support
  - Moves the relevant pieces of the category of CDCS: treatment and training into two new categories of CDCS: individual-directed goods and services and CDCS: community integration and support
- Adds remote support policy to CDCS: Personal Assistance, CDCS: Treatment and Training, CDCS: Individual-directed goods and services, CDCS: Community Integration and Support, CDCS: Support Planning, and CDCS: Financial Management Services
- Updates limitation that people cannot receive CDCS services while also receiving integrated community supports or customized living services
- Changes the number of hours to access the enhanced rate for CDCS

24-hour emergency assistance
- Updates limitations for asleep staffing
- Updates names of services that do not cover enabling technology for remote support

Adult Day Services
- Adds remote delivery to adult day services

Caregiver Living Expenses
- Adds extended community first services and supports as an approved support service that live-in caregivers can provide in order to be eligible to receive caregiver living expenses

Community Residential Services
- Adds limitation to providing extended CFSS when a person receives community residential services
- Corrects language in limitation section for the number of people in a setting to align with Minnesota statute

Day Support Services
- Updates list of services that cannot be provided at the same time as day support services to include individualized home supports (IHS) without training, IHS with training and IHS with family training

Family Residential Services
- Corrects language in limitation section for the number of people in a setting to align with Minnesota statute

- Updates limitations in FRS to exclude access to respite when shift staffing is available

Foster Care Services

- Updates reference to “personal care assistance services” with “assistance with activities of daily living”

Homemaker services

- Clarifies that laundry is covered under all three levels of homemaker since it is covered under homemaker cleaning

Integrated community supports

- Adds limitation of providing community first services and supports by a different provider than the ICS provider

Night supervision services

- Aligns “own home” definition with transitional services
- Removes “awake” which allows for overnight staff to be awake or asleep based on the support needs of the person throughout the night
- Adds limitation to prevent use of the service for preventative or assumptive safety

Respite services

- Clarifies respite can be provided in community settings used by the general public
- Adds licensed hotels as a distinct place to provide respite services

Specialized equipment and supplies

- Adds limitation that utilities are not covered even if required to operate the supplies and/or equipment

Transitional services

- Moves language about what the service doesn’t cover from service definition section to the service limitation section

Other waiver policy

- Removes language which will allow related individuals to provide IHS with training
- Adds community first services and supports wherever PCA policy currently exists.
- Adds language clarifying that extended CFSS policies for paying related individuals are found in appendix C-2-d

3. Nature of the Amendment

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

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

Component of the Approved Waiver	Subsection(s)
☒ Appendix G Participant Safeguards	G-2-a-ii
☐ Appendix H	
☒ Appendix I Financial Accountability	I-1, I-2-a
☒ Appendix J Cost-Neutrality Demonstration	J-2-c-i, d

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

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

Specify:

See previous page

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

1. Request Information (1 of 3)

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

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

Community Access for Disability Inclusion (CADI)

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: MN.0166
Draft ID: MN.007.07.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/20
Approved Effective Date of Waiver being Amended: 10/01/20

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☒ **Waiver(s) authorized under §1915(b) of the Act.**

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

This waiver operates concurrently with Minnesota's case management waiver, CMS control # MN-03.MO1.

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☒ **§1915(b)(4) (selective contracting/limit number of providers)**

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

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

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose
The purpose of the waiver is to provide community-based services as an alternative to institutional care for people who are at risk of the level of care provided in a nursing facility.

Goals
The waiver seeks to ensure that people with disabilities live, learn, work and enjoy life in the most integrated setting. Services and supports that enable people to exercise their right of self-determination, to live in the most integrated settings and to be able to freely participate in their communities will be appropriate to their needs and of their choosing. This is accomplished through comprehensive support planning using a person-centered approach. Waiver services are intended to reasonably ensure a participant's health and safety while addressing care and skill needs.

Objectives
- Supporting people with disabilities in their homes and communities
- Offering people with disabilities the opportunity to achieve a quality of life that is influenced by factors such as expectations and aspirations, skills developed over a lifetime, personal supports, location of one's home, employment, and transportation options.
- Offering people with disabilities the option to direct their own services

Organizational Structure
The waiver is administered by the Minnesota Department of Human Services (Department), the State's Medicaid agency. We delegate certain waiver operations to county agencies, and federally recognized American Indian tribes, including evaluating Medicaid recipients' waiver eligibility; completing needs assessments and level of care determinations; support plan development; authorizing services; and monitoring the services provided. The department provides direction and oversees the operational activities carried out by counties and tribal nations. We refer to counties and tribal nations that carry out delegated waiver operations as "lead agencies." Unless otherwise noted, references to lead agencies in this document include these entities.

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

Cost neutrality is managed through an aggregate budget amount that the department allocates to each lead agency. Lead agencies authorize services within their allocation amount. A detailed description of the methodology used to set the allocation amounts is provided in the Additional Needed Information section of the main module. Services are authorized in and paid through MMIS.

3. Components of the Waiver Request

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

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

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

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

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

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

◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

○ **Not Applicable**

○ **No**

◉ **Yes**

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

◉ **No**

○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Hultman

First Name: Patrick

Title: Deputy Medicaid Director

Agency: Minnesota Department of Human Services

Address: P.O. Box 64983

Address 2: 540 Cedar Street

City: St. Paul

State: **Minnesota**

Zip: 55164-0983

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

Fax: (651) 431-7421

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

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Minnesota**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Minnesota**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

TRANSITION PLAN FOR WAIVER REIMAGINE

During a 2018 study of possible improvements to our HCBS waivers, participants and their supporters shared common concerns, including the lack of easily understood information about waiver services. These concerns will be addressed with a project known as Waiver Reimagine. This amendment proposes several changes to simplify the service menu, making it easier for people to identify what is important to them and for them, and to match the right services to accomplish the goals and needs identified in their plan. This amendment adds five new waiver services:
-Community residential services (replaces foster care and supported living services)
-Family residential services (replaces foster care and supported living services)
-Integrated community supports
-Individualized home supports (with training; with family training)
-Day support services (replaces day training and habilitation/structured day program)

The following transition plan addresses the implementation of these services.

Community residential services and family residential services replace foster care/SLS daily. Participants who currently receive foster care/SLS daily will not experience any loss or interruption of services. These services will instead be authorized and billed under community residential services or family residential services as appropriate. This transition will begin on Jan. 1, 2021, or upon federal approval of these services and the Department’s completion of system updates, whichever is later.

Integrated community supports is a new service available to support participants and does not replace existing services on the BI or CADI waiver. Participants on the BI and CADI waiver can begin receiving this service on Jan. 1, 2021, or upon federal approval of these services and the Department’s completion of system updates, whichever is later. Integrated community supports provide intermittent supports and training, up to 24 hours, in categories of community living to adults18 years of age or older who reside in a living unit of a multifamily housing building (e.g., apartment) controlled directly or indirectly by the service provider. Integrated community supports can be delivered in the participant’s living unit or community settings typically used by the general public.

Individualized home supports replaces personal support, adult companion services, independent living skills training, supported living services (15-min unit), and in-home family supports. Participants receiving personal support, adult companion services, independent living skills training, supported living services (15-min unit), or in-home family support will not experience any loss or interruption of services. These services will instead be authorized and billed under individualized home supports without training, individualized home supports with training or individualized home supports with family training as appropriate. The current service of individualized home support will be authorized as individualized home supports with training. This transition will begin on Jan. 1, 2021, or upon federal approval of these services and the Department’s completion of system updates, whichever is later.
Day support services replaces day training and habilitation and structured day services. Participants receiving day training and habilitation/structured day services will not experience any loss or interruption of services. These services will instead be authorized and billed under day support services. This transition will begin on Jan. 1, 2021, or upon federal approval of these services and the Department’s completion of system updates, whichever is later.

The new services are expected to be authorized at a participant’s annual reevaluation. At any annual reevaluation after Jan. 1, 2021 following federal approval of these new services and the Department’s completion of system updates, whichever is later, case managers must transition participants from current residential or day services to the new services.

COMMUNICATION PLAN
Participants receiving foster care/SLS daily, personal support, adult companion, independent living skills - training, supported living services (15-min unit), individualized home support, in-home family support, or day training and habilitation/structured day program will be notified prior to Jan. 1, 2021 that their services will be transitioning to the new residential or day services at annual reviews occurring after Jan. 1, 2021. 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 services. Prior to Jan. 1, 2021, the Department will send a notice to all participants receiving BI, CAC, CADI, or DD waiver services explaining the transition to these new residential and day 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 eList announcements. The Department will release guidance, conduct training webinars, and host regional meetings to help train service professionals on the new services and prepare them for the transition.

ASSISTED LIVING LICENSURE AND CUSTOMIZED LIVING
This amendment (#0166.R07.06) will not have the effect of restricting the provider pool that is available to meet the needs of the individuals currently receiving customized living services as well as those individuals who demonstrate the need for customized living services.

TRANSITION PLAN FOR Extended CFSS:
This amendment phases out extended personal care assistance (PCA), and transitions participants to extended community first services and supports (CFSS) under 1915(k) state plan amendment. The following transition plan addresses the implementation of ext CFSS and the eventual removal of ext PCA.

Participants who currently receive ext PCA will not experience any loss or interruption of such services. These services will instead be authorized and billed under ext CFSS under the 1915(k) state plan amendment as appropriate.

This transition is anticipated to begin June 2022, or upon federal approval of this amendment and the Department's completion of system updates, whichever is later. The service of ext CFSS is expected to be authorized at a participant's annual eligibility reevaluation. At any annual reevaluation on or after June 2022, or up to 180 days following federal approval of this amendment and the Department's completion of system updates, whichever is later, case managers must transition participants from extended PCA to extended CFSS. After Dec. 2023, or up to 18 months following federal approval of this amendment and the Department's completion of system updates, whichever is later, all participants receiving extended PCA will have transitioned to extended CFSS as appropriate. Extended PCA will not be provided under this waiver effective Jan. 2024 or up to 18 months following federal approval of this amendment and the Department's completion of systems updates, whichever is later.

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

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

TRANSITION PLAN FOR CDCS:
This amendment removes two categories of consumer directed community supports (CDCS) in the process of unbundling the CDCS categories; CDCS: self-direction support activities and CDCS: environmental modifications and provisions. The unbundling of the four CDCS categories creates eight categories for participants within the CDCS option. The categories are:
1. CDCS: Financial Management Services
2. CDCS: Support Planning
3. CDCS: Environmental modifications – home modifications
4. CDCS: Environmental modifications – vehicle modifications
5. CDCS: Individual-directed goods and services
6. CDCS: Personal Assistance
7. CDCS: Treatment and training
8. CDCS: community integration and support.

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

This transition is anticipated to begin June 2022, or upon federal approval of this amendment and the Department's completion of system updates, whichever is later. The unbundled CDCS categories are expected to be authorized at a participant's annual eligibility reevaluation. At any annual reevaluation on or after June 2022, or up to 180 days following federal approval of this amendment and the Department's completion of system updates, whichever is later, case managers must transition participants to the unbundled CDCS categories. After Dec. 2023, or up to 18 months following federal approval of this amendment and the

Department's completion of system updates, whichever is later, all participants receiving CDCS will have transitioned to the unbundled 8 categories of CDCS as appropriate. CDCS: self-direction support activities and CDCS: environmental modifications and provisions will not be provided under this waiver effective Jan. 2024 or up to 18 months following federal approval of this amendment and the Department's completion of systems updates, whichever is later.

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

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

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

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

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

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

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

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

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

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

• Conducted a comprehensive site-specific assessment and validation of all settings serving individuals receiving Medicaid-funded HCBS, included in the STP the outcomes of these activities, and proposed remediation strategies to rectify any issues uncovered through the site specific assessment and validation processes by the end of the transition period.

• Outlined a detailed plan for identifying settings that are presumed to have institutional characteristics, including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under heightened scrutiny;

• Developed a process for communicating with beneficiaries who are currently receiving services in settings that the state has determined cannot or will not come into compliance with the home and community-based settings criteria by March 17, 2022; and

• Established ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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 support plan must be developed for each participant. Services included in the support plan must be necessary to meet a need identified in the participant's assessment, related to the participant's disability, and be for the direct benefit of the participant. 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. Services provided are one-on-one services unless shared staffing is specified in the list below for market rate and framework services, or in Appendix I-2-a for services with a DHS established rate. Framework services are calculated in the Rates Management System, and shared staffing rates are 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)
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 (without training, with training, and with family training) (1:1 or 1:2)
Independent Living Skills (ILS) Training (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)
Community Residential Services (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)
Day Support Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)
Family Residential Services (1:1, 1:2, 1:3, 1:4, 1:5, or 1:6)
Customized living (varies depending on components)

Market rate:
Family training and counseling (varies depending on situation)
Crisis respite, out of home (1:1, 1:2, 1:3, 1:4 or 1:5)
Respite daily, (1:1, 1:2, 1:3 or 1:4)

2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Alternative therapies are only covered under the service of consumer directed community supports (CDCS); educational expenses and utilities are not covered under the waiver. In addition, goods and services are not covered when they:

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

3. 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 support plan. Direct care staff services are defined as community residential services, extended personal care assistance, extended community first services and supports, extended home care nursing, family residential services, 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.

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

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.

6. 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. Minn. Stat. §256B.49 directs that participants of home and community-based services be provided a coordinated services and supports plan (CSSP) that reasonably ensures a participant's health. Minn. Stat. §245D.05 directs the licensed provider to meet service needs in the CSSP, "consistent with the 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 CFR 438.310-438.70))

The department monitors waiver population access to primary health care using two validated HEDIS measures.

7. 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 4128.90), Brain Injury (CMS control number 4169.90), and Community Access for Disability Inclusion (CMS control number 0166.90) 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 participants' assessed needs that are identified through comprehensive evaluation and 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, 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.

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:

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 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 12 assessment variables. Assessment scores are used in a formula that applies coefficients to each then adds 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 table 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
Effective Date: 7/1/15; percent change 1.0; cumulative percent change 12.6596

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 participants 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.

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).

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 CSSP's. Lead agencies are responsible to develop and modify participant CSSP's based on the assessed needs and within the allocation. The CSSP 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.

SPOUSAL IMPOVERISHMENT
Minnesota complies with the spousal protections in section 1924 of the Affordable Care Act as construed by section 3812 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 (P.L. 166-136).

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

Disability Services Division

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

The Medicaid Director is charged with the oversight of all home and community-based waivers, and maintains the waiver documents. The Community Supports Administration operates and manages the CADI waiver, which includes policy development and issuance, quality assurance and monitoring, oversight, training, budget allocation and other operational functions of the waiver program.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the

methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

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

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

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

Minnesota counties are required by state law to conduct certain waiver functions. Refer to Minnesota Statutes §256B.49. In response to question 7 of this Appendix, we identify the waiver functions carried out by the lead agencies.

The Department monitors lead agency activity through site reviews, the waiver management system, and regionally assigned staff. These monitoring functions are discussed in greater detail later in the waiver application. In addition, lead agencies are enrolled providers and there is a provider agreement or contract between the counties, tribal nations and the department.

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

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

Appendix A: Waiver Administration and Operation

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

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

Appendix A: Waiver Administration and Operation

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

The department employs several methods to monitor waiver functions delegated to lead agencies. The waiver review that was submitted in December 2018 included evidence of our monitoring activities. We also emphasize program design features such as MMIS system edits to maximize compliance with department policies and procedures and provide tools and supports to proactively manage the waiver.

For example, we maintain a comprehensive policy manual; provide technical assistance through a variety of means including electronic and call-in help centers; provide lead agencies with management tools such as the waiver management system (that provides MMIS data); and, offer training opportunities including an interactive, on-line training program that offers several topic modules and can be accessed at the convenience of the learner.

The department's waiver monitoring includes:
1. Lead agency reviews
2. Waiver cost neutrality management
3. Regionally assigned staff
4. MMIS reports and encounter data
5. Fair hearing requests
6. Review of lead agency allocation management

1. Lead Agency Reviews. Department staff conduct lead agency reviews. The purpose of the review is to monitor lead agencies' compliance with HCBS program requirements, evaluate how the needs of participants are being met, and identify best practices, quality improvement opportunities, and areas for technical assistance. Lead agency reviews are continuous and ongoing, with approximately 20 lead agencies reviewed each year. As a part of the lead agency review activities, a lead agency will provide DHS with a copy of the required documentation that is used to track the qualified vendors they have approved to provide direct delivery-services and purchased-item services.

2. Waiver cost neutrality management. The department manages waiver cost neutrality through a statewide allocation methodology. One of the tools we use to monitor cost neutrality and provide information to lead agencies is the waiver management system (WMS). The WMS combines information from MMIS with lead agency allocation information in a web-based application that allows lead agencies to monitor individual and aggregate data, and model authorization scenarios. Staff from the department monitor lead agencies' overall waiver authorizations on a monthly basis.

3. Regionally assigned staff. The department has staff assigned to regions of the state who work with lead agencies on an ongoing basis. Staff provide technical assistance, training, and act as a conduit between the department and lead agencies regarding policies and procedures. We also provide technical assistance through a web-based question/response system and call centers, and provide direct training. These contacts provide information regarding waiver activities and are a method of monitoring.

4. MMIS reports and encounter data. Our MMIS provides ongoing reports such as encumbrance and payment reports that may be used to monitor lead agency waiver authorization patterns. We also use ad hoc MMIS reports to gather and analyze information regarding potential concerns.

5. Fair hearing requests. We monitor fair hearing requests to identify patterns or trends that may indicate problems. When possible, we work with the lead agency or provider in advance of the hearing to resolve the issue before the hearing.

6. Review of lead agency allocation management
a. Lead agencies must not spend more than their identified allocation. When overspending occurs, the department will establish a corrective action plan with the lead agency and provide action steps to assure spending is managed within the available budget. If spending is not controlled by the corrective action plan, and if statewide spending exceeds funding approved by the state legislature, the Department will recoup overspending from the lead agency.
b. Lead agencies must spend at least 97 percent of their agency waiver allocation when they maintain a waiting list for participants. When underspending occurs, the Department will establish a corrective action plan with the lead agency to meet this requirement. Corrective action plans must specify the actions that the lead agency will take to assure reasonable and timely access to waiver services for individuals on the waiting list.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of all CADI administrative compliance deficiencies resolved, over the most recent lead agency review cycle. Numerator: Number of CADI administrative compliance deficiencies resolved, per most recent lead agency review cycle. Denominator: Number of CADI administrative compliance deficiencies issued, per most recent lead agency review cycle.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a 4 year cycle.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of all CADI corrective actions issued that were resolved over the most recent lead agency review cycle. Numerator: Number of CADI corrective actions resolved, per the most recent lead agency review cycle. Denominator: Number of CADI corrective actions issued, per most recent lead agency review cycle.

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

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

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a 4-year cycle.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Administrative Systems. The Department has an established infrastructure to manage the waiver. This includes use of MMIS to collect data on the individuals who are screened, authorize eligibility for MA and waiver services, and pay claims that meet certain criteria. MMIS includes comprehensive network of edits that support waiver policies and minimize data entry errors.

We also have a well-established person-centered process to: conduct assessments to determine whether a person is eligible for services (referred to as long term care consultations); address participant concerns through formal fair hearing processes; monitor that providers meet standards; and, pay only those claims that meet certain criteria (e.g., being authorized and corresponding with an appropriate eligibility period, provided by a qualified and enrolled provider, etc.).

Technical Assistance, Training and Consultation. We provide training related to MMIS tools and processes, LTCC and level of care determinations, case management, vulnerable adult and child maltreatment reporting and prevention, etc. Additionally, we have staff assigned to each region of the state. The regionally assigned staff work with groups of counties to provide technical assistance, relay and clarify policy information, and provide training.

b. Methods for Remediation/Fixing Individual Problems

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

Lead Agency Reviews, and follow-up reviews. Corrective actions are issued when patterns of non-compliance are found. Individual or case-specific problems are addressed with the lead agency before the conclusion of the review, and correction is required. Follow-up reviews (within 18 months after an initial review) include a review of the initial samples where correction were needed and a review of additional cases to assure both individual and systemic problem and pattern correction. Corrective actions and follow-up findings are documented in the Department's Lead Agency Waiver Review Database.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance and remediation data is monitored on an ongoing basis. Aggregation occurs at the end of review cycle.

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	64	
	☒	**Disabled (Other)**	0	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

To be eligible for the CADI waiver, participants must:

-Be disabled (individuals with co-occurring conditions or diagnoses, who are otherwise eligible, are not excluded);

-Be determined to require nursing facility level of care: and

-Have assessed needs that cannot be met through the state plan.

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

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

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

Specify:

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 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:

- 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.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services

furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

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

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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

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

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

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

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	39437
Year 2	41231
Year 3	43259
Year 4	45165
Year 5	46772

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

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

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Conversions, and lack of local capacity for diversions.	

Appendix B: Participant Access and Eligibility

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

Purpose *(provide a title or short description to use for lookup):*

Conversions, and lack of local capacity for diversions.

Purpose *(describe):*

The department reserves a state pool of allocations for the purposes of CADI conversions and situations where the lead agency does not have sufficient diversion capacity to serve a participant in an emergency situation. The reserved state pool is determined based on historical need for CADI allocations for conversions and emergency situations.

Describe how the amount of reserved capacity was determined:

The reserve capacity is based on historical need for CADI.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	432
Year 2	432

Waiver Year	Capacity Reserved
Year 3	432
Year 4	432
Year 5	432

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

Please refer to the description of the lead agency allocation methodology in the main module, under Additional Needed Information.

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

See reserved capacity criteria in Appendix B-3 c.

In accordance with Minnesota Statutes, section 256B.49 subd. 11a, the commissioner established the following set of statewide priorities for eligible people waiting on lists to receive HCBS waiver funded programs and services, and for whom existing state plan services or other funding and support resources are deemed not to be completely sufficient in fully meeting the person's needs. The commissioner established categories based on urgency of need that include the following conditions:

(1) the person no longer requires the intensity of services provided where they are currently living;
(2) the person does not oppose leaving an institutional setting;
(3) the person has an unstable living situation due to the age, incapacity, or sudden loss of the primary caregivers;
(4) the person is moving from an institution due to bed closures;
(5) the person experiences a sudden closure of their current living arrangement;
(6) the person requires protection from confirmed abuse, neglect, or exploitation;
(7) the person experiences a sudden change in need that can no longer be met through state plan services or other funding resources alone; or
(8) the person meets other priorities established by the Department.

Lead agency implementation of priority criteria is discussed during lead agency reviews, and the state database is now tracking the number of people on the waiting list.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- ◉ **No**
- ○ **Yes**

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

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

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

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage: 95

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

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

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

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

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

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

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

Specify:

1) Reasonable classification of children with a disability under 21 eligible for section 1915(c) home and community based services using institutional rules under 42 CFR section 435.217
2) Reasonable classification of children with a disability under 19, meeting criteria under section 1902(e)(3)
3) Medically needy reasonable classification of children under 21:
• Child with a disability under age 21 eligible for home and community- based services under section 1915(c) using institutional rules, with excess income
• Child under age 19 with a disability meeting TEFRA requirements under 1902(e), with excess income.

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount: 95

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

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

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a**

community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

- ○ **The following standard included under the state plan**

  (*select one*):

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

    Specify:

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

    (*select one*):

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

      Specify percentage:

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

      Specify dollar amount:

  - ○ **A percentage of the Federal poverty level**

    Specify percentage:

  - ○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

An amount equal to 100 percent of the poverty level standard for one individual.

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

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

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount

changes, this item will be revised.

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

Specify:

○ **Other**

Specify:

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

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

Select one:

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

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

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

- ○ **The following standard included under the state plan**

  (*select one*):

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

    Specify:

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

    (*select one*):

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

      Specify percentage:

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

      Specify dollar amount:

  - ○ **A percentage of the Federal poverty level**

    Specify percentage:

  - ○ **Other standard included under the state Plan**

    Specify:

- ○ **The following dollar amount**

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

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

Specify:

An amount equal to 100 percent of the poverty level standard for one individual.

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

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

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

○ **Other**
Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**
○ **A percentage of the Federal poverty level**

Specify percentage:

○ **The following dollar amount:**

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

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

Specify formula:

An amount equal to 100 percent of the poverty level standard for one individual.

○ **Other**

Specify:

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

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

A participant must receive case management and have authorized and delivered at least one additional waiver service as documented in the support plan. Case management services may be authorized for a maximum of 60 calendar days without the authorization of an additional waiver service. If an additional waiver service is not authorized during this timeframe, the participant must exit the waiver until determined eligible and additional waiver services can be authorized.

If the cause of not authorizing an additional waiver service is the result of a transition between providers, services, or settings, an additional 60 days to authorize waiver services shall be granted. If services are not authorized during this timeframe, the participant must exit the waiver until determined eligible and additional waiver services can be authorized.

Most participants receive waiver services on a monthly basis.

Case managers are responsible for ongoing monitoring of participants' health and safety.

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

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

Specify the entity:

- ◉ **Other**

Specify:

The department delegates responsibility for evaluations and reevaluations to lead agencies.

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

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.

Multidisciplinary 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 team of professionals that includes public health nurses, social workers, and other professionals as defined in Minnesota Statute 256B.0911, Subd. 2b, paragraph (b). 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.

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 polices are used to determine an applicant's level of care:
- MnCHOICES assessment or 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)
- Nursing Facility Level of Care Criteria Guide (DHS-7028)

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.

The 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 certified assessor also uses information from medical histories, physician records, and reports from providers to further evaluate and understand the applicant's or participant's needs. For children, the assessment also includes identifying needs that are beyond what is typical for a parent. For example, a parent of a minor is typically responsible for grocery shopping, meal preparation, supervision, etc.

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.

MnCHOICES summarizes the information captured during the assessment on the LTC Screening Document (DHS-3427). If MnCHOICES is not used, theLTC Screening Document (DHS-3427) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

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

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

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

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

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

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

An initial assessment is completed using the MnCHOICES assessment tool. It is comprehensive and conducted in-person by a certified assessor. Generally, the assessment process 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, the case manager, a nurse (if the participant has a complex medical condition), and others the person deems appropriate.

In addition to the first assessment, reassessments are completed annually and when a significant change in the participant's condition warrants a comprehensive review. Lead agencies enter key summary information from the MnCHOICES assessment, including information related to the level of care, into MMIS screening documents.

Level of care re-evaluations are conducted annually, and include a redetermination of the participant's level of care, choice of services, and support plan.

Minnesota Statute, Chapter 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 social services agencies and medical clinics. The new/initial assessment is conducted in person within 20 calendar days of the request using the 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 toward full implementation of MnCHOICES. Full implementation is targeted for 2022.

Redetermination of level of care must be performed at least annually and using the same forms as used for the new/initial assessment. MnCHOICES summarizes the information captured during the assessment on the LTC Screening Document (DHS-3427). If MnCHOICES is not used, the LTC Screening Document (DHS-3427) is used to summarize the results of the level of care assessment. This information is entered into 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.

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

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

  Specify the other schedule:

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

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

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

Claims are not paid unless there is a current evaluation or reevaluation of level of care entered in MMIS.

Claims are processed through MMIS. In order for a claim to be processed, there must be a valid screening document in MMIS. The screening document summarizes key information from the annual reevaluation, including the level of care determination, and is valid for a maximum of twelve months from an initial evaluation and for a maximum of twelve months from each subsequent reevaluation. The department assists lead agencies in tracking when reevaluations are due through the waiver management system.

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

Evaluation and reevaluation records are maintained at the lead agency. The evaluation and reevaluation records are maintained by the lead agency for a minimum of three years. As described above, key information from the initial evaluation and reevaluations are entered into MMIS screening documents. Screening documents are maintained in MMIS for a minimum of three years, and lead agencies have access to them.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Percent of completed CADI participant assessments (new applicants) that include a level of care determination, per calendar year. Numerator: Number of completed CADI participant assessments that include a level of care determination, per calendar year. Denominator: Number of CADI participant assessments completed, per calendar year

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percent of CADI participants (new applicants) who received a level of care determination within required timelines, per calendar year. Numerator: Number of new CADI participant assessments completed within 20 calendar days, per calendar year. Denominator: Number of assessments requested for new CADI participant assessments, per calendar year.

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

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
Percent of assessments for CADI participants (new applicants) in which all required fields are completed, per calendar year. Numerator: Number of assessments for CADI participants in which all required fields were completed. Denominator: Number of assessments for CADI participants, per calendar year

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Lead Agency Reviews and follow-up reviews. Individual participant issues identified during the initial Lead Agency review are noted and the lead agency is required to make the correction. Individual-level corrections are reviewed and verified, as well as corrective actions, during the follow-up reviews. Documentation of corrections is maintained in the Lead Agency Waiver Review Database.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

request through the Medicaid agency or the operating agency (if applicable).

Case managers and assessors are required to provide participants choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. To acknowledge that choice was offered, participants sign their support plan (DHS-6791D). Participants also sign the Long-Term Services and Supports Assessment and Program Information and Signature Sheet (DHS-2727).

There is also a field on the MMIS screening document that asks the assessor if the individual was given choice (i.e., choice of waiver services versus institutional placement, and choice of providers). MMIS edits prohibit a screening document from being authorized when an assessor indicates in this field that choice was not provided or if the field is left unanswered.

Lead agency practices regarding providing participants with choice are monitored through review of participant files as part of the lead agency reviews conducted by the department.

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

Evaluation and reevaluation records are maintained at the lead agency for a minimum of three years. Electronic MMIS screening document summaries are maintained by the department for a minimum of three years.

Appendix B: Participant Access and Eligibility

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

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

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

In addition, lead agencies are required to have plans addressing how they provide language assistance services to people with limited English proficiency. The plans are required to outline approaches and services to provide meaningful access for all applicants and participants to programs and services. The department provided instructional information to lead agencies regarding requirements related to limited English proficiency and we provide information available on our web site at:

http://www.dhs.state.mn.us/id_000073

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	**Adult Day Service**
Statutory Service	**Caregiver Living Expenses**
Statutory Service	**Case Management**
Statutory Service	**Homemaker**
Statutory Service	**Prevocational Services**
Statutory Service	**Respite**

Service Type	Service
Extended State Plan Service	Extended Community First Services and Supports
Extended State Plan Service	Extended Home Care Nursing
Extended State Plan Service	Extended Home Health Care Services
Extended State Plan Service	Extended Personal Care Assistance Services
Other Service	24-Hour Emergency Assistance
Other Service	Adult Companion Services
Other Service	Adult Day Service Bath
Other Service	Adult Foster Care
Other Service	Child foster care
Other Service	Chore Services
Other Service	Community Residential Services
Other Service	Consumer-directed community supports (CDCS): Community Integration and Support
Other Service	Consumer-directed community supports (CDCS): Individual-Directed Goods and Services
Other Service	Consumer-directed community supports (CDCS): personal assistance
Other Service	Consumer-directed community supports (CDCS): Support Planning
Other Service	Consumer-directed community supports : Financial Management Services
Other Service	Consumer-directed community supports: self-direction support activities
Other Service	Consumer-directed community supports: environmental modifications - vehicle modifications
Other Service	Consumer-directed community supports: environmental modifications and provisions
Other Service	Consumer-directed community supports: environmental modifications – home modifications
Other Service	Consumer-directed community supports: treatment and training
Other Service	Crisis Respite
Other Service	Customized Living
Other Service	Day Support Services
Other Service	Employment Development Services
Other Service	Employment Exploration Services
Other Service	Employment Support Services
Other Service	Environmental Accessibility Adaptations - Home Modifications
Other Service	Environmental Accessibility Adaptations - Vehicle Modifications
Other Service	Family Residential Services
Other Service	Family Training and Counseling
Other Service	Home Delivered Meals
Other Service	Housing Access Coordination
Other Service	In-Home Family Supports
Other Service	Independent Living Skills (ILS) Therapies
Other Service	Independent Living Skills (ILS) Training Services
Other Service	Individualized Home Supports
Other Service	Integrated Community Supports
Other Service	Night Supervision Services
Other Service	Personal Support Services
Other Service	Positive Support Services

Service Type	Service
Other Service	Specialist Services
Other Service	Specialized Equipment and Supplies
Other Service	Transitional services
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

The purpose of adult day service is to provide supervision, care, assistance, training and activities based on the participant's needs and directed toward the achievement of specific outcomes as identified in the support plan. Services must be designed to meet both the health and social needs of the participant. Services shall not be authorized for more than 12 hours in a continuous 24-hour period. Coverage of meals must be in accordance with 42 CFR §441.310 (a)(2)(ii).

In order to be covered as a waiver service, the adult day service must:
A. Include the use of tasks and materials that are age-appropriate for people without disabilities who are the same or near the same chronological age as the participant;
B. Maximize community inclusion opportunities by offering or providing community integration services designed to increase and enhance each participant's social and physical interaction with people without disabilities who are not paid caregivers or staff members;
C. Make available access to and participation in the community through cooperative programming with community agencies such as senior citizens centers or clubs, generic service organizations, and adult education.

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

Authorizations for adult day services after Jan. 1, 2021 may only occur when all of the criteria below is met:
•The service is chosen by a person age 55 or older
•The person did not choose Day Support Services or Employment Services
•Adult Day Services meet the outcomes desired by the person
People who receive adult day services prior to Jan. 1, 2021, regardless of age, may continue to use adult day services if they are assessed to need the service and if they choose it from available options.

Adult day services, remote support, is the following:
Remote support is a provision of adult day services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person’s health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time.
Remote support is initiated by the person or the caregiver on a scheduled basis as documented in the person’s support plan. The person’s support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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.

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 on or 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 on or after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, day support services, prevocational services, structured day services, adult and child foster care, community residential services, family residential services, integrated community supports, customized living and residential habilitation.

Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family homes
Agency	Hospitals
Agency	Freestanding Centers
Agency	Medical Clinics
Agency	Nursing Homes

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Individual

Provider Type:

Family homes

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Caregivers must have demonstrated knowledge of a participant's specific disability, and/or chronic medical condition(s), including but not limited to, brain injury, serious and persistent mental illness, developmental disabilities and related conditions such as cerebral palsy, epilepsy, and autism or previous experience working with people with disabilities.

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

Additional qualifications that are necessary to meet a participant's unique needs and preferences will be documented in the support plan.

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Licensing Division. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Freestanding Centers

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730. For purposes of this service, a center is defined as free-standing when it is only licensed to provide adult day services and is not an individual's home.

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Medical Clinics

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Nursing Homes

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

Caregiver Living Expenses

HCBS Taxonomy:

Category 1:

07 Rent and Food Expenses for Live-In Caregiver

Sub-Category 1:

07010 rent and food expenses for live-in caregiver

Category 2:

Sub-Category 2:

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

Service Definition *(Scope):*

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

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: individualized home supports without training, individualized home support with training, independent living skills training services; adult companion services; extended personal care assistance services; extended community first services and supports; personal support services; 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).

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.

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. Caregiver living expenses are not covered when a person is receiving community residential services, family residential services, customized living or integrated community supports. This service does not cover live-in expenses of related individuals or other legally responsible individuals. Related individuals include any person who is related by blood, marriage or adoption to any degree.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals and agencies that meet the live-in caregiver standards (receipt services)
Agency	Agencies that meet the live-in caregiver standards (receipt services)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Living Expenses

Provider Category:

Individual

Provider Type:

Individuals and agencies that meet the live-in caregiver standards (receipt services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Caregiver living expenses must provide a cost-effective means of meeting the needs defined in the participant's support plan.

The standards in Minnesota Statutes, chapter 245C concerning criminal background studies must be applied to determine if the live-in caregiver is disqualified.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies, or Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Caregiver Living Expenses

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: individualized home supports, independent living skills training services, adult companion services; extended personal care assistance services; extended community first services and supports; personal support services; or consumer directed community supports. Refer to the qualifications for these services.

Caregiver living expenses must provide a cost-effective means of meeting the needs defined in the participant's support plan.

The standards in Minnesota Statutes, Chapter 245C concerning criminal background studies must be applied to determine if the live-in caregiver is disqualified.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies, or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

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 refer the participant for a MnCHOICES reassessment 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 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 those 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 support plan development. Case aides must understand, respect and maintain confidentiality in regard to all details of their work.

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

Minnesota holds a section 1915(b)(4) waiver that restricts the provision of case management services to employees and contractors of the lead agencies.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Social Worker
Individual	Registered or public health nurses
Individual	Case Aides

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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.

Case managers must complete education and training as required under Minnesota Statutes, section 256B.49, subd. 13, paragraph (e).

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.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead Agency

Frequency of Verification:

For case managers that are employees of the lead agency, verification occurs at hire. For case managers under contract with the lead agency, verification occurs with contract cycles, which can be from one to three years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Registered or public health nurses

Provider Qualifications

License *(specify):*

Nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

Case managers must complete education and training as required under Minnesota Statutes, section 256B.49, subd. 13, paragraph (e).

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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department verifies that case management activities are conducted in accordance with policy and regulation during lead agency reviews.

Frequency of Verification:

Lead agencies are randomly selected for review. RN licenses are renewed every two years.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Individual

Provider Type:

Case Aides

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agency.

Frequency of Verification:

For case aides that are employees of the lead agency, verification occurs at hire. For case aides under contract with the lead agency, verification occurs with contract cycles, which can be from one to three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Homemaker Services range from light household cleaning to household cleaning with incidental assistance with home management and activities of daily living. Homemaker services are delivered when the participant is unable to manage the household activities, or the primary caregiver who is regularly responsible for these activities is unable to manage the household activities or is temporarily absent.

A primary caregiver is the person principally responsible for the care and supervision of the participant, must maintain his/her primary residence at the same address as the participant, and is named as an owner or lessee of the primary residence.

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

Home management activities may include meal preparation, shopping for food, clothing and supplies, simple household repairs and arranging for transportation.
Homemaker/home management providers deliver home cleaning services and provide assistance with home management activities.

Homemaker/ assistance with activities of daily living includes: bathing, toileting, grooming, eating, dressing, and ambulating. Homemaker providers that provide assistance with activities of daily living must also provide cleaning services.

All homemakers may assist in monitoring of the participant's well-being in the home, including home safety.

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

This service is not covered when the participant is receiving the following services: community residential services, family residential services, and customized living.

Participants receiving homemaker may receive integrated community supports when services are delivered by separate providers.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers of homemaker services including home management services
Agency	Providers of homemaker services including home management services
Agency	Providers of homemaker services including assistance with activities of daily living
Individual	Providers of Homemaker/Cleaning Service (market service)
Agency	Providers of Homemaker/Cleaning Service (market service)
Individual	Providers of homemaker services including assistance with activities of daily living

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Providers of homemaker services including home management services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.
Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(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.

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 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Providers of homemaker services including home management services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Agencies excluded from licensure under Minnesota Statutes, section 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2, (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Providers of homemaker services including assistance with activities of daily living

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Agencies excluded from licensure under Minnesota Statutes, section 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

For agencies who are excluded under Minnesota Statutes, section 245A.03,subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Providers of Homemaker/Cleaning Service (market service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of homemaker/cleaning services must comply with the criminal background study standards in Minnesota Statutes, Chapter 245C.

Homemaker/cleaning providers must be able to perform the cleaning duties expected and provide a cost-effective, appropriate means of meeting the participant's home cleaning needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Agency

Provider Type:

Providers of Homemaker/Cleaning Service (market service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:

Individual

Provider Type:

Providers of homemaker services including assistance with activities of daily living

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (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.

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 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Prevocational services are provided to people learning to effectively work and meet the challenging demands of work. Prevocational services are work skills training and support services that advance people toward competitively paid employment in community jobs. Prevocational Services involve the development and implementation of person-centered, coordinated service and support plans that focus on strengthening basic, fundamental work skills and achieving individualized work skill goals through meaningful work experiences and vocational training. People receiving prevocational services can explore and pursue competitively paid employment opportunities in community businesses at any time.

The purpose of Prevocational Services is to achieve individualized, habilitation goals in the person's support plan that will lead to greater opportunities for competitive, community-integrated employment and career advancement at or above minimum wage.

Prevocational Services are not intended to teach or develop job-specific work skills to perform a particular job. Prevocational services are intended to teach and develop needed general work skills (e.g., attention span, motor skills, interpersonal relations with co-workers and supervisors) that lead to competitively compensated (i.e., at or above minimum wage), community-integrated employment.

Prevocational services are provided in provider-controlled facilities and businesses (e.g., service provider owned and operated day service centers or proprietary, subsidiary businesses such as retail stores/shops, contracted manufacturing or production businesses, warehouse/storage enterprises, recycling centers, commercial laundries, mobile cleaning services, lawn and landscape companies, farm and garden greenhouse operations, etc.).

Prevocational Services are designed to teach elemental work skills and strengthen work capacity to meet the task-demands of work. Prevocational services consist of intensive training on essential work skills and activities, such as:
1) punctual work attendance;
2) increased attention to work tasks;
3) work capacity strengthening;
4) work completion;
5) increased work production;
6) improved work performance quality;
7) following work instructions;
8) following work schedules and routines;
9) self-direction and time management;
10) worksite transportation, mobility, safety and street safety skills;
11) workplace personal self-care (proper hygiene, grooming, physical appearance and dress/attire);
12) on-the-job problem solving;
13) effective workplace communication, social skills, personal relationship development and positive behavior/mental health functioning; and
14) relevant work-related educational development.

Prevocational service training strategies and activities should assist a person with developing necessary and marketable work skills, strengths and abilities that lead to greater opportunities for competitive, community employment.

Prevocational service outcomes include:
1) developing needed work skills and strengthening work capacity;
2) acquiring resume-building, meaningful work experiences and vocational training; and
3) establishing "next step" community employment goals and support plans.

The participant's support plan must provide that the lead agency has determined that such services are not available under the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).

Prevocational services, remote support, is the following:
Remote support is the provision of prevocational services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and

preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

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 on or 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 on or after July 1, 2019 which deliver any of the following services: adult day services, day support services, day training and habilitation, prevocational services, structured day services, adult and child foster care, community residential services, customized living, family residential services, integrated community supports, and residential habilitation.

• Prevocational Services are not intended to teach competency in specific job skills.
• Waiver funds are not available for vocational services in facility or center based sheltered workshop settings, where the primary purpose is to produce goods and perform services.
• Waiver funds are not available for vocational education and training that is not directly related to a person's Prevocational Services goals.
• 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 statutes and rules.
•Waiver funds are for reimbursing service provider billing claims for providing assistive services and supports to people with disabilities. Waiver funds cannot be used as supplemental capital to directly finance service provider owned, controlled and operated business enterprises.
•Prevocational service providers with established subsidiary business enterprises or business contracts that fully or partially cover the costs of provider staff service support, transportation and overhead expenses through business income must not submit reimbursement billing claims for service and transportation costs that are covered by the business income of the business enterprise or business contract.
•Prevocational Services must be authorized and reimbursed on a 15-minute unit basis when Employment Exploration Services, Employment Development Services, Employment Support Services, Day Support Services, Structured Day Services or Adult Day Services are also provided during the same day as Prevocational Services.
•Prevocational Services, Employment Exploration Services, Employment Development Services, Employment Support Services, Day Support Services, Structured Day Services and Adult Day Services must not be simultaneously billed during the same time period of the day.
•Prevocational Services are not a pre-requisite for Employment Exploration Services, Employment Development Services and Employment Support Services.
•People receiving Prevocational Services can choose to explore, pursue and work at competitively paid employment opportunities in community businesses at any time via Employment Exploration Services, Employment Development Services and Employment Support Services.
•Prevocational Service rates include in-service transportation costs. Transportation services occurring between the person's place of residence and the prevocational service site are not covered as part of this service. These transportation billing claims are reimbursed separately as waiver service transportation.
•People receiving Prevocational Services (including Prevocational Services under DT&H service programs) prior to Jan. 1, 2021 can continue to receive Prevocational Services without a time limit.
•People who begin receiving Prevocational Services on or after Jan. 1, 2021 can receive Prevocational Services for 3 years or 36 months.
• Receiving Prevocational Services beyond 3 years or 36 consecutive months can occur:
o If the person is receiving Prevocational Services (including Prevocational Services under DT&H service programs) prior to Jan. 1, 2021;
o If the person newly receiving Prevocational Services on or after Jan. 1, 2021 experiences a debilitating physical or mental health condition that significantly hinders functioning (including health and safety) and disrupts effective implementation of Prevocational Services, then the person may receive Prevocational Services for an additional year or 12 consecutive months.
o If the person newly receiving Prevocational Services on or after Jan. 1, 2021 experiences disruptive life events (including a Prevocational Services provider change) that significantly hinder effective implementation of Prevocational Services, then the person may receive Prevocational Services for an additional year or 12 consecutive months.
o If the person newly receiving Prevocational Services on or after Jan. 1, 2021 has a continued need for further work skills training and development to mitigate work skill and workplace conduct deficits that could cost the person employment at a community job, then the person may receive Prevocational Services for an additional year or 12

consecutive months.
• Prevocational Services do not include services that are available under section 110 of the Rehabilitation Act 1973 or under the provisions of the Individuals with Disabilities Education Act (IDEA).

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who meet the prevocational services standards
Agency	Agencies that meet the prevocational services standards.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Individual

Provider Type:

Individuals who meet the prevocational services standards

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Agencies that meet the prevocational services standards.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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, community settings used by the general public 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)
• Medicare certified hospital
• Medicare certified nursing facility
• Certified camps
• Unlicensed settings for adults 18 years of age or older where agency and individual providers must be licensed under Minnesota Statutes, Chapter 245D or meet the exclusion requirements
• 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.
• Licensed hotels*

* If a participant is going to receive respite services in a licensed hotel, the 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 respite services as identified in the support plan. This service does not pay for caregivers to stay in a hotel while the participant remains at home. The provider of respite must pay the cost of the hotel room and meals for the participant.

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, excluding licensed hotels.

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.

Respite (in-home/15-minute units), remote support, is the following:
Remote support is the provision of respite by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

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

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

Respite care is not available to participants living in settings where Customized Living, or shift staff Foster Care are 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.

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.

Respite care is limited to 30 consecutive days per respite occurrence when provided 24 hours a day.

For participants receiving respite care the following services are not covered: community residential services, customized living or integrated community supports with the exception of community emergencies or disasters.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Foster Care
Individual	Adult Foster Care

Provider Category	Provider Type Title
Agency	Camps
Agency	Adult Foster Care
Agency	Agencies that meet the respite service standards
Agency	Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6 (2)
Agency	Hospitals as defined in Minnesota Statutes, section 144.696, subd 3.
Agency	Long Term Care Facilities (also referred to as nursing facilities)
Individual	Child Foster Care
Individual	Individuals who meet the respite service standards

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Foster Care

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

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

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Adult foster care is licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26.

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

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

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License *(specify):*

Licensed under Minnesota Statutes, chapter 245D.

Certificate *(specify):*

Certified by the American Camp Association

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Foster Care

Provider Qualifications

License *(specify):*

Adult foster care is licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26.

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

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

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agencies that meet the respite service standards

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Adults 18 years of age or older: 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 for adults 18 years of age or older, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation will be in the person's support plan.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

For agencies who are excluded under Minnesota Statutes, section 245A.03, subd.2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential hospice facilities as defined in Minnesota Statutes, section 144A.75, subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6 (2)

Provider Qualifications

License *(specify):*

Licensed under Minnesota Statutes, sections 144A.75 to 144A.756.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

Every one to three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Licensed under Minnesota Statutes, sections 144.50 to 144.591.

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Long Term Care Facilities (also referred to as nursing facilities)

Provider Qualifications

License *(specify):*

Must be licensed in accordance with MN Statute, chapter 144A and must meet the definition under Minnesota Rules, part 9505.0175, subpart 23.

Certificate *(specify):*

Medicare Certification

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

Long term care facilities are reviewed every two years by the state and receive federal certification annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Child Foster Care

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

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

Providers excluded from licensure under Minnesota Statutes, section 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individuals who meet the respite service standards

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Adults 18 years of age or older: Unrelated Individuals who are excluded from licensure under of Minnesota Statutes, 245A.03, subd. 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.

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.

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 support plan.

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

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(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Community First Services and Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Extended Community First Services and Supports (CFSS) are CFSS 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 CFSS benefit for each month that the extended service is authorized.

The need, amount and duration of the service is determined by the outcome of the MnCHOICES assessment or Supplemental Waiver PCA Assessment and Service Plan (DHS-3428D).

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

Extended CFSS services excludes the Community First Choice (CFC) service optional category of goods and services.

For participants receiving extended CFSS the following services are not covered: community residential services and family residential services.

For participants receiving customized living or integrated community supports, a separate provider must be used for extended CFSS.

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community First Services and Supports provider agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Community First Services and Supports

Provider Category:

Agency

Provider Type:

Community First Services and Supports provider agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements under Minnesota Statutes, section 256B.85, subd. 10, 11a, 11b, 12

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Home Care Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered nurses
Agency	Home health agencies
Agency	Home care nursing agencies
Individual	Licensed practical nurses (LPN)

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Registered nurses

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home health agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Medicare certification.

Other Standard *(specify):*

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

Nurses who provide HCN services as an employee of a home health agency must have a valid license to practice in Minnesota.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home care nursing agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Service, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Licensed practical nurses (LPN)

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services Enrollment, Provider Enrollment.

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Home Health Care Services

HCBS Taxonomy:

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

11 Other Health and Therapeutic Services	11080 occupational therapy

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**
11 Other Health and Therapeutic Services	11090 physical therapy

Extended home health care services are nursing, home health aide, occupational therapy, physical therapy, speech-language pathology, respiratory therapy services, and services furnished by therapy assistants provided by a home health agency as defined in the state plan except that the limitations on the amount (the number of units) and duration of the service (the period of time the service may be authorized) do not apply. The scope of the service is the same as defined in the state plan. To be eligible, the participant must receive and exhaust the state plan benefit of home health care service for each month that the extended service is authorized.

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

Extended home health care services do not include medical supplies and equipment because these services are otherwise covered by the waiver. Specialized maintenance therapy and audiology services are not covered.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home health agencies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home health agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

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

Physical therapists must:
-be registered under Minnesota Statutes 148.65 and 148.78; and
-meet the standards as specified under the Medicaid State plan; and
-be 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 therapy assistants must work under the direction and supervision of a physical therapist as indicated in Minnesota Statutes, section 148.706.

Occupational therapists must:
-meet the standards as specified under the Medicaid State plan; and
-be currently registered by the American Occupational Therapy Association as an occupational therapist; and
-meet the standards as specified in Minnesota Statutes 148.6401 to 148.6449

Occupational therapy assistants must work under the direction and supervision of a occupational therapist as indicated in Minnesota Statutes, sections 148.6401 to 148.6432.

Speech-language pathologists must:
-meet the standards as specified under the Medicaid State plan; and
-have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association; and
-meet the standards as specified in Minnesota Statutes, sections 148.511 to 148.5198.

Speech-language pathology assistants must work under the direction and supervision of a speech-language pathologist as indicated in Minnesota Statutes, sections 148.511 to 148.5192.

Respiratory therapists must:
-meet the licensure requirements as defined in Minnesota Statutes, chapter 147C; and
-meet the standards as specified under the Medicaid State plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

Every one to three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended Personal Care Assistance Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Extended Personal Care Assistance (PCA) are PCA services as defined in the state plan except that the limitations on the amount (the number of units), 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 or assessor based on completion of the MnCHOICES assessment or Supplemental Waiver PCA Assessment and Service Plan (DHS-3428D).

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

Extended PCA under this waiver shall discontinue after the last person has changed to extended CFSS or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Extended PCA will be replaced by extended CFSS as PCA will be replaced by CFSS under a 1915k state plan. No new authorizations for extended PCA will be allowed after the last person has changed to CFSS, or up to 18 months following CMS approval of this waiver amendment package and the Department's completion of system updates, whichever is later. A new authorization means approval for extended PCA for a participant who was not previously receiving extended PCA before mid-June 2024.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal care provider agencies and personal care choice provider agencies.
Agency	Medicare certified home health agencies

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Personal Care Assistance Services

Provider Category:

Agency

Provider Type:

Personal care provider agencies and personal care choice provider agencies.

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every three years

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Extended Personal Care Assistance Services

Provider Category:

Agency

Provider Type:

Medicare certified home health agencies

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health and Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

24-Hour Emergency Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

24-hour emergency assistance provides on-call counseling and problem solving and/or immediate response for assistance at the participant's home due to a health or personal emergency. This service includes provision of electronic personal emergency response systems, which includes the device and monitoring.

This service may be authorized as an integral component of the participant's support plan. If the service is initiated in response to unexpected needs, the authorization of the service must be followed by review of the support plan within five days of the first date of service initiation and amendment of the support plan as necessary to meet the on-going needs of the participant. The support plan will identify the need for the availability of this service, a description of how the service will be provided, what patterns of 24 hour emergency assistance usage will indicate other services are needed, thus prompting a reconvening of the support planning team, the specific qualifications necessary for the service provider to have to meet the participant's needs, and the person(s) or entities which shall be responsible for the provision of such assistance. This service will not duplicate other services provided to the person.

24 hour emergency assistance, remote support, is the following:
Remote support is the provision of 24 hour emergency assistance by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

24-hour emergency assistance services are limited to those participants who live in their own home, are not receiving 24-hour supervision and would otherwise require extensive, routine supervision, or who live with a family member or a primary caregiver who would otherwise require extensive supports in the absence of this service to secure help in the event of an emergency. In order to be considered a primary caregiver, the person must be principally responsible for the care and supervision of the participant and 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.

24 hour emergency assistance does not permit staff to sleep in a participant's home or in the participant's family home.

For participants receiving 24-hour emergency assistance, the following services are not covered: community residential services, customized living, family residential services, and integrated community supports.

The following limitations apply to PERS related costs:
• Purchase costs of the PERS equipment, including necessary training or instruction on use of the equipment, shall not exceed $1,500 per service-agreement year
• Installation, set-up and testing costs for the PERS equipment shall not exceed $500 per service-agreement year
• Monthly monitoring fees shall not exceed $110 per month.

All PERS-related costs for equipment and related services shall not exceed a total of $3,000 per service-agreement year.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies that meet the 24-hour emergency assistance service standards for services other than equipment
Agency	Providers that meet the 24-hour emergency assistance / equipment service standards (receipt service)
Individual	Providers that meet the 24-hour emergency assistance / equipment service standards (receipt services)
Individual	Individuals that meet the 24-hour emergency assistance standards for services other than equipment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 24-Hour Emergency Assistance

Provider Category:
Agency

Provider Type:

Agencies that meet the 24-hour emergency assistance service standards for services other than equipment

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must meet the requirements of: sections 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 agencies holding a license under Minnesota Statutes, Chapter 245D.

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

For agencies who are excluded under Minnesota Statutes, section 245A.03,subd. 2 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 24-Hour Emergency Assistance

Provider Category:

Agency

Provider Type:

Providers that meet the 24-hour emergency assistance / equipment service standards (receipt service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

24-Hour Emergency Assistance equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

All items shall meet applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 24-Hour Emergency Assistance

Provider Category:

Individual

Provider Type:

Providers that meet the 24-hour emergency assistance / equipment service standards (receipt services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

24-Hour Emergency Assistance equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

All items shall meet applicable standards of manufacture, design and installation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports.
Enrolled provider DHS review - Every five years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 24-Hour Emergency Assistance

Provider Category:

Individual

Provider Type:

Individuals that meet the 24-hour emergency assistance standards for services other than equipment

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D.
Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2)must meet the requirements of: sections 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 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Companion Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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

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

Adult companion services shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Adult companion services will be replaced by individualized home supports. No new authorizations for adult companion services will be allowed after Jan. 1, 2021, 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 adult companion services for a participant who was not previously receiving adult companion services before Dec. 31, 2020.

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must meet the standards established by the Corporation for National and Community Service

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Agency

Provider Type:

Agencies that meet the standards to provide adult companion services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(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(2)the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Companion Services

Provider Category:

Individual

Provider Type:

Individuals who meet the standards to provide Adult Companion Services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

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

Individuals meeting the licensing exclusions of Minnesota Statutes, section 245A.03, subd. 2(1) and (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(2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Day Service Bath

HCBS Taxonomy:

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

Service Definition *(Scope):*

A participant may receive a bath provided by an adult day care provider when it is not appropriate to provide baths in the participants living setting. This service is limited to two 15 minute units of service per day.

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

Licensed adult foster care providers cannot provide adult day service baths to foster care participants residing in the adult foster care home.

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 on or 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 on or after July 1, 2019 which deliver any of the following services: adult day services, day training and habilitation, day support services, prevocational services, structured day services, adult and child foster care, community residential services, family residential services, integrated community supports, customized living and residential habilitation.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing homes
Agency	Medical clinics
Individual	Family homes
Agency	Hospitals
Agency	Free-standing centers

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nursing homes

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Medical clinics

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Family homes

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Caregivers must have demonstrated knowledge of a participant's specific disability, and/or chronic medical condition(s), including but not limited to, brain injury, serious and persistent mental illness, developmental disabilities and related conditions such as cerebral palsy, epilepsy, and autism or previous experience working with persons with disabilities.

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

Additional qualifications that are necessary to meet a participant’s unique needs and preferences will be documented in the support plan.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Licensing Division. Some licensing functions are delegated to counties to complete under department supervision.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Free-standing centers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Foster Care

HCBS Taxonomy:

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

Service Definition *(Scope):*

Adult foster care is ongoing residential care and supportive services and includes assistance with activities of daily living, homemaker, chore, behavioral aide services, companion services, and medication oversight (to the extent permitted under State law) provided in a licensed home or community residential setting (CRS).

Adult foster care shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Adult foster care will be replaced by community residential services and family residential services. No new authorizations for adult foster care will be allowed after Jan. 1, 2021, 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 adult foster care for a participant who was not previously receiving adult foster care before Dec. 31, 2020.

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

The following are not covered in adult foster care:

1) Room and board, items of comfort or convenience, payments directly or indirectly to the participant, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the participant's immediate family.

2) Homemaker and chore services are not covered as separate services for participants living in adult foster care because these services are integral to and inherent in the provision of adult foster care services.

3) Respite care is not available to participants living in settings where shift staff Foster Care is provided.

4) 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.

5) The total number of participants living in the home, who are unrelated to the principal care provider, shall not exceed four except when authorized by the commissioner. The commissioner may authorize services provided in settings serving up to five participants living in the home who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert a participant's placement in a hospital, regional treatment center, or nursing facility. 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; or, 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 an individual 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 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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Foster Care Providers
Individual	Adult Foster Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Agency

Provider Type:

Adult Foster Care Providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Adult foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Foster Care

Provider Category:

Individual

Provider Type:

Adult Foster Care Providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Adult foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Child foster care

HCBS Taxonomy:

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

Service Definition *(Scope):*

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

Child foster care is ongoing residential care and supportive services necessary to care for a child (under age 18) who cannot be cared for by his/her natural family. Child foster care includes assistance with activities of daily living, homemaker, chore, behavioral aide services, companion services, and medication oversight (to the extent permitted under State law) provided in a licensed home.

Placement in a child foster care home in which the child foster care license holder does not reside may only occur when the case manager determines that the placement is necessary and appropriate and the least restrictive setting available to meet the participant's needs. Documentation of the determination must be maintained in the participant's record.

Child foster care shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Child foster care will be replaced by community residential services and family residential services. No new authorizations for child foster care will be allowed after Jan. 1, 2021, 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 child foster care for a participant who was not previously receiving child foster care before Dec. 31, 2020.

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

The following are not covered in child foster care:

1) Room and board, items of comfort or convenience, payments directly or indirectly to the participant, the costs of facility maintenance, upkeep and improvement, and services provided, directly or indirectly, to members of the participant's immediate family.

2) Homemaker and chore services are not covered as a separate service for participants living in foster care because these services are integral to and inherent in the provision of foster care.

3) Respite care is not available to participants living in settings where shift staff foster care is provided.

4) 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.

5) The total number of participants living in the home, who are unrelated to the principal care provider, shall not exceed four except when authorized by the commissioner. The commissioner may authorize services provided in settings serving up to five participants living in the home who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert a participants placement in a hospital, regional treatment center, or nursing facility. 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; or, 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 an individual in the setting on or prior to July 1, 2000.

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Foster Care Providers
Individual	Child Foster Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child foster care

Provider Category:

Agency

Provider Type:

Child Foster Care Providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Child foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child foster care

Provider Category:

Individual

Provider Type:

Child Foster Care Providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Child foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 2960.3000-2960.3340.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Chore Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Chore services assist and support the participant or their primary caregiver with sustaining a clean, sanitary, safe and well-maintained environment. Chore services can be provided when the participant or their primary caregiver is incapable of performing the household tasks or when the provision of chore services work allows for the caregiver to provide other needed supports to the participant. Chore services can include, but are not necessarily limited to:

1) heavy household cleaning tasks;
2) indoor and outdoor general home maintenance work;
3) moving or removal of large household furnishings and heavy appliances in order to provide safe access and egress from the home*;
4) Rearrangement of the home furnishings or the securing of household fixtures and items in order to prevent injuries or falls;
5) Extermination and pest control;** and
6) Delivery of grocery store products.***

If the support plan also includes homemaker services, the support plan must be specific enough in order to assure that there is no duplication.

*Dumpster rental and refuse disposal expenses are allowable.

**Extermination and pest control service costs are limited to a reasonable number of treatments required to alleviate the pest problem.

***Customary grocery store delivery service charges are reimbursable when the delivered products represent the majority of the persons total grocery needs for at least seven days.

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

Chore services will only be provided when the person resides within their own home or the home of their primary caregiver. In order to be considered a primary caregiver, the caregiver must be principally responsible for the care and supervision of the person. The primary caregiver must reside at the same address as the person, and must be named as an owner or lessee of this primary residence.

This service shall not be covered in licensed settings or rental situations where the lease agreement identifies the chore services as the responsibility of the landlord.

For participants receiving chore services the following services are not covered: community residential services, family residential services, customized living or integrated community supports.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Chore service providers (market service)
Agency	Structural pest control applicators
Individual	Structural pest control applicators
Individual	Chore service providers (market services)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Chore service providers (market service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Agency

Provider Type:

Structural pest control applicators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements under Minnesota Statutes, Chapter 18B.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Service, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Structural pest control applicators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the standards and requirements of Minnesota Statutes, Chapter 18B.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Services

Provider Category:

Individual

Provider Type:

Chore service providers (market services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Residential Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community residential services is a training service that provides ongoing residential care and supportive services to adults and/or children (who cannot be cared for by his/her biological or adoptive family) in a licensed setting in which the license holder does not reside. Community residential services is provided to adults in a licensed community residential setting for up to four people. A community residential setting (CRS) is a licensed residential setting that serves adults in which the license holder does not reside. Community residential services is provided to children in a licensed corporate child foster care setting or a supervised living facility. A corporate child foster care setting is a licensed residential setting that serves children in which the license holder does not reside. These settings typically use a shift-staff model of support. In these types of settings, at least one person receives community residential services funded by an HCBS waiver program.

Supports are individualized based on the needs of the person, and may include increasing and maintaining the person's physical, intellectual, emotional and social function in the following areas:
• Assistance with activities of daily living
• Self-care
• Communication skills
• Community participation and mobility
• Health care, leisure and recreation
• Household management
• Interpersonal skills
• Medication oversight (to the extent permitted under State law)
• Money management
• Positive behavior and mental health support
• Sensory and motor development
• Socialization.

Services may be provided outside of the person's home in community settings when the service is related to the needs of the person and are provided in settings that are used by the general public.

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

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

Community residential services for children may be delivered in a setting licensed as corporate child foster care that serves four or fewer people, or a supervised living facility.

Community residential services for adults may be delivered in a community residential setting (CRS) for up to four people, or a supervised living facility. 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.

The total number of participants living in the home, who are unrelated to the principal care provider, shall not exceed four except when authorized by the commissioner.

The commissioner may authorize services provided in settings serving up to five participants living in the home who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert a participant's placement in a hospital, regional treatment center, or nursing facility. This exception for services delivered in a setting 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; or,
•Necessary to place siblings together.

This limit does not apply to settings that have continuously provided adult or child foster care to a waiver participant prior to May 1, 2001. Provided means that this was an approved service for an individual in the setting on or prior to May 1, 2001. This size restriction does not apply to people who are 55 years of age or older. 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.

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.

The following are not covered in community residential service:
1) Room and board, items of comfort or convenience, payments directly or indirectly to the participant, the costs of vehicle and facility maintenance (e.g., upkeep and improvements), modifications or adaptions to the setting, upkeep and improvement, and services provided, directly or indirectly, to members of the participant's immediate family.
2) Homemaker and chore services are not covered as separate services because these services are integral to and inherent in the provision of community residential services.

3) For participants receiving community residential service, the following services are not covered: 24-hour emergency assistance, adult companion, behavioral aide services, caregiver living expenses, chore, customized living, homemaker, home-delivered meals, individualized home supports* (without training, with training, and with family training), integrated community supports, night supervision, respite, community first services and supports, and personal care assistance services.

*A participant may receive community residential services and individualized home supports without training services only when individualized home supports without training is provided by a separate service provider who does not have any direct or indirect financial interest in the property or housing in which community residential services are delivered. The individualized home support without training must be delivered in the community, outside of the residential setting.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community residential services provider
Agency	Community residential services provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Residential Services

Provider Category:

Agency

Provider Type:

Community residential services provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Community residential services providers must deliver the service to children in a corporate child foster care facility licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Residential Services

Provider Category:

Agency

Provider Type:

Community residential services provider

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Community residential services providers must deliver the service to adults in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports (CDCS): Community Integration and Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Community Integration and support services focuses specifically on successful participation in community membership that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service provides the participant with development and maintenance of skills related to community membership through engagement in community-based activities.
This service will provide the participant access and supports to engage in acquisition, training and maintenance of skills to increase the participant's independence related to community integration through community-based activities.
Community Integration and support services promote positive growth and develop the skills and social supports necessary for the participant to:
a.) Pursue or retain skills necessary for competitive integrated employment opportunities for working age individuals;
b.) Acquire, improve, or retain living skills necessary to live in and be a member of the community safely;
c.) Develop and pursue meaningful day supports and community engagement for individuals who have elected not to pursue further employment opportunities;
d.) Improve social skills and community behavior through social skills development and relationship building training
e.) Improve positive behavior skills and improve mental health

Community Integration and support services may include caregiver assistance, training and accompaniment to support the person while participating or engaging in the following activities:
1. Engaging in activities that facilitate, develop, and strengthen personal relationships with community members chosen by the person;
2. Self-designing employment/vocational opportunities (i.e. starting a personal business; internships; freelance work)

3. Self-designing day support services that provide the person with opportunities for regular connections to members of the broader community
4. Self-designing independent living skills training based on the persons assessed needs
5. Participating in local community events;
6. Assisting with a person's preferred volunteer experiences focused on community contribution rather than preparation for employment;
7. Participating in community support groups, organizations and clubs, formal informal community associations and neighborhood groups

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services or integrated community supports.

Community integration and support must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

Community Integration and Support cannot be used to cover expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers participant

Community integration and support, remote support, is the following:

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;

• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Unallowable Expenditures. The participant's budget shall not be used for community integration and support for the following:
• Insurance except for insurance costs related to direct support worker employee coverage;
• CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• Vacation expenses other than the cost of direct services;
• Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers;
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.
Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.(

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual as selected by the participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports (CDCS): Community Integration and Support

Provider Category:

Individual

Provider Type:

Individual as selected by the participant

Provider Qualifications

License *(specify):*

Valid business license in good standing, if applicable

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

All individuals providing CDCS-Community Integration and Support must:
a.) Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
b.) Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
c.) Receive customized training provided by the participant and/or his/her representative
d.) Be able, willing and have the capacity to perform the requested work outlined in the participant's support plan
e.) Have the ability to successfully communicate with the person

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of community integration and support.

Frequency of Verification:

At time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports (CDCS): Individual-Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Individual-Directed Goods and Services can be used to purchase items within a global budget. See Appendix E. Individual-directed goods and services includes services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements:
• The item or service would decrease the need for other Medicaid services;
• And/or promote inclusion in the community;
• And/or increase the participant's safety in the home environment;
• And, the participant does not have the funds to purchase the item or service or the item or service is not available through another source.

Participants may purchase individual-directed goods and services that are included in their support plan, meet the criteria for allowable expenditures described below, and are within the means of their CDCS budget to purchase. CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services or integrated community supports .

Individual-Directed Goods must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements".

Allowable Expenditures: Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. Individual-directed goods and services also covers special diets and thickening agents not otherwise available through the State plan that mitigate the participant's disability or condition when prescribed by a physician who is enrolled as a MHCP provider.

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.
**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow

both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

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

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

Unallowable Expenditures. Goods and services that shall not be purchased within the participant's budget are:
• Any fees incurred by the participant such as MHCP fees and co-pays;
• Attorney costs or costs related to advocate agencies;
• Room and board and personal items;
• CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual/Vendor as selected by the participant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports (CDCS): Individual-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual/Vendor as selected by the participant

Provider Qualifications

License *(specify):*

Valid business license in good standing, if applicable

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

All individuals/vendors providing individual-directed goods and services must be able to:
(1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and
(2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

Private individuals may be designated to provide transportation when they meet the participant's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant's actual and projected use of the health club or fitness center. Participants must periodically provide verification to the lead agency that they are using the health club or fitness center

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of individual-directed goods and services.

Frequency of Verification:

Upon purchase of goods/services

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports (CDCS): personal assistance

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

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

-Assistance with activities of daily living
-Assistance with instrumental incidental activities of daily living (i.e. meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal assistance services
-Caregiver relief

The participant or his/her designated representative, as applicable, is the employer of the worker providing personal assistance services. These workers are recruited, selected, employed, and managed by the participant or his/her representative. As described in Appendix E, supports are available to assist the participant or his/her with employer-related responsibilities through the Financial Management Services (FMS) provider.

Services provided under CDCS personal assistance are provided on a one-to-one basis unless the 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. Each participant's lead agency must authorize the use of shared services based on a determination that the shared service is appropriate to meet the assessed needs of its participant.

Participants sharing services must use the same provider of financial management services (FMS) to ensure program integrity and simplify the processing of worker timesheets. 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 while receiving customized living services or integrated community supports.

Services provided under Personal Assistance must meet the additional waiver requirements listed in “Additional Waiver Information and Requirements”.

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

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

and
• whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Shared services cannot be provided:
• To more than three participants by one worker at one time;
• When more than one worker is providing services at the same time to participants who are sharing personal assistance services; or
• For a child care program licensed under chapter 245A or operated by a local school district or public school.

Unallowable Expenditures. Services under Personal Assistance that shall not be purchased within the participant's budget are:
• Attorney costs or costs related to advocate agencies;
• Insurance except for insurance costs related to direct support worker employee coverage;
• CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Vacation expenses other than the cost of direct services;
• Tickets and related costs to attend sporting or other recreational events;
• Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS - environmental modifications and provisions, CDCS - environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CDCS Worker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports (CDCS): personal assistance

Provider Category:

Individual

Provider Type:

CDCS Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CDCS Workers must meet the following qualifications:
a. Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
b. Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
c. Receive customized training provided by the participant and/or his/her representative
d. Be able and willing to provide the service-related responsibilities outlined in the participant's support plan

Providers of CDCS-Personal Assistance excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must meet the requirements of: section 245D.06, regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or authorized representative if designated as the employer of the worker, and the FMS provider determine if the worker has met minimum qualifications.

Frequency of Verification:

At time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports (CDCS): Support Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS support planning is an optional service that is available to help participants develop and implement their person-centered CDCS Community Support Plan. The cost of support planning services is included in the individual's budget.

When selected, support planning services are provided by certified CDCS support planners. The CDCS support planner is selected by the participant.

CDCS support planning services include tasks outlined in the written work agreement between the support planner and the person.

Tasks could include, but are not limited to:
•Providing information about CDCS and provider options
•Applying person-centered thinking and planning principles to facilitate the development of a person-centered CDCS support plan
•Developing a quality CDCS support plan that includes all required components and information required to authorize CDCS services
•Ensuring the CDCS support plan is developed based on assessed needs identified in the person's assessment
•Submitting the CDCS support plan to the lead agency for approval
•Implementing, monitoring and evaluating the approved CDCS support plan and budget on an ongoing basis
•Modifying the CDCS support plan as needed, including revisions and addendums
•Helping and teaching the person to recruit, screen, hire, train, schedule and monitor workers
•Providing information about community resources related to the CDCS support plan.

A CDCS support planner performs support planning services according to established CDCS policy, self-direction principles, federally approved waiver plans and the written work agreement established between the individual and the support planner. The CDCS support planner helps the individual comply with DHS policies, waiver regulations and all applicable Minnesota rules and statutes.

A CDCS support planner must ensure that support planning service are provided within the scope of DHS support planner service standards and are related to an approved CDCS Support Plan (CSP). The CDCS support planner must also ensure that support planning services do not duplicate services provided under CDCS required case management or other services available to the person (e.g., services provided by certified assessors, FMS providers, Office of the Ombudsman, advocacy organizations, free civil legal assistance with appeals and other direct services covered under Minnesota Health Care Programs).

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

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

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support

includes responding to a person's health , safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited);
• ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

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

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

CDCS Support planners cannot:
• Be the employer of people or legal representatives to whom they are delivering support planning services
• Be the parent of a minor child or spouse of the person receiving services
• Have any direct or indirect financial interest in the delivery of the services in the CSP beyond support planning (e.g., a person receiving payment to help develop a support plan cannot employ others or hire independent contractors to deliver services and supports, even if chosen by the CDCS participant).

A parent of a minor or adult, spouse or legal representative can provide many of the same types of support to the person that a support planner can provide. However payment for support plan activities cannot be made to a parent of a minor or adult, spouse, or legal representative.

Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CDCS Support Planners

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports (CDCS): Support Planning

Provider Category:

Individual

Provider Type:

CDCS Support Planners

Provider Qualifications

License *(specify):*

Certificate *(specify):*

For initial certification, a person must:
•Be at least 18 years old
•Complete a minimum of six hours of person-centered planning coursework within three years before taking the initial certification test
•Successfully pass the Support Planner Initial Certification for CDCS test (TrainLink course DS651) with at least 80% correct.

A CDCS Support planner must be recertified every two years. A CDCS support planner must:
•Complete and document 20 hours of training or education if providing support planning services to more than one family.
•Successfully pass the Support Planner Recertification for CDCS test (TrainLink course DS651C) with at least 80% correct.

Support planners must maintain their own training documentation. This documentation must include:
•Name of the trainer
•Course outline
•Course objectives
•Length of training.
Documentation of training is subject to DHS audit.
A person providing support planning services (i.e. CDCS support planners) must:
• Comply with the DHS support planning service standards
• Establish a written work agreement with the person outlining the tasks they are hired to perform
• Provide a copy of the training certificate to the person/legal representative and lead agency, as requested
• Provide evidence they meet any additional required training and qualifications requested by the person and defined in the CSP
• Coordinate services with the lead agency (i.e., case manager/care coordinator) to ensure there is no duplication of functions/tasks
• Have effective written communication skills sufficient to write a CSP that includes all required components.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS is responsible for verifying the qualifications of support planners.

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports : Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Financial management services (FMS) provide help with financial tasks, billing and employer-related responsibilities for people who self-direct their services through consumer directed community supports (CDCS). These services are provided by financial management services (FMS) providers.

FMS providers perform vendor fiscal/employer agent (VF/EA) tasks. This means the FMS provider's role is to support the person to fulfill his/her responsibilities in being the employer of his/her workers. The FMS provider's tasks include:
• Billing DHS and paying vendors or the person's individual workers for authorized goods and services
• Ensuring what the person spends his/her funds on follows the rules of the program and the lead-agency-approved plan
• Helping the person obtain workers' compensation
• Educating the person on how to employ workers
• Documenting and reporting all spending of program funds
• Initiating background studies for workers
• Filing federal and state payroll taxes for workers on the person's behalf

Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

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

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

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

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• respect and maintain the person's privacy at all times, including when the person is in settings typically used by the

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

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

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

The FMS provider may not in any way limit or restrict the participant's choices of services or support providers. Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Financial Management Services Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports : Financial Management Services

Provider Category:
Individual
Provider Type:

Financial Management Services Providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable.

The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.
The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.
The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participant's CDCS support plan approved by the lead agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports: self-direction support activities

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

CDCS: self-direction support activities is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. CDCS: self-direction support activities includes services, supports, and expenses incurred for administering or assisting the participant or their representative in administering CDCS. The following are typically covered under this category:

- Liability insurance and workers compensation
- Payroll expenses including FICA, FUTA, SUTA, and wages, processing fees
- Employer shares of benefits
- Assistance in securing and maintaining workers
- Development and implementation of the support plan
- Monitoring the provision of services

Support planner services are covered under this CDCS category. Participants may select who they want to provide this service. People reimbursed through CDCS to assist with the development of the participant's person-centered support plan must: be 18 years of age or older; pass a certification test developed by the department on person-centered support planning approaches including the Vulnerable Adult and Maltreatment of Minors Acts; provide a copy of their training certificate to the participant; use the support plan template or a support plan format that includes all of the information required to authorize CDCS and, be able to coordinate their services with the lead agency case manager to assure that there is no duplication between functions. Participants may require additional provider qualifications tailored to their individual needs. These will be defined in the participant's support plan. The provider must provide the participant or the participant's representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

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.

Criteria for allowable expenditures

The Purchase of goods and service must meet all of the following criteria:
1. An individual written support plan must be developed for each participant. Services included in the support plan must be necessary to meet a need identified in the participant’s assessment, related to the participant’s disability, and be for the direct benefit of the participant. 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.
2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Services not included in the 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 that 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 support plan. Services included in the 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

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively

involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

TRANSITION PLAN: CDCS: self-direction support activities under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS: self-direction support activities will be replaced by CDCS: financial management services and CDCS: support planning. No new authorizations for CDCS: self-direction support activities will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: self-direction support activities for a participant who was not previously receiving CDCS: self-direction support activities before December 2023.

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 who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• 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.

Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services (FMS) providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: self-direction support activities

Provider Category:

Agency

Provider Type:

Financial Management Services (FMS) providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a support plan for participants who are purchasing financial management services from them.

A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse, legal guardian or conservator can receive payment for support plan activities.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

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

The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and

report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.

The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participant's CDCS support plan approved by the lead agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports: environmental modifications - vehicle modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

CDCS: environmental modifications: - vehicle modifications can be purchased in a consumer-directed manner within a global budget. See Appendix E. CDCS:- environmental modifications: - vehicle modifications are physical adaptations to the participant's primary vehicle, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence.

Examples of adaptations include adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions, wheelchair securing devices. The service may also cover installation, maintenance and repairs of vehicle modifications, and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

For CDCS Environmental environmental modifications (both home and vehicle) the participant must pay the first $5,000 from their CDCS budget during the service agreement/waiver year of the expenditure(s). Regardless of the number of modifications items needed during the plan year, the participant's annual contribution is limited to $5,000. If a participant chooses to use more than $5,000 from their budget to pay for home or vehicle modifications, they can choose to do so.
* Costs exceeding $5,000 (for both home and vehicle modifications combined) may be negotiated with the county of financial responsibility and provided outside of the participant's individual budget. The county of financial responsibility may authorize additional funding for modifications within the lead agency's overall waiver allocation.

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services or integrated community supports .

Environmental modifications must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements"

Additionally, CDCS-Environmental modifications: Vehicle modifications can cover maintenance of vehicle modifications (i.e. wheelchair lift).

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

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

CDCS: -environmental modifications: - vehicle modifications cannot cover general vehicle maintenance.

CDCS-Environmental Modifications (both home and vehicle modifications combined) 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 at least two comparison bids are received and:
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.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers of environmental modifications: - vehicle modifications
Agency	Providers of environmental modifications: - vehicle modifications

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: environmental modifications - vehicle modifications

Provider Category:

Individual

Provider Type:

Providers of environmental modifications: - vehicle modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS: environmental modifications – vehicle modifications must bill through the financial management services (FMS) provider.
Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of environmental modifications – vehicle modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: environmental modifications - vehicle modifications

Provider Category:

Agency

Provider Type:

Providers of environmental modifications: - vehicle modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing CDCS: environmental modifications – vehicle modifications must bill through the financial management services (FMS) provider.
Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of environmental modifications – vehicle modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports: environmental modifications and provisions

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

CDCS: environmental modifications and provisions are one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. CDCS: environmental modifications and provisions include supports, services, and goods provided to the participant to maintain a physical environment that assists the person to live in and participate in the community or are required to maintain health and wellbeing. The following are typically covered under this category:

- Assistive technology*
- Home and vehicle modifications*
- Environmental supports (snow removal, lawn care, heavy cleaning)
- Supplies and equipment
- Special diets
- Adaptive clothing
- Transportation
- For adults, costs related to health clubs and fitness centers

* Costs exceeding $5,000 may be negotiated with the county of financial responsibility and provided outside of the participant's individual budget. The county of financial responsibility may authorize additional funding for assistive technology and home and vehicle modifications within the lead agency's overall waiver allocation.

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.

Criteria for allowable expenditures

The purchase of goods and service must meet all of the following criteria:
1. An individual written support plan must be developed for each participant. Services included in the support plan must be necessary to meet a need identified in the participant’s assessment, related to the participant’s disability, and be for the direct benefit of the participant. 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.
2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Services not included in the 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 support plan. Services included in the 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

TRANSITION PLAN: CDCS: environmental modifications and provisions under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS: environmental modifications and provisions will be replaced by CDCS: environmental modifications-home modifications, CDCS: environmental modifications-vehicle modifications and CDCS: individual-directed goods and services. No new authorizations for CDCS: environmental modifications and provisions will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: environmental modifications and provisions for a participant who was not previously receiving CDCS: environmental modifications and provisions before December 2023.

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 who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
• 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.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Services (FMS) providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: environmental modifications and provisions

Provider Category:

Agency

Provider Type:

Financial Management Services (FMS) providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a support plan for participants who are purchasing financial management services from them.

A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse, legal guardian or conservator can receive payment for support plan activities.
Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Transportation. Standards for common carrier transportation are bus, taxicab, other commercial carrier, or county owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the participant's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

Fitness and Exercise. Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant's actual and projected use of the health club or fitness center. Participants must periodically provide verification to the lead agency that they are using the health club or fitness center.

People or organizations paid to assist in developing the support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a support plan for participants who are purchasing financial management services from them.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP and MCO funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the support plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set

up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, or environmental modifications and provisions provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's support plan.

The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.

The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participant's CDCS support plan approved by the lead agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

specified in statute.

Service Title:

Consumer-directed community supports: environmental modifications – home modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

CDCS: environmental modifications: - home modifications can be purchased in a consumer-directed manner within a global budget. See Appendix E. CDCS: environmental modifications: home modifications include modifications or items to maintain the person's home that assists the person to live in and participate in the community or are required to maintain health and wellbeing. For purposes of home modifications, "home" refers to the participant's primary place of residence (i.e., not vacation homes).

The following are are covered under this category:
- Home modifications
- Monitoring Technology

For CDCS environmental modifications (both home and vehicle) the participant must pay the first $5,000 from their CDCS budget during the service agreement/waiver year of the expenditure(s). Regardless of the number of modifications items needed during the plan year, the participant's annual contribution is limited to $5,000. If a participant chooses to use more than $5,000 from their budget to pay for home or vehicle modifications, they can choose to do so.
Costs exceeding $5,000 (for both home and vehicle modifications combined) may be negotiated with the county of financial responsibility and provided outside of the participant's individual budget. The county of financial responsibility may authorize additional funding for monitoring technology and home modifications within the lead agency's overall waiver allocation.

Monitoring technology is defined as monitoring or surveillance systems* including cameras, motion detectors, GPS trackers, home security systems, and door and window alarms. A CDCS participant that wants to use their funds to purchase monitoring technology must follow service guidelines for monitoring technology usage as described in "Environmental Accessibility Adaptations - home modifications" as follows:

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

(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
(2) the Minnesota Government Data Practices Act as codified in 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, § 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 supervision technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant's needs are met by alternative means.

(4) The use of environmental accessibility adaptations 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 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, concealed cameras, and auto door or window locks are not allowed.

(10) the State must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs.

(11) electronic video and audio recordings of participants shall be stored for five days unless:
(i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or
(ii) the recording captures an incident or event of alleged maltreatment under Minnesota Statutes, section 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 Minnesota Statutes, section 626.557, subdivision 12b

CDCS services are not available to waiver participants receiving licensed foster care while residing in a residential setting licensed by the Department of Human Services (DHS) or while receiving customized living services or integrated community supports.

Environmental modifications: home modifications must meet the additional waiver requirements listed in "Additional Waiver Information and Requirements".

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

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

Unallowable Expenditures. Environmental modifications: home modifications that shall not be purchased within the participant's budget are:
• 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-Environmental Modifications (both home and vehicle modifications combined) 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 at least two comparison bids are received and:
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.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers of environmental modifications : - home modifications
Agency	Providers of environmental modifications : - home modifications

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: environmental modifications – home modifications

Provider Category:
Individual
Provider Type:

Providers of environmental modifications : - home modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing environmental modifications: - home modifications must bill through the financial management services (FMS) provider.
Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Home modifications must meet building codes and be inspected by the appropriate building authority.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of environmental modifications – home modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: environmental modifications – home modifications

Provider Category:

Agency

Provider Type:

Providers of environmental modifications : - home modifications

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing environmental modifications: - home modifications must bill through the financial management services (FMS) provider.
Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Home modifications must meet building codes and be inspected by the appropriate building authority.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of environmental modifications – home modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-directed community supports: treatment and training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11130 other therapies

Service Definition *(Scope):*

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

CDCS: treatment and training is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. Treatment and training includes a range of services that promote the participant's ability to live in and participate in the community. Providers must meet the certification or licensing requirements in state law related to the service. The following are typically covered under this category:

- Specialized health care
- Extended therapy treatment
- Habilitative services
- Day services/programs
- Training and education to paid or unpaid caregivers
- Training and education to participants to increase their ability to manage CDCS services

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.

Criteria for allowable expenditures

The purchase of goods and service must meet all of the following criteria:
1. An individual written support plan must be developed for each participant. Services included in the support plan must be necessary to meet a need identified in the participant’s assessment, related to the participant’s disability, and be for the direct benefit of the participant. 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.
2. The waiver shall cover only those goods and services authorized in the support plan that collectively represent a feasible alternative to institutional care. Services not included in the 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 consumer outcomes:
• Maintain the ability of the participant to remain in the community;
• Enhance community inclusion and family involvement;
• Develop or maintain personal, social, physical, or work related skills;
• Decrease dependency on formal support services;
• Increase independence of the participant;
• Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

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 that 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 support plan. Services included in the 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.
• FSE 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

Within six months from the date of final approval of the CADI waiver renewal (#0166.R07.00), Minnesota will submit amendments for our HCBS waivers proposing modifications to our CDCS service categories to comply with the requirements set forth in 42 C.F.R. § 441.301(b)(4) by unbundling services.

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. Services under treatment and training that shall not be purchased are:
• Services available through other funding sources
• Any fees incurred by the participant such as MHCP fees and co-pays;
• Experimental treatments;
• All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
• Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through CDCS: environmental modifications and provisions, CDCS: environmental modifications – home modifications, environmental accessibility adaptations – home modifications, or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of treatment and training
Individual	Providers of treatment and training

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consumer-directed community supports: treatment and training

Provider Category:

Agency

Provider Type:

Providers of treatment and training

Provider Qualifications

License *(specify):*

Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the service being provided.

Providers of training and education must meet the qualifications as specified in the participant's CDCS Support Plan. For services and supports that do not require professional licensing, credentialing, or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing specialized therapies, behavioral supports, or training and education to caregivers or participants CDCS must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of treatment and training

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer-directed community supports: treatment and training

Provider Category:

Individual

Provider Type:

Providers of treatment and training

Provider Qualifications

License *(specify):*

Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the service being provided.

Providers of training and education must meet the qualifications as specified in the participant's CDCS Support Plan. For services and supports that do not require professional licensing, credentialing, or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Certificate *(specify):*

Other Standard *(specify):*

People or entities providing specialized therapies, behavioral supports, or training and education to caregivers or participants CDCS must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies are responsible for verifying the qualifications of providers of treatment and training

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Crisis Respite

HCBS Taxonomy:

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

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

Service Definition *(Scope):*

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

Crisis-respite services are specialized services that provide short-term care and intervention to a participant 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 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 (for up to five people) 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 or licensed community residential setting (for up to five people) 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 or licensed community residential setting 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 to DHS on a weekly basis for review and approval of the continued need for crisis respite to be provided in a licensed hotel.

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 assessed and determined 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 support plan must occur within five working days of receiving crisis-respite services. However, no Medicaid payment will be made if the assessment process determines that the individual is not eligible for home and community-based services. The assessment 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.

Crisis respite, remote support, is the following:
Remote support is the provision of crisis respite by a staff or caregiver from a remote location who is engaged with a

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	In-home crisis respite providers
Agency	Out-of-home crisis respite providers
Individual	Out-of-home crisis respite providers
Agency	In-home crisis respite providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Respite

Provider Category:

Individual

Provider Type:

In-home crisis respite providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Respite

Provider Category:

Agency

Provider Type:

Out-of-home crisis respite providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Out-of-home crisis respite providers must deliver the service in one of the following licensed facilities:
- Minnesota Rules, parts 9555.5050 to 9555.6265
- Minnesota Statutes, sections 245D.21 to 245D.26
- Minnesota Rules, parts 2960.3000 to 2960.3340

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 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Respite

Provider Category:

Individual

Provider Type:

Out-of-home crisis respite providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Out-of-home crisis respite providers, must deliver the service in one of the following licensed facilities:
- Minnesota Rules, parts 9555.5050 to 9555.6265
- Minnesota Statutes, sections 245D.21 to 245D.26
- Minnesota Rules, parts 2960.3000 to 2960.3340

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 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Respite

Provider Category:

Agency

Provider Type:

In-home crisis respite providers

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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 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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Customized Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**

05 Nursing	05020 skilled nursing

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

02 Round-the-Clock Services	02033 in-home round-the-clock services, other

Service Definition *(Scope):*

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

Customized living (CL) services are provided to adults, as defined in the following section:

• in congregate settings by the management of the setting or a provider under contract with the management of the setting through July, 31, 2021;
• effective Aug. 1, 2021: in a licensed assisted living facility; or
• effective Aug. 1, 2021: in an affordable housing setting as defined under Minnesota Statutes, section 256S.20, subd. 1 or subsequent provisions.

In order for customized living services to be covered by the waiver, participants must have an individualized service plan based on their documented needs. This is a separate and distinct plan from the support plan developed with the case manager that includes all waiver services.

The participant must be given the opportunity to accept, revise, or reject the service plan and the case manager determines whether the plan is approved as part of the participant's overall support plan. Service plans that contain supervision of the participant must include documentation of the participant's specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact will occur. Service plans must also document whether or not there is a need for 24-hr supervision of the participant and whether or not 24-hour supervision is included in the CL plan.

Individualized CL services may include supervision, home care aide tasks (e.g., assistance with activities of daily living), home health aide tasks (e.g., delegated nursing tasks), home management tasks, meal preparation and service, socialization, assisting participants with arranging meetings and appointments, assisting participants with money management, assisting participants with scheduling medical and social services, and arranging for or providing transportation. If socialization is provided, it must be part of the service plan, related to established goals and outcomes and not diversional or recreational in nature. CL providers must make available, and if authorized, provide meal preparation adequate to meet the nutritional needs of participants as defined by current FDA guidelines.

Central storage of medication, administration of medications, medication set-up, individualized home health aide tasks, home health aide-like tasks, and delegated nursing tasks may be provided as allowed by assisted living facility or home care licensure.

Providers must furnish each participant with a means to effectively summon assistance. Staff in the congregate living setting who are providing supervision, oversight and supportive services must have: experience and/or training in caring for individuals with functional limitations; the physical ability to provide the services identified in the participant's service plan; and, if they provide transportation, they must have a valid driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Rules, Part 9505.0315 and 8840.6000.

In addition staff must be able to:
- work under intermittent supervision
- communicate effectively
- read, write, and follow written and verbal instructions
- follow participant's individualized service plans
- recognize the need for and provide assistance or arrange for appropriate assistance
- identify and address emergencies including calling for assistance
- understand, respect, and maintain confidentiality

Staff providing supervision must also:
- Work onsite in the customized living setting
- Have their primary work responsibility be the supervision of participants in the customized living setting
- Have an on-going awareness of the participant's needs and activities
- Be able to respond in-person to a participant within a time frame that meets the participant's needs and that does not exceed ten minutes.

Participants of customized living services cannot be employed to provide customized living services.

This amendment (#0166.R07.06) will not have the effect of restricting the provider pool that is available to meet the

needs of the individuals currently receiving customized living services as well as those individuals who demonstrate the need for customized living services.

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

Homemaking and chore services are integral to customized living. For participants receiving customized living services, homemaking, integrated community supports, community residential services, family residential services, chore, and respite services are not covered as separate waiver services. For participants receiving services that include 24-hour supervision, personal emergency response systems and home monitoring devices are not covered under specialized equipment and supplies.

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.

To support customized living participants and providers to transition to integrated community supports, this location limit does not apply to customized living settings that were in existence and providing customized living services to a waiver participant in the setting on January 11, 2021 and plan to transition to integrated community supports settings by December 31, 2023. Provided means that the customized living service was an approved service for a participant in the setting on or prior to January 11, 2021. The customized living provider transitioning to integrated community supports must fully comply with the integrated community supports setting requirements and HCBS settings rule requirements including the location requirements for the setting by December 31, 2023.

Customized living services cannot be delivered in settings where integrated community supports are delivered.

Customized living services must be delivered to adults, aged 18 years or older. Customized living settings serving people younger than 55 years of age must comply with the total number of individuals living in the setting requirements as defined in the provider qualifications for this service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home care providers (effective through July 31, 2021)
Agency	Minnesota Department of Health Assisted Living Facility Licensed Providers (effective Aug. 1, 2021)
Agency	Minnesota Department of Health Comprehensive Home Care Licensed Providers (effective Aug. 1, 2021)

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Customized Living

Provider Category:

Agency

Provider Type:

Home care providers (effective through July 31, 2021)

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Home care providers must also be registered under Minnesota Statutes §144D, Housing with Services Registration Act as a registered housing with services establishment.

Customized living service providers who provide services in settings with one to five residents, and are not licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 (adult foster care) or Minnesota Statutes, sections 245D.21 to 245D.26 must comply with Minnesota Rules, parts 9555.6205, subparts 1 to 3, parts 9555.6215, subparts 1 and 3, and parts 9555.6225, subparts 1,2,6 and 10.

The total number of individuals living in the setting shall not exceed four except when authorized by the commissioner. The commissioner may authorize services when:

- a person is being discharged from or otherwise would be placed in a nursing facility, intermediate care facility, or hospital and the customized living service is the only available option in the person's home community. The people in the setting who receive services under the BI, CAC, CADI and DD waivers can occupy up to 25% of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Person with AIDS Program; or
- they are 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 adult siblings together

This limit does not apply to settings that have continuously provided this service to a waiver participant prior to May 1, 2001. Provided means that this was an approved service for a participant in the setting on or prior to May 1, 2001. This size restriction does not apply to people who are 55 years of age or older. Beginning Jan. 11, 2021, new customized living settings are limited to serving people aged 55 and older. As outlined in Minnesota's Home and Community-Based Settings Statewide Transition Plan, customized living settings operational on Jan. 10, 2021 may continue to deliver customized living services. Customized living settings operational on Jan. 10, 2021 must comply with the total number of individuals living in the setting requirements.

To support residential care participants and providers to transition to customized living: this limit also does not apply to settings that have continuously provided the residential care service to a waiver participant prior to July 1, 2000. Provided means that the residential care service 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. Residential care service will be discontinued effective June 30, 2018. The residential care provider transitioning to customized living must comply with HCBS settings rule requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health.

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

As scheduled by Minnesota Department of Health. Providers must renew their license annually.

Enrolled providers: every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized Living

Provider Category:

Agency

Provider Type:

Minnesota Department of Health Assisted Living Facility Licensed Providers (effective Aug. 1, 2021)

Provider Qualifications

License *(specify):*

Minnesota Department of Health assisted living facility license in accordance with Minnesota Statutes, Chapter 144G.

Certificate *(specify):*

Other Standard *(specify):*

Customized living service providers who provide services in settings with one to five residents, and are not licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 (adult foster care) or Minnesota Statutes, sections 245D.21 to 245D.26, must comply with Minnesota Rules, parts 9555.6205, subparts 1 to 3, parts 9555.6215, subparts 1 and 3, and parts 9555.6225, subparts 1,2,6 and 10.

The total number of individuals living in the setting shall not exceed four except when authorized by the commissioner. The commissioner may authorize services when:
-- a person is being discharged from or otherwise would be placed in a nursing facility, intermediate care facility, or hospital and the customized living service is the only available option in the person's home community. The people in the setting who receive services under the BI, CAC, CADI and DD waivers can occupy up to 25% of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Person with AIDS Program; or
-- they are 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 May 1, 2001. Provided means that this was an approved service for a participant in the setting on or prior to May 1, 2001. This size restriction does not apply to people who are 55 years of age or older. Beginning Jan. 11, 2021, new customized living settings are limited to serving people aged 55 and older. As outlined in Minnesota's Home and Community-Based Settings Statewide Transition Plan, customized living settings operational on Jan. 10, 2021 may continue to deliver customized living services. Customized living settings operational on Jan. 10, 2021 must comply with the total number of individuals living in the setting requirements.

To support residential care participants and providers to transition to customized living: this limit also does not apply to settings that have continuously provided the residential care service to a waiver participant prior to July 1, 2000. Provided means that the residential care service 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. Residential care service was discontinued effective June 30, 2018. The residential care provider transitioning to customized living must comply with HCBS settings rule requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health
Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

As scheduled by Minnesota Department of Health. Providers must renew their license annually.
Enrolled providers: every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized Living

Provider Category:

Agency

Provider Type:

Minnesota Department of Health Comprehensive Home Care Licensed Providers (effective Aug. 1, 2021)

Provider Qualifications

License *(specify):*

Minnesota Department of Health comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Must deliver services in an affordable housing setting defined under:
• Minnesota Statutes, section 144G.08, subdivision 7, paragraphs 11-13; or
• Minnesota Statutes, section 256S.20, subdivision 1 or subsequent provisions.

Customized living service providers who provide services in settings with one to five residents, and are not licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 (adult foster care) or Minnesota Statutes, sections 245D.21 to 245D.26, must comply with Minnesota Rules, parts 9555.6205, subparts 1 to 3, parts 9555.6215, subparts 1 and 3, and parts 9555.6225, subparts 1,2,6 and 10.

The total number of individuals living in the setting shall not exceed four except when authorized by the commissioner. The commissioner may authorize services when:
-- a person is being discharged from or otherwise would be placed in a nursing facility, intermediate care facility, or hospital and the customized living service is the only available option in the person's home community. The people in the setting who receive services under the BI, CAC, CADI and DD waivers can occupy up to 25% of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Person with AIDS Program; or
-- they are 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 May 1, 2001. Provided means that this was an approved service for a participant in the setting on or prior to May 1, 2001. This size restriction does not apply to people who are 55 years of age or older. Beginning Jan. 11, 2021, new customized living settings are limited to serving people aged 55 and older. As outlined in Minnesota's Home and Community-Based Settings Statewide Transition Plan, customized living settings operational on Jan. 10, 2021 may continue to deliver customized living services. Customized living settings operational on Jan. 10, 2021 must comply with the total number of individuals living in the setting requirements.

To support residential care participants and providers to transition to customized living: this limit also does not apply to settings that have continuously provided the residential care service to a waiver participant prior to July 1, 2000. Provided means that the residential care service 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. Residential care service was discontinued effective June 30, 2018. The residential care provider transitioning to customized living must comply with HCBS settings rule requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health
Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

As scheduled by Minnesota Department of Health. Providers must renew their license annually.
Enrolled providers: every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Day Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day Support Services are individualized, home and community-based services (HCBS) that provide opportunities for community-based training and support for people with disabilities. Day Support Services develop and maintain essential and personally enriching life skills to ensure that people with disabilities can fully access and participate in personally preferred activities within their community.

Day Support Services can provide training, supervision and support in the following essential life skills:
•Community access, mobility, well-being and safety
o Use of various community resources
o Street safety
o Use of public and private transportation
o Self-preservation
•Independent living
•Therapeutic intervention activities or accommodations to increase adaptive skill functioning
•Money management and budgeting
•Communication
•Socialization - Social skills development and relationship building
o Assertiveness
o Self-advocacy
o Self-direction and goal setting
o Interest-based decision-making
o Active listening
o Empathy
o Problem-solving/conflict-resolution
•Positive behavior and mental health support
o Self-care (e.g., proper hygiene, grooming, physical appearance and dress/attire)
o Personal health and wellness

Day Support Services can provide learning opportunities and support in the following life enriching activities:
•Exploring community activities and discovering personal preferences
•Discovering and supporting participation in preferred recreational and fitness activities
•Identifying and supporting participation in preferred leisure and hobby activities
•Facilitating opportunities and supporting participation in community civic events of interest
•Arranging and providing assistance with preferred volunteer work experiences
•Finding and supporting participation in preferred educational or training courses in the community
•Connecting with and teaching use of various community resources
•Establishing informal supports in the community
•Developing and strengthening personal relationships with preferred people in the community.

Day Support Services must be person-centered and provide individualized assessment and planning that assists people with identifying essential life skill needs and discovering life enriching activities. Day Support Service provider documentation and reporting must indicate that services and supports are achieving desirable and measurable outcomes specified in the person's support plan. Person-centered outcomes could include:
•Skill development
•Increasing participation in new community experiences
•Exploration and discovery of personally preferred community activities or events
•Increasing independent participation in personally preferred community activities or events
•Increasing independent participation in preferred volunteer work experiences
•Increasing independent participation in preferred educational or training courses in the community
•Increasing contact and involvement with preferred people in the community

Day Support Service providers can plan, initiate and deliver services and supports from non-residential HCBS site settings (i.e., separate from the person's home) or public settings in the community as described in the person's support plan. Day Support Services can be provided to a participant in their own home, family home or licensed residential setting if:
•The day service facility or community cannot be accessed due to community emergency or disaster
•Accessing the day service facility or community puts a person's health and safety at risk

Day Support Service staff supervision and service support ratios must comply with staffing ratios in Minnesota

Statutes, section 256B.4914.

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

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

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

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

…

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

Day Support Services are not physical, occupational, sensorimotor, speech-language-communication or cognitive rehabilitation therapies. However, Day Support Services shall be coordinated with and support any physical, occupational, sensorimotor, speech-language-communication and cognitive rehabilitation therapies in the person's support plan.

Day Support Services do not include Employment Exploration Services, Employment Development Services, Employment Support Services, Prevocational Services, Adult Day Services, Individualized Home Supports (with Training and without Training) or Positive Supports.

Participants receiving Day Support Services can also choose to receive Employment Exploration Services, Employment Development Services, Employment Support Services, Prevocational Services, Adult Day Services, Individualized Home Supports (with Training and without Training) or Positive Supports.

Day Support Services must be authorized and reimbursed on a 15-minute unit basis when Employment Exploration Services, Employment Development Services, Employment Support Services, Prevocational Services, Adult Day Services, Individualized Home Supports (with Training and without Training) are also provided during the same day.

Day Support Services must not be provided simultaneously (during the same period of the day) as Employment Exploration Services, Employment Development Services, Employment Support Services, Prevocational Services, Adult Day Services, Independent Living Skills Training Services, Individualized Home Supports (without training, with training, with family training), and Personal Support Services, with the exception of indirect support provided through Employment Exploration Services, Employment Development Services, and Employment Support Services.

Day Support Services must not involve:
- Finding and maintaining paid employment in the community;
- Working at paid jobs in the community; or
- Performing center-based, paid work in a Prevocational Service provider's facility.

People receiving Day Support Services can choose to explore, pursue and work at competitively paid employment opportunities in community businesses at any time via Employment Exploration Services, Employment Development Services and Employment Support Services.

Day Support Service rates include in-service transportation costs. Transportation services occurring between the person's place of residence and the day support service site are not covered as part of this service. These transportation billing claims are reimbursed separately as transportation services under the waiver.

When day support services are provided in a participant's own home, family home or licensed residential setting, the provider of day support services must be different than the residential service(s) provider. 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 on or 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 on or after July 1, 2019, which deliver any of the following services: adult day services, day support services, day training and habilitation, prevocational services, structured day services, adult and child foster care, community residential services, customized living, family residential services, integrated community supports and residential habilitation.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies.

Remote support does not include the use of cameras in bathrooms.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who meet the service standards for day supports
Agency	Agencies that meet the service standards for day supports

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Support Services

Provider Category:

Individual

Provider Type:

Individuals who meet the service standards for day supports

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Support Services

Provider Category:

Agency

Provider Type:

Agencies that meet the service standards for day supports

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Employment Development Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

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 should not exceed 120 days of service delivery);
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

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.

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

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

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;

• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

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

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

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.).
- 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. This limit does not restrict service provider board members or employees from connecting people to employment opportunities through personal contacts in community businesses.

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 conditions or life events that hinder employment, etc.) or service 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.
- Individualized assessment and person-centered discovery experiences should not exceed 120 days of service delivery.

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.
- Employment support services, day 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 direct-time employment development 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 waiver transportation services and are not covered as part of employment development services.

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 micro-enterprise 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 for employment development 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).
• 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.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers that meet the service standards for employment development services
Individual	Providers who meet the service standards for employment development services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Development Services

Provider Category:

Agency

Provider Type:

Providers that meet the service standards for employment development services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.
Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Employment Development Services

Provider Category:

Individual

Provider Type:

Providers who meet the service standards for employment development services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.
Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Exploration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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 positions within 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.

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.

Employment exploration services, remote support, is the following:
Remote support is the provision of employment exploration services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);

• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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.
- 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. This limit does not restrict service provider board members or employees from connecting people to employment opportunities through personal contacts in community businesses.

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:
  - When a person is interested in actively seeking competitively paid employment and starts receiving employment development services; or
  - When a person obtains competitively paid employment; or
  - After a maximum of 12 months of receiving 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 service provider change, debilitating health conditions or life events that significantly hinder 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 group employment support services, day training and habilitation services (DT&H), prevocational services, structured day services or adult day services.
- Individual employment support services cannot be provided when a person is receiving employment exploration services.
- Group employment support services, day 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 direct-time 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 participant's place of residence and the site of service are waiver transportation services and are not covered as part of employment exploration services.

Other Limitations

- Waiver funds for employment exploration 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).

• 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.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers that meet the service standards for employment exploration services
Individual	Providers who meet the service standards for employment exploration services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Exploration Services

Provider Category:

Agency

Provider Type:

Providers that meet the service standards for employment exploration services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.

Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Providers must have the capacity to provide a range of essential informed choice educational activities, learning opportunities, and work experiences.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, Chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Exploration Services

Provider Category:

Individual

Provider Type:

Providers who meet the service standards for employment exploration services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.
Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Providers must have the capacity to provide a range of essential informed choice educational activities, learning opportunities, and work experiences.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, Chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Employment Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**

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 for 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, full-time or part-time, paid job position in the community or through self-employment, with opportunities for interactions with co-workers 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.

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.

Employment support services, remote support, is the following:
Remote support is the provision of employment support services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and

preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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.
- 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. This limit does not restrict service provider board members or employees from connecting people to employment opportunities through personal contacts in community businesses.
- 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:
  - Made to an employer as an incentive for participation in a person's employment support services;
  - Passed through to subsidize a person receiving employment support services;
  - For vocational education and training that is not directly related to a person's employment support services;
  - For routine supervision and support rendered as a normal function of the business setting; or
  - 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 micro-enterprise 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 day training and habilitation (DT&H), prevocational services, structured day or adult day services.
- Other allowable employment services, day 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 direct-time employment support 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 waiver transportation services and are not covered as part of employment support services.
- 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).
- 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.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility

adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers who meet the service standards for employment support services
Agency	Providers that meet the service standards for employment support services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Support Services

Provider Category:

Individual

Provider Type:

Providers who meet the service standards for employment support services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.
Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Employment Support Services

Provider Category:

Agency

Provider Type:

Providers that meet the service standards for employment support services

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. The license holder must ensure staff competency in key areas of knowledge for employment service delivery.
Staff competency in key areas of employment service delivery may be demonstrated through credentials that the Department deems acceptable, such as the Certified Employment Support Professional (CESP) credential or the Direct Support Professional Specialist in Employment Support (DSP-S-ES) credential.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment
Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

Licensing Division: 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.
Provider Enrollment: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations - Home Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental accessibility adaptations - home modifications are physical adaptations to the participant's home, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence. Examples of adaptations include 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, and oversight of the project by an assessment provider to assure ADA requirements or accessibility needs are met. 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). Exceptions to the requirement that home modifications be limited to the participant's primary place of residence, may be authorized by the case manager when the following criteria are met and documented in the participant's support plan. The accessibility adaptation:

1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, lead agencies may authorize home modifications in separate payment amounts:
• Line 1: Materials and permits
• Line 2: Down payment
• Line 3: Completion and inspection, or final payment

If, for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), the lead agency may bill for environmental accessibility adaptation - home modifications as a Medicaid administrative cost.

* (a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:
(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
(2) the Minnesota Government Data Practices Act as codified in chapter 13.
(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, § 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 supervision technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant's needs are met by alternative means.
(4) The use of environmental accessibility adaptations 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 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, concealed cameras, and auto door or window locks are not allowed.
(10) the State must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs.
(11) electronic video and audio recordings of participants shall be stored for five days unless: (i) a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under Minnesota Statutes, section 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 Minnesota Statutes, section 626.557, subdivision 12b.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental accessibility adaptations excludes adaptations or improvements to the home that add to the total square footage of the home or that are not of direct and specific benefit to the participant due to his/her disability, such as carpeting, roof repair, central air conditioning, kitchen and laundry appliances, swimming pools, etc.

For new construction or unfinished rooms in existing homes, the waiver will only pay for the additional costs directly related to the person's disability needs and not the typical costs related to building or finishing a room.

An assessment provider completing an evaluation of the participant's home and collecting comparison bids cannot also bid on the same project unless there are no other install providers within the participant's region as documented by the lead agency in the support plan.

Environmental Accessibility Adaptations (both home and vehicle modifications combined) 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 at least two comparison bids are received and:
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.

When a participant has an approved modification based on requesting additional square footage, the rate maximum does not apply.

Adaptations that add to the total square footage of the home may be covered when it is necessary to build a new or modify an existing bathroom when all of the following criteria are met:
- The accessibility adaptation is necessary to accommodate a wheelchair or scooter.
- The accessibility adaptation is to an unlicensed private residence of the individual and is owned by the individual or a family member.
- The annual waiver and home care costs for the individual, including the cost of the environmental accessibility adaptations, does not exceed the overall waiver and home care costs (minus the cost of the adaptations) projected for the individual in the succeeding 12 month period following the adaptation.
- At least two comparison bids were received.
- An evaluation by an expert in the field of home modifications must be completed to determine whether the accessibility adaptation is necessary based on the health and safety needs identified in the participant's support plan. The expert must have no financial interest in the delivery of the accessibility adaptation.
- The accessibility adaptation is reasonable and is limited to materials that are the least costly and of reasonable standards.

The lead agency will determine whether the above criteria are met and will submit all documentation to the department for the final determination.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Environmental Accessibility Adaptations/Home Modification Assessments

Provider Category	Provider Type Title
Individual	Environmental Accessibility Adaptations/Home Modification Assessments
Individual	Environmental Accessibility Adaptations/Home Modification/Installations (market service)
Agency	Environmental Accessibility Adaptations/Home Modification/Installations (market service)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Home Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
• An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, section 148.6401 to 148.6449
• A Physical Therapist that is licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
• A Certified Aging-in-Place Specialist
• A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industryunder Minnesota Statutes, section 326B.133, subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Home Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
• An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, section 148.6401 to 148.6449
• A Physical Therapist that is licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
• A Certified Aging-in-Place Specialist
• A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industryunder Minnesota Statutes, section 326B.133, subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Home Modification/Installations (market service)

Provider Qualifications

License *(specify):*

Providers who meet the definition of residential building contractor as defined in Minnesota Statutes, Chapter 326B.802, subdivision 11, must be licensed as a residential building contractor.

As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

Limited Install Providers: Providers who do exclusively small install projects, such as grab bars and ramps are excluded from licensure when the skills they perform meet the definition of "special skill" as defined in Minnesota Statutes Chapter 326B.802, subd. 15.

Certificate *(specify):*

Other Standard *(specify):*

The provider must be qualified, by professional certification or references, to install, repair and/or maintain the home modification defined in the participant's support plan. All installations shall be executed in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Home Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Home Modification/Installations (market service)

Provider Qualifications

License *(specify):*

Providers who meet the definition of residential building contractor as defined in Minnesota Statutes, section 326B.802, subdivision 11, must be licensed as a residential building contractor.

As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

Limited Install Providers: Providers who do exclusively small install projects, such as grab bars and ramps are excluded from licensure when the skills they perform meet the definition of "special skill" as defined in Minnesota Statutes, Chapter 326B.802, subd. 15.

Certificate *(specify):*

Other Standard *(specify):*

The provider must be qualified, by professional certification or references, to install, repair, and/or maintain the home modification defined in the participant's support plan. All installations shall be executed in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: Every five years
Non-enrolled providers: Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations - Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Environmental accessibility adaptations – vehicle modifications are physical adaptations to the participant's primary vehicle, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence. Examples of adaptations include adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions, wheelchair securing devices. The service also covers the necessary assessments to determine the most appropriate adaptation or equipment. The service may also cover installation, maintenance and repairs of vehicle modifications, and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

For purposes of the waiver, "vehicle" refers to the participant's primary vehicle. Exceptions to the requirement that vehicle modifications be limited to the participant's primary vehicle may be authorized by the case manager when the following criteria are met and documented in the participant's support plan. The accessibility adaptation:

1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, lead agencies may authorize vehicle modifications in separate payment amounts:
• Line 1: Materials and permits
• Line 2: Down payment
• Line 3: Completion and inspection, or final payment

If, for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), the lead agency may bill for environmental accessibility adaptation – vehicle modification as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Accessibility Adaptations (both home and vehicle modifications combined) 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 at least two comparison bids are received and:
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.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Accessibility Adaptations/Vehicle Installations
Agency	Environmental Accessibility Adaptations/Vehicle Installations
Individual	Environmental Accessibility Adaptations/Vehicle Modification Assessments
Agency	Environmental Accessibility Adaptations/Vehicle Modification Assessments

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Vehicle Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Vehicle Installations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals who provide vehicle installation services must:
-Install equipment according to the manufacturer's requirements and instructions;
-Meet state and federal ADA requirements;
-Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 C.F.R. section 595.7;
-Follow the recommended practices of the Society of Automotive Engineers; and
-Register as a "vehicle modifier" with the National Highway Traffic Safety Administration.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: every five years
Non-enrolled providers: every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Vehicle Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Vehicle Installations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide vehicle installation services must:
-Install equipment according to the manufacturer's requirements and instructions;
-Meet state and federal ADA requirements;
-Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 C.F.R. section 595.7;
-Follow the recommended practices of the Society of Automotive Engineers; and
-Register as a "vehicle modifier" with the National Highway Traffic Safety Administration.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment
Non-enrolled providers: Lead agencies

Frequency of Verification:

Enrolled providers: every five years
Non-enrolled providers: every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Vehicle Modifications

Provider Category:

Individual

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals who provide vehicle modification assessments must meet one of the following:
1) Certified driver rehabilitation specialist
2) Occupational therapist with a specialty certification in driving and community mobility
3) Five years of full time experience in the field of driver rehabilitation
4) Four year undergraduate degree in a health related field with
a. One year full time experience in the degree area of study; and
b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
c. Supervision by:
i. A certified driver rehabilitation specialist; or
ii. An occupational therapist with a specialty certification in driving and community mobility; or
iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations - Vehicle Modifications

Provider Category:

Agency

Provider Type:

Environmental Accessibility Adaptations/Vehicle Modification Assessments

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies that provide vehicle modification assessments must meet one of the following:
1) Certified driver rehabilitation specialist
2) Occupational therapist with a specialty certification in driving and community mobility
3) Five years of full time experience in the field of driver rehabilitation
4) Four year undergraduate degree in a health related field with
a. One year full time experience in the degree area of study; and
b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
c. Supervision by:
i. A certified driver rehabilitation specialist; or
ii. An occupational therapist with a specialty certification in driving and community mobility; or
iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Residential Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02023 shared living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02011 group living, residential habilitation

Service Definition *(Scope):*

Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02021 shared living, residential habilitation

Family residential services is a training service that provides ongoing residential care and supportive services to adults or children (who cannot be cared for by their biological or adoptive family) in a licensed family foster care setting for up to four people. Family foster care setting is a licensed family foster care setting in which the license holder resides in the home.

Supports are individualized based on the needs of the person, and may include increasing and maintaining the person's physical, intellectual, emotional and social function in the following areas:
• Assistance with activities of daily living
• Self-care
• Communication skills
• Community participation and mobility
• Health care, leisure and recreation
• Household management
• Interpersonal skills
• Medication oversight (to the extent permitted under State law)
• Money management
• Positive behavior and mental health support
• Sensory and motor development
• Socialization.

Services may be provided outside of the person's home in community settings when the service is related to the needs of the person and are provided in settings that are used by the general public.

Family residential services, remote support, is the following:
Remote support is the provision of family residential services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Family residential services for children may be delivered in a setting licensed as child foster care that serves four or fewer people.

Family residential services for adults may be delivered in a setting licensed as adult foster care for up to four people. 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.

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.

The total number of participants living in the home, who are unrelated to the principal care provider, shall not exceed four except when authorized by the commissioner.

The commissioner may authorize services provided in settings serving up to five participants living in the home who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert a participant’s placement in a hospital, regional treatment center, or nursing facility. This exception for services delivered in a setting 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; or,
•Necessary to place siblings together.

This limit does not apply to settings that have continuously provided adult or child foster care to a waiver participant prior to May 1, 2001. Provided means that this was an approved service for an individual in the setting on or prior to May 1, 2001. This size restriction does not apply to people who are 55 years of age or older. 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.

The following are not covered in family residential service:
1) Room and board, items of comfort or convenience, payments directly or indirectly to the participant, the costs of vehicle and facility maintenance (e.g., upkeep and improvements), modifications or adaptions to the setting, upkeep and improvement, and services provided, directly or indirectly, to members of the participant’s immediate family.
2) Homemaker and chore services are not covered as separate services because these services are integral to and inherent in the provision of family residential services.
3) For participants receiving family residential service, the following services are not covered: 24 hour emergency assistance, adult companion, behavioral aide services, caregiver living expenses, chore, customized living, homemaker, home delivered meals, individualized home supports* (without training, with training, and with family training), integrated community supports, night supervision, respite when the family residential services provider utilizes a shift staff model, community first services and supports and personal care assistance services.

*A participant may receive family residential services and individualized home supports without training services only when individualized home supports without training is provided by a separate service provider who does not have any direct or indirect financial interest in the property or housing in which family residential services are delivered. The individualized home support without training must be delivered in the community, outside of the residential setting.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family residential services provider
Individual	Family residential services provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Residential Services

Provider Category:

Individual

Provider Type:

Family residential services provider

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Family residential services providers must deliver the service to adults in a family foster care facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Residential Services

Provider Category:

Individual

Provider Type:

Family residential services provider

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapters 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Family residential services providers must deliver the service to children in a family foster care facility licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Some licensing functions are delegated to counties to complete under department supervision.

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training and Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Training participants or their family members. For purposes of this service, "family" is defined as the people who live with or routinely provide care to the participant, and may include a parent, spouse, children, relatives, foster family, or in-laws. Family members who are employed to care for the participant can not be reimbursed for training and counseling activities that are the responsibility of their employer.

Training for participants includes education to develop self-advocacy skills, exercise civil rights, and acquire skills that enable participants to exercise control and responsibility over the supports they receive as well as facilitation of a person-centered learning and discovery process and development of a comprehensive person-centered description and plan. Training for participants or their family members also includes application of person-centered principles, information gathering skills and summary techniques, instruction about interventions and supports, use of equipment specified in the support plan, and updates as needed to safely maintain the participant at home. Areas of training and intended outcomes will be documented in the participant's support plan. Training may be provided by professionals listed as provider types both inside or outside of the home or by individuals, agencies, or educational facilities offering classes, courses or conferences.

Counseling services are available for family members, as approved by the case manager for issues pertaining to the maintenance of the participant at home. Counseling may include helping the participant and/or his or her family members with crisis, coping strategies, stress reduction, etc.

Documentation of the need for training and an outline of the training (i.e., a course syllabus, training objectives, workshop description, etc.) must be submitted to the lead agency by the individual requesting the training. Based on this information and the participant's needs, the case manager determines whether the training will be authorized. If the training is authorized, the submitted documentation is maintained by the lead agency in the participant's file.

Family training and counseling, remote support, is the following:
Remote support is the provision of family training and counseling by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review. [end

add]

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Coverage is limited to registration fees for training courses or conferences. Costs related to transportation, travel, meals, and lodging are not covered. If any such costs are included in the registration fee, they must be deducted. Family training and counseling services are limited to a maximum of 500 15-minute units per year.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, environmental accessibility adaptations or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers that meet the Family Training and Counseling service standards
Individual	Mental Health Professionals
Individual	Social Workers
Individual	Medical equipment suppliers
Agency	Providers that meet the Family Training and Counseling service standards
Individual	Physical Therapists
Agency	Home Health Agencies: Nurses, speech and language pathologists, and physical, occupational, and respiratory therapists
Individual	Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)
Individual	Registered and Public Health Nurses
Individual	Occupational Therapists
Individual	Speech and language pathologists
Agency	Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)
Individual	Nutritional therapists including licensed dietitians and licensed nutritionists
Individual	Physicians

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Providers that meet the Family Training and Counseling service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals, agencies or educational facilities who have demonstrated expertise as determined by the case manager, and based on the participant's needs as identified in the support plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies.

Frequency of Verification:

Lead agencies are responsible to work with participants to assure that Family Training and Counseling services meet the participant's needs and are directed at the outcomes identified in the support plan.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Mental Health Professionals

Provider Qualifications

License *(specify):*

Must be licensed and/or qualified according to Minnesota Statutes, sections 245.462, subd. 18, or 245.4871, subd. 27.

Certificate *(specify):*

Other Standard *(specify):*

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Mental health professionals that are psychologists, nurses, or social workers must renew their licenses every two years. Psychiatrist, and marriage and family therapist must renew their license annually. DHS verifies every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Social Workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be a graduate of a school of social work accredited by the Council on Social Work Education and must meet the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Social workers must renew their licenses every two years. DHS verifies every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Medical equipment suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310.

Must be authorized by the case manager to provide training in use of equipment and must be a provider under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Agency

Provider Type:

Providers that meet the Family Training and Counseling service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals, agencies or educational facilities who have demonstrated expertise as determined by the case manager, and based on the participant's needs as identified in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies

Frequency of Verification:

Lead agencies are responsible to work with participants to assure that Family Training and Counseling services meet the participant's needs and are directed at the outcomes identified in the support plan

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Physical Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be 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 licensed under Minnesota Statutes, sections l48.65 to 148.78.

Providers of family training/counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Physical therapists must renew their licenses annually.

DHS verifies every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Agency

Provider Type:

Home Health Agencies: Nurses, speech and language pathologists, and physical, occupational, and respiratory therapists

Provider Qualifications

License *(specify):*

Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.

Individual practitioners employed by a home health agency must meet the standards in Minnesota Rules, part 9505.0290.

A respiratory therapist must be a graduate of a program in respiratory therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association, or its equivalent.

Providers of family training/counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals, agencies or educational facilities who have demonstrated expertise as determined by the case manager, and based on the participant's needs as outlined in the support plan.

Providers of family training must be able to perform the duties expected and provide a cost-effective, appropriate means of meeting the participant's family training needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies, or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports

Enrolled provider DHS review: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Registered and Public Health Nurses

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, sections l48.l7l to 148.285.

Certificate *(specify):*

Other Standard *(specify):*

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Nurses must renew their licenses every two years. DHS verifies every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Occupational Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must be currently registered by the American Occupational Therapy Association as an occupational therapist.

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Occupational therapists must renew their licenses every two years.

DHS verifies every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Speech and language pathologists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.

Other Standard *(specify):*

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

.Minnesota Department of Human Services. Provider Enrollment

Frequency of Verification:

Speech and language pathologists must renew their licenses every two years. DHS verifies every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Agency

Provider Type:

Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals, agencies or educational facilities who have demonstrated expertise as determined by the case manager, and based on the participant's needs as outlined in the support plan.

Providers of family training must be able to perform the duties expected and provide a cost-effective, appropriate means of meeting the participant's family training needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies, or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports

Enrolled provider DHS review: Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Nutritional therapists including licensed dietitians and licensed nutritionists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A nutritional therapist must have a bachelor's or master's degree in nutrition and foods or a closely related field and is registered as a dietitian or licensed nutritionist with the National Board of Dietetics and Nutrition Practice.

Providers of family training/counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Nutritional therapists must renew their licenses every two years.

DHS verifies every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training and Counseling

Provider Category:

Individual

Provider Type:

Physicians

Provider Qualifications

License *(specify):*

Must be licensed under Minnesota Statutes, Chapter l47.

Certificate *(specify):*

Other Standard *(specify):*

Providers of family training and counseling must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies, if the service provided meets the definition of direct contact as defined in Minnesota Statutes, section 245C.02, subdivision 11.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Medical licenses must be renewed annually. DHS verifies every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

A home delivered meal is an appropriate, nutritionally balanced meal that is provided to participants who are unable to prepare their own meals and for whom no one else is available to prepare the meals. Meals must contain at least one-third of the current Recommended Dietary Allowance (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council and must be modified, as needed, to meet the participants dietary requirements. Menu plans must be reviewed and approved by a registered dietician. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of one meal per day may be covered. Meals that the participant is eligible for under Title IIIC of the Older Americans Act are not covered. Home delivered meals are restricted to enrolled adults who are 18 years of age or older.

For participants receiving home delivered meals, the following services are not covered: community residential services, family residential services, and customized living.

Participants receiving home delivered meals may receive integrated community supports when services are delivered by separate providers.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Hospitals, schools, restaurants or other entities that meet the provider standards
Agency	Hospitals, schools, restaurants or other entities that meet the provider standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Hospitals, schools, restaurants or other entities that meet the provider standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must comply with all state and local health regulations and ordinances related to food preparation, and handling and serving of food as defined under Minnesota Rules, chapter 4626. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures.

Licensed dieticians and nutritionists must meet requirements as specified in Minnesota Statutes, 148.621 and Minnesota Rules, chapter 3250.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Hospitals, schools, restaurants or other entities that meet the provider standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must comply with all state and local health regulations and ordinances related to food preparation, and handling and serving of food as defined under Minnesota Rules, chapter 4626.

Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures.

Licensed dieticians and nutritionists must meet requirements as specified in Minnesota Statutes, 148.621 and Minnesota Rules, chapter 3250.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Access Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Housing access coordination provides assistance in acquiring housing for participants moving to their own home or an integrated community supports setting from any of the following settings:

1. Unlicensed settings;
2. Hospitals licensed under Minnesota Statutes, sections 144.50 to 144.591;
3. Adult foster care homes licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26;
4. Family and group child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340;
5. Nursing facilities licensed under Minnesota Statutes, chapter 144A;
6. Intermediate care facilities for persons with developmental disabilities (ICF/DD's) as defined under Minnesota Rules, part 9525.1800 subp. 18 and licensed under Minnesota Statutes, section 252.28;
7. Intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
8. Institution for Mental Diseases (IMD); or
9. Housing with services establishment as defined in Minnesota Statutes, Chapter 144D (effective through July 31, 2021)
10. Assisted living facilities licensed under Minnesota Statutes, Chapter 144G (effective Aug. 1, 2021).

Housing access coordination services are provided to people moving into their own home or an integrated community supports setting. A person's own home means a setting that a participant owns, rents, or leases and is not owned, operated or leased by a provider of service, and the person has full control of their housing and full choice of service providers.

In addition to the above, housing access coordination staff may assist with:
- Locating housing
- Completing rental applications, lease agreements and publicly financed housing applications
- Locating affordable furnishings and related household goods
- Packing and moving belongings
- Meeting and negotiating with landlords or property staff
- Developing household budgets
- Ongoing follow-up with housing related matters

The purpose of the service is to promote participant choice of housing, and enhance identification, selection and acquisition of affordable, accessible housing which offers opportunities for community inclusion, and assure appropriate separation of housing from service provision. Services include counseling and assistance in identifying options and making choices with respect to the participants preferences of locations, types of housing, roommates (if any); identifying the participants accessibility requirements (including need for modifications); and planning for on-going maintenance and repair, financial resources, and eligibility for housing subsidies and other benefits.

This service shall be separate and distinct from all other services and shall not duplicate other services or assistance available to the participant. Housing acquired for the participant through this service must be obtained from the same housing market used by the general public. Reimbursement will occur for actual time spent assisting a participant in obtaining housing.

Authorization and Billing:

Housing access coordination services must be reasonable and necessary as determined by the case manager. The case manager determines whether housing access coordination services will be authorized. If authorized, the case manager must clearly define in the participant's support plan what will be covered to assure that there is no duplication with other waiver or State plan services. Waiver services may only be billed after the participant is enrolled in the waiver.

If for any unforeseen reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the lead agency may bill for the housing access coordination services as a Medicaid administrative cost.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Housing access coordination services are limited to a maximum of 150 hours for each move, and up to an additional 50 hours of housing related support each year thereafter.

Additional moves occurring in less than eight months after relocation will trigger a suspended edit in MMIS so that it may be reviewed. Approval of up to an additional 150 hours of HAC service in less than eight months after relocation will occur if a person wants to be closer to a new job, alter proximity to family, or no longer feels safe in their environment due to intimidation or harm.

Housing access coordination under this waiver shall discontinue after mid-July 2021, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Housing access coordination will be replaced by housing stabilization services under a 1915(i) state plan amendment. No new authorizations for housing access coordination will be allowed after mid-July 2020, 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 housing access coordination for a participant who was not previously receiving housing access coordination before mid-July 2020.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies that meet the Housing Access Coordination service standards
Individual	Individuals who meet the housing access coordination service standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Access Coordination

Provider Category:

Agency

Provider Type:

Agencies that meet the Housing Access Coordination service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual providers of Housing Access Coordination must assure they have:

1) Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects.
2) Successfully passed online Housing Access Coordination training
3) A valid driver's license and automobile insurance
4) Completed mandated reporter training which includes training on Vulnerable Adult law

Providers of Housing Access Coordination services must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Access Coordination

Provider Category:

Individual

Provider Type:

Individuals who meet the housing access coordination service standards

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual providers of Housing Access Coordination must assure they have:

1) Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects.
2) Successfully passed online Housing Access Coordination training
3) A valid driver's license and automobile insurance
4) Completed mandated reporter training which includes training on Vulnerable Adult law

Providers of Housing Access Coordination services must apply the standards in Minnesota Statutes, Chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

In-Home Family Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

In-home family supports are 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.

In-home family support 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 including community participation; health, safety, and wellness; and household management.

In-home family support can be delivered in the participant's family home or community settings typically used by the general public.

In-home family supports shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. In-home family supports will be replaced by individualized home supports. No new authorizations for in-home family supports will be allowed after Jan. 1, 2021, 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 in-home family supports for a participant who was not previously receiving in-home family supports before Dec. 31, 2020.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

• In-home family support services are not covered for families, including extended family members that are licensed to provide foster care.
• Payments will not be made for the routine care and supervision that would be expected to be provided by a family member, spouse, or for activities or supervision for which a payment is made by a source other than Medicaid.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who meet the service standards for In-Home Family Supports
Agency	Agencies that meet the service standards for In-Home Family Supports

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Family Supports

Provider Category:
Individual
Provider Type:

Individuals who meet the service standards for In-Home Family Supports

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In-Home Family Supports

Provider Category:

Agency

Provider Type:

Agencies that meet the service standards for In-Home Family Supports

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Living Skills (ILS) Therapies

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Independent Living Skills (ILS) therapies are directed toward the acquisition, retention, maintenance and improvement of a participant's community living skills.

ILS therapies include recreation, music, and art therapies. ILS therapies must have specific therapeutic goals and outcomes established and specified in the participant's support plan, and shall not be merely diversionary in nature.

ILS therapies may be provided in the participant's home or in the community.

This service is effective January 1, 2021.

ILS therapies, remote support, is the following:
Remote support is the provision of ILS therapies by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Therapeutic recreational specialists
Individual	Art therapists
Individual	Music Therapists

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills (ILS) Therapies

Provider Category:

Individual

Provider Type:

Therapeutic recreational specialists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Therapeutic recreational specialists must meet all of the following certification requirements:
- Graduate from an accredited baccalaureate program;
- Successfully complete an internship of 360 hours under the supervision of a certified therapeutic recreation specialist;
- Pass the National Council for Therapeutic Recreation Certification (NCTRC) exam; and
- Be certified as a Therapeutic Recreation Specialist.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Independent Living Skills (ILS) Therapies

Provider Category:

Individual

Provider Type:

Art therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Art therapists must meet all of the following educational and credential requirements:
• Graduate from a master's program in art therapy; and
• Hold one of the following credentials granted by the Art Therapy Credentials Board (ATCB):
- Art Therapist Registered (ATR)
- Art Therapist Registered – Board Certified (ATR-BC)
- Art Therapist Registered – Provisional (ATR-P) and be under the supervision of an ATR or ATR-BC

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills (ILS) Therapies

Provider Category:

Individual

Provider Type:

Music Therapists

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Music therapists must meet all of the following certification requirements:
- Graduate from an institution accredited by the American Music Therapy Association;
- Credentialed under the Certification Board for Music Therapists (CBMT); and
- Be board certified as a Music Therapist.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Living Skills (ILS) Training Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 challenging 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 support plan, as well as, regular written reviews of progress and periodic written reports.

ILS training shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. ILS training will be replaced by individualized home supports. No new authorizations for ILS training will be allowed after Jan. 1, 2021, 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 ILS training for a participant who was not previously receiving ILS training before Dec. 31, 2020.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers who meet the ILS training services standards
Agency	Providers who meet the ILS training services standards.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills (ILS) Training Services

Provider Category:
Individual
Provider Type:

Providers who meet the ILS training services standards

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Living Skills (ILS) Training Services

Provider Category:

Agency

Provider Type:

Providers who meet the ILS training services standards.

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individualized Home Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Individualized home supports (IHS) include direct supports and/or training in categories of community living for participants who reside in their own home or family's home. Individualized home supports can be delivered in the participant's own home, family's home or community settings typically used by the general public.

Individualized home supports can be delivered in three different ways. Individualized home supports can be delivered to:
•Adults or children when support, assistance and supervision is needed for the participant in one or more categories of community living service as individualized home supports without training; or
•Adults when support and training is needed for the participant in one or more categories of community living service as Individualized home supports with training; or
•Adults or children when support and training is needed for the participant and his/her family in the family's home in one or more categories of community living service as individualized home supports with family training.

The definition of support in a community living service area means staff providing direct supervision, cueing, skill maintenance, guidance, instruction, assistance with activities of daily living, or assistance with coordination of community living activities. Individualized home supports cannot be authorized to primarily deliver activities of daily living supports.

The definition of training means instruction in the acquisition, retention, and improvement in categories of community living. Training is instructional services, whereby an enrolled participant receives direct training from a staff person on individually assessed community living service areas. There must be clear documentation of service needs and outcomes that are identified in the coordinated services and support plan, as well as, regular written reports of progress by the Individualized Home Supports service provider.

The individualized home supports service requires:
•Support, assistance and supervision, at minimum, in one or more categories of community living service; or
•Support and training, at a minimum, in one or more categories of community living service.

The categories of community living service include, but are not limited to: community participation; health and safety; and wellness; household management; and adaptive skills.

For individualized home supports, "own home" means a setting in which the participant or, if applicable, legal guardian:
(1) decides who lives in the home with the participant and within the restrictions of the lease agreement;
(2) decides who provides services in the home; and
(3) is responsible for maintenance of the home.

If a response to 1 through 3 is the service provider(s), the setting is not a participant's own home. The responsibility for home maintenance does not prevent the participant from hiring a service provider to complete home maintenance tasks. When a setting is a participant's own home, the lease is held in the participant's name, or if the participant has a legal guardian, it may be the responsibility of the legal guardian to sign the lease on behalf of the participant. When a participant and provider comply with Minnesota Statutes, section 256B.49, subd. 23, regarding community-living settings, it may be considered a participant's own home.

Individualized home supports must be delivered in person or through remote support. When remote support is delivered, in-person service delivery will be scheduled a minimum of weekly. Remote support is only available when individualized home supports without training, individualized home supports with training or individualized home supports with family training is needed in one or more categories of community living service.

Individualized home support, remote support, is the following:
Remote support is real-time, two-way communication between the provider and the participant. The service meets intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in person service delivery. Remote support is limited to check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of individualized home supports. 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 secure 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 service delivery occurs.

Individualized home supports, remote support, is the following:
Remote support is the provision of individualized home supports by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individualized home supports with family training is not covered for families, including extended family members, that are licensed to provide foster care, family residential services, or community residential services.

Individualized home supports without training, individualized home supports with training, or individualized home supports with family training cannot be authorized to primarily deliver activities of daily living supports. If authorized, the case manager must clearly define in the participant's support plan what will be covered to assure that there is no duplication with other waiver or State plan services.

A participant may receive individualized home supports without training and individualized home supports with training or individualized home supports with family training services only when individualized home supports without training is provided by a separate service provider.

When a participant receives individualized home supports without training, individualized home supports with training, or individualized home supports with family training:

- The following services are not covered: community residential services*, adult foster care, customized living**, family residential services*, integrated community supports, and independent living skills (ILS) training.
- Services cannot be delivered to provide supervision services during the participant's primary sleeping hours or delivered as a 24-hour on-site supervision service.
- The service provider cannot have any direct or indirect financial interest in the property or housing in which services are delivered.
- The method of in-person service delivery can be authorized as a 15-minute unit at a 1:1 or 1:2 staff-to-participant ratio or authorized as a daily unit at a 1:1 staff-to-participant ratio.
- Services are limited to a maximum of 16 hours of in-person service per day.

*A participant may receive community residential services or family residential services and individualized home supports without training services only when individualized home supports without training is provided by a separate service provider who does not have any direct or indirect financial interest in the property or housing in which community residential services or family residential services are delivered. The individualized home support without training must be delivered in the community, outside of the residential setting.

**A participant may receive customized living services and individualized home supports with training services only when individualized home supports with training is provided by a separate service provider who does not have any direct or indirect financial interest in the property or housing in which customized living services are delivered.

Limitations applicable to remote support service delivery of individualized home supports without training, individualized home supports with training, and individualized home supports with family training:
- Remote support is limited to the average of two (2) hours per day. The participant's case manager may request an exception to this limit . Requests will be reviewed by the Department, or a Department designee(s), and approved or denied. When the participant's assessed needs and choice of this service delivery method are addressed in the support plan approval may be granted.
- Providers may not:
  - Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature
  - Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered written electronic messaging)
- The remote support method of service delivery can be authorized as a 15-minute unit at a 1:1 staff-to-participant ratio

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers who meet the service standards for Individualized Home Supports without training
Agency	Providers who meet the service standards for Individualized Home Supports without training
Agency	Providers who meet the service standards for Individualized Home Supports with training and with family training
Agency	Organizations that provide individualized home supports without training under the Corporation for National and Community Service
Individual	Providers who meet the service standards for Individualized Home Supports with training and with family training

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Home Supports

Provider Category:

Individual

Provider Type:

Providers who meet the service standards for Individualized Home Supports without training

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must be:
1. licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
2. licensed for home care under Minnesota Statutes, section 144A.43 through 144A.483 with a Home and Community Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (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.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Home Supports

Provider Category:

Agency

Provider Type:

Providers who meet the service standards for Individualized Home Supports without training

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must meet the requirements of: 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.

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Cchapter 245D

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Home Supports

Provider Category:

Agency

Provider Type:

Providers who meet the service standards for Individualized Home Supports with training and with family training

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Home Supports

Provider Category:

Agency

Provider Type:

Organizations that provide individualized home supports without training under the Corporation for National and Community Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must meet the standards established by the Corporation for National and Community Service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individualized Home Supports

Provider Category:

Individual

Provider Type:

Providers who meet the service standards for Individualized Home Supports with training and with family training

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Integrated Community Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02031 in-home residential habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Integrated community supports provide intermittent supports and training, up to 24 hours per day, in categories of community living to adults, 18 years of age or older, who reside in a living unit of a multifamily housing building (e.g., apartment) controlled directly or indirectly by the service provider. Integrated community supports can be delivered in the participant's living unit or community settings typically used by the general public.

The definition of support in a community living service area means staff providing direct supervision, cueing, skill maintenance, guidance, instruction, assistance with activities of daily living, or assistance with coordination of community living activities.

The definition of training means instruction in the acquisition, retention, and improvement in categories of community living. Training is instructional services, whereby an enrolled participant receives direct training from a staff person on individually assessed community living service areas. There must be clear documentation of service needs and outcomes that are identified in the coordinated services and support plan, as well as, regular written reports of progress by the integrated community supports service provider.

Integrated community supports service provide support and training to a participant in one or more categories of community living. The community living service categories include, but are not limited to: community participation; health and safety; and wellness; household management; and adaptive skills.

A service provider has direct or indirect control over a participant's living unit when the service provider owns, operates, or leases the living unit or has direct or indirect financial interest in the property or housing including a financial relationship with the property owner. An integrated community supports service setting does not meet the requirements of a person's own home, community residential program or family residential program.

Integrated community supports, remote support, is the following:
Remote support is the provision of integrated community supports by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants receiving integrated community supports, the following services are not covered: 24-hour emergency assistance, adult foster care, community residential services, customized living, caregiver living expense, family residential services, independent living skills training, individualized home supports without training, individualized home supports with training, individualized home supports with family training, in-home family supports, night supervision, and respite.

Participants receiving integrated community supports may receive home-delivered meals and homemaker services delivered by another provider. Participants may receive personal care assistance or community first services and supports as a separate service when delivered by another provider. If authorized, the case manager must clearly define in the participant's support plan what will be covered to assure that there is no duplication with other waiver or State plan services.

HCBS service providers will deliver integrated community supports in multifamily housing living units (e.g., apartment) where the HCBS provider owns, operates, leases or has direct or indirect interest in the property or housing including a financial relationship with the property owner. These are considered HCBS provider-controlled settings. An individual living unit must contain living, sleeping, eating, cooking and bathroom areas. The service provider or their delegated staff person(s) may not live or otherwise occupy space for business related purposes (e.g., office space, break rooms) in the individual living unit.

If more than one participant resides and receives integrated community supports in a single living unit, the provider must:
- Not direct or facilitate who will or will not live in the unit, except for as allowed by rental guidelines or a lease agreement
- Allow each participant to choose who lives in the unit with them
- Maintain documentation affirming that each participant, their case manager, and legal representative if applicable, are aware of and have chosen the living arrangement.

Only one HCBS provider may deliver integrated community supports at the address of an approved multifamily housing building. Integrated community supports cannot be delivered in settings licensed to deliver customized living services or assisted living services under Minnesota Statute, Chapter 144G, or settings licensed to deliver adult foster care, child foster care, community residential services, or family residential services under Minnesota Statute, Chapter 245A and 245D.

A participant may live in integrated community supports settings and receive HCBS services from providers who are not the integrated community supports provider who controls the setting. The HCBS provider must ensure that a person's refusal to receive integrated community supports from the HCBS provider does not affect the participants lease or rental costs. Housing that is developed, funded or designed specifically for people with disabilities to receive HCBS must be approved through the site-review process before the Integrated Community Supports service may be authorized and paid for in the multifamily housing setting.
Integrated community supports funded under BI, CAC, CADI and DD waivers may be provided in:
- All of the living units in a multifamily building of three or four units.
- Less than 25 percent of the living units of a multifamily housing building of five or more units.
- Following a site-specific review and approval by DHS, 25% or more of the living units in a multifamily housing building

A setting where 25 percent or more of the units of a multifamily housing building are occupied by participants who receive integrated community supports funded under BI, CAC, CADI and DD waivers in the HCBS provider-controlled units must have a site-specific review approved by the commissioner.

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.

When more than one setting is located on the same or adjoining property and the settings or property are 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 which delivers any of the following services: adult day services, day support services, day training and habilitation, prevocational services, structured day services, community residential services, family

residential services, child foster care, adult foster care, and customized living.

To support customized living participants and providers to transition to integrated community supports, this location limit does not apply to customized living settings that were in existence and providing customized living services to a waiver participant in the setting on January 11, 2021 and plan to transition to integrated community supports settings by December 31, 2023. Provided means that the customized living service was an approved service for a participant in the setting on or prior to January 11, 2021. The customized living provider transitioning to integrated community supports must fully comply with the integrated community supports setting requirements and HCBS settings rule requirements including the location requirements for the setting by December 31, 2023.

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies that meet the integrated community supports standards
Individual	Individuals who meet the integrated community supports standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Community Supports

Provider Category:

Agency

Provider Type:

Agencies that meet the integrated community supports standards

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapters 245D as a provider of intensive services.

Certificate *(specify):*

Other Standard *(specify):*

Providers of integrated community supports must submit a Setting Capacity Report as required under Minnesota Statutes, Chapter 245D and receive approval from the commissioner before providing integrated community supports in order to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in Minnesota Statutes, section 256B.492. Providers of integrated community supports must notify the commissioner, through a Setting Capacity Report, of any change that would increase a setting's capacity to or beyond 25 percent of the individual living units of a multifamily housing building being occupied by a participant who receives integrated community supports funded under BI, CAC, CADI or DD waivers even if the setting has already had a site-specific review. Such changes in capacity must be approved by the commissioner prior to the change taking effect.

Settings where integrated community supports are delivered, or will be delivered, must have a site-specific review by the commissioner when 25 percent or more of the units of the multifamily housing building are occupied by people who receive integrated community supports funded under BI, CAC, CADI and DD waivers in order to ensure that settings, by their nature, do not isolate or create a stigma for people living there. Information submitted by the provider to the commissioner for the site-specific review must include, but not limited to, the following:

- Setting-specific provider community integration plan that includes strategies to reduce the potential effects of isolating;
- Provider's policies and practices demonstrating staff training and monitoring of the community integration plan;
- Provider documentation of the community living area supports and training offered at the setting;
- Provider documentation of how the provider ensures participants are given informed choice to receive HCBS services from HCBS providers who are not the integrated community supports provider who controls the multifamily housing setting;
- Description of provider's continuous quality improvement process including measures to demonstrate a person's experience over time;
- Identification, by the provider, of any specialized care or populations to be served by the provider at the setting;
- Lead agency and community perspective input from county of the setting's location which includes local perspective of the setting with supporting information or strategies to address potential concerns.

The commissioner may not approve the site-specific review when the information submitted does not:

- Demonstrate the setting meets the HCBS setting rule characteristics and does not have the effects of isolating
- Identify a plan to monitor and remediate participants ongoing experience at the setting
- Ensure participants in the setting have choice to receive HCBS services from HCBS providers who are not the integrated community supports provider who controls the multifamily housing setting.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Integrated Community Supports

Provider Category:

Individual

Provider Type:

Individuals who meet the integrated community supports standards

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, Chapters 245D as a provider of intensive services.

Certificate *(specify):*

Other Standard *(specify):*

Providers of integrated community supports must submit a Setting Capacity Report as required under Minnesota Statutes, Chapters 245D and receive approval from the commissioner before providing integrated community supports in order to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in Minnesota Statutes, section 256B.492. Providers of integrated community supports must notify the commissioner, through a Setting Capacity Report, of any change that would increase a setting's capacity to or beyond 25 percent of the individual living units of a multifamily housing building being occupied by a participant who receives integrated community supports funded under BI, CAC, CADI or DD waivers even if the setting has already had a site-specific review. Such changes in capacity must be approved by the commissioner prior to the change taking effect.

Settings where integrated community supports are delivered, or will be delivered, must have a site-specific review by the commissioner when 25 percent or more of the units of the multifamily housing building are occupied by people who receive integrated community supports funded under BI, CAC, CADI and DD waivers in order to ensure that setting, by their nature, do not isolate or create a stigma for people living there. Information submitted by the provider to the commissioner for the site-specific review must include, but not limited to, the following:

- Setting-specific provider community integration plan that includes strategies to reduce the potential effects of isolating;
- Provider's policies and practices demonstrating staff training and monitoring of the community integration plan;
- Provider documentation of the community living area supports and training offered at the setting;
- Provider documentation of how the provider ensures participants are given informed choice to receive HCBS services from HCBS providers who are not the integrated community supports provider who controls the multifamily housing setting;
- Description of provider's continuous quality improvement process including measures to demonstrate a person's experience over time;
- Identification, by the provider, of any specialized care or populations to be served by the provider at the setting;
- Lead agency and community perspective input from county of the setting's location which includes local perspective of the setting with supporting information or strategies to address potential concerns.

The commissioner may not approve the site-specific review when the information submitted does not:

- Demonstrate the setting meets the HCBS setting rule characteristics and does not have the effects of isolating
- Identify a plan to monitor and remediate participants ongoing experience at the setting
- Ensure participants in the setting have choice to receive HCBS services from HCBS providers who are not the integrated community supports provider who controls the multifamily housing setting.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Night Supervision Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Night supervision services provide overnight assistance and supervision 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 a participant owns, rents, or leases that is not owned, operated or leased by a provider of service, and a home in which the person has full control of their housing and full choice of service providers. For this service, “own home” is defined as a home that a participant owns, rents, or leases and is not owned, operated or leased by a provider of service, and a home in which the person has full control of their housing and full choice of service providers.

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 activities of daily living and instrumental activities of daily living.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Night supervision cannot be used for preventative or assumptive safety and must be based on the assessed areas of need for a participant.

For participants receiving night supervision the following services are not covered: community residential services, customized living, family residential services or integrated community supports.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who provide night supervision services
Agency	Agencies that provide night supervision services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Night Supervision Services

Provider Category:

Individual

Provider Type:

Individuals who provide night supervision services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Individuals excluded 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.

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 from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Night Supervision Services

Provider Category:

Agency

Provider Type:

Agencies that provide night supervision services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:
- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Agencies excluded under Minnesota Statutes, 245A.03, subd. 2 (1) and (2) must meet the requirements of: section 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and 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 agencies holding a license under Minnesota Statutes, Chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.

For agencies who are excluded from licensure under Minnesota Statutes, section 245A.03,subd.2 (1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Personal support services are provided for a participant in his or her own home or in the community to achieve increased independence, achieve one's full potential, and to meet community inclusion goals that are both important to and important for the person. "Own home" is defined as a home that is not licensed or operated by another entity. Personal support services may include supervision, support or assistance with ADLs either in the person's home or in the community, as well as assistance with accessing community services and participating in community activities of the person's choosing. The person must require supervision or assistance beyond ADL assistance. Services provided in the community should be provided in a way that results in the person having meaningful connections with other community members. This may include establishing new relationships and nurturing existing ones.

This service is provided in accordance with outcomes identified during the person centered planning process and documented in the support plan, when teaching and training are determined not to be necessary for achieving those goals. The case manager will assure there is coordination with other services, the personal support services do not duplicate other services provided for the participant, and the provision of personal support services is monitored.

Personal support services shall discontinue after June 30, 2022, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Personal support services will be replaced by individualized home supports. No new authorizations for personal support services will be allowed after Jan. 1, 2021, 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 personal support services for a participant who was not previously receiving personal support services before Dec. 31, 2020.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services provided one-on-one with the person outside of their home must be provided in integrated community settings that enable the person to interact with people without disabilities.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers that meet the service standards for Personal Support Services
Individual	Individuals who meet the service standards for Personal Support Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support Services

Provider Category:

Agency

Provider Type:

Providers that meet the service standards for Personal Support Services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must be:
1. licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
2. licensed for Home Care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Agencies excluded from licensure under Minnesota Statutes, 245A.03, subd. 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.

For agencies who are excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Support Services

Provider Category:

Individual

Provider Type:

Individuals who meet the service standards for Personal Support Services

Provider Qualifications

License *(specify):*

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must be:
1. licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
2. licensed for Home Care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify):*

Other Standard *(specify):*

Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.

Individuals excluded from licensure under Minnesota Statutes, 245A.03, subd. 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.

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 from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Positive Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

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 challenging behavior. Positive support services include the use of person-centered approaches incorporating a comprehensive functional behavior assessment of both positive as well as challenging 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. 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), 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, and training on positive behavior support plans. All other indirect time is accounted for in the rate framework.

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, direct support staff, other paid staff, caregivers, family or other people who implement the positive support transition plan and/or behavior support plan
• Supervise data collection
• Provide feedback to and coordinate with the positive support professional

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.

3) Positive support specialists:
• Complete an individualized functional behavior assessment
• Implement the person-centered, positive support transition plan and/or behavior support plan
• Collect and record behavioral data
• Communicate questions or concerns to the positive support professional or positive support analyst

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.

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.

Positive support services, remote support, is the following:
Remote support is the provision of positive support services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis

depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Positive Support Professionals
Individual	Positive Support Professionals
Individual	Positive Support Analysts
Agency	Positive Support Specialists
Individual	Positive Support Specialists
Agency	Positive Support Analysts

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Agency

Provider Type:

Positive Support Professionals

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

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 148.99; or

2) Clinical social worker licensed as an independent clinical social worker under Minnesota Statutes, chapter 148E, 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 outlined in the person's 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 qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Individual

Provider Type:

Positive Support Professionals

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

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 148.99; or

2) Clinical social worker licensed as an independent clinical social worker under Minnesota Statutes, chapter 148E, 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 outlined in the person's 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 qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Individual

Provider Type:

Positive Support Analysts

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Positive support analysts must have four years of supervised experience working directly with 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) Meet the qualifications of a Mental Health Practitioner as defined in Minnesota Statutes, section 245.462, subd. 17; or
3) certified as a 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
- 20 hours of instruction in understanding the function of behavior; and
- ten hours of instruction on design of positive practices behavior support strategies; and
- 20 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 qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Agency

Provider Type:

Positive Support Specialists

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Positive support specialists must have:
-an associate's degree in a social services discipline; or
-two years of supervised experience working with participants who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorders.

Additionally, positive support specialists must have:
-a minimum of four hours of training in functional behavior assessment; and
-20 hours of instruction in the understanding of the function of behavior; and
-ten hours of instruction on preparing written intervention strategies, designing data collection protocols, training other staff to implement positive practice strategies, and summarizing/reporting program evaluation data; and
-eight hours of instruction on person-centered thinking principles; and
-a determination by a positive support professional to have the training and prerequisite skills required to provide positive practice strategies to the person who receives positive support services; and
-direct supervision by a positive support professional or positive support analyst

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Individual

Provider Type:

Positive Support Specialists

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Positive support specialists must have:
-an associate's degree in a social services discipline; or
-two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorders.

Additionally, positive support specialists must have:
-a minimum of four hours of training in functional behavior assessment; and
-20 hours of instruction in the understanding of the function of behavior; and
-ten hours of instruction on preparing written intervention strategies, designing data collection protocols, training other staff to implement practice strategies, and summarizing/reporting program evaluation; and
-eight hours of instruction on person-centered thinking principles; and
-a determination by a positive support professional to have the training and prerequisite skills required to provide positive practice strategies to the person who receives positive support services; and
-direct supervision by a positive support professional or positive support analyst

To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Positive Support Services

Provider Category:

Agency

Provider Type:

Positive Support Analysts

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

Positive support analysts must have four years of supervised experience working directly with 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) Meet the qualifications of a Mental Health Practitioner as defined in Minnesota Statutes, section 245.462, subd. 17; or
3) certified as a 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
- 20 hours of instruction in understanding the function of behavior; and
- ten hours of instruction on design of positive practices behavior support strategies; and
- 20 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 qualified professional provided by Minnesota Rules, 9544.0020, subp. 47.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialist Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 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.

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.

Specialist services, remote support, is the following:
Remote support is the provision of specialist services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by a direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop or suspend the use of remote support at any time.

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
• the assessed needs and identified goals of the person that can be met using remote supports;
• how remote support will support the person to live and work in the most integrated community settings;
• the needs that must be met with in-person support;
• how remote support does not replace in-person support provided as a core service function;
• the plan for providing in-person and remote supports based on the person’s needs to ensure their health and safety; and
• whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

The direct staff or caregiver responsible for responding to a person's health, safety and other support needs through remote support must:
• Respect and maintain the person’s privacy at all times, including when the person is in settings typically used by the general public;
• Respect and maintain the person’s privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety and other support needs for personal cares (DHS approval is required for cameras in bedrooms. Use of cameras in bathrooms are prohibited.);
• Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). During the enrollment process, providers sign the MHCP Provider Agreement (DHS-4138) and agree to comply with the data privacy provisions in paragraph 21 of the agreement.

*Enabling technology is the technology that makes the on-demand remote supervision and support possible.

**Live two-way communication is the real-time transmission of information between a person and an actively

involved caregiver. It can be conveyed through the exchange of speech, visuals, signals or writing but must flow both ways and be in actual time. All transmitted electronic written messages must be retrievable for review.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Remote support does not fund the enabling technology. Technology may be covered through CDCS - environmental modifications and provisions, CDCS - environmental modifications-home modifications, environmental accessibility adaptations-home modifications or specialized equipment and supplies. Remote support does not include the use of cameras in bathrooms.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals who meet the specialist service standards
Agency	Agencies that meet the specialist service standards

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialist Services

Provider Category:

Individual

Provider Type:

Individuals who meet the specialist service standards

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

An individual providing specialist services must have the specific experience, skills, and any other qualifications required to meet the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialist Services

Provider Category:

Agency

Provider Type:

Agencies that meet the specialist service standards

Provider Qualifications

License *(specify):*

Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.

Certificate *(specify):*

Other Standard *(specify):*

An agency providing specialist services must have the specific experience, skills, and any other qualifications required to meet the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.

Frequency of Verification:

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.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Equipment and Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
17 Other Services	17010 goods and services
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized equipment and supplies include devices, controls, or appliances, specified in the support plan, that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with their environment.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not covered under the State plan. Specialized Equipment and Supplies does not cover utilities that may be required to operate the supplies and/or equipment purchased for a participant.

All items must meet applicable standards of manufacture, design and installation.

Thickening agents may be covered when there is a determination of medical need.
Equipment repair and upkeep can be covered, unless covered by the warranty. Training is not covered separately.

An item is not covered if it restricts a participant's rights or restrains a participant and:
a. the items are not adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition; or
b. the items violate the provisions of Minnesota Rules, chapter 9544.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Items that are not of direct medical or remedial benefit to the participant are not covered. Experimental treatments are not covered.

All prescription and over-the counter medications, compounds and solutions, and related fees including premiums and co-payments are not covered.

Oral nutritional products, electrolyte products, foods including organic or special diet needs, organ extracts, and over-the-counter food supplement products are not covered.

Specialized equipment and supplies are limited to a maximum of $3,909.00 per year per waiver participant.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home health agencies
Individual	Individuals who provide supplies or equipment (receipt services)
Agency	Medical suppliers (including wheelchair and oxygen vendors)
Agency	Agencies that provide supplies or equipment (receipt services)
Agency	Pharmacies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Home health agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicare certification

Other Standard *(specify):*

Providers must meet the definition under Minnesota Rules, part 9505.0195

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Health

Frequency of Verification:

One to three years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Individual

Provider Type:

Individuals who provide supplies or equipment (receipt services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical suppliers (including wheelchair and oxygen vendors)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310.

Providers must meet the definition under Minnesota Rules, part 9505.0195

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Agencies that provide supplies or equipment (receipt services)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Equipment and Supplies

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

Pharmacies are licensed by the Minnesota Board of Pharmacy in accordance with Minnesota Rules, parts 6800.0100 to 6800.9954

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transitional services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
17 Other Services	17010 goods and services
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 or an integrated community supports setting from the following settings:
-unlicensed settings,
-hospitals licensed under Minnesota Statutes, sections 144.50 to 144.591;
-adult foster care homes licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 or Minnesota Statutes, sections 245D.21 to 245D.26;
-family and group child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340;
-nursing facilities licensed under Minnesota Statutes, chapter 144A;
-intermediate care facilities for persons with developmental disabilities (ICF/DDs) as defined under Minnesota Rules, part 9525.1800 subp. 18 and licensed under Minnesota Statutes, section 252.28;
-intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
-institutions for mental diseases (IMDs);
- assisted living facilities licensed under Minnesota Statutes, Chapter 144G (effective Aug. 1, 2021).

For purposes of this service, own 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, 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 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, homemaker services, and environmental accessibility adaptations-home modifications, 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.

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 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 after the participant’s move from the licensed or unlicensed setting. Waiver services may only be billed after the participant is enrolled in the waiver.

If for any unforeseen reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the lead 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:

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).

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.

Transitional services are not covered when the home includes the provision of these items (durable household goods) or services (moving expenses), and when they are inherent to the service being provided.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Providers of items and expenses (receipt services)
Agency	Providers of items and expenses (receipt services)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional services

Provider Category:

Individual

Provider Type:

Providers of items and expenses (receipt services)

Provider Qualifications

License *(specify):*

Maintain all applicable licenses, permits, registrations as required for their business.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transitional services

Provider Category:

Agency

Provider Type:

Providers of items and expenses (receipt services)

Provider Qualifications

License *(specify):*

Maintain all applicable licenses, permits, registrations as required for their business.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Transportation is covered in order to enable participants to gain access to waiver and other community services, resources, activities, and employment as specified in the support plan. Whenever possible, family, neighbors, friends, or community agencies who are able to provide this service without charge will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not replace transportation services covered by the state plan (e.g., to medical appointments) or supplant transportation that is available at no charge.

This service does not cover transportation provided by providers for which the cost of transportation is included in their rates.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	**Common carriers including buses, taxicabs, other commercial carrier, and county-owned or leased vehicles (receipt services)**
Individual	**Individuals who are not common carrier providers (receipt services)**
Individual	**Special transportation 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 Category	Provider Type Title
Agency	Special transportation to transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Common carriers including buses, taxicabs, other commercial carrier, and county-owned or leased vehicles (receipt services)

Provider Qualifications

License *(specify):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies, or Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Individuals who are not common carrier providers (receipt services)

Provider Qualifications

License *(specify):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

Certificate *(specify):*

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Lead agencies or Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Lead agency review: Upon purchase of goods / supports
Enrolled provider DHS review - Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Individual

Provider Type:

Special transportation 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):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

Certificate *(specify):*

Providers of special transportation, not excluded in Minnesota Statutes, section l74.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections l74.29 to l74.315.

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment.

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Special transportation 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):*

Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

Certificate *(specify):*

Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.315.

Other Standard *(specify):*

Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

Minnesota Department of Human Services, Provider Enrollment

Frequency of Verification:

Every five years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Minnesota Statutes, Chapter 245C establishes the Department of Human Services Background Studies Act. It describes the applicability and scope of background studies, and the disqualification criteria and appeal process.

(a) Positions for which the background studies apply.

Minnesota Statutes, Chapter 245C requires criminal and maltreatment background checks to be completed for:

-All employees, owners, managers, contractors and volunteers within programs and organizations licensed by the Minnesota Department of Human Services (DHS), certified by the Minnesota Department of Health, regulated by the Minnesota Department of Corrections, or operating as a Personal Care, Community First Services and Supports, and/or Home Care Provider Organization that provide "direct contact" services under the home and community-based waiver programs.

-People who are not providers but who reside in a licensed setting in which direct contact waiver services are provided to waiver participants. This required background check is limited to individuals age 13 years or older, and can apply to individuals age 10 to 12 where there is reasonable cause.

-All individuals, including employees, contractors, volunteers, etc., regardless of setting, who provide direct contact services to people enrolled in the waiver. Short-term, substitute caregivers providing direct contact services for a child are not required to have a background check.

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
-Community residential services
-Consumer-directed community supports (personal assistance, treatment and training, self-directed support, community integration and support, support planning, and financial management services)
-Customized living
-Crisis respite
-Day support services
-Employment Exploration
-Employment Development
-Employment Support
-Extended community first services and supports
-Extended Home Health Care Services
-Extended Personal Care Assistance
-Extended Home Care Nursing
-Family residential services
-Family Training and Counseling (for direct contact in the home)
-Homemaker services
-Housing Access Coordination
-In-home family supports
-Independent living skills (ILS) training
-Independent living skills (ILS) therapies
-Individualized home supports (without training, with training, and with family training)
-Integrated community supports
-Night supervision services
-Prevocational services
-Personal supports
-Positive support services
-Respite

-Specialist services

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.

(b) Scope of the background studies.

Background studies are submitted through an on-line system to the department. A background study must be initiated prior to an individual providing direct service. The scope of the study includes:

-a search of criminal records on file with the Minnesota Bureau of Criminal Apprehension (BCA):
-a search of other states criminal records;
-a search of maltreatment records maintained by the state and counties within the Social Service Information System (SSIS); and
-if there is reasonable cause, an Federal Bureau of Investigation (FBI) fingerprint check, along with a search of FBI investigation case files and criminal arrest records.

(c) Process for ensuring background studies are completed.

Providers are responsible for completing, submitting and maintaining all mandatory background study forms. Respective government agencies with regulatory enforcement authority (e.g., DHS Licensing Division, the Minnesota Department of Health, the Minnesota Department of Corrections, counties, tribal agencies, etc.) review providers for their compliance. Disqualified employees of a provider are barred from service. Provider information is managed and maintained by the Provider Screening and Enrollment Unit within the Member and Provider Services Division. If a provider is disqualified from participation, the Provider Enrollment Unit will deny any new requests for enrollment and terminate an existing enrollment effective the date of disqualification. The provider cannot be authorized to provide services, or bill for or be paid for their services on or after their date of disqualification.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The department maintains a database of individuals who were determined through adult protection investigations to have committed maltreatment. The Minnesota Department of Health also maintains a database of individuals who have been determined to commit maltreatment and shares that information with the department. When the department completes a background study, the individual is screened against both databases.

Our response to background studies in Appendix C-2, paragraph(a) addresses which positions require background studies and the process to complete them, including review of the databases described above.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Facilities licensed to provide board and lodging	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to Appendix C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Facilities licensed to provide board and lodging

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Independent Living Skills (ILS) Therapies	☐
Employment Support Services	☐
Extended Home Care Nursing	☐
Adult Foster Care	☐
Individualized Home Supports	☐
Adult Day Service Bath	☐
Environmental Accessibility Adaptations - Home Modifications	☐
Consumer-directed community supports: treatment and training	☐
24-Hour Emergency Assistance	☐
Consumer-directed community supports (CDCS): personal assistance	☐
Transitional services	☐
Consumer-directed community supports: environmental modifications – home modifications	☐

Waiver Service	Provided in Facility
Positive Support Services	☐
Night Supervision Services	☐
Consumer-directed community supports (CDCS): Support Planning	☐
Consumer-directed community supports : Financial Management Services	☐
Consumer-directed community supports (CDCS): Community Integration and Support	☐
Homemaker	☐
Extended Personal Care Assistance Services	☐
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐
Consumer-directed community supports: environmental modifications - vehicle modifications	☐
Specialist Services	☐
Home Delivered Meals	☐
Case Management	☐
Day Support Services	☐
Adult Day Service	☐
Transportation	☐
Consumer-directed community supports: environmental modifications and provisions	☐
Employment Development Services	☐
Housing Access Coordination	☐
Personal Support Services	☐
Chore Services	☐
Family Training and Counseling	☐
Community Residential Services	☐
In-Home Family Supports	☐
Specialized Equipment and Supplies	☐
Consumer-directed community supports: self-direction support activities	☐
Adult Companion Services	☐
Family Residential Services	☐
Environmental Accessibility Adaptations - Vehicle Modifications	☐
Child foster care	☐
Caregiver Living Expenses	☐
Crisis Respite	☐
Employment Exploration Services	☐
Integrated Community Supports	☐
Extended Home Health Care Services	☐

Waiver Service	Provided in Facility
Respite	☐
Prevocational Services	☐
Independent Living Skills (ILS) Training Services	☐
Customized Living	☒
Extended Community First Services and Supports	☐

Facility Capacity Limit:

Four people unrelated to the caregiver, under age 55 years, with some exceptions.

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Provision of or arrangement for necessary health services: Board and lodge providers must be registered with the Minnesota Department of Health as a housing with services provider. The housing with services standards govern the scope of health services and monitoring that may be provided or arranged without a home care license. The majority of board and lodge providers who furnish waiver services are required to be licensed as a comprehensive home care provider based on the scope of services they provide.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may

not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Extended community first services and supports (CFSS)

For minor children: Legally responsible individuals (parents and guardians) and step parents can be paid to provide CFSS.

For adult participants:

Non-paid legal guardians, parents, step parents and spouses who are not the participant's representative may provide extended CFSS services. Paid guardians and the participant’s representative cannot be paid to provide CFSS.

CFSS support workers must be employed by an enrolled agency or the participant and the support worker must:
-Successfully complete training requirements. The provider is required to maintain documentation of the CFSS staff training.
-Be able to provide the CFSS according to participant's support plan, respond appropriately to the needs of the participant, and report changes in the participant's condition as required.
-Pass a background study as specified in Minnesota Statutes, Chapter 245C. Pass a background study means the individual must not be disqualified or have a disqualification set-aside.
-Enroll as an individual CFSS provider with the Minnesota Health Care Programs.
-Not be the participant's paid legal guardian or participant’s representative.
-Effectively communicate with the person and the CFSS provider agency.
-Maintain daily written records including, but not limited to, documentation of hours worked.
-Complete training and orientation on the needs of the participant within no more than 14 days after services begin.
-Be supervised by the participant or the agency provider.
The assessment and support planning process is used to determine the participant's CFSS needs. This includes use of the MnCHOICES assessment or the Long Term Care Consultation Services Assessment Form (DHS-3428) and Supplemental Waiver Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3428D). The information from the assessment identifies the amount of state plan CFSS services that can be authorized. Additional time can be authorized as Extended CFSS services based on the participant's needs identified in the assessment and support planning process. The case manager authorizes the CFSS hours in the participant’s waiver service agreement.
The department uses several mechanisms to enforce appropriate billing procedures for CFSS including the following:
- Participants must verify the workers’ time documentation. This is done in order to verify that the time and type of CFSS provided are recorded. Support workers must document if the participant was in the hospital, nursing facility or incarcerated so the department does not pay for days the participant was not in their home.
-Every support worker is required to have an individual provider number. This allows the department to monitor the total number of hours an individual support worker provides. This is important because support workers may provide services to multiple participants and be employed by more than one provider. Reports can be run on individual support workers to monitor that the number of hours being billed is within the 310 hours per month limit and does not duplicate other claims.
-The department can cross-reference claims with IRS information to verify that the support worker was not employed at another setting at the time they recorded providing CFSS.
-The department conducts quality assurance compliance inquiries. This includes reviewing the provider's time documentation, other required documentation and participant interviews as needed.
-The department uses automated reports to identify potential overuse of services. As part of the automated process, MMIS sends letters to participants, providers, and lead agency case managers to notify them of the potential overuse of services. In cases where there are questions regarding the use of CFSS, department staff may request additional information, such as signed time documentation, support plan and a plan for use of authorized services and documentation of services provided, assessments that indicate a change in condition that would necessitate the need for increased services, etc. Department staff will work with the provider and participant to ensure accurate billing and use of services.
-The department conducts random audits to evaluate provider's billing practices and appropriate use of services, and case managers are responsible for monitoring the use of services and accurate billing for services authorized.

Extended personal care assistance (PCA)

For children:

Legally responsible individuals (parents and guardians) and step parents must not provide PCA services.

For adult participants:
Non-paid legal guardians and parents and step parents who are not the participant's responsible party may provide extended PCA services. Spouses, paid guardians and responsible parties may not be paid to provide PCA services.

PCAs must be employed by an enrolled agency and the PCA must:

-Be over 18 years of age unless between the ages of 16 and 18 years, and then must only be employed by one provider agency and be supervised by a qualified professional every 60 days.
-Successfully complete training requirements. The provider is required to maintain documentation of the PCAs training.
-Be able to provide the PCA services according to participant's support plan, respond appropriately to the needs of the participant, and report changes in the participant's condition as required.
-Pass a background study as specified in Minnesota Statutes, Chapter 245C. Pass a background study means the individual must not be disqualified or have a disqualification set-aside.
-Enroll as an individual PCA provider with the Minnesota Health Care Programs.
-Not be the participant's paid legal guardian, guardian of a minor, or responsible party.
-Not be receiving PCA services.
-Effectively communicate with the person and the PCA provider agency.
-Maintain daily written records including, but not limited to, time sheets.
-Complete training and orientation on the needs of the participant within no more than 14 days after services begin.
-Be supervised by the participant or the qualified professional.

The assessment and support planning process is used to determine the participant’s PCA service needs and whether the service is appropriately provided by a legal guardian or parent. This includes use of the MnCHOICES assessment, or the Long Term Care Consultation Services Assessment Form (DHS-3428) and Supplemental Waiver PCA Assessment and Service Plan (DHS-3428D). The information from the assessment identifies the amount of state plan PCA services that can be authorized. Additional time can be authorized as Extended PCA services based on the participant’s needs identified in the assessment and support planning process. The case manager authorizes the PCA hours in the participant’s waiver service agreement.

The department uses several mechanisms to enforce appropriate billing procedures for PCA services including the following.

-Participants must sign PCAs time sheets to verify that the time and type of PCA services provided are recorded. PCAs must note on the timesheet if the participant was in the hospital, nursing facility or incarcerated so the department does not pay for days the participant was not in their home.
-Every PCA is required to have a provider number. This allows the department to monitor the total number of hours an individual PCA provides. This is important because PCAs may provide services to multiple participants and be employed by more than one provider. Reports can be run on individual PCAs to monitor that the number of hours being billed is reasonable and does not duplicate other claims.
-The department can cross-reference claims with IRS information to verify that the PCA was not employed at another setting at the time they recorded providing PCA services.
-The department conducts quality assurance compliance inquiries. This includes reviewing the provider's time sheets, other required documentation and participant interviews as needed.
-The department uses automated reports to identify potential overuse of services. As part of the automated process, MMIS sends letters to participants, providers, and lead agency case managers to notify them of the potential overuse of services. In cases where there are questions regarding the use of PCA services, department staff may request additional information, such as signed time sheets, support plan and month to month plan for use of authorized services and documentation of services provided, assessments that indicate a change in condition that would necessitate the need for increased services, etc. Department staff will work with the provider and participant to ensure accurate billing and use of services.
-The department conducts random audits to evaluate provider's billing practices and appropriate use of services, and case managers are responsible for monitoring the use of services and accurate billing for services authorized.

☒ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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.

NOTE: All Extended CFSS policies related to the provision of services by legally responsible individuals are found in appendix C-2-d.

EXTENDED HOME CARE NURSING:
Spouses, 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 (CDCS).

The spouse, 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, physician, advanced practice registered nurse, or physician assistant determines that the home care nursing care provided by the spouse, legal guardian, or parent of a minor is unsafe.

CONSUMER-DIRECTED COMMUNITY SUPPORT (CDCS) SERVICES 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 consumer directed community supports (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:
- 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.

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 support plan;
• be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant’s support plan;
• be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services or community first services and supports;
• 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 (ADL), which is determined based on the ADL items included in the assessment the person receives.*

* The MnCHOICES assessment is a comprehensive, broad assessment that looks at ADL dependencies across several program areas. The assessment is 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.

Any ADL dependency documented in the MnCHOICES/LTCC assessment, which meets the eligibility criteria for any program, is valid for determining the ADL dependency requirement for paying a spouse or parent of a minor for personal assistance services.

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 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 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 financial management services provider of hours billed for family provided care and the

total amounts billed for all goods and services during the month;
• planned work schedules must be available two weeks in advance, and variations to the schedule must be noted and supplied to the financial management services provider when billing;
• at least quarterly reviews by the 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.

WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO ADULTS:
Related individuals cannot provide adult companion services, individualized home supports (with family training), 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 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.

ALL WAIVER SERVICES, OTHER THAN EXTENDED HOME CARE NURSING:
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.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Department enrolls providers who meet the state qualifications, complete a required state provider training, and submit a signed Minnesota Health Care Program provider agreement. Providers access all service enrollment information, including enrollment forms, on the Department's web site.

Every waiver service provider must comply with state requirements. Direct enrollment with the department is required for most waiver services. Enrolled waiver service providers are listed in an on-line directory (MinnesotaHelp.info). Enrollment, while available to market and receipt-based waiver service providers, is not required.

Market services are those purchased at a price typically charged on a community market basis. Market services include six basic services directed to a broad community market:
-Chore
-cleaning-only component of homemaker services
-home construction component of environmental accessibility adaptations
-vehicle installation component of environmental accessibility adaptations
-training component of family training and counseling
-individual drivers providing transportation.

Lead agencies assure compliance with non-enrolled market services and maintain payment records in a manner directed by the state.

Receipt-based services are services that involve the purchase of goods and supports from vendors on a retail basis (i.e. public transportation, community classes). Receipt-based service providers have the choice of enrolling as a Medicaid provider, or receiving reimbursement for goods and supports through lead agencies. The state directs lead agencies to authorize the purchase of waiver goods and supports in compliance with federal waiver requirements, and to maintain payment records in a manner directed by the state.

Annually, the Department will review qualifications of applicants for Financial Management Services (FMS) providers through a Request for Proposal process.

Federally recognized tribal nations may establish alternative provider qualifications for waiver services in accordance with Minn. Stat., §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 tribal nations.

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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of total CADI claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI claims paid, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of HCBS provider applications that met all required standards in a calendar year. Numerator: Number of HCBS provider applications that met all required standards. Denominator: Number of HCBS provider applications randomly reviewed, in a calendar year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Health Care Program (MHCP) Quality Control Audit Record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: MHCP program area random audit sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of lead agencies that employed mandated protocol for reviewing non-enrolled providers authorized to deliver basic waiver services (e.g., chore, cleaning) in the current review cycle. Numerator: Number lead agencies that employed mandated protocol for reviewing non-enrolled providers. Denominator: Number lead agencies that authorized non-enrolled providers to deliver basic waiver services.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Data derived from most recent cycle of lead agency review. The Department reviews lead agencies on a four-year cycle.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of total CADI claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI claims paid, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of HCBS provider applications that met all required standards in a calendar year. Numerator: Number of HCBS provider applications that met all required standards. Denominator: Number of HCBS provider applications randomly reviewed, in a calendar year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Health Care Program (MHCP) Quality Control Audit Record

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☒ **Other** Specify: MHCP program area random audit sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of total CADI claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI claims paid, per calendar year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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. Many waiver service providers are required to be licensed by either the Department, local lead agencies under delegation from the Department, or the Minnesota Department of Health. In addition to periodic compliance reviews (usually annual or biennial), these agencies provide ongoing monitoring via complaint and maltreatment investigations involving the providers they license. Corrective actions and other sanctions may be imposed when deficiencies are identified.

Requisite provider and staff training is reviewed and verified as a condition of licensure for many waiver service provider types.

Minnesota Health Care Programs. MHCP verifies that waiver providers meet and maintain many program requirements as a condition of initiating and maintaining enrollment.

Disability Services Division. The Disability Services Division receives complaints from lead agency case managers of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The division may independently, through the Department's enrollment area, or with the affected lead agency(ies) seek to remedy the situation with the provider.

Certification. The Department certifies Support Planners (for Consumer Directed Community Supports service). Initial certification requires successful completion of test requirements prior to providing services. Support Planners must verify training requirements are met (if applicable) and pass the Departments recertification test every two years.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Case Managers. As part of oversight of waiver service delivery (Refer to Appendix C1/C3: Service Specification, Case Management), case managers monitor and address service delivery problems and assist participants in selecting providers who can meet their needs. Case managers also bring to the attention of the department persistent performance concerns and patterns with non-licensed waiver service providers.

Licensing. When licensed providers are found to be out of compliance with applicable requirements, the licensing agency will issue a citation for each violation determined and require corrective action. Depending on the nature, severity, and/or chronicity of the violation, the licensing agency establishes the method and timeframe by which evidence of remediation must be submitted or observed. Other sanctions available include fines and conditional, suspended, and revoked licensure.

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) are found to be out of compliance with applicable requirements, the Department will issue a corrective action order for each violation determined and require corrective action. The FMS provider must submit evidence of remediation. Depending on the nature, severity, and/or chronicity of the violation, the Department may take action up to and including:

- Requiring the FMS provider to have an additional readiness review or performance review conducted at the provider's expense;
- Limiting a provider's ability to receive payment;
- Suspending or terminating the provider's enrollment; or
- Terminating the contract with the State.

When a 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, certification may be revoked.

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.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
Minnesota Department of Health Lead agencies	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☒ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

See Appendix C-3, and Appendix E.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

On Feb. 12, 2019, CMS gave its final approval to Minnesota's Home and Community-Based Services Rule Statewide Transition Plan to bring settings into compliance with the federal HCBS regulations.

Minnesota will use the following strategies to ensure compliance with the HCBS settings rule:
1. Provider attestation requirement for every setting
2. Desk audit of every setting's attestation and submitted documentation to support compliance
3. Identify Prong 1, 2 and 3 – Presumed not to be HCBS settings
4. Assess and validate Prong 1, 2 and 3 – Presumed not to be HCBS settings: On-site visits and outreach
5. Implement person's experience assessments
6. Develop and implement residential tiered standards for BI, CAC, CADI and DD waivers
7. Develop and implement non-residential tiered standards for BI, CAC, CADI and DD waivers
8. Implement methods for ongoing HCBS compliance, including assessing people's ongoing experience and assessing lead agencies and service gaps.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Community Support Plan and Coordinated Services and Supports Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Lead agencies provide case management and may also provide other waiver services. If a lead agency provides other waiver services, they are generally provided by areas or divisions that are organizationally separate from the area that provides case management services. For example, a public health department at a lead agency may provide personal care assistance and community first services and supports while the social service agency is responsible for case management. In small lead agencies, it is essential for service access to allow lead agencies to provide both case management and other waiver services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the

service plan development process and (b) the participant's authority to determine who is included in the process.

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.

Person-centered planning principles are required to be used in all support plan development. This includes engaging participants and their representatives, as appropriate, in the 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

For participants who have not elected consumer-directed services, the following requirements apply.

(a) Community support plan development, process and timing
Through the assessment process, the certified assessor conducts a conversational interview 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 sixty calendar days from the assessment. This process applies to both initial and annual reassessments. Generally, for minors, the family participates in the community support plan development. If a child's family elects not to participate, 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 assessment process), the case manager (for LTCC only) or certified assessor 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, psychosocial, social, safety needs, etc. Assessment information may also be obtained from other sources, including medical records, clinical assessments, schools, service providers and vocational rehabilitation agencies.

Once this information is collected and reviewed, 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 (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.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 services and 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.

The coordinated services and supports plan (CSSP) is developed and signed by the person, the person's legal representative (if applicable), the case manager, and providers responsible for delivering services under the plan within 60 calendar days of the assessment. The plan is distributed to the person, the person's legal representative (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 participants' strengths and preferences in the support planning process, and requires the use of person-centered planning for all 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 and assessors 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 coordinated services and supports plan (CSSP) and services provided. If a provider fails to carry out their responsibilities as identified in the participant's support plan or develop an individual service plan when needed, the case manager shall notify the provider and, as necessary, the multidisciplinary team. If the concerns are not resolved by the provider or multidisciplinary team, the case manager shall notify the participant, the appropriate licensing and certification agencies, and the 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) Coordinated services and supports plan (CSSP) updates
Case managers must meet with participants at least twice within the twelve month period and reevaluate level of care at least annually. Case managers also meet with participants as identified in the participant's CSSP and upon request, and CSSPs 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 community support services:

Support 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 law, waiver manual, provider manual, bulletins, and instructional materials applicable to support plan development are available upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the

arrangements that are used for backup.

Through the assessment and support planning process, case managers and assessors 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 support plan. Case managers and assessors 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 Minnesota Statutes, 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Case managers are required to provide participants choice of feasible alternatives available through the waiver and choice of institutional care or waiver services. Refer to Minnesota Statutes, Section 256B.49, subd. 12. Case managers are also required to assist the participant in the support planning process by providing information regarding service options and choice of providers. Case managers must provide information regarding:

1) Service types that would meet the level and frequency of services needed by the participant, the funding streams, the general comparative costs, and the location of services;

2) Resources, enrolled waiver service providers listed in the on-line MinnesotaHelp.Info directory and, as needed, additional local providers qualified by state standards to deliver chore, cleaning only component of homemaker, home construction and vehicle installation components of environmental accessibility adaptations, training component of family training and counseling, the non-commercial individual driver component of transportation service, and receipt-based services;

3) Provider capacity to meet assessed needs and preferences of the participant, or to develop services if they are not immediately available; and,

4) Other community resources or services necessary to meet the participant's needs.

Refer to Appendix B-7, Freedom of Choice.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

In order for a waiver claim to be paid, the service must be authorized in an MMIS service agreement. The department has access to all service agreements. Also, support plans are reviewed during the lead agency reviews.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are responsible for monitoring the implementation of coordinated services and supports plans (CSSPs) 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. Certified assessors must conduct reevaluations of level of care at least annually. Support plans are to be updated any time there is a change in the participant's condition or situation that warrants a reassessment (e.g., change in caregivers' capacity). Additional monitoring is individualized, based on the needs of the participant, and included in the CSSP.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Case managers are responsible for monitoring the support plan implementation including monitoring that the health and safety needs of the participant as identified in the support plan are addressed.

Participant safeguards related to possible conflicts of interest include fair hearing rights, free choice of provider, and the ability to request a different case manager from the same lead agency or seek case management services from another lead agency. There are circumstances when the lead agency may provide case management and other waiver services. In these circumstances, it is generally a service provided by another arm of the lead agency or the lead agency acts as the billing agent (e.g., one-time environmental accessibility adaptations provided via contract with the lead agency, or county or tribal public health agencies may provide extended home care services that a waiver participant may use).

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan documents participant goals. Numerator: Number of CADI participant files reviewed where the support plan documents participant goals. Denominator: Number of CADI participant files reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan documents services to address all (100%) domains of assessed need. Numerator: Number of CADI files reviewed where the support plan documents services to address all domains of assessed need. Denominator: Number of CADI participant files reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan documents all (100%) domains of assessed need. Numerator: Number of CADI participant files reviewed where the support plan documents all domains of assessed need. Denominator: Number of CADI participant files reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan documents assessed health and safety issues.
Numerator: Number of CADI participant files reviewed where the support plan

documents assessed health and safety issues. Denominator: Number of CADI participant files reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan was updated within the past 366 days. Numerator: Number of CADI participant files reviewed where the support plan was updated within the past 366 days. Denominator: Number of CADI participant files (with a documented support plan date) reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI participant files reviewed during the current review cycle in which support plans were completed within timelines following assessment/reassessment.
Numerator: Number of CADI files reviewed during the current review cycle in which support plans were completed within 60 days of assessment/reassessment.
Denominator: Number of CADI files reviewed during the current review cycle

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐	
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle in which the support plan is signed, dated, and disseminated to all relevant parties as required. Numerator: Number of CADI case files reviewed in which the support plan is signed, dated, and disseminated to all relevant parties. Denominator: Number of CADI case files reviewed during the current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sampling: case file sampling for lead agency reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent difference between the dollar amount encumbered for CADI waiver services compared to the dollar amount claimed for CADI waiver services provided to participants, per calendar year. Numerator: Dollar amount claimed for CADI services provided to participants, per calendar year. Denominator: Dollar amount encumbered for CADI services, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI 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 CADI participant files reviewed during current review cycle in which participant choice was documented. Denominator: Number of CADI participant files reviewed during current review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Lead Agency Reviews, and follow-up reviews. Corrective actions are issued when patterns of non-compliance are found. Individual or case-specific problems are addressed with the lead agency before the conclusion of the review, and correction is required. Follow-up reviews (within 18 months after an initial review) include a review of the initial samples where correction was needed and a review of additional cases to assure both individual and systemic problem and pattern correction. Corrective actions and follow-up findings are documented in the Department's Lead Agency Waiver Database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Consumer directed community supports (CDCS) may include traditional goods & services provided by the waiver, and alternatives that support participants. Ten categories of CDCS are covered: personal assistance; treatment & training; environmental modifications & provisions; environmental modifications: - home modifications; environmental modifications: - vehicle modifications; individual-directed goods and services, community integration and support, financial management services, support planning, and self direction support activities. Refer to Appendix C. Participants or their representative hire, fire, manage and direct their support workers. The participants or their representative must purchase assistance with these functions through a financial management services (FMS) provider.

FMS providers offer supports as defined in the agreement between the FMS and the participant; the contract with the State; and provider standards. Support planners may also provide assistance with employee related functions as defined in the service standards. Support planners shall not be the employer of record.

When more than one CDCS participant 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.

Participants or their representatives have control over the goods and services to be provided through developing the support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, & managing the CDCS budget. The individual budget maximum amount is set by the state.

Support Plan. The participant or their representative will direct the development and revision of the support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the participant's strengths, needs, and preferences. The plan may include a mix of paid and non-paid services. The plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The support plan identifies: the goods and services that will be provided to meet the participant's needs; safeguards to reasonably maintain the participant's health and safety; and, how emergency needs of the participant will be met. The support plan must also specify the overall outcome(s) expected as the result of CDCS and how monitoring will occur.

The support plan will specify provider qualifications including training requirements (if they exceed the provider standards). The support plan will also specify who is responsible to assure that the qualification and training requirements are met. The cost of background studies is not included in the individual budget amount but will be covered as a service expense through the lead agency's waiver allocations.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the lead agency when the revision does not change or modify what was authorized by the case manager. If a revision results in a change or modification of the approved support plan, the participant or their representative will work with the lead agency to have the support plan reviewed and re-authorized.

Participant Budgets. The individual budget maximum amount is set by the state. The lead agency is responsible to review and approve final spending decisions as delineated in the participant's support plan.

In a 12 month service agreement period, the participant's individual budget will include all goods & services to be purchased through the waiver and State plan home care services with the exception of required case management and criminal background studies.

Case management is separated into activities that are required and those that are flexible. Required case management functions are provided by lead agencies and are not included in the participant's budget. Support planner services are included in the budget.

Case managers must apply the criteria for allowable expenditures (See Appx C, CDCS services) to all CDCS services, supports, and items to determine whether the service, support, or item may be authorized in the support plan. If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures (listed in Appendix C), it cannot be authorized and the case manager must provide the participant or their representative a notice of appeal rights.

Budgets may include:

(1) Goods or services that augment State plan services, or provide alternatives to waiver or State plan services. The rates for these goods and services are negotiated and included in the support plan.

(2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.

(3) Therapies, special diets and behavioral supports that mitigate the participant's disability when they are not covered by the State plan and are prescribed by a physician, advanced practice registered nurse, or physician assistant that is enrolled as a MHCP provider.

(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. There must be no other reasonable alternative of meeting the participant's fitness or exercise need and the condition must be identified in the participant's support plan and monitored by a MHCP enrolled physician, advanced practice registered nurse, or physician assistant. Because children have other resources available to meet these needs, fitness and exercise programs are limited to adults.

(5) Expenses related to the development and implementation of the support plan will be included in the budget. This may include but is not limited to assistance in determining what will best meet the participant's needs, accessing goods and services, coordinating service delivery, and advocating and problem solving. The participant chooses who will provide the service and how much will be included in the support plan. This support may be provided via case management through the lead agency or by another entity.

(6) Costs incurred to manage the budget; advertise and train staff; pay employer fees (FICA, FUTA, SUTA, and workers compensation, unemployment and liability insurance) as well as the employer share of employee benefits, and retention incentives (i.e., bonus, health insurance, paid time off).

Lead agencies will inform the participant prior to development of the support plan of the amount that will be available for implementing the support plan over a one year period. Participants may not carry forward unspent budgeted amounts from one plan year to the next.

Case Management Functions. The term case management is being used for purposes of common understanding in this document. Case management or other direct support functions provided as a CDCS service are flexible and may be provided by traditional or nontraditional providers.

Direct support functions are flexible in terms of who provides them and whether they are covered as a paid service. CDCS participants must have a support plan that is developed through a person-centered process. Participants must also manage and monitor their CDCS services. If participants need assistance with these tasks, support may be purchased through traditional lead agency case management, or provided by private providers, or someone else the participant may make arrangements with and not pay. If the service is paid for the cost related to support planning tasks are included in the participant's budget. A nonexclusive list of support planner functions is included in Appendix E-1-j.

There are some case management functions performed by the lead agency that are not included in the participant's CDCS budget. These functions are required if a person chooses to use CDCS. A list of many of the required lead agency functions is included in Appendix E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for

participants who exercise this authority.

- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participants are not eligible for CDCS if they have been placed in the Minnesota Restricted Recipient program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP. CDCS services are not available to waiver participants receiving licensed foster care while residing in residential settings licensed by the Department of Human Services (DHS) or while receiving customized living services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants have had the option to self-direct their waiver services through the consumer directed community supports (CDCS) service, since 2004. Approximately 8.9% of CADI participants are currently using CDCS.

CDCS allows participants to design an individualized set of supports to meet their needs. The service includes ten categories of supports: personal assistance; treatment & training; environmental modifications & provisions; environmental modifications: - home modifications; environmental modifications: - vehicle modifications; individual-directed goods and services, community integration and support, financial management services, support planning, and self direction support activities. Participants choose the level of support they want to assist them in developing support plans, monitoring services, and managing budgets and payments. This model provides far more opportunity to individually tailor and staff services compared to simply allowing a participant to self direct a pre-designed waiver service.

Waiver participants are given information upon waiver eligibility regarding their choice of CDCS services. The lead agency case manager provides the participant with information regarding benefits, responsibilities and liabilities of self-direction, so the participant can make an informed choice.

The lead agency is charged with providing participants with information and education about the goods and services that may be purchased under CDCS; information that helps participants understand their roles and responsibilities, information about resources, tools and technical assistance; information about enrolled financial management services (FMS) providers that are available to the participant; and information about the qualifications for and activities of a support planner. This is all done before or during support plan development.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☐ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representatives are chosen freely by adult participants. The extent of the decision-making authority of the participant and their representative is part of the support planning. The lead agency case manager is required to conduct in-home, face-to-face visits twice per year, and is required to conduct quarterly reviews of expenditures and services provided, and the health, safety and well-being of the participant. See the CDCS Community Supports Lead Agency Operations Manual.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Consumer-directed community supports: treatment and training	☒	☒

Waiver Service	Employer Authority	Budget Authority
Consumer-directed community supports (CDCS): personal assistance	☒	☒
Consumer-directed community supports: environmental modifications – home modifications	☐	☐
Consumer-directed community supports (CDCS): Support Planning	☐	☐
Consumer-directed community supports : Financial Management Services	☐	☐
Consumer-directed community supports (CDCS): Community Integration and Support	☐	☐
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐	☐
Consumer-directed community supports: environmental modifications - vehicle modifications	☐	☐
Consumer-directed community supports: environmental modifications and provisions	☒	☒
Consumer-directed community supports: self-direction support activities	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Consumer-directed community-supports: Self-direction support activities

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

See Appendix C, Consumer-directed community-supports: Self-direction support activities.

The fees are negotiated between the participant and the FMS provider, and documented in the support plan.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

These services are included in the global budget, under the category of consumer-directed community supports: self-direction support activities.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

  Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Oversight is achieved through a readiness review prior to enrollment and a performance review every three years. Entities completing the readiness and performance reviews have previously performed a VF/EA readiness review for a vendor that has an agreement (including subcontract) with a government entity to provide services under a Medicaid or another federally funded health care program.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

This section delineates and distinguishes those mandatory functions of the lead agency (required case management), and those optional functions that are covered under CDCS: support planning services.

Required Lead Agency Functions that are not included within the CDCS budget:

-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 applicant or participant with information regarding HCBS alternatives to make an informed choice
-If the applicant or 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
-Evaluate that the participant's health and safety needs are expected to be met given the support plan, including provider training and standards
-Evaluate 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 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 the management of the budget and services
-Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. “Budget and fiscal records management” refers to the participant’s ability to manage budget and recordkeeping tasks such as retaining and submitting receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider.
-Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction
-Assist the state agency in completing satisfaction measurements as requested
-Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested
-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 support plan
-Monitor and assist with revisions to the 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 support plan.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Independent Living Skills (ILS) Therapies	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Employment Support Services	☐
Extended Home Care Nursing	☐
Adult Foster Care	☐
Individualized Home Supports	☐
Adult Day Service Bath	☐
Environmental Accessibility Adaptations - Home Modifications	☐
Consumer-directed community supports: treatment and training	☐
24-Hour Emergency Assistance	☐
Consumer-directed community supports (CDCS): personal assistance	☐
Transitional services	☐
Consumer-directed community supports: environmental modifications – home modifications	☐
Positive Support Services	☐
Night Supervision Services	☐
Consumer-directed community supports (CDCS): Support Planning	☐
Consumer-directed community supports : Financial Management Services	☐
Consumer-directed community supports (CDCS): Community Integration and Support	☐
Homemaker	☐
Extended Personal Care Assistance Services	☐
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐
Consumer-directed community supports: environmental modifications - vehicle modifications	☐
Specialist Services	☐
Home Delivered Meals	☐
Case Management	☐
Day Support Services	☐
Adult Day Service	☐
Transportation	☐
Consumer-directed community supports: environmental modifications and provisions	☐
Employment Development Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Housing Access Coordination	☐
Personal Support Services	☐
Chore Services	☐
Family Training and Counseling	☐
Community Residential Services	☐
In-Home Family Supports	☐
Specialized Equipment and Supplies	☐
Consumer-directed community supports: self-direction support activities	☒
Adult Companion Services	☐
Family Residential Services	☐
Environmental Accessibility Adaptations - Vehicle Modifications	☐
Child foster care	☐
Caregiver Living Expenses	☐
Crisis Respite	☐
Employment Exploration Services	☐
Integrated Community Supports	☐
Extended Home Health Care Services	☐
Respite	☐
Prevocational Services	☐
Independent Living Skills (ILS) Training Services	☐
Customized Living	☐
Extended Community First Services and Supports	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The lead agency case manager initiates a change in the support plan in order to provide waiver services other than CDCS. All of the standard CADI waiver services that are necessary to the participant are available to a participant who voluntarily terminates CDCS services. There are no gaps in services during transition.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The 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.

CDCS services are not available to an individual who has been placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person in in the MRRP. Also, if a CDCS participant exits with the waiver more than once during a service plan year, the participant is ineligible for CDCS services for the remainder of that service plan year. Finally, a participant can become ineligible for CDCS services if they move to and receive licensed foster care in a residential setting licensed by DHS or receive customized living services.

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 support plan and arranging for waiver services. There are no gaps in service availability during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		3193
Year 2		3361
Year 3		3553
Year 4		3801
Year 5		3846

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Background checks are paid outside of the participant's CDCS budget.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Participant Budgets. The individual budget maximum amount is set by the state. The lead agency is responsible to review and approve final spending decisions as delineated in the participant's support plan.
CDCS Budgets for participants on BI, CAC, and CADI are determined through a three-step process:

1) Calculation of base rate for each participant
2) Adjustment of the base rate to exclude cost of services that are not allowed under CDCS.
3) Adjustment of the base rate to account for cost of living adjustments provided through legislation to all services.

Step 1: A base rate is determined for each participant using scores on 12 assessment variables. Assessment scores are used in a formula that applies coefficients to each and then adds a constant to determine the base rate.

Assessment variables, coefficients, and constant were identified through multiple regression analyses of assessment information with historic expenditures.

The following summarizes the variables, coefficients, and constants 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 3 (CADI only); Coefficient: 22.462; Range: 0-4
- Variable: Behaviors 4 (CADI only); Coefficient: 5.494; Range: 0-4
- 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

Step 2: The Base rate calculated in step one is adjusted to exclude the cost of non-eligible services. The major non-eligible service is foster care. Because foster care is our state's most costly services, exclusion of these costs results in a reduction of the individual base rate. The formula is:
((Individual Base Rate from step 1) -2.90) X 0.7

Step 3: The rate from step 2 is adjusted to account for the cumulative effect of cost of living adjustments approved by the legislature. This adjustment produces the final CDCS budget.

The yearly percentage 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; cumulative percent change 6.2345
Effective Date: 7/1/14; percent change 5; cumulative percent change 11.54
Effective Date: 7/1/15: percent change 2.53; cumulative percent change 14.37
Effective Date: 7/1/16: percent change 0.2; cumulative percent change 14.595
Effective Date 8/1/17: percent change 1.642; cumulative percent change 16.4938
Effective Date 7/1/19: percent change 2.37; cumulative percent change 19.2547

When a CDCS participant experiences a significant change in need, the commissioner may authorize a budget change for that CDCS participant based on the results of the assessment.

If a CDCS participant exits the waiver more than once during the participant's support plan year, the participant is ineligible for CDCS for the remainder of their support plan year.

Expenses covered outside of the individual budget, must also be managed within the lead agency's allowable waiver budget. These supports whether included in the individual budget or not, must be identified in the support plan.

In a 12 month service agreement period, the participant's individual budget will include all goods and services to be purchased with the exception of required case management and criminal background studies.

Case management is separated into activities that are required and those that are flexible. Required case management functions are provided by lead agencies and are not included in the participant's budget. Support planning services are included in the budget.

If the combined costs of environmental modifications and assistive technology (including assistive technology provided though supplies and equipment), during a 12 month service agreement period, exceed $5000 and cannot be covered within a participant's individual budget, the participant may request additional funding from the lead agency to cover these items.

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 five 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 7.5% when the following criteria are met:
   a. The individual is eligible for 10 or more daily hours of personal care assistance or community first services and supports
   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. For item #5, this rate is subject to COLA or SEIU collective bargaining increases as enacted by the Legislature

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The lead agency case manager informs each participant of the participant's budget amount, as determined through the statewide budget methodology. The full array of traditional waiver services is available to those participants who are not satisfied with the CDCS budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Required Case Management. The lead agency is responsible to:

(1) Review and approve the support plan if it meets the criteria in Appendix C-1/C-3. All goods and services to be covered by CDCS must be specified in the support plan and prior authorized by the lead agency case manager. There must be a clear audit trail.

(2) Evaluate requests for environmental modification and assistive technology that in combination exceed $5000 and cannot be otherwise covered within the participant's individual budget. The county of financial responsibility may authorize additional funding if the lead agency determines that the cost can be managed within the lead agency's overall budget allocation.

(3) Monitor and evaluate the implementation of the support plan. This includes reviewing that health and safety needs are being adequately met, the participant's level of satisfaction, the adequacy of the current plan and the possible need for revisions, the maintenance of financial records, and the management of the budget and services.

(4) Review each participant's CDCS expenditures, at a minimum, within three months, six months, and twelve months of the support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved support plan.

(5) Review expenditures and the participant's health and safety at least once per quarter when a parent of a minor or spouse is being paid through CDCS.

(6) Provide additional technical assistance and support to the participant or their representative if it is determined that the participant or their representative has not followed the authorized support plan. This may include a corrective action plan. If efforts to resolve problems in using CDCS are unsuccessful, the CDCS authorization will be discontinued after providing the required notifications. The participant's support plan will return to traditional waiver or state plan services.

(7) Provide notice, and terminate CDCS services if there are immediate concerns regarding the participant's health and safety or misuse or abuse of public funds and report the concern to the appropriate local or state agency for investigation. The notice will include fair hearing rights and inform participants that their CDCS services are being terminated or suspended pending the outcome of the hearing if one is requested. The participant's support plan will return to other waiver or state plan services pending the outcome of the hearing.

(8) Provide or arrange for the provision of information and/or tools for participants or their representatives to direct and manage goods and services provided through CDCS. This will include information or assistance in locating, selecting, training, and managing workers as well as completing, retraining, and submitting paperwork associated with billing, payment and taxes and monitoring on-going budget expenditures.

(9) Assist the state agency in conducting participant satisfaction measurements as requested. Provide participant satisfaction, utilization, budget and discharge summary information to the state agency as requested.

State Agency Responsibilities. Annually, the state agency will review and analyze access and utilization data, and the number and disposition of CDCS appeals.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

How Information is Provided

Fair hearing information is provided at the time an individual applies for Medicaid, at the time an individual is assessed for home and community-based services 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:

-Minnesota Health Care Programs (MHCP) Application for Certain Populations (DHS-3876) and MHCP Renewal Form (DHS-3418). These forms are used to apply for and renew 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 is initially assessed 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, decrease, or termination in of the person’s waiver services.

These forms are available on the department's web site at:

https://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.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

A grievance or complaint may be reported to the following agencies and offices:

Lead agencies
The Office of Ombudsman for Mental Health and Developmental Disabilities
The Office of Ombudsman for Long-Term Care
The Minnesota Department of Health, Office of Health Facility Complaints
The Minnesota Department of Human Services, Surveillance and Integrity Review Section
The Minnesota Department of Human Services, Disability Services Division
The Minnesota Department of Human Services, Licensing Division

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Fair hearing rights are not affected when a participant reports a concern to any of the entities noted below, and participants may concurrently request a fair hearing while working with an Ombudsman's Office or regulatory agency. Depending upon the nature of the concern, local adult or child protection units may also be notified.

The Ombudsman's offices listed above provide assistance and referral regarding any service concerns including those related to Medicaid waivers. They speak with the individual registering the complaint or concern as quickly as possible. Depending upon the nature of the concern, they may contact the lead agency, provider or department to assist the participant in resolving the issue.

The Minnesota Department of Health, Office of Health Facility Complaints, addresses complaints and allegations concerning providers that they license (e.g. home care agencies) to determine if an investigation is warranted. If there is an indication that an individual in is imminent jeopardy, the county or tribal adult or child protection units may initiate immediate protective services for alleged victims.

The Office of Health Facility Complaints takes action within ten days or sooner depending upon the allegation. The Department of Health informs the provider of its findings and issues correction orders. The time frame allowed for the provider to remedy the problem is based on the risk of harm to individuals. If the problem is not remedied satisfactorily, the Department of Health takes further action, which can include license revocation.

The Minnesota Department of Human Services Surveillance and Integrity Review Section and the Medicaid Fraud Control Unit in the Office of the Minnesota Attorney General are responsible for follow-up on and investigation of complaints related to provider billing.

The Department's licensing division is responsible for follow-up on complaints concerning providers that are licensed by the department. Depending upon the situation, an investigation may be conducted. The time lines and action taken are dependent on the nature and scope of the allegation(s) and finding(s). If a participant is determined to be in imminent jeopardy, action is taken as soon as possible to address the participant's health and safety.

The Department’s Disability Services Division is responsible for follow-up on complaints of persistent performance concerns and patterns with non-licensed waiver service providers. Depending upon the situation, the division may work with lead agencies to conduct an investigation. The time lines and action the division undertakes depend upon the nature and scope of the allegation(s) and finding(s).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Minnesota manages intake and response to reports of maltreatment of vulnerable adults and children through the state's adult and child protection systems pursuant to Minnesota Statute § 626.557 to 626.5572 and Minnesota Statute § 626.556, respectively. Maltreatment includes critical events, incidents, abuse, neglect or exploitation.

Critical events or incidents defined as maltreatment require immediate reporting. Maltreatment includes, but is not limited to, criminal acts, actions that cause physical pain, injury or emotional distress, adverse or deprivation procedures not authorized under statute, unreasonable confinement, involuntary seclusion, forced separation, the failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision, and, for adults, failure by the person to meet their own basic needs as well as financial exploitation.

State law requires immediate reporting of suspected maltreatment by mandated reporters and encourages reporting of suspected maltreatment by any person. Mandated reporters include professionals or a professional's delegate engaged in the care of vulnerable adults and children, those engaged in social services, law enforcement, vocational rehabilitation, licensed health care providers, those who work in a health care facility or licensed service, and for children, those employed in education. Mandated and voluntary reports of suspected maltreatment are encouraged through information, training and education provided by department.

Maltreatment reports involving vulnerable adults are made to the Minnesota Adult Abuse Reporting Center (MAARC), as required in statute. Minnesota's adult protection reporting data system currently captures all adult maltreatment reports collected by the centralized Minnesota Adult Abuse Reporting Center and reflects county-investigated dispositions for adult waiver participants. The MAARC operates on a 24-hour basis. All reports of suspected maltreatment made to the MAARC are forwarded to the lead investigative agency(ies) responsible, under statute, for investigation and for protective services. If a report is made initially to law enforcement or a lead investigative agency, those agencies are required to take the report and immediately forward it to the MAARC. Lead investigative agencies include the Department of Human Services, the Department of Health, and county social service agencies. Reports alleging a crime are also referred to law enforcement for criminal investigation. When death is alleged as a result of maltreatment, referral is also made to the medical examiner and the Ombudsman for Mental Health and Developmental Disabilities. The MAARC assesses all maltreatment reports for immediate risk to the vulnerable adult and makes immediate referral to the county for emergency protective services.

Maltreatment reports involving children are made to the county/tribal social service agency or the police. (Reports involving state licensed facilities may, but rarely, come directly into the state licensing entity.) The county local welfare agency receiving a maltreatment report is responsible for assessing allegations and providing child protection services. County agencies undertake family assessment or, where they have jurisdiction, investigation activities. Where a maltreatment allegation involves a state licensed facility, the county forwards the maltreatment report to the appropriate state lead investigative entity, the Department of Human Services or the Department of Health. County lead investigative agencies follow up, to conclusion, on the vast majority of maltreatment reports involving children.

Additionally, providers licensed under Minnesota Statutes, Chapter §245D are required to report the following incidents to the department and the Ombudsman for Mental Health and Developmental Disabilities:
1. serious injury of a person as determined by Minnesota Statutes section 245D.06;
2. a person's death; and
3. any emergency use of manual restraint as identified in Minnesota Statutes, section 245D.061.

Providers licensed under Minnesota Statutes, Chapter 245D must report the following incidents to the person's authorized representative and case manager:
1. serious injury of a person as determined by Minnesota Statutes, section 245D.06;
2. a person's death;
3. any emergency use of manual restraint as identified in Minnesota Statutes, section 245D.061;
4. any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition that requires the program to call 911, physician treatment or hospitalization;
5. any mental health crisis that requires the program to call 911 or a mental health crisis intervention team;
6. an act or situation involving a person that requires the program to call 911, law enforcement or the fire department;
7. a person's unauthorized or unexplained absence from a program;
8. conduct by a person receiving services against another person receiving services that
a. is so severe, pervasive or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

b. places the person in actual and reasonable fear of harm;
c. places the person in actual and reasonable fear of damage to property of the person;
d. or substantially disrupts the orderly operation of the program;
9. any sexual activity between persons receiving services involving force or coercion as defined under Minnesota Statutes, section 609.341, subdivisions 3 and 14.
10. A report of alleged or suspected child or vulnerable adult maltreatment under Minnesota Statutes, section 626.556 or 626.557

License holders under Minnesota Statutes, Chapter 245D must report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided or within 24 hours of discovery or receipt of information that an incident occurred. License holders under Minnesota Statutes, Chapter 245D must report the death or serious injury of a person to the department and the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours. Case managers are responsible for developing a support plan that reasonably ensures the health and safety of the participant and for coordinating, monitoring, and evaluating the services provided. Case managers will consult with the participant and their team after an incident to evaluate if a change is necessary in the person's coordinated services and supports plan, up to and including a change in the service provider.

In addition to the above, providers subject to Minnesota Rules, Chapter 9544 (which includes providers licensed under Minnesota Statutes, Chapter 245D to provide home and community based services, as well as all other providers licensed under Minnesota Statutes, Chapter 245A for services to people with developmental disabilities or related conditions) are required to report the following incidents via an electronic form, the Behavior Intervention Report Form (DHS-5148), to the department and the Office of the Ombudsman for Mental Health and Developmental Disabilities (OMHDD):
1. the emergency use of manual restraint (physical holding);
2. prohibited procedures incorporated into a positive support transition plan in accordance with Minnesota Statutes, section 245D.06, subdivision 8. These procedures may include:
a. mechanical restraint;
b. programmatic use of manual restraint;
c. seclusion;
d. time out;
e. an aversive or deprivation procedure;
3. a medical emergency occurring as a result of the use of restrictive intervention with a person that leads to a call to 911 or seeking physician treatment or hospitalization for a person;
4. a behavioral incident that results in a call to 911;
5. a mental health crisis occurring as a result of the use of a restrictive intervention that leads to a call to 911 or a provider of mental health crisis services as defined in Minnesota Statutes, section 245.462, subdivision 14c;
6. an incident that requires a call to mental health mobile crisis intervention services;
7. a person's use of pro re nata (PRN) medication to intervene in a behavioral situation. This does not include the use of a psychotropic medication prescribed to treat a medical symptom or a symptom of a mental illness or to treat a child with severe and emotional disturbance; or
8. an incident that the person's positive support transition plan requires the program to report

The incidents listed above must generally be reported to the person's team within 24 hours, reviewed by the team and electronic report submitted to the Department and the OMHDD within 15 working days of the incident. The authority to collect this information was provided by Minnesota Statutes, section 245.8251, subdivision 2 and the subsequent behavior intervention report form instructions issued by the Department: Instructions and Definitions for the Behavior Intervention Reporting Form (DHS-5148A).

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The department provides maltreatment reporting and response training to lead agencies, including training for waiver case managers. The department offers an online training course on Vulnerable Adult Mandated Reporting, at http://registrations.dhs.state.mn.us/WebManRpt and publishes a vulnerable adult brochure: “Report suspected abuse, neglect, self-neglect or financial exploitation of vulnerable adults” (DHS-6778E). The brochure includes information about what may be considered abuse, neglect, and exploitation, and how to report concerns. The department provides similar resource information regarding suspected child abuse or neglect. Refer to the brochure: “Resource Guide for Mandated Reporters of Child Maltreatment Concerns” (DHS-2917).

The department publishes a handbook for participants and families. “Older Minnesotans, Know Your Rights About Services,” (DHS-4134) includes information about participants’ rights to “be safe and free from harm,” including how to report a concern and information about advocacy assistance. “Family Guide to Child Protection” (DHS-3247) explains what county social services staff do when accepting a report of child abuse or neglect. Brochures and additional information regarding vulnerable adult and child protections are available on the department’s web site. Brochures are also available through lead agencies, who provide copies during waiver assessments. All DHS forms, in addition to participant resources, are available at https://mn.gov/dhs/general-public/publications-forms-resources/edocs/

The LTC Screening Document (DHS-3428) or the MnCHOICES assessment tool used to determine waiver eligibility contain assessment questions intended to help discover any risk for maltreatment the applicant maybe experiencing. An assessor is required to report to the MAARC reports of any suspected maltreatment. Actions taken would follow those outlined above related to the MAARC and next steps related to investigation and the provision of protective services.

The Senior Linkage Line (SLL) and Disability Hub are widely publicized public resources that include information on vulnerable adults and how to report maltreatment. These resources are operated by the department and other partners and include toll free phone numbers and a searchable web data base. Information about this resource is also provided during assessment. Information about the SLL and Disability Hub can be viewed at:
- http://www.mnaging.net/en/Advisor/SLL.aspx
- https://disabilityhubmn.org

Providers who furnish home care services are required to provide their clients with a copy of the Home Care Bill of Rights and information on how to report maltreatment concerns. The Bill of Rights is provided to waiver participants who receive services through a home health care agency. Routine licensing reviews of providers include monitoring that participants are informed of their rights as required. The Home Care Bill of Rights, including copies in other languages, can be accessed at
https://www.health.state.mn.us/facilities/regulation/billofrights/index.html

Foster care providers are required to complete an “Individual Residential Placement Agreement” as defined in MN Rule, part 9555.5105, subpart 19. This placement agreement must include the development of an individual abuse prevention plan with the participant.

Adult Day Care providers are required under MN Rule, part 9555.9640 to provide participants with a copy of their rights, and must include either a copy or written summary of Minn Stat. § 626.557 (Reporting of Maltreatment of Vulnerable Adults).

Routine licensing reviews of providers include monitoring that participants are informed of their rights as required. Providers licensed under Minnesota Statutes, Chapter 245D must provide participants with a written copy of their rights as defined in Minn. Stat. §245D.04, subdivisions 2 and 3.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

INITIAL REPORT REVIEW AND RESPONSE:
The MAARC receives reports of incidents of suspected abuse, neglect, or exploitation involving adults. MAARC staff screen reports for immediate risks, making all necessary referrals before forwarding reports to the county or state lead investigative agency. MAARC staff work with a standardized screening and decision-making framework in responding to reports. The MAARC immediately refers cases involving an identified safety need to county social services. It immediately forwards reports containing information involving an alleged crime to law enforcement. The MAARC forwards reports of suspicious death to the medical examiner and the ombudsman for mental health and developmental disabilities. The MAARC notifies the lead agency responsible for report review and investigation within two working days.

Incidents of suspected abuse and neglect involving children are similarly managed. Local agencies screen all reports for immediate risk and make all necessary referrals in keeping with the Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines (DHS-5144). Counties and authorized tribal agencies make immediate referral for child protection services when there is an identified safety need. County social services forward reports involving an alleged crime to law enforcement and reports of suspicious death additionally to the medical examiner and the ombudsman for mental health and developmental disabilities.

Reports involving alleged maltreatment of children prompt variable response. Local agencies must, within 24 hours, see the alleged victim of a child maltreatment allegation that involves substantial endangerment. In the case of allegations that do not involve substantial endangerment, the alleged victim must be seen within 5 calendar days. The department's Child Maltreatment Screening Guidelines promote statewide consistency in definition and practice in response to maltreatment reports.

LEAD INVESTIGATIVE AGENCY REVIEW AND RESPONSE:
Investigation guidelines for all lead investigative agencies are established in statute and include interviews with alleged victims and perpetrators, evaluation of the environment surrounding the allegation, access to and review of pertinent documentation and consultation with professionals. Each lead investigative agency evaluates reports based on prioritization guidelines. The department requires county lead investigative agencies to use structured decision-making tools to assess reports for investigation and determine the need for protective services. (For reports involving vulnerable adults, counties assess the safety, strengths and needs of the vulnerable adult for individualized protective services.) Statewide implementation of structured decision-making tools promotes safety through consistent, accurate and reliable assessment. Lead investigative and law enforcement agencies cooperate in the pursuit of civil and criminal maltreatment investigations.

Lead investigative agencies have 60 calendar days to complete investigations involving adults as the alleged victims of maltreatment with authority to extend the investigation when a final investigative disposition is not able to be made within this time frame. (Upon request of the reporter, the lead investigative agency will provide initial disposition information within five working days.)

Lead investigative agencies have 45 calendar days to complete investigations and family assessments involving children as the alleged victim of maltreatment. Local agencies complete a family assessment where a child is not at risk of imminent harm and not living in a licensed setting. Assessment offers a holistic approach to addressing family issues and minimizing the prospect of future maltreatment.

The lead investigative agency is responsible to notify the proper agencies or individuals of the findings. Participants, who are the subject of reports, or their legal surrogate with appropriate authority, are informed of the findings of the investigation at the conclusion of the investigation with an opportunity to engage an appeal process. If maltreatment is substantiated, information about the perpetrator is entered into the perpetrator registry maintained by the department. This information is made available as part of required provider employment background checks. Licensing boards receive notification of substantiated maltreatment that they may refer on for criminal prosecution. Information on specific categories of providers substantiated for maltreatment is available to the public via web-based information maintained by the lead investigative agencies for those providers.
See MDH: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
DHS Licensing Information Lookup: http://licensinglookup.dhs.state.mn.us/

REMEDIATION AT THE LEVEL OF THE INDIVIDUAL:
County agencies provide individual remediation to adults who are the subject of reports of suspected maltreatment,

including the following:
• Offering emergency and continuing adult protective services;
• Medical examination and treatment for sexual assault;
• Seeking authority to remove the vulnerable adult from the situation;
• Seeking a restraining order for removal of the perpetrator;
• Appointment or replacement of a guardian or conservator;
• Referral to a prosecuting attorney for criminal prosecution;
• Use of a multidisciplinary adult protection team for case consultation, prevention, and intervention.

Substantiated maltreatment may be the result of relationships, scams, stranger crimes and circumstances that are unrelated to a service or provider. It is not possible for the lead investigative agency or the county agency responsible for protective services to remediate forms of maltreatment which occur in conjunction with an adult's autonomy and right to personal choice.

Remediation of child maltreatment transpires at a number of levels. It can involve immediate removal of the child from the home and reporting the suspected offender to law enforcement. Alleged maltreatment investigation always includes assessment of the need for protective services.

Where necessary, the county's child protection unit develops a protective service plan for the child and assists the family in accessing services such as counseling or parent education. When protective services are provided to a child remaining in the home, the county case worker meets with or contacts the family at least monthly to monitor the provision of services and the child's welfare. Quarterly, at a minimum, the case worker consults with providers delivering services to review the protective service plan and evaluate the appropriateness of services.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS developed and manages the Social Services Information System (SSIS) that houses maltreatment reports and tracks critical steps in the response process statewide. DHS requires Minnesota's 87 counties to use SSIS to support intake, referral and management of maltreatment reports. Upon completion of a maltreatment investigation, the county (or tribal nation in the case of minors), as Lead Investigative Agency, documents its investigative findings in SSIS.

The SSIS system has the capacity to provide statewide maltreatment summary information to DHS. DHS reviews SSIS data reports on a quarterly and annual basis, analyzing report receipt, referral, investigation, and investigative disposition patterns and trends. Data analysis yields routine reporting and efforts, with maltreatment program partners, to make prevention and response improvements. SSIS maltreatment data enables DHS to evaluate the quality of its preventive and protective services and discern where policy and training enhancements are needed.

The department extracts adult and child waiver participant maltreatment data differently from SSIS. DHS retrieves waiver adult data that is collected through MAARC and subsequently identified by the LIA as involving a waiver participant. The Department extracts waiver minor data collected and investigated by county and tribal nation LIAs. Information entered in SSIS narrative data fields, whether for waiver child or waiver adult, cannot be extracted in an aggregated format.

Waiver program staff review waiver participant data and waiver program maltreatment reports regularly, monitoring for patterns and trends that indicate atypical activity in the state's waiver populations or of possible broader based state adult and child protective system concern.

SSIS data currently contains all MAARC reports and findings from county investigations. DHS and Department of Health Licensing investigations involving adults are scheduled for incorporation into SSIS. DHS and MDH licensing units generate their own licensed facility maltreatment reports on a regular basis.

Licensing lead investigative agencies provide public investigation memorandums for substantiated reports of maltreatment. They forward substantiated findings to the appropriate licensing boards of the substantiated perpetrator. Substantiated findings for licensed providers are available on the DHS and Minnesota Health Department public websites and are used for licensing sanctions or revocation.
-DHS Licensing Information Lookup: http://licensinglookup.dhs.state.mn.us/
-MDH Licensing: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

Lead investigative agencies provide DHS with the names of substantiated perpetrators. DHS maintains a registry of substantiated perpetrators of maltreatment who are disqualified from providing direct services. People applying for a license, including owners, managers, employees and contractors providing services in licensed programs and facilities are checked against the DHS disqualified perpetrator registry.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In this state, the use of restraints are generally considered to constitute abuse under the Vulnerable Adult Act and Maltreatment of Minors act unless they can be considered therapeutic conduct or the use of reasonable force. All providers and case managers must report incidents of suspected abuse according to the process described in G-1.

In the context of the Vulnerable Adults Act, therapeutic conduct includes the provision of program services, health care, or other personal care services done in good faith in the interest of the vulnerable adult by an individual, facility, or an employee or person providing services in a facility under the rights, privileges, and responsibilities conferred by state license, certification or registration, or a caregiver. A caregiver includes family members and persons or entities who have assumed responsibility for the care of an individual voluntarily, or by contract or agreement.

The Vulnerable Adults Act and the Maltreatment of Minors Act (Minnesota Statutes, Chapter 626) require mandated reporting and investigation of abuse and neglect of vulnerable adults and children. This law defines abuse and neglect of an adult to include any use of aversive or deprivation procedures, unreasonable confinement or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against their will. Accidents and therapeutic conduct are not considered abuse. Minnesota Statutes, Chapter 626 also defines abuse of children to include any aversive or deprivation procedures, or regulated interventions that have not been authorized under Minnesota Statutes, section 125A.0942 (dealing with discipline in school) or Minnesota Statutes, section 245.8251 (applicable to (a) all providers licensed under Minnesota Statutes, Chapter 245D, and (b) all other providers licensed by the Department under Minnesota Statutes, Chapter 245A for services to persons with developmental disabilities or related conditions).

Services licensed under Minnesota Statutes, Chapter 245D. Minnesota Statutes, section 245D.06, subdivisions 5 to 8 and section 245D.061, provide the requirements for the use of restraint, aversive and restrictive procedures for license holders. Minnesota Statutes, section 245D.06, subdivision 5 prohibits license holders from using chemical restraints, mechanical restraints, manual restraints, time out, seclusion, or any other aversive or deprivation procedure as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience. Minnesota Statutes, section 245D.061, subd. 2, provides the conditions for which the emergency use of manual restraint may be utilized. Any emergency use of manual restraint by a license holder under Minnesota Statutes, chapter 245D must be reported to the person's legal guardian, the case manager, the department, and the Ombudsman for Mental Health and Developmental Disabilities as described in Appendix G-1. The state has created an online form for licensed service providers to complete for this purpose, known as the Behavior Intervention Report Form (BIRF). Multiple uses of an emergency use of manual restraint requires the creation of a plan to avoid the future emergency use of manual restraint.

As noted above, the use of mechanical restraint, programmatic use of manual restraint, or drugs used as a restraint – labeled chemical restraint in Minnesota – is prohibited under the conditions of licensure (see Minnesota Statutes section 245D.06, subdivision 5). Under Minnesota Statutes, section 245D.06 subd. 8, the commissioner has limited authority to authorize the use of a prohibited procedure for persons at risk of serious injury, defined in Minnesota Statutes, section 245.91, subdivision 6, due to self-injurious behavior. The Department created an External Program Review Committee to review plans seeking the use of a prohibited procedure and make recommendations to the commissioner regarding authorization. This panel also has the duty to review reported uses of emergency use of manual restraint, evaluate the license holder's response to those emergency uses, and provide guidance to the license holder about its response when the committee determines a change is needed to reduce the frequency or duration of future emergency uses.

On August 31, 2015, the Department promulgated Minnesota Rules, part 9544 governing the use of positive support strategies that apply to (a) all providers licensed under Minnesota Statutes, Chapter 245D, and (b) all other providers licensed by the Department under Minnesota Statutes, chapter 245A for services to persons with developmental disabilities or related conditions. The conditions of Minnesota Statutes, Chapter 245D noted above apply to all providers licensed by the Department under Minnesota Statutes, Chapter 245A for services to persons with developmental disabilities or related conditions.

Out-of-home placement for children. Minnesota Rules, parts 2960.0010 to 2960.0120 govern the use of restrictive procedures in these settings, including the documentation required, and the training required for

those involved. These rules require a restrictive procedures plan approved by the commissioner of human services prior to the use of restrictive procedures, which includes physical escort; physical holding; seclusion; and the limited use of mechanical restraint only for transporting a resident. The restrictive procedures plan must include the procedures and techniques that will be used; and a description of the training that staff must have prior to implementing the emergency use of restrictive procedures. That training must include the needs and behaviors of residents; relationship building; alternatives to restrictive procedures; de-escalation methods; avoiding power struggles; documentation standards for the use of restrictive procedures; how to obtain emergency medical care; time limits; obtaining approval; updated training; and the proper use of techniques approved for the facility. These rules apply to child foster care.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The state detects unauthorized use of restrictive interventions through maltreatment reports required under the Vulnerable Adults Act and the Maltreatment of Minors Act, through the Behavior Intervention Report Form (DHS-5148) and through licensing of providers under Minnesota Statutes, Chapters 245A and 245D. Reporting, response and investigation of these reports is described in Appendix G-1. For licensed facilities, the misuse of aversive and deprivation procedures can result in licensing action, including loss of license.

The required documentation for the authorized use of aversive and deprivation procedures are contained in the rules cited above. The Vulnerable Adults Act and the Maltreatment of Minors Act include mandated reporting of abuse.

Education and training requirements for personnel who are involved in the administration of aversive or deprivation procedures are contained in the licensing rules cited above. In addition, as noted previously, the state offers an on-line learning module to lead agencies, provider staff, advocates and interested participants regarding functional assessment and positive behavior support plan development in order to provide positive behavior support to enhance an individual's quality of life and to minimize problem behaviors.

In addition, all waiver providers are mandated reporters under the Vulnerable Adults Act and are required to provide staff training regarding issues that must be reported, MAARC contacts, and follow-up within the provider agency. This requirement is included in the provider agreement that is used for waiver provider enrollment. The Maltreatment of Minors Act requires the reporting of abuse by any operator, employee or volunteer worker of a day care or residential facility, and any professional engaged in the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement.

The online Mandated Reporter Training related to child maltreatment is available at: https://mn.gov/dhs/people-we-serve/children-and-families/services/child-protection/programs-services/mandated-reporting-training-overview.jsp

The Online Vulnerable Adults Mandated Reporter Training is available at: http://registrations.dhs.state.mn.us/WebManRpt/default.htm

The Minnesota Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under Minnesota Statutes, Chapters 245A (foster care and residential providers) and 245D. The local human services agencies are responsible for assessing and investigating maltreatment in child foster care settings, and reports involving children served by personal care provider organizations or community first services and supports provider organizations.

All emergency use of manual restraints utilized by providers licensed under Minnesota Statutes, Chapter 245D are reported to the department, and the Ombudsman for Mental Health and Developmental Disabilities. License holders submit reports to both agencies through the use of the online behavioral intervention report form.

For adults, the Department of Human Services is also the lead investigative agency for reports of programs licensed as adult day care, adult foster care, mental health programs, and personal care provider organizations. The Department of Health is the lead investigative agency for investigating home care providers, board and lodge facilities, and boarding care homes.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

See responses for a.i. above.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

See responses for a.ii. above.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

In this state, the use of seclusion is generally considered to be abuse under the Vulnerable Adult Act. This law defines abuse to include any use of unreasonable confinement, involuntary seclusion or the forced separation of the vulnerable adult from other persons against their will. The exception to this is if the use of seclusion could be considered an accident or therapeutic conduct. The Maltreatment of Minors Act also protects minors from unreasonable confinement or restraint not permitted under the use of reasonable force under Minnesota Statutes, section 609.379.

For providers licensed under Minnesota Statutes, section 245D.06, subdivision 5 further prohibits the use of seclusion by a license holder as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience. This language narrows what could be considered therapeutic conduct for an adult or the use of reasonable force with a minor. Minnesota Statutes, section 245D.02, subdivision 29 defines seclusion as:

"Seclusion" means: (1) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room; or (2) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.

The Department is responsible for detecting the unauthorized use of seclusion through routine licensing inspections and/or reports of maltreatment submitted to the Minnesota Adult Abuse Reporting Center or local welfare agency. Additionally, the use of restricted procedures identified in Minnesota Statutes, section 245D.06, subdivision 6, paragraph (a) items (1) and (2) require reporting to both the Department and the Office of the Ombudsman for Mental Health and Developmental Disabilities. These reports are monitored for the use of seclusion or otherwise prohibited procedure. If a report appears to include the use of seclusion, it is forwarded to the Licensing division of the Department for further investigation.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Department of Human Services continuously monitors reports submitted either via the Minnesota Adult Abuse Reporting Center, local welfare agency or behavior intervention report form. The Department also completes routine licensing inspections of licensed facilities and services on a bi-annual basis.

The Minnesota Department of Health maintains oversight of some facilities offering home and community-based services. The Department of Health also completes routing licensing inspection of licensed facilities and services on a bi-annual basis.

The Office of the Ombudsman for Mental Health and Developmental Disabilities continuously monitors reports submitted via the behavior intervention report form or the serious injury or death reports.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The participant's support plan must address health and safety needs. This includes plans to address the need for medication assistance, and a determination by the case manager as part of support planning of whether and which provider is able to reasonably meet the medication management needs identified in the participant's support plan.

The waiver includes participants who receive ongoing services in foster care homes, community residential settings, and customized living. Providers have on-going responsibilities related to monitoring participants, which may include monitoring medication regimens.

Services licensed under Minnesota Statutes, Chapter 245D
Minnesota Statutes, sections 245D.05 and 245D.051 contain licensing standards regarding meeting health needs, which includes medication setup, medication assistance, medication administration, and maintaining medication records. The operator's compliance with requirements related to medication management is reviewed during routine licensing visits.

Services that must have a service license under Minnesota Statutes, chapter 245D include:
• 24-hour emergency assistance
• Adult companion
• Adult foster care
• Child foster care
• Community residential services
• Crisis respite
• Day support services
• Employment development
• Employment exploration
• Employment support
• Family residential services
• Homemaker
• Independent living skills (ILS) training
• Individualized home support (without training, with training, and with family training)
• In-home family support
• Integrated community supports
• Night supervision
• Personal support
• Positive support services
• Prevocational services
• Respite
• Specialist services

Customized Living
Providers of Customized Living must maintain an assisted living facility license or a comprehensive home care license issued by the Minnesota Department of Health. Minnesota Statutes, section 144A.4792 addresses medication set-up, administration and monitoring for providers with a comprehensive home care license. Minnesota Statutes, section 144G.71 addresses medication set-up, administration and monitoring for providers with an assisted living facility license.

Home Care
For individuals who receive state plan home care, medication assistance may be provided through the licensed home health agency. Other medication management strategies include those made available through pharmacies, clinics, primary care physicians, advanced practice registered nurses, and physician assistants. In addition, medication set up and administration assistive devices can be utilized for individuals who can benefit from this level of assistance.

Licensed providers are subject to discovery and remediation through the licensing process of application, inspection and corrective action.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that

participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Services that must have a service license under Minnesota Statutes, chapter 245D include:
• 24-hour emergency assistance
• Adult companion
• Adult foster care
• Child foster care
• Community residential services
• Crisis respite
• Day support services
• Employment development
• Employment exploration
• Employment support
• Family residential services
• Homemaker
• Independent living skills (ILS) training
• Individualized home support (without training, with training, and with family training)
• In-home family support
• Integrated community supports
• Night supervision
• Personal support
• Positive support services
• Prevocational services
• Respite
• Specialist services

These services must follow medication standards under Minnesota Statutes, sections 245D.05 and 245D.051. The provider is required to document the administration of the medication in the individual's medication administration record. The provider is required to review the record regularly, at a minimum of every three months. If there are problems identified, the provider must develop and implement a plan to correct patterns of administration errors.

Under Minnesota Statutes, Chapter 245D, the provider must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the coordinated services and supports plan:
-Any reports made to the person's physician or prescriber;
-A person's refusal or failure to take or receive medication or treatment as prescribed; and
-Concerns about a person's self-administration of medication or treatment.

For customized living, the provider must hold an assisted living facility license or a comprehensive license as a home health agency. This includes licensed nurses who complete or provide oversight to any medication management procedures. Medication management procedures include medication set-up, administration, and monitoring. Provider's compliance is monitored through surveys conducted by the Minnesota Department of Health. Medications may also be set up by physicians, advanced practice registered nurses, physician assistants, or pharmacists.

Case managers are responsible to develop a support plan that identifies and addresses the participant's health and safety needs, and conduct monitoring reviews at least twice within the twelve-month period.

Physicians, advanced practice registered nurses, and physician assistants are responsible for prescribing and monitoring medications in accordance with their scope of practice.

Nurses are responsible for medication administration in accordance with their scope of practice as indicated in Minnesota Statutes, sections 148.171 to 148.285. The Minnesota Board of Nursing issues the license and is responsible for follow-up and oversight.

Medical Assistance covers medication therapy management services for participants who are taking four or more prescriptions to treat or prevent two or more chronic conditions and who are not eligible for Medicare Part D.

Medication therapy management services are provided by licensed pharmacists who meet certain provider standards. The service includes:
1. Performing or obtaining necessary assessments of the participant's health status;
2. Formulating a medication treatment plan;
3. Monitoring and evaluating the participant's response to therapy, including safety and effectiveness;
4. Performing a comprehensive medication review to identify, resolve, and prevent medication related problems, including adverse drug events;
5. Documenting the care delivered and communicating essential information to the participant's other primary care providers;
6. Providing verbal education and training designed to enhance participant understanding and appropriate use of participant's medications;
7. Providing information, support services, and resources designed to enhance the participant's adherence with their therapeutic regimens;
8. Coordinating and integrating medication therapy management services within the broader health care management services being provided to the participant.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The provider licensed under Minnesota Statutes, Chapter 245D must implement the following medication administration procedures to ensure a person takes medication and treatments as prescribed:
(1) Checking the person's medication record;
(2) Preparing the medication as necessary;
(3) Administering the medication or treatment to the person;
(4) Documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and
(5) Reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

For customized living, the assisted living facility license or comprehensive home care license allows providers to administer, set up, or provide reminders to take medications. Licensing standards govern medication management including record keeping and storage. Refer to Minnesota Statutes, sections 144A.43 through 144A.483 and 144G.43 and 144G.71.

Medication administration by non-medical waiver provider staff. Minnesota Statutes, Chapter 245D require new staff to review and receive instruction on medication administration procedures established for the person when medication administration is assigned to the license holder according to section 245D.05, subd. 1, paragraph (b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant or physician. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health condition that affects the service options available to the person because the health condition requires:
-specialized or intensive medical or nursing supervision; and
-nonmedical services providers to adapt their services to accommodate the health and safety needs of the person.

The following services must meet the licensing standards in Minnesota Statutes, chapter 245D:
• 24-hour emergency assistance
• Adult companion
• Adult foster care
• Child foster care
• Community residential services
• Crisis respite
• Day support services
• Employment development
• Employment exploration
• Employment support
• Family residential services
• Homemaker
• Independent living skills (ILS) training
• Individualized home support (without training, with training, and with family training)
• In-home family support
• Integrated community supports
• Night supervision
• Personal support
• Positive support services
• Prevocational services
• Respite
• Specialist services

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

According to Minnesota Chapter 245D.05, Subd. 4, when assigned responsibility for medication administration, licensed Minnesota Statutes, Chapter 245D providers must develop and implement a plan to correct patterns of medication administration errors when identified. The license holder must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the support plan:
• If a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and the occurrence of possible adverse reactions to the medication or treatment; or
• a person's refusal or failure to take or receive medication or treatment as prescribed; or
• concerns about a person's self-administration of medication or treatment.

Please reference Appendix G-3, a.ii. for additional information on Minnesota Statutes, Chapter 245D requirements for license holders to document, track and review the administration of medications.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DHS or MDH review all providers licensed under Minnesota Statutes, Chapter 245D every three years. The review includes requirements related to medication administration.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI participants who are not victims of maltreatment per calendar year. Numerator: Number of CADI participants who were not the victims of county-substantiated maltreatment while on CADI per calendar year. Denominator: Number of CADI participants per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Adult Protection database and Minnesota Child Protection database (Social Service Information System [SSIS])

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle where the support plan documents assessed health and safety issues. Numerator: Number of CADI participant files reviewed where the support plan documents assessed health and safety issues. Denominator: Number of CADI participant files reviewed during the current lead agency review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI adult deaths associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per calendar year. Numerator: Number of CADI adult deaths associated with alleged maltreatment reported to MAARC that were referred to the ME. Denominator: Number of CADI adult deaths associated with alleged maltreatment reported to the MAARC.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Adult Protection database (Social Service Information System [SSIS])

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of CADI participant files reviewed during the current lead agency review cycle that include an emergency back-up plan. Numerator: Number of CADI participant files reviewed during the current lead agency review cycle that include an emergency back-up plan. Denominator: Number of CADI participant files reviewed during the lead agency review cycle.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Lead Agency Waiver Review Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☒ **Other** Specify: Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

Performance Measure:
Percent of CADI waiver minors who did not experience death as a result of maltreatment, per calendar yr. Numerator: Number of CADI minor participants determined not to have experienced death as a result of county-substantiated maltreatment. Denominator: Number of minors enrolled on the CADI waiver, per calendar year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Child Protection database (Social Service Information System [SSIS])

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of reports of maltreatment of CADI 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 CADI adults reported to MAARC and referred to a LIA within two working days. Denominator: Number of allegations of maltreatment of CADI adults reported to MAARC, per calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Adult Protection database (Social Service Information System [SSIS])

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent CADI 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 CADI participants who did not have a determination of substantiated maltreatment within 12 mos. of a determination in the reporting year. Denominator: Number of CADI participants in the reporting year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Minnesota Adult Protection database and Minnesota Child Protection database (Social Service Information System [SSIS])

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI participants served by 245D-licensed providers who have not been the subject of BIRF-reported prohibited interventions, per calendar year.
Numerator: Number of CADI participants served by 245D-licensed providers who have not been the subject of BIRF-reported prohibited interventions, per year.
Denominator: Number of CADI participants served by 245D providers, per year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Behavior Intervention Report Form database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent of Behavioral Intervention Report Forms (BIRF) involving CADI participants that do not report prohibited interventions, per calendar year. Numerator: Number of BIRFs involving CADI participants that do not report prohibited interventions, per calendar year. Denominator: Number of BIRFs involving CADI participants filed, per calendar year.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Behavior Intervention Report Form database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Percent CADI participant restricted procedure interventions in compliance with regulatory requirements, per calendar year. Numerator: Number of BIRF-reported CADI restricted procedure interventions implemented with the mandated approval of the DHS Commissioner. Denominator: Number of BIRF-reported CADI interventions involving restricted procedures requiring DHS Commissioner approval.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Behavior Intervention Report Form database, and Commissioner Restricted Procedure database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI 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 CADI participants >1yr, per calendar yr. *AAP – Adults' Access to Preventative/Ambulatory Health Services **CAP – Children and Adolescents' Access to Primary Care**

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Maltreatment Report Investigations; Child and Adult Protection. When a report of suspected maltreatment is received, the local intake agency determines the agency responsible to assess and investigate the alleged maltreatment (the lead investigative agency) and forwards the report for investigation, determination and final disposition. The local welfare agency and/or local law enforcement authorities are required to take immediate protective measures if a serious or imminent threat to the participant's safety exists. For suspected victims under age 18, a family assessment may also be conducted by the local welfare agency to determine and follow-up on child safety, risk of subsequent child maltreatment and family strengths and needs.

Methods for addressing individual problems include protective services by local child and adult protective services units; criminal, civil, licensure and/or certification sanctions (as applicable) against substantiated perpetrators; and corrective action requirements for licensed/certified providers. Revisions to support plans by case managers also address identified risks.

Lead Agency Reviews, and follow-up reviews. The Department issues corrective actions to lead agencies when it finds patterns of non-compliance. Individual or case-specific deficiencies are addressed with the lead agency before the conclusion of the review, and correction is required. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made. Follow-up reviews (within 18 months after an initial review) include a review of the initial samples where correction was needed and a review of additional cases to assure both individual and systemic problem and pattern correction. Corrective actions and follow-up findings are documented in the Department's Waiver Lead Agency Review Database.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Waiver Quality Monitoring and Management Process
The DHS Quality Essentials Team (QET) will review and analyze 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 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 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.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Per the same process outlined above, QET will monitor and analyze the effects of system design changes, and additional system re-design/improvement will be undertaken by the appropriate policy team, with support from QET.

High-level monitoring and trending data will be communicated to stakeholders and the public via:
- a web-based performance measure dashboard;
- annually providing information to DHS-CSA quality management-related stakeholder bodies; and
- mandated legislative reports.

Regarding the rate management system implemented on 1/1/2014, the state will monitor and conduct fiscal analysis to ensure the rates management system is used correctly. Fiscal impact of the system will be analyzed at the regional, lead agency, provider and service levels. This analysis will investigate differences between historical rates, banded rates and framework rates to detect trends, identify and correct errors, and evaluate the effectiveness of system improvements.

Additionally, the system will be monitored through review and comparison of rate management system (RMS) and MMIS data to ensure lead agencies are utilizing RMS to determine appropriate rates, and that those rates are correctly entered in MMIS.

Full system evaluation reports will be provided to the legislature on the following schedule:

•January 15, 2021

A report will be provided to the legislature once every four years thereafter.
Beginning in 2012 and every two years thereafter, the state has conducted a Gaps Analysis Survey which reports the current capacity and gaps in long-term care services and supports

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Biennially, QET will submit an evaluation of the effectiveness of the Quality Improvement Strategy, with recommendations for QIS re-design/improvement, to the DHS Disability Services Division leadership team. The leadership team will consider the findings and recommendations of the biennial QIS evaluation and approve changes as needed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population

in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

We conduct the NCI and NCI-AD surveys annually.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

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 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.

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 community first services and supports
• 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).

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.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver

actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI waiver claims paid that align to Rate Management System (RMS) records, per calendar year. Numerator: Dollar amount of CADI waiver claims paid for services with service agreement lines matching the RMS record, per calendar year. Denominator: Dollar amount of CADI waiver claims paid for services with service agreement lines requiring a RMS record, per calendar year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
RMS and MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Percent of CADI waiver claims paid for which there is corresponding prior authorization, per calendar year. Numerator: Dollar amount paid for CADI waiver claims with a corresponding prior authorization, per calendar year. Denominator: Dollar amount of all paid CADI waiver claims, per calendar year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***

☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of CADI waiver service authorizations that align to Rate Management System (RMS) records, per calendar year. Numerator: Dollar amount of authorized CADI waiver service agreement lines that have a matching RMS record, per calendar year. Denominator: Dollar amount of authorized CADI waiver service agreement lines requiring a RMS record, per calendar year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
RMS and MMIS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Surveillance and Integrity Review Section (SIRS). SIRS performs a federally mandated function of statewide surveillance and utilization control. SIRS monitors the delivery of waiver services by providers and the use of waiver services by participants through activities such as routine claims data analysis for unusual patterns, periodic reviews of selected providers, and investigations of identified or reported fiscal integrity issues.

Waiver Management System (WMS) and Management Reporting System (MRS). The Department manages waiver cost neutrality through allocations (amounts) to lead agencies. Lead agencies manage waiver expenditures within the allocation. The allocation formula is based on historic costs with acuity adjustments as provided by the legislature. All services are authorized in and claims paid through MMIS. The Department provides lead agencies with allocation, authorization and claims data through the Waiver Management System. Information from this system is reviewed by Department staff on a monthly basis to monitor lead agencies' authorization patterns.

Department staff also monitor regularly (e.g., quarterly, ad hoc) generated encumbrance and payment summary reports that are downloaded into the MRS to monitor lead agencies. MMIS data is used to generate the reports. The reporting system requires less technical training to use than MMIS and allows policy and regional staff immediate access to reports and data.

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.*

Surveillance and Integrity Review Section (SIRS). When individual problems are identified, SIRS is able to address them through various methods as appropriate, including:
- *Recovering overpayments due to error, abuse, or fraud;*
- *Suspending or terminating provider participation in the MHCP; and/or*
- *Facilitating prosecution of health care fraud.*

Administrative Data System Reports. Department staff review county authorization patterns on a monthly basis and provide technical assistance if an issue, such as under or over spending, is identified. Follow-up information is entered into and tracked in DHS Workplace (the Departments Sharepoint-based intranet system).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment*

rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Minnesota pays for services in 3 ways.

1. DHS sets rates for state plan services, including home care, home care nursing, CFSS & PCA services. These rates are approved in the state plan. Personal care for participants who elect CDCS are not state-set rates. The budget methodology for CDCS is described in Appendix E-2-b-ii.

DHS establishes rates for case mgmt, ext PCA, ext CFSS, homemaker, home-delivered meals & chore services. Case mgmt is paid at $24.47/15-min unit. Ext PCA is paid for 1:1, 1:2 and 1:3 ratios at $4.90, $3.68 and $3.23 respectively per 15-min units. Ext CFSS is paid for 1:1, 1:2 and 1:3 ratios at $4.90, $3.68, and $3.23 respectively per 15-min units. For persons eligible for 10 or more hours of daily PCA & CFSS, ext PCA & CFSS rates are increased by 7.5% when the service is provided by persons who have completed the required training. Ext home care nursing is paid for 1:1 or 1:2, rates are set by the state and based on the type of nursing and staffing ratio. Homemaker (home mgmt & w/ADLs) is paid at $4.61/15-min unit, and home-delivered meals are paid at $6.53/meal. 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-hr emergency assistance
-Caregiver Living Expenses
-Chore services
-Crisis Respite
-Environmental Accessibility Adaptations - Home Modifications
-Environmental Accessibility Adaptations - Vehicle Modifications
-Family Training & Counseling
-Homemaker (cleaning component)
-ILS Therapies
-Respite (daily)
-Specialized Equipment & Supplies
-Transitional Services
-Transportation
-Specialist Services

3. For all other waiver services, rate methods are described in MN Stat. 256B.4914 and calculated in the rate management system (RMS). Rate methods are grouped into 4 categories:
Payment for residential support services:
-Community residential services
-Customized living
-Family residential services
-Foster Care
-Integrated community supports

Payment for day program services:
-Adult Day Service/Adult Day Service Bath
-Day Support Services
-Prevocational Services

Payments for unit-based services w/programming:
-Independent Living Skills Training
-Individualized Home Supports
-In-Home Family Supports
-Personal Support Services
-Positive Support Services
-Housing Access Coordination
-Employment Exploration
-Employment Development
-Employment Support

Payments for unit-based services w/o programming:
-Respite (15-min unit)
-Adult Companion
-Night Supervision

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 RMS that calculates individualized participant 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 and 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 individual 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. For the CADI and BI waivers, customized living is not affected by the competitive workforce factor as its rate is determined under a rate-setting framework in state statute for the Elderly Waiver. The framework for customized living, which relies on base wage and additional cost factors based on established data sources, was implemented on January 1, 2019. The Minnesota Legislature did not apply a competitive workforce factor to this newly established framework.

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 of 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 identified in the 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 and client programming and support for residential services, facility use factor for day services, and meals and snacks for adult day.

Automatic inflationary adjustments within the model will impact the component values every two years on 7/1/22, 11/1/24, 7/1/26, and every other July thereafter. 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.

https://mn.gov/dhs/assets/DWRS-component-values-effective-01012022_tcm1053-502511.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), a customization option is available in the RMS. This customization applies to individuals who meet Long Term Care and assessment 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 assessment criteria.

There are circumstances when an individual may have exceptional needs which cannot be met by an increase in service units in RMS. In these cases, lead agencies may submit an exception request to increase an individual's service rate based on the person's service plan, as described in Minn. Stat. 256B.4914, subd. 14. 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.

Specific exception policies exist for the following services (see Appendix C-1/C-3): environmental accessibility adaptations, CDCS, extended PCA and remote support.

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 & Supports Service 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 1/15/21 & every 4 yrs thereafter.

DHS uses several methods to monitor 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 & create two 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 services, the licensing process under Minnesota Statutes, 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 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 Minnesota Statutes, Chapter 245D.

For residential supports and day 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.

Changes to rate methodologies and standards for waiver services are published in our State Register for public comment in accordance with the requirements set forth in 42 CFR § 447.205. Such changes are also included in proposed waiver amendments or renewals, which are published for public comment prior to submission in accordance with 42 CFR § 441.304(f). See Main Section 6-I.

Every 2 years, 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.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from*

providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill Medical Assistance directly through MMIS and claims are processed through MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

All claims are processed through MMIS. For a waiver claim to be paid, the claim must correspond with the applicable MMIS service authorization and eligibility information. The service authorization is based on the participant's support plan and includes the provider, type of service, rates, units, and applicable time period. Claims are not paid if the eligibility information is inconsistent with the information on the claim (e.g., the date a waiver service is provided must fall within the participant's MA and waiver eligibility date spans).

The Department's Surveillance and Integrity Review Section (SIRS) is responsible for post-payment review of provider claims paid through MMIS. Providers and claims are selected for review based on data analysis, complaints, and referrals. This includes identifying and investigating possible Medicaid fraud.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☒ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

For example, county-owned hospitals and nursing facilities may provide services such as home-delivered meals or respite care. Lead agencies provide case management and other services such as home health.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Costs related to room and board in residential settings are excluded from the statewide rate setting frameworks.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ○ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ◉ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

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 related individuals (i.e. any person who is related by blood, marriage or adoption to any degree) or other legally responsible individuals.

(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.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	36015.05	19331.47	55346.52	83007.00	28569.00	111576.00	56229.48
2	37824.92	19950.08	57775.00	87655.00	29483.00	117138.00	59363.00
3	38935.90	20588.48	59524.38	97034.00	30426.00	127460.00	67935.62
4	39720.32	21314.13	61034.45	102790.00	31499.00	134289.00	73254.55
5	40302.72	21927.22	62229.94	107181.00	32405.00	139586.00	77356.06

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	39437	39437
Year 2	41231	41231
Year 3	43259	43259
Year 4	45165	45165
Year 5	46772	46772

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay estimates are based on the actual value from the initial CMS-372 report for waiver year four. Estimates for future years were trended based upon this base value and ancitipated waiver use.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D estimates are based on recipients, payments, and units used by service from the initial report data available via MMIS for waiver year four (WY2019) of the current approval period. These costs have been adjusted with a completion factor to estimate the final costs for WY2019. To determine the completion factor, the ratio of APC lag to APC initial was calculated for WY2017, and also for WY018.

The average of those two years were applied as a completion factor for WY2019. Estimates for future time periods incorporate expected growth in recipients, keeping the percentage of recipients using each service fixed at WY2019 rates (exceptions noted below). Average units per user for each service are also based on WY2019 rates of use (exceptions noted below). Unit costs per service are projected to increase at an annual inflation rate for CMS Home Health Agency Market Basket as projected by IHS as follows: 3% in WY1, 3.1% in WY2 – WY5.

Exceptions:

1. The new service Independent Living Skills (ILS) Therapy Serivce will begin in October 2020 (WY2021). This service is currently available for enrollees in Minnesota's Brain Injury waiver. Based on department data on use of this service in that waiver, it is expected that 0.2% of CADI enrollees will use an average of 212 units of this service, at unit cost of $33.02.

2. During WY2018-WY2020, Minnesota has been in the process of phasing in new employment services (Employment Exploration, Employment Development, and Employment Support Services) to replace Supported Employment services and partially offset Prevocational services. Projected recipients of these services were adjusted in the bridge year, WY2020, to account for these transitions.

3. Implementation of Electronic Visit Verification is expected in March 2021, phasing in over 12 months. Affected services are CDCS Personal Assistance, crisis respite, extended PCA, extended home health care, homemaker, in-home family support, personal support, respite, and individualized home supports. It is expected that this will result in an average 1% reduction in use of these services through reduced billing of units. The annual impact is assumed to be a 0.5% decrease in units per user in WY21 and another 0.5% decrease in WY22.

Community Residential Services:
These services replace the existing corporate adult foster care and corporate child foster care services. The change is expected to be cost neutral. The new services are expected to phase in over Jan 1 2021 to June 30 2022. For each year and each waiver the users, average units per user and average cost per unit were calculated as a weighted average of the previously submitted values for adult and child corporate foster care, subject to a phase-in.

Day Support Services:
These services replace Adult Day Services only for new recipients under age 55. The change is expected to be cost neutral. We estimate that each year 10% of Adult Day Service users are new users.
In CADI, users in the first year were assumed to be 5% of Adult Day users, with increases of 10% each following year. Average units per user and average cost per unit were assumed to be the same as the previously submitted value for Adult Day Services. 1 user per waiver year was assumed for Day Support Services, with the same average units per user and average cost per unit as previously submitted for Adult Day Services.

Family Residential Services:
These services replace the existing family adult foster care and family child foster care services. The change is expected to be cost neutral. The new services are expected to phase in over Jan 1 2021 to June 30 2022. For each year and each waiver the users, average units per user and average cost per unit were calculated as a weighted average of the previously submitted values for adult and child family foster care, subject to a phase-in.

Employment Exploration Services:
Increased employment service use is expected due to the prevocational services requirement. The additional costs were calculated in a fiscal note (Minnesota 2019 Session). For the appendix J projections, it was assumed that these costs would primarily be incurred in Employment Exploration Services (EES). Additional recipients were added to EES to match the fiscal note costs.

Housing Access Coordination:

After mid-July 2021, or up to 18 months following federal approval of this amendment and the Department's completion of system updates, whichever is later, all participants receiving housing access coordination will have transitioned to housing stabilization services (a state plan service) as appropriate. Housing stabilization services will not be provided under this waiver effective January 1, 2022.

Individualized Home Supports:
These services have 3 components:

1.IHS w/ family training
These services replace In-Home Family Supports. The new services are expected to phase in over Jan 1 2021 to June 30 2022. For each year and each waiver the users, average units per user and average cost per unit were assumed to be the same as the previously submitted values for in-home family supports, subject to a phase-in on users.

2.IHS w/o training
These service replace Personal Support and Adult Companion services. The new services are expected to phase in over Jan 1 2021 to June 30 2022. For each year and each waiver the users, average units per user and average cost per unit were calculated as a weighted average of the previously submitted values for personal support and adult companion services, subject to a phase-in.

3.IHS w/training
These services replace the existing Individualized Home Supports (IHS) services and ILS training services. The new services are expected to phase in over Jan 1 2021 to June 30 2022. For each year and each waiver the users, average units per user and average cost per unit were calculated as a weighted average of the previously submitted values for IHS and ILS training services, subject to a phase-in.

Individualized Home Supports users and payments are the sum of the users of these 3 components. The average price per unit is calculated as a weighted average cost of these 3 components, with average units per user calculated from the total cost, cost per unit, and users.

Integrated Community Supports:
New recipients under age 55 will be enrolled in Integrated Community Supports (ICS) instead of Customized Living (CL) beginning January 1, 2021. We assume that about 10% of CL users are under age 55 and new to the service each year. A 5% impact is assumed for partial impact in WY2021 and an additional 10% per year after that. We assume same units per user and same unit cost as CL.

Prevocational Services:
Prevocational services were expected to be used by 5.6% of the CADI waiver population prior to the 3-year limit. We do not have data to directly address how many recipients would receive services past the 3-year limit if they could, given that by the time this limit is enacted there will be a different mix of employment services in place than there are now. To reflect reduced usage in the our projections, we are assuming a reduction of recipients of 10% in WY4 and 28% in WY5 relative to the 5.6% proportion.

Extended Community First Services and Supports: This service will replace Extended State Plan Personal Care Assistant. The new service is expected to phase in beginning 6/1/2022 - 5/31/2023. The average units per user and unit cost were assumed to be the same as the previously submitted values. WY22 was adjusted for four month phase in. WY23 was adjusted for an eight month phase in. All services were migrated to Extended CFSS in WY's 24 and 25.

Extended PCA and CFSS Rate Increase effective 10/1/21: Applied 10.26% increase to WY22.

CDCS Rate Increase: Applied 2.4% increase to WY22.

CDCS Unbundling: Personal Care Assistance was split into two categories. Using the currently approved projections, ten percent of the recipients and dollars were moved into individual Services and Goods, ninety percent of the recipients and dollars remained in Personal Assistance. Self Direction Support Activities was split into two categories, using currently approved projections, twenty percent of the recipients and dollars were

moved to Support Planner and eighty percent of the recipients and dollars were moved to Financial Management. Environmental Modifications and Provisions was split into three services. Thirty percent of recipients and dollars were moved to Environmental Modifications and Provisions - Home. Ten percent of recipients and dollars were moved into Environmental Modifications and Provisions - Vehicle. Sixty percent of recipients and dollars were moved into Individual Directed Goods and Services. Treating and Training was split into three services. Using current projections, ten percent of recipients and dollars were moved to Individual Directed Goods and Services. Eighty-five percent of recipients and dollars remained in Treatment and Training. Five percent of recipients and dollars were moved to Community Integration and Supports.

DWRS: 9.7% increase Jan 1 2022 instead of July 1 2022, 12 month phase in: impact Jan 1 2022 to July 1 2023, 6.1% increase Nov 1 2024 instead of July 1 2024, 12 month phase in: impact Jul 1 2024 to Nov 1 2025

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

D' estimates are based on the actual non-waiver MA costs of CADI waiver recipients from the initial report data available via MMIS for waiver year four (WY2019). These costs have been adjusted with a completion factor to estimate the final costs for WY2019. To determine the completion factor, the ratio of APC lag to APC initial was calculated for WY2017, and also for WY018.
The average of those two years were applied as a completion factor for WY2019. Per capita expenditures and average waiver days were used to calculate an average daily payment for these non-waiver MA costs. The average daily payment is trended at an annual inflation rate for Hospital Market Basket as projected by IHS as follows: 3.1% in WY1, 3.2% in WY2 – WY5. Per capita D' estimates are then calculated from the projected average daily payment and average waiver days.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

G estimates are based on long term Nursing Facility costs for under age 65 recipients paid by MA for waiver year four (WY2019) using data from MMIS. These are the same estimates used in the CMS 372 reporting. Per capita expenditures and average waiver days were used to calculate an average daily payment for these institutional costs. The average daily payment is trended at the average NF daily rate increase in the DHS forecast for 2021-2025. This forecast takes into account rate increases expected to result from a cost-based Nursing Facility rate-setting system. Per capita G estimates are then calculated from the projected average daily payment and average waiver days.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

G' estimates are based on the actual non-institutional MA costs of Nursing Facility recipients under age 65 in waiver year four (WY2019) using MMIS data. Per capita expenditures and average waiver days were used to calculate an average daily payment for these non-institutional MA costs. The average daily payment is trended at an annual inflation rate for Hospital Market Basket as projected by IHS as follows: 3.1 in WY1, 3.2% in WY2 – WY5. Per capita G' estimates are then calculated from the projected average daily payment and average waiver days.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
Caregiver Living Expenses	

Waiver Services	
Case Management	
Homemaker	
Prevocational Services	
Respite	
Extended Community First Services and Supports	
Extended Home Care Nursing	
Extended Home Health Care Services	
Extended Personal Care Assistance Services	
24-Hour Emergency Assistance	
Adult Companion Services	
Adult Day Service Bath	
Adult Foster Care	
Child foster care	
Chore Services	
Community Residential Services	
Consumer-directed community supports (CDCS): Community Integration and Support	
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	
Consumer-directed community supports (CDCS): personal assistance	
Consumer-directed community supports (CDCS): Support Planning	
Consumer-directed community supports : Financial Management Services	
Consumer-directed community supports: self-direction support activities	
Consumer-directed community supports: environmental modifications - vehicle modifications	
Consumer-directed community supports: environmental modifications and provisions	
Consumer-directed community supports: environmental modifications – home modifications	
Consumer-directed community supports: treatment and training	
Crisis Respite	
Customized Living	
Day Support Services	
Employment Development Services	
Employment Exploration Services	
Employment Support Services	
Environmental Accessibility Adaptations - Home Modifications	
Environmental Accessibility Adaptations - Vehicle Modifications	
Family Residential Services	
Family Training and Counseling	
Home Delivered Meals	
Housing Access Coordination	
In-Home Family Supports	
Independent Living Skills (ILS) Therapies	
Independent Living Skills (ILS) Training Services	
Individualized Home Supports	
Integrated Community Supports	
Night Supervision Services	
Personal Support Services	
Positive Support Services	
Specialist Services	
Specialized Equipment and Supplies	
Transitional services	

Waiver Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**24025996.80**
Adult Day Service	☐	Decremental	2630	549.00	16.64	**24025996.80**	
Caregiver Living Expenses Total:							**177487.20**
Caregiver Living Expenses	☐	Daily	33	162.00	33.20	**177487.20**	
Case Management Total:							**89406722.90**
Case Management	☐	15 min	39061	94.00	24.35	**89406722.90**	
Homemaker Total:							**37659090.24**
Homemaker	☐	15 min	11958	648.00	4.86	**37659090.24**	
Prevocational Services Total:							**17140795.02**
Prevocational Services	☐	daily/hour	2193	251.00	31.14	**17140795.02**	
Respite Total:							**8299498.19**
Respite	☐	Decremental	757	1193.00	9.19	**8299498.19**	
Extended Community First Services and Supports Total:							**0.00**
Extended Community First Services and Supports	☐		0	0.00	0.01	**0.00**	

GRAND TOTAL:	**1420325577.95**
Total: Services included in capitation:	
Total: Services not included in capitation:	1420325577.95
Total Estimated Unduplicated Participants:	**39437**
Factor D (Divide total by number of participants):	**36015.05**
Services included in capitation:	
Services not included in capitation:	36015.05
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Extended Home Care Nursing Total:							**173773.60**
Extended Home Care Nursing	☐	15 min	7	2480.00	10.01	**173773.60**	
Extended Home Health Care Services Total:							**800902.80**
Extended Home Health Care Services	☐	15 min/visit	40	3411.00	5.87	**800902.80**	
Extended Personal Care Assistance Services Total:							**23486971.20**
Extended Personal Care Assistance Services	☐	15 min	2398	2120.00	4.62	**23486971.20**	
24-Hour Emergency Assistance Total:							**16006666.50**
24-Hour Emergency Assistance	☐	Decremental	1230	239.00	54.45	**16006666.50**	
Adult Companion Services Total:							**6401436.32**
Adult Companion Services	☐	15 min	908	1046.00	6.74	**6401436.32**	
Adult Day Service Bath Total:							**52326.00**
Adult Day Service Bath	☐	15 min	54	114.00	8.50	**52326.00**	
Adult Foster Care Total:							**453962636.40**
Adult Foster Care	☐	daily	5213	294.00	296.20	**453962636.40**	
Child foster care Total:							**21327670.98**
Child foster care	☐	daily	231	222.00	415.89	**21327670.98**	
Chore Services Total:							**1265798.22**
Chore Services	☐	15 min	843	389.00	3.86	**1265798.22**	
Community Residential Services Total:							**92901522.80**
Community Residential Services	☐	daily	1063	292.00	299.30	**92901522.80**	

	GRAND TOTAL:	***1420325577.95***
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*1420325577.95*
	Total Estimated Unduplicated Participants:	***39437***
	Factor D (Divide total by number of participants):	***36015.05***
	Services included in capitation:	
	Services not included in capitation:	*36015.05*
	Average Length of Stay on the Waiver:	*318*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer-directed community supports (CDCS): Community Integration and Support Total:							**0.00**
Consumer-directed community supports (CDCS): Community Integration and Support	☐		*0*	*0.00*	*0.01*	**0.00**	
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services Total:							**0.00**
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐		*0*	*0.00*	*0.01*	**0.00**	
Consumer-directed community supports (CDCS): personal assistance Total:							**75344186.60**
Consumer-directed community supports (CDCS): personal assistance	☐	*decremental*	*3335*	*244.00*	*92.59*	**75344186.60**	
Consumer-directed community supports (CDCS): Support Planning Total:							**0.00**
Consumer-directed community supports (CDCS): Support Planning	☐		*0*	*0.00*	*0.01*	**0.00**	
Consumer-directed							**0.00**

	GRAND TOTAL:	***1420325577.95***
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*1420325577.95*
	Total Estimated Unduplicated Participants:	***39437***
	Factor D (Divide total by number of participants):	***36015.05***
	Services included in capitation:	
	Services not included in capitation:	*36015.05*
	Average Length of Stay on the Waiver:	*318*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
community supports : Financial Management Services Total:							
Consumer-directed community supports : Financial Management Services	☐		0	0.00	0.01	**0.00**	
Consumer-directed community supports: self-direction support activities Total:							**12240014.92**
Consumer-directed community supports: self-direction support activities	☐	decremental	3524	203.00	17.11	**12240014.92**	
Consumer-directed community supports: environmental modifications - vehicle modifications Total:							**0.00**
Consumer-directed community supports: environmental modifications - vehicle modifications	☐		0	0.00	0.01	**0.00**	
Consumer-directed community supports: environmental modifications and provisions Total:							**4596729.45**
Consumer-directed community supports: environmental modifications and provisions	☐	decremental	1699	15.00	180.37	**4596729.45**	
Consumer-directed community supports:							**0.00**

GRAND TOTAL:		**1420325577.95**
Total: Services included in capitation:		
Total: Services not included in capitation:		1420325577.95
Total Estimated Unduplicated Participants:		**39437**
Factor D (Divide total by number of participants):		**36015.05**
Services included in capitation:		
Services not included in capitation:		36015.05
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
environmental modifications – home modifications Total:							
Consumer-directed community supports: environmental modifications – home modifications	☐		0	0.00	0.01	**0.00**	
Consumer-directed community supports: treatment and training Total:							**7704067.14**
Consumer-directed community supports: treatment and training	☐	decremental	1323	51.00	114.18	**7704067.14**	
Crisis Respite Total:							**7258238.78**
Crisis Respite	☐	Decremental	179	83.00	488.54	**7258238.78**	
Customized Living Total:							**286121060.88**
Customized Living	☐	daily	5933	258.00	186.92	**286121060.88**	
Day Support Services Total:							**1260679.68**
Day Support Services	☐	15 min	138	549.00	16.64	**1260679.68**	
Employment Development Services Total:							**3855530.88**
Employment Development Services	☐	15 min	1286	216.00	13.88	**3855530.88**	
Employment Exploration Services Total:							**511623.84**
Employment Exploration Services	☐	15 min	338	168.00	9.01	**511623.84**	
Employment Support Services Total:							**14147742.93**
Employment Support Services	☐	15 min	3209	821.00	5.37	**14147742.93**	

GRAND TOTAL:	**1420325577.95**
Total: Services included in capitation:	
Total: Services not included in capitation:	1420325577.95
Total Estimated Unduplicated Participants:	**39437**
Factor D (Divide total by number of participants):	**36015.05**
Services included in capitation:	
Services not included in capitation:	36015.05
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations - Home Modifications Total:							**19277682.56**
Environmental Accessibility Adaptations - Home Modifications	☐	item/per year	2168	2.00	4445.96	**19277682.56**	
Environmental Accessibility Adaptations - Vehicle Modifications Total:							**0.00**
Environmental Accessibility Adaptations - Vehicle Modifications	☐	item	0	0.00	9384.33	**0.00**	
Family Residential Services Total:							**18731197.44**
Family Residential Services	☐	daily	214	288.00	303.92	**18731197.44**	
Family Training and Counseling Total:							**320055.07**
Family Training and Counseling	☐	15 min	151	79.00	26.83	**320055.07**	
Home Delivered Meals Total:							**14895140.40**
Home Delivered Meals	☐	meal	9948	217.00	6.90	**14895140.40**	
Housing Access Coordination Total:							**1699377.12**
Housing Access Coordination	☐	15 min	844	153.00	13.16	**1699377.12**	
In-Home Family Supports Total:							**781328.73**
In-Home Family Supports	☐	15 min	71	1131.00	9.73	**781328.73**	
Independent Living Skills (ILS) Therapies Total:							**553018.96**
Independent Living Skills (ILS)	☐	15 min	79	212.00	33.02	**553018.96**	

GRAND TOTAL:	**1420325577.95**
Total: Services included in capitation:	
Total: Services not included in capitation:	1420325577.95
Total Estimated Unduplicated Participants:	**39437**
Factor D (Divide total by number of participants):	**36015.05**
Services included in capitation:	
Services not included in capitation:	36015.05
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapies							
Independent Living Skills (ILS) Training Services Total:							**71513481.86**
Independent Living Skills (ILS) Training Services	☐	15 min	9223	634.00	12.23	**71513481.86**	
Individualized Home Supports Total:							**22523054.40**
Individualized Home Supports	☐	Decremental	2376	1036.00	9.15	**22523054.40**	
Integrated Community Supports Total:							**15046312.32**
Integrated Community Supports	☐	daily	312	258.00	186.92	**15046312.32**	
Night Supervision Services Total:							**9402552.72**
Night Supervision Services	☐	15 min	276	4362.00	7.81	**9402552.72**	
Personal Support Services Total:							**3491505.00**
Personal Support Services	☐	15 min	333	1500.00	6.99	**3491505.00**	
Positive Support Services Total:							**4055385.04**
Positive Support Services	☐	15 min	602	491.00	13.72	**4055385.04**	
Specialist Services Total:							**815842.92**
Specialist Services	☐	1 hour	201	47.00	86.36	**815842.92**	
Specialized Equipment and Supplies Total:							**8453107.40**
Specialized Equipment and Supplies	☐	per year	12107	10.00	69.82	**8453107.40**	
Transitional services Total:							**1949872.76**
Transitional services	☐	Decremental	914	22.00	96.97	**1949872.76**	
Transportation Total:							**20687492.98**
Transportation	☐					**20687492.98**	

GRAND TOTAL:	**1420325577.95**
Total: Services included in capitation:	
Total: Services not included in capitation:	1420325577.95
Total Estimated Unduplicated Participants:	**39437**
Factor D (Divide total by number of participants):	**36015.05**
Services included in capitation:	
Services not included in capitation:	36015.05
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		trip/per mile	15442	7051.00	0.19		

GRAND TOTAL:		**1420325577.95**
Total: Services included in capitation:		
Total: Services not included in capitation:		1420325577.95
Total Estimated Unduplicated Participants:		**39437**
Factor D (Divide total by number of participants):		**36015.05**
Services included in capitation:		
Services not included in capitation:		36015.05
Average Length of Stay on the Waiver:	318	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**23783009.40**
Adult Day Service	☐	Decremental	2460	549.00	17.61	**23783009.40**	
Caregiver Living Expenses Total:							**194084.10**
Caregiver Living Expenses	☐	daily	35	162.00	34.23	**194084.10**	
Case Management Total:							**96350817.80**
Case Management	☐	15 min	40837	94.00	25.10	**96350817.80**	
Homemaker Total:							**40336952.88**
Homemaker	☐	15 min	12502	644.00	5.01	**40336952.88**	
Prevocational Services Total:							**18958386.42**
Prevocational Services	☐	daily/hour	2293	251.00	32.94	**18958386.42**	
Respite Total:							**9126273.24**

GRAND TOTAL:		**1559559250.57**
Total: Services included in capitation:		
Total: Services not included in capitation:		1559559250.57
Total Estimated Unduplicated Participants:		**41231**
Factor D (Divide total by number of participants):		**37824.92**
Services included in capitation:		
Services not included in capitation:		37824.92
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	☐	Decremental	791	1187.00	9.72	9126273.24	
Extended Community First Services and Supports Total:							9256401.00
Extended Community First Services and Supports	☐	15 min	836	2109.00	5.25	9256401.00	
Extended Home Care Nursing Total:							179155.20
Extended Home Care Nursing	☐	15 min	7	2480.00	10.32	179155.20	
Extended Home Health Care Services Total:							862415.40
Extended Home Health Care Services	☐	15 min/visit	42	3394.00	6.05	862415.40	
Extended Personal Care Assistance Services Total:							18501729.75
Extended Personal Care Assistance Services	☐	15 min	1671	2109.00	5.25	18501729.75	
24-Hour Emergency Assistance Total:							17254853.56
24-Hour Emergency Assistance	☐	Decremental	1286	239.00	56.14	17254853.56	
Adult Companion Services Total:							1663129.54
Adult Companion Services	☐	15 min	223	1046.00	7.13	1663129.54	
Adult Day Service Bath Total:							57392.16
Adult Day Service Bath	☐	15 min	56	114.00	8.99	57392.16	
Adult Foster Care Total:							117816466.32
Adult Foster Care	☐	daily	1279	294.00	313.32	117816466.32	
Child foster care Total:							5566874.22
Child foster care	☐	daily	57	222.00	439.93	5566874.22	

GRAND TOTAL:		1559559250.57
Total: Services included in capitation:		
Total: Services not included in capitation:		1559559250.57
Total Estimated Unduplicated Participants:		41231
Factor D (Divide total by number of participants):		37824.92
Services included in capitation:		
Services not included in capitation:		37824.92
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Chore Services Total:							**1363981.82**
Chore Services	☐	15 min	881	389.00	3.98	**1363981.82**	
Community Residential Services Total:							**438185887.20**
Community Residential Services	☐	daily	4740	292.00	316.59	**438185887.20**	
Consumer-directed community supports (CDCS): Community Integration and Support Total:							**141405.15**
Consumer-directed community supports (CDCS): Community Integration and Support	☐	decremental	23	51.00	120.55	**141405.15**	
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services Total:							**4056826.62**
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐	decremental	2303	314.00	5.61	**4056826.62**	
Consumer-directed community supports (CDCS): personal assistance Total:							**80143465.50**
Consumer-directed community supports (CDCS): personal assistance	☐	decremental	3374	243.00	97.75	**80143465.50**	
Consumer-directed community							**901880.28**

GRAND TOTAL:	**1559559250.57**
Total: Services included in capitation:	
Total: Services not included in capitation:	1559559250.57
Total Estimated Unduplicated Participants:	**41231**
Factor D (Divide total by number of participants):	**37824.92**
Services included in capitation:	
Services not included in capitation:	37824.92
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
supports (CDCS): Support Planning Total:							
Consumer-directed community supports (CDCS): Support Planning	☐	*decremental*	*246*	*203.00*	*18.06*	***901880.28***	
Consumer-directed community supports : Financial Management Services Total:							***3600188.76***
Consumer-directed community supports : Financial Management Services	☐	*decremental*	*982*	*203.00*	*18.06*	***3600188.76***	
Consumer-directed community supports: self-direction support activities Total:							***9004138.08***
Consumer-directed community supports: self-direction support activities	☐	*decremental*	*2456*	*203.00*	*18.06*	***9004138.08***	
Consumer-directed community supports: environmental modifications - vehicle modifications Total:							***168521.70***
Consumer-directed community supports: environmental modifications - vehicle modifications	☐	*decremental*	*59*	*15.00*	*190.42*	***168521.70***	
Consumer-directed community supports: environmental modifications and							***3381859.20***

GRAND TOTAL:		***1559559250.57***
Total: Services included in capitation:		
Total: Services not included in capitation:		*1559559250.57*
Total Estimated Unduplicated Participants:		***41231***
Factor D (Divide total by number of participants):		***37824.92***
Services included in capitation:		
Services not included in capitation:		*37824.92*
Average Length of Stay on the Waiver:	*318*	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
provisions Total:							
Consumer-directed community supports: environmental modifications and provisions	☐	decremental	1184	15.00	190.42	**3381859.20**	
Consumer-directed community supports: environmental modifications – home modifications Total:							**508421.40**
Consumer-directed community supports: environmental modifications – home modifications	☐	decremental	178	15.00	190.42	**508421.40**	
Consumer-directed community supports: treatment and training Total:							**8066241.60**
Consumer-directed community supports: treatment and training	☐	decremental	1312	51.00	120.55	**8066241.60**	
Crisis Respite Total:							**7817617.28**
Crisis Respite	☐	Decremental	187	83.00	503.68	**7817617.28**	
Customized Living Total:							**275941449.00**
Customized Living	☐	daily	5550	258.00	192.71	**275941449.00**	
Day Support Services Total:							**4305748.89**
Day Support Services	☐	15 min	434	549.34	18.06	**4305748.89**	
Employment Development Services Total:							**4261662.72**
Employment Development Services	☐	15 min	1344	216.00	14.68	**4261662.72**	

GRAND TOTAL:		**1559559250.57**
Total: Services included in capitation:		
Total: Services not included in capitation:		1559559250.57
Total Estimated Unduplicated Participants:		**41231**
Factor D (Divide total by number of participants):		**37824.92**
Services included in capitation:		
Services not included in capitation:		37824.92
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Exploration Services Total:							**1881222.00**
Employment Exploration Services	☐	15 min	1175	168.00	9.53	**1881222.00**	
Employment Support Services Total:							**15645304.40**
Employment Support Services	☐	15 min	3355	821.00	5.68	**15645304.40**	
Environmental Accessibility Adaptations - Home Modifications Total:							**19172205.60**
Environmental Accessibility Adaptations - Home Modifications	☐	item/per year	2040	2.00	4699.07	**19172205.60**	
Environmental Accessibility Adaptations - Vehicle Modifications Total:							**2130242.91**
Environmental Accessibility Adaptations - Vehicle Modifications	☐	item	227	1.00	9384.33	**2130242.91**	
Family Residential Services Total:							**88155809.28**
Family Residential Services	☐	daily	952	288.00	321.53	**88155809.28**	
Family Training and Counseling Total:							**345252.12**
Family Training and Counseling	☐	15 min	158	79.00	27.66	**345252.12**	
Home Delivered Meals Total:							**16045848.00**
Home Delivered Meals	☐	meal	10400	217.00	7.11	**16045848.00**	
Housing Access Coordination Total:							**0.00**
Housing Access Coordination	☐	15 min	0	153.00	13.92	**0.00**	

GRAND TOTAL:	**1559559250.57**
Total: Services included in capitation:	
Total: Services not included in capitation:	1559559250.57
Total Estimated Unduplicated Participants:	**41231**
Factor D (Divide total by number of participants):	**37824.92**
Services included in capitation:	
Services not included in capitation:	37824.92
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Family Supports Total:							**196796.25**
In-Home Family Supports	☐	15 min	17	1125.00	10.29	**196796.25**	
Independent Living Skills (ILS) Therapies Total:							**607223.12**
Independent Living Skills (ILS) Therapies	☐	15 min	82	212.00	34.93	**607223.12**	
Independent Living Skills (ILS) Training Services Total:							**18557357.52**
Independent Living Skills (ILS) Training Services	☐	15 min	2262	634.00	12.94	**18557357.52**	
Individualized Home Supports Total:							**94462139.42**
Individualized Home Supports	☐	Decremental	10589	902.00	9.89	**94462139.42**	
Integrated Community Supports Total:							**49940513.04**
Integrated Community Supports	☐	daily	979	258.00	197.72	**49940513.04**	
Night Supervision Services Total:							**10412704.68**
Night Supervision Services	☐	15 min	289	4362.00	8.26	**10412704.68**	
Personal Support Services Total:							**905952.40**
Personal Support Services	☐	15 min	82	1493.00	7.40	**905952.40**	
Positive Support Services Total:							**4484342.28**
Positive Support Services	☐	15 min	629	491.00	14.52	**4484342.28**	
Specialist Services Total:							**878824.80**
Specialist Services	☐	1 hour	210	47.00	89.04	**878824.80**	
Specialized Equipment and Supplies Total:							**9111228.40**

GRAND TOTAL:	**1559559250.57**
Total: Services included in capitation:	
Total: Services not included in capitation:	1559559250.57
Total Estimated Unduplicated Participants:	**41231**
Factor D (Divide total by number of participants):	**37824.92**
Services included in capitation:	
Services not included in capitation:	37824.92
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Equipment and Supplies	☐	per year	12658	10.00	71.98	9111228.40	
Transitional services Total:							2102779.36
Transitional services	☐	Decremental	956	22.00	99.98	2102779.36	
Transportation Total:							22766268.80
Transportation	☐	trip/per mile	16144	7051.00	0.20	22766268.80	

GRAND TOTAL:		1559559250.57
Total: Services included in capitation:		
Total: Services not included in capitation:		1559559250.57
Total Estimated Unduplicated Participants:		41231
Factor D (Divide total by number of participants):		37824.92
Services included in capitation:		
Services not included in capitation:		37824.92
Average Length of Stay on the Waiver:	318	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							22576318.38
Adult Day Service	☐	Decremental	2277	549.00	18.06	22576318.38	
Caregiver Living Expenses Total:							211528.26
Caregiver Living Expenses	☐	daily	37	162.00	35.29	211528.26	
Case Management Total:							104232321.12
Case Management	☐	15 min	42846	94.00	25.88	104232321.12	

GRAND TOTAL:		1684327957.62
Total: Services included in capitation:		
Total: Services not included in capitation:		1684327957.62
Total Estimated Unduplicated Participants:		43259
Factor D (Divide total by number of participants):		38935.90
Services included in capitation:		
Services not included in capitation:		38935.90
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Homemaker Total:							**43672789.16**
Homemaker	☐	15 min	13117	644.00	5.17	**43672789.16**	
Prevocational Services Total:							**20418061.86**
Prevocational Services	☐	daily/hour	2406	251.00	33.81	**20418061.86**	
Respite Total:							**9812691.60**
Respite	☐	Decremental	830	1187.00	9.96	**9812691.60**	
Extended Community First Services and Supports Total:							**20001186.57**
Extended Community First Services and Supports	☐	15 min	1753	2109.00	5.41	**20001186.57**	
Extended Home Care Nursing Total:							**184710.40**
Extended Home Care Nursing	☐	15 min	7	2480.00	10.64	**184710.40**	
Extended Home Health Care Services Total:							**931856.64**
Extended Home Health Care Services	☐	15 min/visit	44	3394.00	6.24	**931856.64**	
Extended Personal Care Assistance Services Total:							**10006298.13**
Extended Personal Care Assistance Services	☐	15 min	877	2109.00	5.41	**10006298.13**	
24-Hour Emergency Assistance Total:							**18661148.68**
24-Hour Emergency Assistance	☐	Decremental	1349	239.00	57.88	**18661148.68**	
Adult Companion Services Total:							**0.00**
Adult Companion Services	☐	15 min	0	1046.00	7.32	**0.00**	
Adult Day Service Bath Total:							**62013.72**

GRAND TOTAL:		**1684327957.62**
Total: Services included in capitation:		
Total: Services not included in capitation:		1684327957.62
Total Estimated Unduplicated Participants:		**43259**
Factor D (Divide total by number of participants):		**38935.90**
Services included in capitation:		
Services not included in capitation:		38935.90
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Bath	☐	15 min	59	114.00	9.22	62013.72	
Adult Foster Care Total:							0.00
Adult Foster Care	☐	daily	0	294.00	321.46	0.00	
Child foster care Total:							0.00
Child foster care	☐	daily	0	222.00	451.35	0.00	
Chore Services Total:							1473687.60
Chore Services	☐	15 min	924	389.00	4.10	1473687.60	
Community Residential Services Total:							582381210.40
Community Residential Services	☐	daily	6140	292.00	324.83	582381210.40	
Consumer-directed community supports (CDCS): Community Integration and Support Total:							310575.72
Consumer-directed community supports (CDCS): Community Integration and Support	☐	decremental	49	51.00	124.28	310575.72	
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services Total:							8773828.20
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐	decremental	4833	313.00	5.80	8773828.20	
Consumer-directed community supports (CDCS):							83631779.10

GRAND TOTAL:	1684327957.62
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Total Estimated Unduplicated Participants:	43259
Factor D (Divide total by number of participants):	38935.90
Services included in capitation:	
Services not included in capitation:	38935.90
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
personal assistance Total:							
Consumer-directed community supports (CDCS): personal assistance	☐	decremental	3415	243.00	100.78	**83631779.10**	
Consumer-directed community supports (CDCS): Support Planning Total:							**1947673.35**
Consumer-directed community supports (CDCS): Support Planning	☐	decremental	515	203.00	18.63	**1947673.35**	
Consumer-directed community supports : Financial Management Services Total:							**7794475.29**
Consumer-directed community supports : Financial Management Services	☐	decremental	2061	203.00	18.63	**7794475.29**	
Consumer-directed community supports: self-direction support activities Total:							**4871074.32**
Consumer-directed community supports: self-direction support activities	☐	decremental	1288	203.00	18.63	**4871074.32**	
Consumer-directed community supports: environmental modifications - vehicle modifications Total:							**365155.20**
Consumer-	☐					**365155.20**	

GRAND TOTAL:	**1684327957.62**
Total: Services included in capitation:	
Total: Services not included in capitation:	1684327957.62
Total Estimated Unduplicated Participants:	**43259**
Factor D (Divide total by number of participants):	**38935.90**
Services included in capitation:	
Services not included in capitation:	38935.90
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
directed community supports: environmental modifications - vehicle modifications		decremental	124	15.00	196.32		
Consumer-directed community supports: environmental modifications and provisions Total:							**1825776.00**
Consumer-directed community supports: environmental modifications and provisions	☐	decremental	620	15.00	196.32	**1825776.00**	
Consumer-directed community supports: environmental modifications – home modifications Total:							**1098410.40**
Consumer-directed community supports: environmental modifications – home modifications	☐	decremental	373	15.00	196.32	**1098410.40**	
Consumer-directed community supports: treatment and training Total:							**8277793.68**
Consumer-directed community supports: treatment and training	☐	decremental	1306	51.00	124.28	**8277793.68**	
Crisis Respite Total:							**8447809.72**
Crisis Respite	☐	Decremental	196	83.00	519.29	**8447809.72**	
Customized Living Total:							**263319743.28**
Customized Living	☐	daily	5137	258.00	198.68	**263319743.28**	

GRAND TOTAL:		**1684327957.62**
Total: Services included in capitation:		
Total: Services not included in capitation:		1684327957.62
Total Estimated Unduplicated Participants:		**43259**
Factor D (Divide total by number of participants):		**38935.90**
Services included in capitation:		
Services not included in capitation:		38935.90
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Support Services Total:							**7683782.04**
Day Support Services	☐	15 min	759	549.00	18.44	**7683782.04**	
Employment Development Services Total:							**4586673.60**
Employment Development Services	☐	15 min	1410	216.00	15.06	**4586673.60**	
Employment Exploration Services Total:							**2840816.16**
Employment Exploration Services	☐	15 min	1729	168.00	9.78	**2840816.16**	
Employment Support Services Total:							**16848233.60**
Employment Support Services	☐	15 min	3520	821.00	5.83	**16848233.60**	
Environmental Accessibility Adaptations - Home Modifications Total:							**20743105.60**
Environmental Accessibility Adaptations - Home Modifications	☐	item/per year	2140	2.00	4846.52	**20743105.60**	
Environmental Accessibility Adaptations - Vehicle Modifications Total:							**2304787.24**
Environmental Accessibility Adaptations - Vehicle Modifications	☐	item	238	1.00	9683.98	**2304787.24**	
Family Residential Services Total:							**117134605.44**
Family Residential Services	☐	daily	1233	288.00	329.86	**117134605.44**	
Family Training and Counseling Total:							**374011.28**
Family Training and Counseling	☐	15 min	166	79.00	28.52	**374011.28**	

GRAND TOTAL:		**1684327957.62**
Total: Services included in capitation:		
Total: Services not included in capitation:		1684327957.62
Total Estimated Unduplicated Participants:		**43259**
Factor D (Divide total by number of participants):		**38935.90**
Services included in capitation:		
Services not included in capitation:		38935.90
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**17356736.32**
Home Delivered Meals	☐	meal	10912	217.00	7.33	**17356736.32**	
Housing Access Coordination Total:							**0.00**
Housing Access Coordination	☐	15 min	0	153.00	14.28	**0.00**	
In-Home Family Supports Total:							**0.00**
In-Home Family Supports	☐	15 min	0	1125.00	10.56	**0.00**	
Independent Living Skills (ILS) Therapies Total:							**653434.88**
Independent Living Skills (ILS) Therapies	☐	15 min	86	212.00	35.84	**653434.88**	
Independent Living Skills (ILS) Training Services Total:							**0.00**
Independent Living Skills (ILS) Training Services	☐	15 min	0	634.00	13.27	**0.00**	
Individualized Home Supports Total:							**124678440.00**
Individualized Home Supports	☐	decremental	13716	900.00	10.10	**124678440.00**	
Integrated Community Supports Total:							**89650368.90**
Integrated Community Supports	☐	daily	1713	258.00	202.85	**89650368.90**	
Night Supervision Services Total:							**11194680.42**
Night Supervision Services	☐	15 min	303	4362.00	8.47	**11194680.42**	
Personal Support Services Total:							**0.00**
Personal Support Services	☐	15 min	0	1493.00	7.59	**0.00**	
Positive Support							**4828494.00**

GRAND TOTAL:	**1684327957.62**
Total: Services included in capitation:	
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Total Estimated Unduplicated Participants:	**43259**
Factor D (Divide total by number of participants):	**38935.90**
Services included in capitation:	
Services not included in capitation:	38935.90
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Positive Support Services	☐	15 min	660	491.00	14.90	**4828494.00**	
Specialist Services Total:							**949212.00**
Specialist Services	☐	1 hour	220	47.00	91.80	**949212.00**	
Specialized Equipment and Supplies Total:							**9855830.10**
Specialized Equipment and Supplies	☐	per year	13281	10.00	74.21	**9855830.10**	
Transitional services Total:							**2274563.28**
Transitional services	☐	decremental	1003	22.00	103.08	**2274563.28**	
Transportation Total:							**25080265.98**
Transportation	☐	trip/per mile	16938	7051.00	0.21	**25080265.98**	

GRAND TOTAL:	**1684327957.62**
Total: Services included in capitation:	
Total: Services not included in capitation:	1684327957.62
Total Estimated Unduplicated Participants:	**43259**
Factor D (Divide total by number of participants):	**38935.90**
Services included in capitation:	
Services not included in capitation:	38935.90
Average Length of Stay on the Waiver:	318

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**20714845.00**
Adult Day	☐					**20714845.00**	

GRAND TOTAL:	**1793968362.97**
Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service		decremental	2060	551.00	18.25		
Caregiver Living Expenses Total:							**229848.84**
Caregiver Living Expenses	☐	daily	39	162.00	36.38	**229848.84**	
Case Management Total:							**113382796.40**
Case Management	☐	15 min	44734	95.00	26.68	**113382796.40**	
Homemaker Total:							**47227344.45**
Homemaker	☐	15 min	13695	647.00	5.33	**47227344.45**	
Prevocational Services Total:							**19463411.52**
Prevocational Services	☐	daily/hour	2261	252.00	34.16	**19463411.52**	
Respite Total:							**10389521.10**
Respite	☐	Decremental	867	1190.00	10.07	**10389521.10**	
Extended Community First Services and Supports Total:							**32422790.88**
Extended Community First Services and Supports	☐	15-min	2746	2116.00	5.58	**32422790.88**	
Extended Home Care Nursing Total:							**190976.73**
Extended Home Care Nursing	☐	15 min	7	2487.00	10.97	**190976.73**	
Extended Home Health Care Services Total:							**1006835.12**
Extended Home Health Care Services	☐	15 min/visit	46	3404.00	6.43	**1006835.12**	
Extended Personal Care Assistance Services Total:							**0.00**
Extended Personal Care Assistance Services	☐	15 min	0	2116.00	5.58	**0.00**	
24-Hour							**20163686.40**

GRAND TOTAL:	**1793968362.97**
Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Assistance Total:							
24-Hour Emergency Assistance	☐	Decremental	1408	240.00	59.67	**20163686.40**	
Adult Companion Services Total:							**0.00**
Adult Companion Services	☐	15 min	0	1049.00	7.40	**0.00**	
Adult Day Service Bath Total:							**65873.76**
Adult Day Service Bath	☐	15 min	62	114.00	9.32	**65873.76**	
Adult Foster Care Total:							**0.00**
Adult Foster Care	☐	daily	0	295.00	324.80	**0.00**	
Child foster care Total:							**0.00**
Child foster care	☐	daily	0	223.00	456.04	**0.00**	
Chore Services Total:							**1591960.50**
Chore Services	☐	15 min	965	390.00	4.23	**1591960.50**	
Community Residential Services Total:							**616498428.60**
Community Residential Services	☐	daily	6411	293.00	328.20	**616498428.60**	
Consumer-directed community supports (CDCS): Community Integration and Support Total:							**496670.64**
Consumer-directed community supports (CDCS): Community Integration and Support	☐	decremental	76	51.00	128.14	**496670.64**	
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services							**14216958.00**

GRAND TOTAL:	**1793968362.97**
Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐	decremental	1701	1393.00	6.00	**14216958.00**	
Consumer-directed community supports (CDCS): personal assistance Total:							**87167189.52**
Consumer-directed community supports (CDCS): personal assistance	☐	decremental	3438	244.00	103.91	**87167189.52**	
Consumer-directed community supports (CDCS): Support Planning Total:							**3114374.40**
Consumer-directed community supports (CDCS): Support Planning	☐	decremental	807	201.00	19.20	**3114374.40**	
Consumer-directed community supports : Financial Management Services Total:							**12643430.40**
Consumer-directed community supports : Financial Management Services	☐	decremental	3228	204.00	19.20	**12643430.40**	
Consumer-directed community supports: self-direction support activities Total:							**0.00**
Consumer-directed community	☐	Decremental	0	0.00	18.75	**0.00**	

GRAND TOTAL:	**1793968362.97**
Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
supports: self-direction support activities							
Consumer-directed community supports: environmental modifications - vehicle modifications Total:							***592049.25***
Consumer-directed community supports: environmental modifications - vehicle modifications	☐	*decremental*	*195*	*15.00*	*202.41*	***592049.25***	
Consumer-directed community supports: environmental modifications and provisions Total:							***0.00***
Consumer-directed community supports: environmental modifications and provisions	☐	*Decremental*	*0*	*0.00*	*197.66*	***0.00***	
Consumer-directed community supports: environmental modifications – home modifications Total:							***1773111.60***
Consumer-directed community supports: environmental modifications – home modifications	☐	*decremental*	*584*	*15.00*	*202.41*	***1773111.60***	
Consumer-directed community supports: treatment and training Total:							***8417260.32***
Consumer-directed	☐	*Decremental*				***8417260.32***	

	GRAND TOTAL:	***1793968362.97***
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*1793968362.97*
	Total Estimated Unduplicated Participants:	***45165***
	Factor D (Divide total by number of participants):	***39720.32***
	Services included in capitation:	
	Services not included in capitation:	*39720.32*
	Average Length of Stay on the Waiver:	*319*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
community supports: treatment and training			1288	51.00	128.14		
Crisis Respite Total:							**9109660.85**
Crisis Respite	☐	Decremental	205	83.00	535.39	**9109660.85**	
Customized Living Total:							**252216624.24**
Customized Living	☐	daily	4754	259.00	204.84	**252216624.24**	
Day Support Services Total:							**11394294.30**
Day Support Services	☐	15 min	1110	551.00	18.63	**11394294.30**	
Employment Development Services Total:							**4861633.28**
Employment Development Services	☐	15 min	1472	217.00	15.22	**4861633.28**	
Employment Exploration Services Total:							**2996011.20**
Employment Exploration Services	☐	15 min	1805	168.00	9.88	**2996011.20**	
Employment Support Services Total:							**17814452.25**
Employment Support Services	☐	15 min	3675	823.00	5.89	**17814452.25**	
Environmental Accessibility Adaptations - Home Modifications Total:							**22438966.20**
Environmental Accessibility Adaptations - Home Modifications	☐	item/per year	2234	2.00	5022.15	**22438966.20**	
Environmental Accessibility Adaptations - Vehicle Modifications Total:							**2493215.92**
Environmental Accessibility Adaptations - Vehicle	☐	item	248	1.00	10053.29	**2493215.92**	

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Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications							
Family Residential Services Total:							***123964882.47***
Family Residential Services	☐	*daily*	*1287*	*289.00*	*333.29*	***123964882.47***	
Family Training and Counseling Total:							***406896.00***
Family Training and Counseling	☐	*15 min*	*173*	*80.00*	*29.40*	***406896.00***	
Home Delivered Meals Total:							***18776575.44***
Home Delivered Meals	☐	*meal*	*11393*	*218.00*	*7.56*	***18776575.44***	
Housing Access Coordination Total:							***0.00***
Housing Access Coordination	☐	*15 min*	*0*	*154.00*	*14.43*	***0.00***	
In-Home Family Supports Total:							***0.00***
In-Home Family Supports	☐	*15 min*	*0*	*1128.00*	*10.67*	***0.00***	
Independent Living Skills (ILS) Therapies Total:							***694145.70***
Independent Living Skills (ILS) Therapies	☐	*15 min*	*90*	*213.00*	*36.21*	***694145.70***	
Independent Living Skills (ILS) Training Services Total:							***0.00***
Independent Living Skills (ILS) Training Services	☐	*15 min*	*0*	*636.00*	*13.41*	***0.00***	
Individualized Home Supports Total:							***129166400.00***
Individualized Home Supports	☐	*decremental*	*14320*	*902.00*	*10.00*	***129166400.00***	
Integrated Community Supports Total:							***127296966.72***
Integrated	☐					***127296966.72***	

GRAND TOTAL:	***1793968362.97***
Total: Services included in capitation:	
Total: Services not included in capitation:	*1793968362.97*
Total Estimated Unduplicated Participants:	***45165***
Factor D (Divide total by number of participants):	***39720.32***
Services included in capitation:	
Services not included in capitation:	*39720.32*
Average Length of Stay on the Waiver:	*319*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Supports		daily	2398	259.00	204.96		
Night Supervision Services Total:							**11836904.96**
Night Supervision Services	☐	15 min	316	4376.00	8.56	**11836904.96**	
Personal Support Services Total:							**0.00**
Personal Support Services	☐	15 min	0	1498.00	7.66	**0.00**	
Positive Support Services Total:							**5112138.85**
Positive Support Services	☐	15 min	689	493.00	15.05	**5112138.85**	
Specialist Services Total:							**1044936.00**
Specialist Services	☐	1 hour	230	48.00	94.65	**1044936.00**	
Specialized Equipment and Supplies Total:							**10608876.60**
Specialized Equipment and Supplies	☐	per year	13866	10.00	76.51	**10608876.60**	
Transitional services Total:							**2448053.52**
Transitional services	☐	decremental	1047	22.00	106.28	**2448053.52**	
Transportation Total:							**27517365.04**
Transportation	☐	trip/per mile	17684	7073.00	0.22	**27517365.04**	

GRAND TOTAL:	**1793968362.97**
Total: Services included in capitation:	
Total: Services not included in capitation:	1793968362.97
Total Estimated Unduplicated Participants:	**45165**
Factor D (Divide total by number of participants):	**39720.32**
Services included in capitation:	
Services not included in capitation:	39720.32
Average Length of Stay on the Waiver:	319

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**18372383.82**
Adult Day Service	☐	decremental	1806	549.00	18.53	**18372383.82**	
Caregiver Living Expenses Total:							**243064.80**
Caregiver Living Expenses	☐	daily	40	162.00	37.51	**243064.80**	
Case Management Total:							**119793670.50**
Case Management	☐	15 min	46325	94.00	27.51	**119793670.50**	
Homemaker Total:							**50232644.00**
Homemaker	☐	15 min	14182	644.00	5.50	**50232644.00**	
Prevocational Services Total:							**16308566.87**
Prevocational Services	☐	daily/hour	1873	251.00	34.69	**16308566.87**	
Respite Total:							**10904422.98**
Respite	☐	decremental	898	1187.00	10.23	**10904422.98**	
Extended Community First Services and Supports Total:							**34488477.00**
Extended Community First Services and Supports	☐	15 min	2844	2109.00	5.75	**34488477.00**	
Extended Home Care Nursing Total:							**196341.60**
Extended Home Care Nursing	☐	15 min	7	2480.00	11.31	**196341.60**	
Extended Home Health Care Services Total:							**1080106.56**
Extended Home Health Care Services	☐	15 min/visit	48	3394.00	6.63	**1080106.56**	
Extended Personal Care Assistance Services Total:							**0.00**
Extended Personal Care Assistance	☐	15 min	0	2109.00	5.75	**0.00**	

GRAND TOTAL:		**1885038659.27**
Total: Services included in capitation:		
Total: Services not included in capitation:		1885038659.27
Total Estimated Unduplicated Participants:		**46772**
Factor D (Divide total by number of participants):		**40302.72**
Services included in capitation:		
Services not included in capitation:		40302.72
Average Length of Stay on the Waiver:	318	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services							
24-Hour Emergency Assistance Total:							**21437382.24**
24-Hour Emergency Assistance	☐	Decremental	1458	239.00	61.52	**21437382.24**	
Adult Companion Services Total:							**0.00**
Adult Companion Services	☐	15 min	0	1046.00	7.51	**0.00**	
Adult Day Service Bath Total:							**69020.16**
Adult Day Service Bath	☐	15 min	64	114.00	9.46	**69020.16**	
Adult Foster Care Total:							**0.00**
Adult Foster Care	☐	daily	0	294.00	329.85	**0.00**	
Child foster care Total:							**0.00**
Child foster care	☐	daily	0	222.00	463.12	**0.00**	
Chore Services Total:							**1694343.96**
Chore Services	☐	15 min	999	389.00	4.36	**1694343.96**	
Community Residential Services Total:							**646131380.40**
Community Residential Services	☐	daily	6639	292.00	333.30	**646131380.40**	
Consumer-directed community supports (CDCS): Community Integration and Support Total:							**535838.16**
Consumer-directed community supports (CDCS): Community Integration and Support	☐	decremental	78	52.00	132.11	**535838.16**	
Consumer-directed community supports (CDCS): Individual-							**15146096.85**

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Services included in capitation:	
Services not included in capitation:	40302.72
Average Length of Stay on the Waiver:	318

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Directed Goods and Services Total:							
Consumer-directed community supports (CDCS): Individual-Directed Goods and Services	☐	decremental	1761	1385.00	6.21	**15146096.85**	
Consumer-directed community supports (CDCS): personal assistance Total:							**92676020.40**
Consumer-directed community supports (CDCS): personal assistance	☐	decremental	3560	243.00	107.13	**92676020.40**	
Consumer-directed community supports (CDCS): Support Planning Total:							**3360218.40**
Consumer-directed community supports (CDCS): Support Planning	☐	decremental	836	203.00	19.80	**3360218.40**	
Consumer-directed community supports : Financial Management Services Total:							**13436854.20**
Consumer-directed community supports : Financial Management Services	☐	decremental	3343	203.00	19.80	**13436854.20**	
Consumer-directed community supports: self-direction support activities Total:							**0.00**
Consumer-	☐					**0.00**	

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
directed community supports: self-direction support activities		*decremental*	*0*	*0.00*	*19.33*		
Consumer-directed community supports: environmental modifications - vehicle modifications Total:							***629170.20***
Consumer-directed community supports: environmental modifications - vehicle modifications	☐	*decremental*	*201*	*15.00*	*208.68*	***629170.20***	
Consumer-directed community supports: environmental modifications and provisions Total:							***0.00***
Consumer-directed community supports: environmental modifications and provisions	☐	*decremental*	*0*	*0.00*	*203.79*	***0.00***	
Consumer-directed community supports: environmental modifications – home modifications Total:							***629170.20***
Consumer-directed community supports: environmental modifications – home modifications	☐	*decremental*	*201*	*15.00*	*208.68*	***629170.20***	
Consumer-directed community supports: treatment and training Total:							***8987971.74***

GRAND TOTAL:	***1885038659.27***
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Total: Services not included in capitation:	*1885038659.27*
Total Estimated Unduplicated Participants:	***46772***
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Services included in capitation:	
Services not included in capitation:	*40302.72*
Average Length of Stay on the Waiver:	*318*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer-directed community supports: treatment and training	☐	decremental	1334	51.00	132.11	8987971.74	
Crisis Respite Total:							9712816.04
Crisis Respite	☐	decremental	212	83.00	551.99	9712816.04	
Customized Living Total:							235547387.46
Customized Living	☐	daily	4323	258.00	211.19	235547387.46	
Day Support Services Total:							15341717.16
Day Support Services	☐	15 min	1477	549.00	18.92	15341717.16	
Employment Development Services Total:							5089184.64
Employment Development Services	☐	15 min	1524	216.00	15.46	5089184.64	
Employment Exploration Services Total:							3149339.76
Employment Exploration Services	☐	15 min	1869	168.00	10.03	3149339.76	
Employment Support Services Total:							18685861.48
Employment Support Services	☐	15 min	3806	821.00	5.98	18685861.48	
Environmental Accessibility Adaptations - Home Modifications Total:							23837824.26
Environmental Accessibility Adaptations - Home Modifications	☐	item/per year	2313	2.00	5153.01	23837824.26	
Environmental Accessibility Adaptations - Vehicle Modifications Total:							2648649.71
Environmental Accessibility	☐					2648649.71	

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptations - Vehicle Modifications		item	257	1.00	10306.03		
Family Residential Services Total:							**129939986.88**
Family Residential Services	☐	daily	1333	288.00	338.47	**129939986.88**	
Family Training and Counseling Total:							**428613.71**
Family Training and Counseling	☐	15 min	179	79.00	30.31	**428613.71**	
Home Delivered Meals Total:							**19943693.14**
Home Delivered Meals	☐	meal	11798	217.00	7.79	**19943693.14**	
Housing Access Coordination Total:							**0.00**
Housing Access Coordination	☐	15 min	0	153.00	14.65	**0.00**	
In-Home Family Supports Total:							**0.00**
In-Home Family Supports	☐	15 min	0	1125.00	10.84	**0.00**	
Independent Living Skills (ILS) Therapies Total:							**724957.32**
Independent Living Skills (ILS) Therapies	☐	15 min	93	212.00	36.77	**724957.32**	
Independent Living Skills (ILS) Training Services Total:							**0.00**
Independent Living Skills (ILS) Training Services	☐	15 min	0	634.00	13.62	**0.00**	
Individualized Home Supports Total:							**135596376.00**
Individualized Home Supports	☐	decremental	14829	900.00	10.16	**135596376.00**	
Integrated Community Supports Total:							**165557469.96**

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Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Community Supports	☐	daily	3083	258.00	208.14	165557469.96	
Night Supervision Services Total:							12395190.06
Night Supervision Services	☐	15 min	327	4362.00	8.69	12395190.06	
Personal Support Services Total:							0.00
Personal Support Services	☐	15 min	0	1493.00	7.78	0.00	
Positive Support Services Total:							5356770.72
Positive Support Services	☐	15 min	714	491.00	15.28	5356770.72	
Specialist Services Total:							1091529.88
Specialist Services	☐	1 hour	238	47.00	97.58	1091529.88	
Specialized Equipment and Supplies Total:							11326379.20
Specialized Equipment and Supplies	☐	per year	14359	10.00	78.88	11326379.20	
Transitional services Total:							2613025.36
Transitional services	☐	decremental	1084	22.00	109.57	2613025.36	
Transportation Total:							29698741.49
Transportation	☐	trip/per mile	18313	7051.00	0.23	29698741.49	

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