

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.6

Includes Changes Implemented through January 2019

Submitted by:

[add]Minnesota is submitting this request to renew the Community Access for Disability program for an additional five years from Oct. 1, 2020 to Sept. 30, 2025.

Changes to the current program that are proposed in this renewal request include:

- Replaces references to “consumer,” “recipient” and “enrollee” to reflect “participant” where appropriate
- Updates references to “county and tribe” to reflect “lead agency” where appropriate
- Updates references to “tribes” to reflect “tribal nations”
- Updates references to “screening” to reflect “assessment” where appropriate
- Updates references to “community support plan” to reflect “support plan,” “CSP” or “CSSP” where appropriate
- Replaces references to “Common Entry Point (CEP)” with “Minnesota Adult Abuse Reporting Center (MAARC)”
- Corrects statutory references, form numbers, and websites
- Updates the public input process
- Updates the Statewide Transition Plan language to reflect CMS’ final approval granted on Feb. 12, 2019
- Removes outdated language regarding a corrective action plan that will have expired
- Updates “other specified groups” in the Medicaid Eligibility Groups section to match those in the Medicaid state plan
- Updates the lead agency review information in the “Assessment Methods and Frequency section” under Appendix A (Waiver Administration and Operation)
- Updates the maximum number of participants that can be served on the waiver each year while the waiver is in effect, under Appendix B-3 (Participant Access and Eligibility)
- Updates Appendix B-6 (Evaluation/Reevaluation of Level of Care) to reflect the current criteria, forms, and process
- Aligns the “own home” definition in night supervision services and housing access coordination with transitional services
- Removes references to supported employment services which ended Aug. 31, 2018
- Removes references to residential care which ended Jun. 30, 2018
- Corrects provider categories (agency and individual) where needed
- Updates Appendix C-2-d (Provision of Personal Care or Similar Services by Legally Responsible Individuals) to provide clarity
- Updates Appendix C-2-e (Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians) to clarify payment to legal guardians for extended home care nursing
- Removes duplicative language in Appendix E-1 (Participant Direction of Services)
- Updates the number of participants expected to select CDCS
- Updates Appendix G-1 (Response to Critical Incident or Events), Appendix G-2 (Safeguards Concerning Restraints and Restrictive Interventions) and G-3 (Medication Management and Administration) to reflect 245D licensing standards
- Updates Quality Assurance measures to correct technical errors and be consistent with BI, CAC and DD waiver plans where appropriate

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• Updates language to be consistent with BI, CAC and DD waiver plans where appropriate[end
add]

Submission Date:

CMS Receipt Date (*CMS Use*)

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 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.

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1. Request Information

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

B. **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:** (the system will automatically populate new, amendment, or renewal)

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

<input type="radio"/>	3 years
<input checked="" type="radio"/>	5 years

<input type="checkbox"/>	New to replace waiver		
	Replacing Waiver Number:		
	Base Waiver Number:	MN.0166	
	Amendment Number (if applicable):		
	Effective Date: (mm/dd/yy)	10/01/2020	

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

<input type="radio"/>	Model Waiver
<input checked="" type="radio"/>	Regular Waiver

E. **Proposed Effective Date:** 10/01/2020

Approved Effective Date (CMS Use):

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

<input type="checkbox"/>	Hospital (select applicable level of care)		
<input type="radio"/>	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:		

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	<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>		Nursing Facility (<i>select applicable level of care</i>)
	<input checked="" type="radio"/>	<p>Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155</p> <p>If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:</p>
	<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>		<p>Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)</p> <p>If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID facility level of care:</p>

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

Select one:

<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	Applicable	
Check the applicable authority or authorities:		
<input type="checkbox"/>	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I	
<input checked="" type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i> This waiver operates concurrently with Minnesota's case management waiver, CMS control # MN-03.M01.	
Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:</i>	
<input type="checkbox"/>	A program authorized under §1915(i) of the Act.	
<input type="checkbox"/>	A program authorized under §1915(j) of the Act.	
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>	

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

<input checked="" type="checkbox"/>	This waiver provides services for individuals who are eligible for both Medicare and Medicaid.
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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 ~~Minnesota is a place where~~ 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 ~~community~~ 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; ~~community~~ support plan development; authorizing services; and monitoring the services provided. The department provides direction and oversees the operational activities carried out by counties and ~~tribes~~ tribal nations. We refer to counties and ~~tribes~~ 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

~~Thirty-seven~~ Thirty-eight services are covered. ~~Participants~~ Participant’s service needs are assessed and an individualized ~~community~~ 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 ~~community~~ support plan development.

Cost neutrality is managed through an aggregate budget amount that the department allocates to each ~~county and tribe~~ 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.

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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):*

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. <i>Appendix E is required.</i>
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. <i>Appendix E is not required.</i>

- 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.

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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*):

<input type="radio"/>	Not Applicable
<input type="radio"/>	No
<input checked="" type="radio"/>	Yes

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

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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

<input type="checkbox"/>	<p>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.</p> <p><i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>
<input type="checkbox"/>	<p>Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make <i>participant direction of services</i> 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.</p> <p><i>Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i></p>

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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.

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- I. **Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. **Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR §440.160.

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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.

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During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified throughout the application and in **Appendix H**.

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

[add]The public comment period for the renewal begins on Monday, May 18, 2020, and ends on Wednesday, June 17. The Department sends a notice for public comment on the proposed renewal via an e-mail listserv for stakeholders and advocates. The notice includes a copy of the proposed waiver renewal. The notice for public comment is also sent to tribal nations. The Department is submitting an Appendix K to CMS to request the non-electronic notification be waived during the peacetime emergency. [end add]

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State’s intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

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7. Contact Person(s)

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

Last Name:	Berg			
First Name:	Ann			
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:	651-431-2193	Ext:		<input type="checkbox"/> TTY
Fax:	651-431-7421			
E-mail:	ann.berg@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:				
Zip :				
Phone:		Ext:		<input type="checkbox"/> TTY
Fax:				
E-mail:				

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8. Authorizing Signature

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

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

Signature:

_____ State Medicaid Director or Designee

**Submission
Date:**

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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:				
Zip:				
Phone:		Ext:		<input type="checkbox"/> TTY
Fax:				
E-mail:				

State:	
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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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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 [add]HCB Settings[end add] 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.

[delete]Introduction:

The Centers for Medicare & Medicaid Services (CMS) issued new rules governing home and community-based services funded through the Medical Assistance Program in January, 2014. The rule is intended to afford participants receiving home and community-based services increased choice and integration into the community and outlines the requirements for person-centered planning and home and community-based settings. CMS requires each state to create a waiver-specific transition plan detailing how the state will come into compliance with the requirements for home and community-based settings by March 17, 2019. This document offers the framework Minnesota will use to ensure that the Community Access for Disability Inclusion waiver complies with the final rule.

The new federal rule applies to programs authorized under sections 1915(e), 1915(i) and 1915(k) of the Social Security Act. The rule requires immediate compliance for person-centered planning requirements for all programs, and for home and community-based setting requirements for new programs. The rule allows a transition period of up to five years from the effective date of the rule for the home and community-based setting requirements for existing programs.

Minnesota is required to develop and implement an Olmstead Plan. The Olmstead Plan is an effort to ensure that Minnesotans with disabilities will have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life. The implementation of this transition plan to come into compliance with the home and community-based setting requirements in the rule will help Minnesota further the goals expressed in the Olmstead Plan. The rule impacts a subset of the population of people covered by

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the Olmstead Plan; however, the values expressed in the rule and the Olmstead Plan are similar and will lead to similar outcomes.

Preliminary work:

The Minnesota Department of Human Services (DHS) sought input on the development of the transition plan from stakeholders at many points in the process and will continue to do so as the plan is implemented. Major phases that have been completed include:

1. March 2014 to June 2014: Planning phase—DHS released a document for public review and comment that identified the steps DHS would take over the summer and fall to prepare a transition plan to submit to CMS.
2. June 2014 to September 2014: Public input phase—DHS established an advisory committee to advise on the public input process used in the development of the transition plan. From June until September 2014, DHS collected stakeholder input which was used to inform the transition plan. This was accomplished through focus groups and other in-person meetings with seniors, people with disabilities, and family members, which were used as mechanisms to inform people of the new rule and to get their initial input on how the rule would impact their lives. DHS also provided information to and sought input from other stakeholders, such as providers, lead agencies, advocacy organizations and other interested parties through videoconferences and in-person meetings. DHS also established an email address to allow interested parties to submit questions or comments related to the development of the transition plan. In addition to these strategies for input specific to the new federal rule, DHS also reviewed input collected from seniors and people with disabilities from other initiatives with similar focuses, in order to assure a broader look at input on the topic.
3. September 2014 to December 2014: Plan development phase—On September 29, 2014, DHS issued a notice in the State Register of a draft transition plan available for public comment, as requested by CMS. DHS refined the transition plan based on public input and analysis.

Assessment Process and Remediation Strategies:

DHS will complete an assessment process to determine Minnesota’s current level of compliance with the home and community-based setting requirements outlined in the CMS rule. There are two components to the assessment—a regulatory review and a settings review. Each assessment component includes remediation strategies that will be used to comply with the CMS rule.

Regulatory Review:

Assessment start date: June 2014 Assessment end date: April 2015

The regulatory review includes a comparative analysis of the setting requirements in the home and community-based services rule with Minnesota’s current statute, rule, and federally-approved waiver plans. Topics covered by this analysis will include, but are not limited to:

- Regulatory requirements governing non-residential services, including employment and day services
- Regulatory requirements governing residential services
- Applicability of state and local landlord-tenant law
- Regulatory requirements governing any home and community based services, provider qualifications and settings

The analysis is in the process of being conducted by DHS staff.

Remediation start date: October 2014 Remediation end date: December 2018

Once the gaps in regulatory requirements are identified, DHS will propose changes to state statute, federal waiver plans, and DHS policy manuals to align regulatory requirements, service descriptions and provider standards with the federal rule. The changes to statute will be proposed in phases over the next several legislative sessions, concluding in the 2018 legislative session. Phasing in the statutory changes

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over several legislative sessions allows the opportunity to work with stakeholders, especially for issues that are more complicated. The timeline for remediation also allow for the necessary time to amend the waiver plans and policy manuals. The timelines will also allow adequate time for stakeholder input on specific remediation strategies. The bulk of the legislative changes will be proposed prior to and during the 2017 legislative session. The final legislative session in 2018 will be used, if necessary, to address any final refinements.

Setting Identification and Review:

Provider Self Assessment start date: October 2014

Provider Self Assessment end date: June 2015

The process to identify and review settings will include several components. There will be an initial data analysis to identify those settings that may not comply with the rule and settings that may fall under the category of presumed not to be home and community-based.

DHS will require all providers of residential, day, and employment services to complete a self-assessment of their compliance with the CMS rule. The self-assessment will be sent to providers by May 1, 2015, with a response expected by June 1, 2015. The providers will receive training and information on how to complete the self-assessment. This training will also provide opportunity to educate the providers on the CMS rule. The information gathered through this process will further inform the list of settings that are not home and community-based settings, as well as settings that are presumed not to be home and community-based.

DHS will determine whether the settings controlled by providers meet the criteria of a home and community-based setting. While DHS gathers information to assist with determining the criteria to identify settings that isolate people from the broader community, DHS will use an initial criterion in residential settings in which people receive home and community-based services from the service provider affiliated with the housing provider. This initial criterion is when people receiving Medicaid home and community-based services are living in more than 25% of the units in a building. All providers will have the opportunity to demonstrate that the setting meets the requirements of a home and community-based setting, as defined by the CMS rule. No provider will be determined to not be home and community-based due to the concentration levels alone. Information obtained during the assessment phase will determine what the ongoing evaluation criteria will be, and will be submitted through the waiver amendment process.

DHS is aware that there is a lack of affordable housing for people in Minnesota, which impacts seniors and people with disabilities receiving services through home and community-based services waivers. Some buildings receive funding through the U.S. Department of Housing and Urban Development, which may require a building to be specifically designed for people with disabilities. DHS will work with Minnesota's Housing Finance Agency to provide information to these housing providers about the setting requirements included in home and community-based services rule, to determine whether these settings meet the requirements, and to determine what resources will be necessary to assist these settings with coming into compliance with the rule.

For settings in which day and employment services are provided solely to individuals receiving home and community-based services, DHS will determine whether the setting meets the criteria.

Using the information gathered to determine the list of settings that are presumed not to be home and community-based; DHS will review data from on-site assessments to determine whether a setting is permissible under the rule.

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Remediation start date: January 2015 Remediation end date: December 2018

Concurrently with the provider self-assessment, DHS will require providers who are not in compliance with any component of the CMS rule to establish a transition plan specific to each site of service. The transition plan will identify any component of the rule the provider is not currently in compliance with, identify steps the provider will take and the timelines for completion of each action step. Provider transition plans will be monitored by DHS to ensure compliance of all settings, with full implementation completed by December 2018.

Settings that are listed as either presumed non-compliant or non-compliant will require some action, which will naturally vary by the setting and the nature of the problem. Examples of possible settings and action steps are summarized below:

Setting type: Service is provided in a setting that is adjacent or attached to a public institution (i.e., county-owned, city-owned, state-owned nursing facility, hospital, ICF/DD or IMD)

Actions: Provider/setting must provide information on how the setting meets the criteria of a home and community-based setting or providers indicate that they will not take necessary steps to comply with HCBS setting requirements. DHS will assure settings are verified for compliance. DHS will implement plans to assist individuals in transitioning to other HCBS services and settings.

End date: June 2017 or June 2018

Setting type: Service is provided in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.

Actions: Provider/setting must provide information on how the setting meets the criteria of a home and community-based setting or providers indicate that they will not take necessary steps to comply with the HCBS settings requirements. DHS will assure settings are verified for compliance. Individuals receiving services will receive information on options for other services and support on making choices.

End date: June 2017

Setting type: Service is provided in a setting that has the effect of isolating people from the broader community of people not receiving Medicaid HCBS.

Actions: Provider/setting must provide information on how the setting meets the criteria of a home and community-based setting. DHS will verify that all settings are in compliance. Individuals receiving services will receive information on options for other services and support on making choices.

End date: June 2018

Setting type: Service is provided in a nursing facility, hospital, ICF/DD, or IMD and is part of the institutional services

Actions: Provider may choose to seek a separate license or separate services from the institutional setting and provide information on how the setting meets the criteria of a home and community-based setting. If the provider chooses to not continue to provide HCBS, individuals receiving services will receive information on options for other services and support on making choices.

End date: June 2018

On-going compliance:

Minnesota will use several strategies at the provider, lead agency, and individual recipient levels to assure on-going compliance with the home and community based settings requirements. To assure on-going compliance with the requirements at a provider level, DHS will use mechanisms that are already in place, to the extent possible, with some necessary revisions to accomplish the requirements of the CMS rule. The primary mechanisms are the provider enrollment process and licensing. In 2017 and 2018, all home and community-based services providers will be required to re-enroll as a Medicaid

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provider, which includes submitting assurances of compliance with the waiver requirements. DHS will require provider assurances upon re-enrollment related to compliance with the CMS rule. Setting requirements for the CMS rule will be included in Minnesota Statutes, Chapter 245D to allow licensors to assure on-going compliance for individual settings. Minnesota will also use on-site reviews by lead agency assessors or case managers to assure individual outcomes are being realized.

Minnesota conducts waiver reviews of all five Medicaid waiver programs and the Alternative Care Program in each lead agency (counties, tribes and health plans). Site visits include a review of participant case files, interviews and focus groups with staff, and a review of lead agency data. The reports include feedback about promising practices and identification of program strengths, areas needing improvement, and areas requiring corrective action. We plan to incorporate a lead agency review process to monitor and enforce compliance with the settings rule.

DHS will use the existing Gaps Analysis survey and waiver review processes to assure that individuals have a choice between settings. The Gaps Analysis, developed by DHS, reports on the current capacity and gaps in long-term services and supports and housing to support older adults, people with disabilities, children and youth with mental health conditions and adults living with mental illnesses in Minnesota. Lead agencies will be asked to respond to questions about the availability of choice of type of residential, day and employment settings in their county beginning with the 2015 Gaps Analysis Survey.

The experience of individuals will be monitored through the MnCHOICES comprehensive assessment and service planning tool. Questions in the tool will address a person's choice of where they live and work. Minnesota will explore mechanisms to get direct input from seniors and people with disabilities outside of the assessment process.

Appendix: Statewide Transition Plan work plan grid

Key:

- CCA— Continuing Care Administration
- CMS— Centers for Medicare and Medicaid Services
- DHS— Minnesota Department of Human Services
- GRH— Group Residential Housing
- HCBS— Home and community-based services
- MDH— Minnesota Department of Health
- MHCP— Minnesota Health Care Programs
- MMIS— Medicaid Management Information System

A: Assessment process— Regulatory Review:

Analyze current Minnesota regulatory requirements governing nonresidential services including employment

- DHS responsibilities: Complete a comparison of the rule requirements with current requirements in state statute, waiver plans and Minnesota's Olmstead Plan.
- Timeframe: June 2014—April 2015
- Sources: MN Statutes, MN Rules, Community-Based Services Manual, Olmstead Plan, HCBS waiver plans
- Key stakeholders: DHS staff, Minnesota Employment Learning Community, Olmstead Subcabinet, Dept. of Health
- Outcome(s): Identified gaps in regulations
- Progress status and notes: In process

Analyze applicability of state landlord-tenant law requirements to all HCBS regulatory settings

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–DHS responsibilities: Complete an analysis of current statutory requirements of land lord tenant law and how this complies with the rule. This analysis will include individuals outside of DHS with expertise in this area of law.

–Timeframe: July 2014 – July 2015

–Sources: MN Statutes

–Key stakeholders: Disability Law Center, Legal Aid, attorneys representing provider organizations, ombudsman, DHS staff

–Outcome(s): Identified HCBS settings where landlord tenant law or comparable protections does/does not apply

–Progress status and notes: DHS completed the initial analysis of settings in which Minnesota landlord tenant law currently does/does not apply.

Analyze current Minnesota regulatory requirements governing HCBS settings for residential services
–DHS responsibilities: Compare current Minnesota regulations with federal HCBS rule requirements regarding HCBS residential settings.

–Timeframe: Sept. 2014 – April 2015

–Sources: Minnesota statutes and rules and HCBS waiver plans

–Key stakeholders: DHS staff – Outcome(s): Identified gaps between federal HCBS requirements and Minnesota’s current regulations

–Progress status and notes: Completed

Analyze current Minnesota regulatory requirements governing all other waiver services, provider standards, and setting requirements

–DHS responsibilities: Compare current Minnesota regulations with CMS rule requirements regarding HCBS settings.

–Timeframe: Oct. 2014 – April 2015

–Sources: Minnesota statutes, rules and HCBS waiver plans

–Key stakeholders: DHS staff

–Outcome(s): Identified gaps between CMS rule requirements and Minnesota’s current regulations

–Progress status and notes: Completed

B: Assessment process – Setting Identification and Review:

Identify settings that may not be HCBS and may be “presumed not to be HCBS”

–DHS responsibilities: Conduct an initial data analysis to determine settings that may be in an institutional setting, or meet the criteria of presumed not to be HCBS

–Timeframe: Oct. 2014 – Dec. 2014

–Sources: State data bases including housing with services registration data, provider enrollment records, MMIS, Uniform Consumer Information Guide

–Key stakeholders: DHS staff

–Outcome(s): Identified number and types of settings that will require further analysis

–Progress status and notes: Completed

Train providers on completing the provider self-assessment

–DHS responsibilities: Provide training to providers that will be completing the provider self-assessment. The training will include assisting providers with identifying the appropriate person within the agency to complete the assessment, providing the list of questions to providers, and walking through the self-assessment process

–Timeframe: March 2015 – June 2015

–Sources: MMIS, MN-ITS (provider communication mechanism)

–Key stakeholders: DHS staff, HCBS providers, lead agencies, trade associations, service recipients

–Outcome(s):

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–Progress status and notes: Completed

Collect provider self assessment

–DHS responsibilities: Develop and distribute a provider self assessment to all providers of residential, day and employment services to determine their compliance with the CMS rule. The development of the survey will include input from stakeholders, as well as testing by providers and trade associations. Providers will have 30 days to complete and submit the self assessment

–Timeframe: Oct. 2014 – June 2015

–Sources: MMIS, MN ITS (provider communication mechanism)

–Key stakeholders: DHS staff, advocates, service recipients, HCBS providers, trade associations, lead agencies

–Outcome(s): Information on providers’ current level of compliance with CMS rule

–Progress status and notes: In process

Verify provider self assessment results

–DHS responsibilities: Develop and implement mechanisms to gather data necessary to independently validate provider surveys results

–Timeframe: Jan. 2015 – June 2017

–Sources: Surveys, assessment tools, individual planning tools

–Key stakeholders: Seniors, people with disabilities, advocates, lead agencies

–Outcome(s): Verify overall HCBS settings’ level of compliance with CMS rule

–Progress status and notes: Determining mechanisms for independent verification of setting compliance.

Review and determine settings that are presumed not to be home and community based

–DHS responsibilities: Verify settings’ compliance with federal rule that are presumed not to be home and community based,

–Timeframe: Jan. 2015 – December 2017

–Sources: Surveys, assessment tools, comments, individual planning tools

–Key stakeholders: Seniors, people with disabilities, advocates, lead agencies

–Outcome(s): Verify HCBS settings’ compliance with CMS rule

–Progress status and notes: In progress

C: Remedial strategies – Regulatory Review

Align state regulatory requirements with CMS rule standards

–DHS responsibilities: Propose changes to align state regulatory requirements with CMS Rule standards.

–Timeframe: Oct. 2014 – May 2018

–Sources: MN Statute and rules, policy analysis

–Key stakeholders: DHS staff, MDH staff, advisory committee, legislators, legislative staff, other stakeholders

–Outcome(s): Minnesota regulatory requirements will comport with the requirements in the federal rule

–Progress status and notes: In progress

Adopt provider standards that align with federal HCBS regulations

–DHS responsibilities: Submit waiver amendments to CMS aligning provider standards with federal HCBS regulations.

–Timeframe: Jan. 2015 – Dec. 2018

–Sources: Waiver guidelines and federal HCBS regulation and CMS guidance

–Key stakeholders: DHS staff with stakeholders and public through 30 day public comment period

–Outcome(s): HCBS waiver provider standards that align with federal HCBS regulations

–Progress status and notes: Changes will be determined by regulatory analysis and legislation

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Address changes needed to policy manuals and website content

- DHS responsibilities: Make changes to DHS policy manuals and websites to address language that conflicts with the rule, as identified in the assessment process.
- Timeframe: Dec. 2014—Dec. 2018
- Sources: Community-Based Services Manual, MHCP Provider Manual, DHS public website
- Key stakeholders: DHS staff, other stakeholders
- Outcome(s): DHS policy manuals and websites that align with the requirements in the federal rule.
- Progress status and notes: Changes will be based on legislation and waiver amendments

D: Remedial strategies—Settings Identification and Review

Monitor HCBS site specific transition plans

- DHS responsibilities: Review and track site-specific transition plans developed by providers addressing all areas of non-compliance.
- Timeframe: Oct. 2014—June 2018
- Sources: MMIS, MN-ITS (provider communication), provider self-assessment
- Key stakeholders: DHS staff, HCBS providers, trade associations, lead agencies
- Outcome(s): Setting-specific transition plans
- Progress status and notes: In process

Develop evaluation of overall status of compliance with CMS rules

- DHS responsibilities: Aggregate data on HCBS settings; Develop training needed for providers, lead agencies and service recipients; Develop mechanism for tracking compliance over time.
- Timeframe: April 2014—June 2018
- Sources: HCBS specific site assessment and transition plans
- Key stakeholders: DHS will aggregate data; provider and lead agency training and support developed in consultation with stakeholders
- Outcome(s): Detailed training and support plans and mechanism to track compliance will be developed.
- Progress status and notes: In progress

Monitor HCBS settings to assure compliance with requirements

- DHS responsibilities: DHS will assure HCBS settings are in compliance
- Timeframe: July 2015—December 2018
- Sources: DHS licensing reviews and participant and case manager feedback
- Key stakeholders: DHS licensing, HCBS case managers
- Outcome(s): Settings comply with HCBS requirements
- Progress status and notes: Not started

Finalize compliance

- DHS responsibilities: Assure that transition is complete by verifying compliance of all settings
- Timeframe: Jan. 2018—Mar. 2019
- Sources: Data gathered
- Key stakeholders: DHS staff, providers, seniors, people with disabilities, lead agencies
- Outcome(s): Final compliance
- Progress status and notes: To be developed

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal. [end delete]

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[add]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>[end add]

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 [delete]participants[end delete] [add]participant’s[end add] behalf) [delete]has conferred[end delete] [add]may confer those rights and obligations[end add] to a guardian, conservator or authorized representative. The use of the term [add] “[end add]participant[add]” [end add] does not preclude the representative from meeting those obligations or exercising those rights, to the extent of the [delete]representatives[end delete] [add]representative’s[end add] authority.

The following are additional waiver requirements:

1. An individual written [delete]community[end delete] support plan must be developed for each participant. Services included in the [delete]community[end delete] 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. A shared staffing rate is calculated in the [delete]Disability Waiver[end delete] Rates [add]Management[end add] System, and a shared staffing rate is authorized in MMIS. Shared staffing is allowed for the following services (within the same service only) at the ratio indicated:

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

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

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

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Prevocational Services (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8, 1:9, or 1:10)
 Respite Services (1:1, 1:2, or 1:3)
 Individualized Home Support (1:1 or 1:2)
 Independent Living Skills [add] (ILS) Training[end add] (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)

2. The waiver shall cover only those goods and services authorized in the [delete]community[end delete] 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), and educational expenses 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 [delete]community[end delete] support plan;
- b) are not included in the [delete]community[end delete] support plan;
- c) are recreational or diversionary in nature;
- d) duplicate other services in the [delete]community[end delete] support plan;
- e) supplant natural supports appropriately meeting the participant's needs;
- f) are not the least costly and effective means to meet the participants needs; or
- g) 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 community support plan. Direct care staff services are defined as extended personal care assistance, extended home care nursing, foster care services, and a CDCS worker that provides ADL assistance under the category of Personal Assistance.

All waiver plan requirements continue to apply to services provided outside of Minnesota including, prior authorization, provider standards, participant health and safety assurances, case management visits and annual assessments in the participant's permanent Minnesota residence, etc. Travel expenses for participants and their companions (including paid or non-paid caregivers), such as airline tickets, mileage, lodging, meals, entertainments, etc. are not covered.

LOCAL TRADE AREA / USE OF PROVIDERS FROM A BORDERING STATE:

A participant who resides in Minnesota may need to use a provider who is in the participant's local trade area of North Dakota, South Dakota, Iowa or Wisconsin. The services must be provided in accordance with state and federal laws and regulations. The local trade area is defined in Minnesota Rules, Part 9505.0175, subp. 22, as the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services.

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

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services when it is part of the ~~participants~~ participant's ~~community~~ 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 ~~community~~ coordinated service and support plan (CSSP) that reasonably ensures a participant's health. Minn. Stat. §245D.05 directs the licensed provider to meet service needs in the ~~community support plan~~ 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 ~~funding or money~~ 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 ~~community~~ support planning processes. Participants who are otherwise eligible shall not be terminated from the waiver by a lead agency for the sole purpose of the lead agency's management of its allocation.

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

Lead Agency Allocations.

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

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 ~~recipient~~ participant;
- 2) Adjustment to the base rate to account for cost-of-living adjustments provided under state law.

The base rate is determined using scores from ~~11~~ 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~~ 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

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- 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 (~~TBI-NF~~ BI-NF only); Coefficient: 22.462; Range: 0-4
- Variable: Behaviors 2 (~~TBI-NF~~ 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.

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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 ~~Community Support Plans~~ [add]CSSPs[end add]. Lead agencies are responsible to develop and modify participant ~~community support plans~~ [add]CSSPs[end add] based on the assessed needs and within the allocation. The ~~community support plan~~ [add]CSSP[end add] 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 allocation plans~~, lead agency reviews, fair hearing requests, and staff contact with lead agencies.

~~CORRECTIVE ACTION PLAN REGARDING SPOUSAL IMPOVERISHMENT REQUIREMENTS~~

1) We will implement the anti-spousal impoverishment rules, as interpreted by CMS, to be effective for new applicants no later than June 1, 2016. Current enrollees who applied for and attained eligibility on or after January 1, 2014, will have their eligibility determined using anti-spousal impoverishment rules by March 1, 2017. Current enrollees who attained eligibility before January 1, 2014, are not subject to this corrective action plan.

2) Minnesota will identify current enrollees to whom the anti-spousal impoverishment rules have not been applied, but will be applied effective March 1, 2017, and will determine the value of marital assets as of June 1, 2016. In August 2016, Minnesota will inform affected enrollees of the amount of assets they may keep and that any excess must be spent down by March 1, 2017. Effective March 1, 2017, the State will terminate eligibility for enrollees who have not reduced assets below the applicable resource allowance and asset standard, unless granted an exemption under section 1924(c)(3).

3) We will begin development of training materials for eligibility workers and notifications to affected enrollees. Draft training materials will be shared with CMS by April 1, 2016 and with eligibility workers by May 1, 2016. Training materials will be deployed by June 1, 2016. The initial notice to current enrollees, informing them of the need to review marital assets, will be issued no later than March 1, 2016. Another notice will be issued in August 2016, requesting information necessary to determine the community spouse resource allowance, and any excess assets the couple may have. Follow-up notices, informing affected enrollees of their asset assessment results will be sent within thirty days of the

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agency's receipt of the enrollee's asset information. For enrollees with excess assets, the follow up notice will include the deadlines by which MA limits must be met, and a description of the process and standards used to request and approve a waiver on the basis of undue hardship. Affected enrollees will have the ability to submit information regarding assets prior to March 1, 2017. Eligibility workers will review marital assets prior to March 1, 2017, review for other bases of eligibility, and if no other basis exists, the case will be terminated after a 10-day notice and due process rights have been afforded. If necessary, a notice terminating eligibility will be issued at least 10 days prior to March 1, 2017. All notices will be provided to CMS in draft form at least 30 days in advance.

~~4) The state agrees to provide monthly updates to CMS beginning in April, 2016 and ending May, 2017, regarding progress on these requirements. [end delete]~~

[add]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). [end add]

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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*):

<input checked="" type="radio"/>	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 (<i>select one</i>):	
<input type="radio"/>	The Medical Assistance Unit (<i>specify the unit name</i>) (<i>Do not complete Item A-2</i>)	
<input checked="" type="radio"/>	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. (<i>Complete item A-2-a</i>)	Disability Services Division
<input type="radio"/>	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. (<i>Complete item A-2-b</i>).	

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

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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:

--

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*):

<input type="radio"/>	<p>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. <i>Complete Items A-5 and A-6.</i></p>
<input checked="" type="radio"/>	<p>No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).</p>

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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*):

<input type="radio"/>	Not applicable
<input checked="" type="radio"/>	Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
<input checked="" type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i></p> <p>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.</p> <p>The Department monitors lead agency activity through site reviews, the waiver management system, lead agency waiver allocation plans, 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, and tribes and tribes and tribal nations and the department.</p>
<input type="checkbox"/>	<p>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). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>

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

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

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

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The department employs several methods to monitor waiver functions delegated to lead agencies. The waiver review that was submitted in December [delete]2013-[end delete] [add]2018[end add] included evidence of our monitoring activities. We also emphasize program design features such as MMIS system edits to maximize compliance with department policies and [delete]procedure[end delete] [add]procedures[end add] 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 [delete]departments-[end delete][add]department's[end add] 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 [delete]policies-[end delete]

1. Lead Agency Reviews. Department staff conduct lead agency reviews. The purpose of the [delete]lead agency-[end delete] review is to monitor [delete]Minnesota's-[end delete] lead agencies compliance with HCBS program requirements, evaluate how the needs of participants are being met, [add]and[end add] identify best practices [add],[end add] and quality improvement opportunities [delete];[end delete] and [delete]identify[end delete] areas for technical assistance. [delete]Lead agencies are randomly selected for review. Lead agency reviews-[end delete] [add]The reviews[end add] are continuous and ongoing, with [delete]about-[end delete] [add]approximately[end add] 30 lead agencies reviewed each year [delete], and all lead agencies are reviewed at least once every three years[end delete]. [add]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. [end add]

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.

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6. [delete]Lead agency spending requirements[end delete] [add]Review of lead agency allocation management[end add]

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.

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	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

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.

[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of all CADI [delete]waiver[end delete] administrative compliance deficiencies resolved, over the most recent lead agency review cycle. Numerator: Number of CADI [delete]waiver[end delete] administrative compliance deficiencies resolved, per most recent lead agency review cycle. Denominator: Number of CADI [delete]waiver[end delete] administrative compliance deficiencies issued, per most recent lead agency review cycle.
Data Source (Select one) (Several options are listed in the on-line application):	
Other	
If 'Other' is selected, specify:	
Lead Agency Waiver Review Database	

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	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input checked="" type="checkbox"/> Other Specify:	
		Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a [delete]3 [end delete][add]4[end add] year cycle.	<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify:
	Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

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

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[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of all CADI [delete]waiver[end delete] corrective actions issued that were resolved over the most recent lead agency review cycle. Numerator: Number of CADI [delete]waiver[end delete] corrective actions resolved, per the most recent lead agency review cycle. Denominator: Number of [add]CADI[end add] corrective actions issued, per most recent lead agency review cycle.		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input checked="" type="checkbox"/> Other Specify:	
		Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a [delete]3[end delete][add]4[end add] year cycle.	<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

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<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	[add] <input checked="" type="checkbox"/> <i>Annually</i> [end add]
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input checked="" type="checkbox"/> <i>Other</i> <i>Specify:</i>
	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 [delete]assessment[end delete] [add]person-centered[end add] process to: conduct screenings[end delete] [add]assessments[end add] 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 [delete]regional resource specialists[end delete] [add]regionally assigned staff[end add] 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 state’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Lead Agency Reviews, 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.

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ii Remediation Data Aggregation

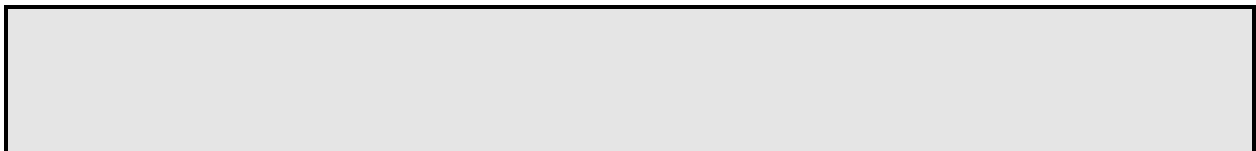
Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input checked="" type="checkbox"/> 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.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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



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Appendix B: Participant Access and Eligibility

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

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

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input checked="" type="checkbox"/>	Aged or Disabled, or Both - General			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input checked="" type="checkbox"/> Disabled (Physical)	0	64	
	<input checked="" type="checkbox"/> Disabled (Other)	0	64	
<input type="checkbox"/>	Aged or Disabled, or Both - Specific Recognized Subgroups			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/>	Intellectual Disability or Developmental Disability, or Both			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input type="checkbox"/> Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/> Mental Retardation			<input type="checkbox"/>
<input type="checkbox"/>	Mental Illness (check each that applies)			
	<input type="checkbox"/> Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/> Serious Emotional Disturbance			<input type="checkbox"/>

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:*

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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.

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Appendix B-2: Individual Cost Limit

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

<input type="radio"/>		No Cost Limit. The state does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>	
<input type="radio"/>		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. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the state is (<i>select one</i>):	
<input type="radio"/>	%		A level higher than 100% of the institutional average Specify the percentage:
<input type="radio"/>		Other (<i>specify</i>):	
<input type="radio"/>			
<input type="radio"/>		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. <i>Complete Items B-2-b and B-2-c.</i>	
<input type="radio"/>		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. <i>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.</i>	
<input type="radio"/>			
<input type="radio"/>		The cost limit specified by the state is (<i>select one</i>):	
<input type="radio"/>		The following dollar amount:	
<input type="radio"/>		Specify dollar amount:	
<input type="radio"/>		The dollar amount (<i>select one</i>):	
<input type="radio"/>		Is adjusted each year that the waiver is in effect by applying the following formula:	
<input type="radio"/>		Specify the formula:	
<input type="radio"/>			
<input type="radio"/>		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.	

State:	
Effective Date	

	○	The following percentage that is less than 100% of the institutional average:		
	○	Other: <i>Specify:</i>		

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*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	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:
<input type="checkbox"/>	Other safeguard(s) <i>(Specify):</i>

State:	
Effective Date	

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	[delete]26250-[end delete] [add]39437[end add]
Year 2	[delete]28765-[end delete] [add]41231[end add]
Year 3	[delete]31328-[end delete] [add]43259[end add]
Year 4 (only appears if applicable based on Item 1-C)	[delete]33738-[end delete] [add]45165[end add]
Year 5 (only appears if applicable based on Item 1-C)	[delete]35570[end delete] [add]46772[end add]

- 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)*:

<input checked="" type="radio"/>	The state does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The state limits the number of participants that it serves at any point in time during a waiver year.

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

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (only appears if applicable based on Item 1-C)	

State:	
Effective Date	

Year 5 (only appears if applicable based on Item 1-C)	
--	--

State:	
Effective Date	

- 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*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.		
<input checked="" type="radio"/>	The state reserves capacity for the following purpose(s). Purpose(s) the state reserves capacity for: Conversions, and lack of local capacity for diversions.		
Table B-3-c			
	Purpose (provide a title or short description to use for lookup):	Purpose (provide a title or short description to use for lookup):	
	Conversions, and lack of local capacity for diversions.		
	Purpose (describe):	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:	Describe how the amount of reserved capacity was determined:	
	The reserve capacity is based on historical need for CADI.		
	Waiver Year	Capacity Reserved	Capacity Reserved
	Year 1	432	
	Year 2	432	
	Year 3	432	
Year 4 (only if applicable based on Item 1-C)	432		
Year 5 (only if applicable based on Item 1-C)	432		

State:	
Effective Date	

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*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	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 <i>intra-year</i> limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.**

Select one:

<input type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input checked="" type="radio"/>	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:

<p>See reserved capacity criteria in Appendix B-3 c.</p> <p>In accordance with Minnesota Statutes, section 256B.49 subd. [delete]11(a)[end delete] [add]11a[end add], 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 [delete]persons[end delete] [add]person's[end add] needs. The commissioner established categories based on urgency of need that include the following conditions:</p> <ol style="list-style-type: none"> (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. <p>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.</p>

State:	
Effective Date	

B-3: Number of Individuals Served - Attachment #1

Waiver Phase-In/Phase Out Schedule

Based on Waiver Proposed Effective Date:

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

<input type="radio"/>	Phased-in
<input type="radio"/>	Phased-out

b. **Phase-In/Phase-Out Time Schedule.** Complete the following table:

Beginning (base) number of Participants:

--

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

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

Year One	Year Two	Year Three	Year Four	Your Five
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

State:	
Effective Date	

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

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

State:	
Effective Date	

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

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

<input type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input checked="" type="radio"/>	209(b) State

2. Miller Trust State.

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

<input checked="" type="radio"/>	No
<input type="radio"/>	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:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input type="checkbox"/>	SSI recipients
<input checked="" type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional state supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of the Federal poverty level (FPL)
<input checked="" type="radio"/>	95% of FPL, which is lower than 100% of FPL Specify percentage:
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)
<input checked="" type="checkbox"/>	Medically needy in 209(b) States (42 CFR §435.330)
<input type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) <i>specify:</i>

State:	
Effective Date	

<p>[delete] Reasonable classifications of optional categorically and medically needy groups for children with disabilities under §1902(a)(10)(A)(ii) and (C) and §1905(a)(i) described in supplement 1 of Attachment 2.2 A of Minnesota's Medicaid State Plan. [end delete]</p> <p>[add] 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</p> <p>2) Reasonable classification of children with a disability under 19, meeting criteria under section 1902(e)(3)</p> <p>3) Medically needy reasonable classification of children under 21:</p> <ul style="list-style-type: none"> • 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. [end add] 	
<p>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</p>	
<input type="radio"/>	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.
<input checked="" type="radio"/>	Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217
<input checked="" type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):
<input type="checkbox"/>	A special income level equal to (select one):
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	% A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
<input type="radio"/>	\$ A dollar amount which is lower than 300% Specify percentage:
<input checked="" type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
<input type="checkbox"/>	Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
<input checked="" type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)
<input checked="" type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of FPL
<input checked="" type="radio"/>	95 % of FPL, which is lower than 100%
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver) <i>specify</i> :

State:	
Effective Date	



State:	
Effective Date	

Appendix B-5: Post-Eligibility Treatment of Income

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

- a. 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 five-year period beginning January 1, 2014, 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.

<input checked="" type="checkbox"/>	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 <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>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)[add] and [end add] 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 December 31, 2018.</i>
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Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

<input type="checkbox"/>	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 (<i>select one</i>):
<input type="checkbox"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State)[add] and [end add] Item B-5-d.</i>
<input type="checkbox"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	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. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules. However, for the five-year period beginning on January 1, 2014, post-eligibility treatment-of-income rules may not be determined in accordance with B-5-b-1 and B-5-c-1, because use of spousal eligibility and post-eligibility rules are mandatory during this time period.

State:	
Effective Date	

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

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

i. Allowance for the needs of the waiver participant (select one):		
<input type="radio"/>	The following standard included under the state plan (Select one):	
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons (select one):	
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	Other standard included under the state Plan Specify:	
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$ _____ If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:	
<input type="radio"/>	Other Specify:	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	Not Applicable	
Specify the amount of the allowance (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ _____ If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	

State:	
Effective Date	

	<i>Specify:</i>	
	iii. Allowance for the family (select one):	
<input type="radio"/>	Not Applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input style="width: 80px;" type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula:	
	<i>Specify:</i>	
<input type="radio"/>	Other	
	<i>Specify:</i>	
	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:	
<input type="radio"/>	Not applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.	
<input type="radio"/>	The state does not establish reasonable limits.	
<input type="radio"/>	The state establishes the following reasonable limits	
	<i>Specify:</i>	

State:	
Effective Date	

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

c-1. 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):			
<input type="radio"/>	The following standard included under the state plan (select one)		
<input type="radio"/>	The following standard under 42 CFR §435.121 Specify:		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one):		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify percentage:
<input type="radio"/>	<input type="radio"/>	\$	A dollar amount which is less than 300% of the FBR Specify dollar amount:
<input type="radio"/>	<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	<input type="radio"/>	Other standard included under the state Plan (specify):	
<input type="radio"/>	<input type="radio"/>	The following dollar amount: \$	Specify dollar amount: If this amount changes, this item will be revised.
<input checked="" type="radio"/>	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.		
<input type="radio"/>	Other (specify)		
ii. Allowance for the spouse only (select one):			
<input checked="" type="radio"/>	Not Applicable (see instructions)		
<input type="radio"/>	The following standard under 42 CFR §435.121 Specify:		
<input type="radio"/>	Optional state supplement standard		

State:	
Effective Date	

<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> If this amount changes, this item will be revised. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
iii. Allowance for the family (select one)	
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i> <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under state law but not covered under the State's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.	
<i>Select one:</i>	
<input checked="" type="radio"/>	Not applicable (<i>see instructions</i>) <i>Note: If the state protects the maximum amount for the waiver participant, not applicable must be checked.</i>
<input type="radio"/>	The state does not establish reasonable limits.
<input type="radio"/>	The state establishes the following reasonable limits (<i>specify</i>): <input type="text"/>

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

State:	<input type="text"/>
Effective Date	<input type="text"/>

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

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the state plan (Select one):		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one):		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:	
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:	
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:	
<input type="radio"/>	Other standard included under the state Plan Specify:		
<input type="radio"/>	The following dollar amount	\$	If this amount changes, this item will be revised.
<input type="radio"/>	Specify dollar amount:		
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:		
<input type="radio"/>	Specify:		
<input type="radio"/>	Other Specify:		
<input type="radio"/>	Specify:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	Not Applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: Specify:		
<input type="radio"/>	Specify:		
Specify the amount of the allowance (select one):			

State:	
Effective Date	

<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
iii. Allowance for the family (select one):		
<input type="radio"/>	Not Applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
<input type="radio"/>	Other <i>Specify:</i>	
	<input type="text"/>	
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:		
<input type="radio"/>	Not applicable (see instructions) <i>Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.</i>	
<input type="radio"/>	The state does not establish reasonable limits.	
<input type="radio"/>	The state establishes the following reasonable limits <i>Specify:</i>	
	<input type="text"/>	

State:	<input type="text"/>
Effective Date	<input type="text"/>

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

c-2. 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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the state plan (Select one):		
<input type="radio"/>	The following standard under 42 CFR §435.121: Specify:		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one):		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:	
<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:	
<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:	
<input type="radio"/>	Other standard included under the state Plan Specify:		
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:		
<input type="radio"/>	Other Specify:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	Not Applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		

State:	
Effective Date	

Specify:	
Specify the amount of the allowance (select one):	
<input type="radio"/>	The following standard under 42 CFR §435.121: Specify:
<input type="radio"/>	Optional state supplement standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> If this amount changes, this item will be revised. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: Specify:
iii. Allowance for the family (select one):	
<input type="radio"/>	Not Applicable (see instructions)
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ <input type="text"/> 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. Specify dollar amount:
<input type="radio"/>	The amount is determined using the following formula: Specify:
<input type="radio"/>	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:	
<input type="radio"/>	Not applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.

State:	
Effective Date	

<input type="radio"/>	The state does not establish reasonable limits.
<input type="radio"/>	The state establishes the following reasonable limits <i>Specify:</i> <div style="background-color: #cccccc; height: 20px; width: 100%;"></div>

State:	
Effective Date	

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).

i. Allowance for the personal needs of the waiver participant			
<i>(select one):</i>			
<input type="radio"/>	SSI Standard		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons		
<input type="radio"/>	%	Specify percentage:	
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:		
	<i>Specify formula:</i>		
<input type="radio"/>	Other		
	<i>Specify:</i>		
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:			
<input type="radio"/>	Allowance is the same		
<input type="radio"/>	Allowance is different.		
	<i>Explanation of difference:</i>		
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.			
<i>Select one:</i>			
<input type="radio"/>	Not applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.		
<input type="radio"/>	The state does not establish reasonable limits.		

State:	
Effective Date	

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

NOTE: Items B-5-e, B-5-f and B-5-g only apply for the five-year period beginning January 1, 2014. If the waiver is effective during the five-year period beginning January 1, 2014, and if the state indicated in B-5-a that it uses spousal post-eligibility rules under §1924 of the Act before January 1, 2014 or after December 31, 2018, then Items B-5-e, B-5-f and/or B-5-g are not necessary. The state's entries in B-5-b-2, B-5-c-2, and B-5-d, respectively, will apply.

State:	
Effective Date	

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

- e. **Regular Post-Eligibility Treatment of Income: SSI State and §1634 State – 2014 through 2018.** The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the state plan (Select one):		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one):		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="radio"/>	<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	Other standard included under the state Plan Specify:		
<input type="radio"/>			
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance: Specify:		
<input type="radio"/>			
<input type="radio"/>	Other Specify:		
<input type="radio"/>			
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	Not Applicable		
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: Specify:		
<input type="radio"/>			
Specify the amount of the allowance (select one):			
<input type="radio"/>	SSI standard		

State:	
Effective Date	

<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
iii. Allowance for the family (select one):		
<input type="radio"/>	Not Applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
	<input type="text"/>	
<input type="radio"/>	Other <i>Specify:</i>	
	<input type="text"/>	
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:		
<input type="radio"/>	Not applicable (see instructions) <i>Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.</i>	
<input type="radio"/>	The state does not establish reasonable limits.	
<input type="radio"/>	The state establishes the following reasonable limits <i>Specify:</i>	
	<input type="text"/>	

State:	<input type="text"/>
Effective Date	<input type="text"/>

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

- f. Regular Post-Eligibility: 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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant’s income:

i. Allowance for the needs of the waiver participant (select one):			
<input type="radio"/>	The following standard included under the state plan (Select one):		
<input type="radio"/>	The following standard under 42 CFR §435.121: Specify:		
<input type="radio"/>	Optional state supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (select one):		
<input type="radio"/>	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	<input type="radio"/>	%	A percentage of the FBR, which is less than 300% Specify the percentage:
<input type="radio"/>	<input type="radio"/>	\$	A dollar amount which is less than 300%. Specify dollar amount:
<input type="radio"/>	<input type="radio"/>	%	A percentage of the Federal poverty level Specify percentage:
<input type="radio"/>	Other standard included under the state Plan Specify:		
<input type="radio"/>	The following dollar amount Specify dollar amount:	\$	If this amount changes, this item will be revised.
<input checked="" type="radio"/>	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.		
<input type="radio"/>	Other Specify:		
ii. Allowance for the spouse only (select one):			
<input checked="" type="radio"/>	Not Applicable		

State:	
Effective Date	

<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: <i>Specify:</i>	
Specify the amount of the allowance (select one):		
<input type="radio"/>	The following standard under 42 CFR §435.121: <i>Specify:</i>	
<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
iii. Allowance for the family (select one):		
<input checked="" type="radio"/>	Not Applicable (see instructions)	
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount: Specify dollar amount:	\$ <input type="text"/> 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.
<input type="radio"/>	The amount is determined using the following formula: <i>Specify:</i>	
<input type="radio"/>	Other <i>Specify:</i>	
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:		

State:	
Effective Date	

<input checked="" type="radio"/>	Not applicable (see instructions) <i>Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.</i>
<input type="radio"/>	The state does not establish reasonable limits.
<input type="radio"/>	The state establishes the following reasonable limits <i>Specify:</i>

State:	
Effective Date	

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		
<i>(select one):</i>		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional state supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	Specify percentage:
<input type="radio"/>	The following dollar amount:	\$ _____ If this amount changes, this item will be revised
<input checked="" type="radio"/>	The following formula is used to determine the needs allowance:	
	<i>Specify formula:</i>	
	An amount equal to 100 percent of the poverty level standard for one individual.	
<input type="radio"/>	Other	
	<i>Specify:</i>	

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:		
<input checked="" type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different.	
	<i>Explanation of difference:</i>	

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.		
<i>Select one:</i>		
<input checked="" type="radio"/>	Not applicable (see instructions) Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.	

State:	
Effective Date	

<input type="radio"/>	The state does not establish reasonable limits.
<input type="radio"/>	The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

State:	
Effective Date	

Appendix B-6: Evaluation / Reevaluation of Level of Care

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

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

i.	<p>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:</p> <div style="border: 1px solid black; width: 100px; text-align: center; margin: 5px 0;">2</div>				
ii.	<p>Frequency of services. The state requires (select one):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"><input type="radio"/></td> <td style="padding: 5px;">The provision of waiver services at least monthly</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="radio"/></td> <td style="padding: 5px;"> <p>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:</p> <p>A participant must receive case management and have authorized and delivered at least one additional waiver service as documented in the [delete]community[end delete] 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.</p> <p>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.</p> <p>Most participants receive waiver services on a monthly basis.</p> <p>Case managers are responsible for ongoing monitoring of participants' health and safety.</p> </td> </tr> </table>	<input type="radio"/>	The provision of waiver services at least monthly	<input checked="" type="radio"/>	<p>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:</p> <p>A participant must receive case management and have authorized and delivered at least one additional waiver service as documented in the [delete]community[end delete] 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.</p> <p>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.</p> <p>Most participants receive waiver services on a monthly basis.</p> <p>Case managers are responsible for ongoing monitoring of participants' health and safety.</p>
<input type="radio"/>	The provision of waiver services at least monthly				
<input checked="" type="radio"/>	<p>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:</p> <p>A participant must receive case management and have authorized and delivered at least one additional waiver service as documented in the [delete]community[end delete] 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.</p> <p>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.</p> <p>Most participants receive waiver services on a monthly basis.</p> <p>Case managers are responsible for ongoing monitoring of participants' health and safety.</p>				

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

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input type="radio"/>	<p>By a government agency under contract with the Medicaid agency. <i>Specify the entity:</i></p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

State:	
Effective Date	

●	<p>Other <i>Specify:</i></p> <p>The department delegates responsibility for evaluations and reevaluations to lead agencies.</p>
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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 ([delete]DHS form[end delete] [add]DHS-3428[end add] [delete]-or-3428A[end delete])
- [add]For children: Minnesota[end add] Long Term Care Consultation Services Form: Supplemental Form for Assessment of Children under 18 ([delete]DHS form[end delete] [add]DHS-3428C[end add])
- [delete]• OBRA Level I Criteria— Screening for Developmental Disabilities or Mental Illness (DHS form 3426)[end delete]
- Nursing Facility Level of Care Criteria [delete]:-Determining Service Eligibility for Medical Assistance Payment of Nursing Facility Services and Home and Community Based Programs[end delete] [add]Guide (DHS-7028[end add] [delete]-form-7028[end delete])

[add]Assessment Process

State:	
Effective Date	

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. [end add]

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, the LTC Screening Document (~~[[delete]DHS form[end delete]~~ ~~form~~ ~~[end delete]~~ ~~[add]DHS-3427[end add]~~) is used to summarize the results of the level of care assessment. This information is entered into MMIS.

All forms can be found at: ~~[[delete]http://www.dhs.state.mn.us/main/id_000100[end delete]~~ ~~[add]https://mn.gov/dhs/general-public/publications-forms-resources/edocs/-[end add]~~

- 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*):

State:	
Effective Date	

●	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:

[add]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 community support plan. [end add]

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 ~~DHS Form 3428 or 3428A, or a~~ [add]the~~[end delete]~~ [end add] 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 ~~assessment requests~~~~[end delete]~~ [add]assessments~~[end delete]~~ in 2013. All lead agencies are now using MnCHOICES for new/initial ~~assessment requests~~~~[end delete]~~ [add]assessments. ~~[end delete]~~ ~~By September 2015,~~ MnCHOICES will begin~~[end delete]~~ [add]In January 2017, MnCHOICES began~~[end add]~~ implementation statewide for reassessments. [add]We are working toward full implementation of MnCHOICES. Full implementation is targeted for 2022. ~~[end add]~~ ~~By September 2016,~~

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~~MnCHOICES will be the sole assessment tool used by Minnesota lead agencies to conduct all assessments for LTSS.~~ [end delete]

Redetermination of level of care must be performed at least annually, in person, and using the same forms as used for the new/initial assessment. [delete]Lead agency staff complete the assessment and use DHS 3427 titled LTC Screening Document to summarize and document the results of the level of care assessment in [end delete] [add]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[end add] 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*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule <i>Specify the other schedule:</i>

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

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input type="radio"/>	The qualifications are different. <i>Specify the qualifications:</i>

- 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 [add]evaluation or reevaluation of[end add] level of care [delete]reevaluation[end delete] 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

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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.

Quality Improvement: Level of Care

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

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

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.

i. 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.

[add]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.[end add]

[NO CHANGES TO PERFORMANCE MEASURE]

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) (Several options are listed in the on-line application):	
Other	
If 'Other' is selected, specify:	
MMIS	

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	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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI [delete]waiver[end delete] participants (new applicants) who received a level of care determination within required timelines, per calendar year. Numerator: Number of [delete]requested[end delete] [add]new[end add] CADI participant assessments completed within 20 calendar days, per calendar year. Denominator: Number of assessments requested for [add]new[end add]
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CADI [delete]waiver participants[end delete] [add]participant assessments[end add], per calendar year.			
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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i. 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.

[add]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. [end add]

<i>Performance Measure:</i>	[add]NOTE FOR PUBLIC COMMENT PURPOSES: Sub-assurance eliminated per March 12, 2014 CMS Communication: Modifications to Quality Measures and Reporting in § 1915 (c) Home and Community-Based Waivers[end add]
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- c Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine the initial participant level of care.***

i. 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.

[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

<i>Performance Measure:</i>	Percent of assessments for CADI participants (new applicants) in which all required fields are completed, per calendar year. Numerator: Number of assessments for [add]CADI[end add] participants [delete]in CADI[end delete] in which all required fields were completed. Denominator: Number of assessments for [add]CADI[end add] participants [delete]in CADI[end delete], per calendar year		
<i>Data Source (Select one) (Several options are listed in the on-line application):</i>			
Other			
<i>If 'Other' is selected, specify:</i>			
MMIS			
	<i>Responsible Party for data collection/generation</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>

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	<i>(check each that applies)</i>		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other Specify:</i>	[delete] <input checked="" type="checkbox"/> <i>Annually</i> [end delete]	
		[add] <input checked="" type="checkbox"/> <i>Continuously and Ongoing</i> [end add]	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
	[delete] <input checked="" type="checkbox"/> <i>Continuously and Ongoing</i> [end delete]
	<input type="checkbox"/> <i>Other Specify:</i>

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

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.

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b. Methods for Remediation/Fixing Individual Problems

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

Lead Agency Reviews 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)

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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.

<input checked="" type="radio"/>	No
<input type="radio"/>	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.

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Appendix B-7: Freedom of Choice

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

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. Procedures.** Specify the state’s procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Case managers [add]and assessors[end add] 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 [delete]the Application for Title XIX Home Community Based Waiver and Alternative Care Program Information and-[end delete] [add]their support plan (DHS-6791D). Participants also sign the Long-Term Services and Supports Assessment and Program Information and[end add] Signature Sheet ([delete]DHS form-[end delete] [add]DHS-[end add]2727).

There is also a field on the MMIS screening document that asks the [delete]case manager-[end delete] [add]assessor[end add] 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 [delete]a case manager-[end delete] [add]an assessor[end add] 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.

[delete]Signed screening document forms-[end delete] [add]Evaluation and reevaluation records[end add] 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.

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

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

When people are ~~screened~~ assessed for waiver services, they receive the ~~Application for Title XIX Home Community Based Waiver and Alternative Care Program~~ Long-Term Services and Supports Assessment and Program Information and Signature Sheet (~~DHS form~~ 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

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Appendix C: Participant Services

Appendix C-1/C-3: Summary of Services Covered and Services Specifications

C-1-a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input checked="" type="checkbox"/>	
Homemaker	<input checked="" type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input checked="" type="checkbox"/>	Adult Day Service
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input type="checkbox"/>	
Day Habilitation	<input type="checkbox"/>	
Prevocational Services	<input checked="" type="checkbox"/>	
Supported Employment	<input type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input checked="" type="checkbox"/>	Caregiver Living Expenses
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the state requests the authority to provide the following additional services not specified in statute (list each service by title):	
a.	24-Hour Emergency Assistance	
b.	Adult Companion Services	

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c.	Adult Day Service Bath
d.	Adult Foster Care
e.	Child Foster Care
f.	Chore Services
g.	Consumer-directed community supports (CDCS): personal assistance
h.	Consumer-directed community supports (CDCS): self-direction support activities
i.	Consumer-directed community supports (CDCS): environmental modifications and provisions
j.	Consumer-directed community supports (CDCS): treatment and training
k.	Crisis Respite
l.	Customized Living
m.	Employment Development Services
n.	Employment Exploration Services
o.	Employment Support Services
p.	Environmental Accessibility Adaptations
q.	Family Training and Counseling
r.	Home Delivered Meals
s.	Housing Access Coordination
t.	In-Home Family Supports
u.	Independent Living Skills (ILS) Training Services
v.	Individualized Home Supports
w.	Night Supervision Services
x.	Personal Support Services
y.	Positive Support Services
z.	Residential Care Services
aa.	Specialist Services
bb.	Specialized Equipment and Supplies
cc.	Transitional Services
dd.	Transportation
Extended State Plan Services <i>(select one)</i>	
<input type="radio"/>	Not applicable

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●	The following extended state plan services are provided (<i>list each extended state plan service by service title</i>):
a.	Extended Home Care Nursing
b.	Extended Home Health Care Services
c.	Extended Personal Care Assistance Services

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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 Specification	
Service:	
Case Management	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
<p>Service Definition (Scope):</p> <p>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.</p> <p>The case manager or case aide shall not have a personal financial interest in the services provided to the participant.</p> <p>Case managers shall refer the participant for a MnCHOICES reassessment of the participant's level of care and provide the necessary information to the certified assessor. Case managers are responsible for ongoing monitoring of the provision of services included in the participant's 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.</p> <p>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 participant community initial assessments, reassessments, or community support plan development. Case aides must understand, respect and maintain confidentiality in regard to all details of their work.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
--	--------------------------	----------------------------	--------------------------	----------	--------------------------	----------------

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
		Social Worker		
		Registered or public health nurses		
		Case Aides		

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Social Worker			<p>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.</p> <p>For lead agencies that use the Minnesota Merit System or a county civil service system, social workers must:</p> <ul style="list-style-type: none"> • 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. <p>Standards for the Minnesota Merit System are authorized under Minnesota Rules 9575.0010 to 9575.1580. Authority to set personnel standards is granted to the commissioner of human services under Minnesota Statutes, section 256.012.</p> <p>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</p>

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			services. The lead agency will be responsible for monitoring the terms of the contract.
Registered or public health nurses	Nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285.		[add]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. [end add]
Case Aides			Case aides must be high school graduates with one year of experience as a case aide or in a closely related field. One year of education beyond high school, such as business school or college, may be substituted for the experience

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Social Worker	Lead Agency	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.
Registered or public health nurses	The Department verifies that case management activities are conducted in accordance with policy and regulation during lead agency reviews.	Lead agencies are randomly selected for review. RN licenses are renewed every two years.
Case Aides	Lead agency	For case [delete]managers-[end delete] [add]aides [end add] that are employees of the lead agency, verification occurs at hire. For case [delete]managers [end delete] [add]aides [end add] under contract with the lead agency, verification occurs with contract cycles, which can be from one to three years.

[\[BACK to List of Services\]](#)

Service Specification	
Service:	
Homemaker	
Alternate Service Title:	

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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:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>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.</p> <p>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.</p> <p>Homemaker cleaning services includes light housekeeping tasks. Homemaker cleaning services must meet the needs defined in the participant's [delete]community[end delete] support plan and not duplicate other homemaker or cleaning services. Homemaker/cleaning providers deliver exclusively home cleaning services.</p> <p>Home management activities may include assistance with [add]laundry.[end add] 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.</p> <p>Homemaker/ assistance with activities of daily living includes: bathing, toileting, grooming, eating[add], dressing.[end add] and ambulating. Homemaker providers that provide assistance with activities of daily living must also provide cleaning services.</p> <p>All homemakers may assist in monitoring of the participant's well-being in the home, including home safety.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
This service is not covered when the participant resides in a licensed foster care home.	
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed

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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (<i>check one or both</i>):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	[add]Providers of[end add] Homemaker/Cleaning Service (market service)		[add]Providers of[end add] Homemaker/Cleaning Service (market service)	
	Providers of homemaker services including assistance with activities of daily living		Providers of homemaker services including assistance with activities of daily living	
	Providers of homemaker services including home management services		Providers of homemaker services including home management services	

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individual: [add]Providers of[end add] Homemaker/Cleaning Service (market service)			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.
Agency: [add]Providers of[end add] Homemaker/Cleaning Service (market service)			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.
Individual: Providers of homemaker services including assistance with activities of daily living	Providers that are not [delete]exempt [end delete] [add]excluded[end add] from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:		Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, [delete]section 144A.43 to 144A.483 [end delete] [add]chapter 245D[end add]. 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

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	<p>- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or</p> <p>- 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.</p>		<p>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.</p>
<p>Agency: Providers of homemaker services including assistance with activities of daily living</p>	<p>Providers that are not exempt [end delete] [add]excluded[end add] from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <p>- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or</p> <p>- 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.</p>		<p>Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, section 144A.43 to 144A.483 [end delete] [add]chapter 245D[end add].</p> <p>Agencies meeting the licensing exclusions of [end delete] [add]excluded from licensure under[end add] 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.</p>
<p>Individual: Providers of homemaker</p>	<p>Providers that are not exempt [end delete]</p>		<p>Individuals licensed under Minnesota Statutes, Chapter 144A as a home care</p>

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<p>services including home management services</p>	<p>[end delete] [add]excluded[end add] 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.</p>		<p>provider must meet the provider standards in Minnesota Statutes, [delete]section 144A.43 to 144A.483 [end delete] [add]chapter 245D[end add].</p> <p>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.</p>
<p>Agency: Providers of homemaker services including home management services</p>	<p>Providers that are not [delete]exempt [end delete] [add]excluded[end add] 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</p>		<p>Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, [delete]144A.43 to 144A.483 [end delete] [add]chapter 245D[end add].</p> <p>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.</p>

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	Community Based Services designation under Minnesota Statutes, section 144A.484.		
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Individual: [add]Providers of [end add] Homemaker/Cleaning Service (market service)	Enrolled providers: Minnesota Department of Human Services[add], Provider[end add] Enrollment Non-enrolled providers: [delete]Counties/Tribes [end delete] [add]Lead agencies[end add]	Every five years	
Agency: [add]Providers of [end add] Homemaker/Cleaning Service (market service)	Enrolled providers: Minnesota Department of Human Services[add], Provider[end add] Enrollment Non-enrolled providers: [delete]Counties/Tribes [end delete] [add]Lead agencies[end add]	Every five years	
Individual: Providers of homemaker services including assistance with activities of daily living	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D. The Minnesota Department of Health monitors individuals holding a home care license under [add]Minnesota Statutes, [end add] Chapter 144A. For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.	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.	
Agency: Providers of homemaker services including assistance with activities of daily living	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D. The Minnesota Department of Health monitors individuals holding a home care license under [add]Minnesota Statutes,[end add] Chapter 144A. For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.	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.	
Individual: Providers of homemaker services including home management services	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D. The Minnesota Department of Health monitors individuals holding a home care license under [add]Minnesota Statutes,[end add] Chapter 144A. For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.	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.	

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Agency: Providers of homemaker services including home management services	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D. The Minnesota Department of Health monitors agencies holding a home care license under [add]Minnesota Statutes,[end add] Chapter 144A. For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2, (1) and (2) the lead agency monitors the provider.	[delete]Every one to three years-[end delete] [add]Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of violations of law or rule.[end add]
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Service Specification	
Service:	
Adult Day Health	
Alternate Service Title:	
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:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope): The purpose of adult day service is to provide supervision, care, assistance, training and activities based on the [delete]participants-[end delete] [add]participant's[end add] needs and directed toward the achievement of specific outcomes as identified in the [delete]community[end delete] 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;	

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B. Maximize community inclusion opportunities by offering or providing community integration services designed to increase and enhance each ~~participants~~ ~~end delete~~ ~~add~~ ~~participant's~~ ~~end add~~ 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~~;~~~~end delete~~ ~~add~~ ~~end add~~

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

Adult day service will be available to individuals who are at least 18 years of age.

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, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Family homes		Freestanding Centers
				Nursing Homes
				Hospitals
				Medical Clinics

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Family homes	Must be licensed under Minnesota Statutes, section 245A.143, or Minnesota Rules,		Caregivers must have demonstrated knowledge of participants end delete add a participant's end add specific disability, and/or chronic medical condition(s), including but not limited to,

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	<p>parts [delete]9555.5105 [end delete] [add]9555.5050[end add] to 9555.6265 with additional licensing authorization to provide family adult day services.</p>	<p>brain injury, serious and persistent mental illness, developmental disabilities and related conditions such as cerebral palsy, epilepsy, and autism or previous experience working with [delete]individuals[end delete] [add]people[end add] with disabilities.</p> <p>[add]Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.24. [end add]</p> <p>Additional qualifications that are necessary to meet a [delete]participants [end delete] [add]participant's[end add] unique needs and preferences will be documented in the [delete]community [end delete] support plan.</p> <p>[delete]Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16. [end delete]</p> <p>The license holder is responsible to assess the compatibility of all persons being served in the home to ensure each [delete]persons[end delete] [add]person's[end add] health and safety needs are being met. This assessment must be conducted prior to admission and on an ongoing basis.</p> <p>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 [delete]residents[end delete] [add]resident's[end add] legal representative documenting the [delete]residents[end delete] [add]resident's[end add] informed choice to [delete]living[end delete] [add]live[end add] in a home that provides adult day services. The informed consent must include a statement that the [delete]residents[end delete] [add]resident's[end add] refusal to consent will not result in service termination.</p>
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			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.
Freestanding Centers	<p>Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.</p> <p>For purposes of this waiver center that is only licensed to provide adult day care services and is not an individual's home, a <u>service center</u> <u>is defined as a</u> free-standing adult day care center <u>setting when it</u> is only licensed to provide adult day services and is not an individual's <u>individual's</u> home.</p>		<p>Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16 <u>245A.24</u>, with the exception of section 245A.143.</p> <p><u>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.</u></p>
Nursing Homes	<p>Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.</p>		<p>Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16 <u>245A.24</u>, with the exception of section 245A.143.</p> <p><u>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.</u></p>
Hospitals	<p>Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730</p>		<p>Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to 245A.16 <u>245A.24</u>, with the exception of section 245A.143.</p>

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			[add]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. [end add]
Medical Clinics	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16[end delete] [add]245A.24[end add], with the exception of section 245A.143. [add]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. [end add]

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family homes	Minnesota Department of Human Services[add], <u>Licensing Division</u> [end add]. Some licensing functions are delegated to counties to complete under department supervision.	Every five years.
Freestanding Centers	Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add].	Every five years.
Nursing Homes	Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add].	Every five years.
Hospitals	Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add].	Every five years.
Medical Clinics	Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add].	Every five years.

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Service Specification	
Service:	
Prevocational Services	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Prevocational services that are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)) may be covered. Services are aimed at preparing a participant for paid or unpaid employment, but are not job-task oriented. Services consist of teaching such concepts as attendance, task completion, problem solving and safety. Prevocational services are provided to participants not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year [delete]-(excluding supported employment programs)[end delete].

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying goals directed at assisting the person towards greater independence, such as attention span and motor skills. All prevocational services will be reflected in the [delete]participants[end delete] [add]participant's[end add] [delete]community[end delete] support plan as they relate to assisting the participant toward greater independence, rather than explicit employment objectives.

Documentation will be maintained in the file of each participant receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Transportation will be provided between the [delete]participants[end delete] [add]participant's[end add] place of residence and the site of the prevocational services[delete], or between prevocational sites[end delete] (in cases where the participant receives prevocational services in more than one place) as a component part of prevocational services. The cost of this transportation may be included in the rate paid to providers of the appropriate type of [delete]habilitation[end delete] [add]prevocational[end add] services.

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 training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation.

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Service Delivery Method <i>(check each that applies):</i>				<input type="checkbox"/>	Participant-directed as specified in Appendix E		<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>			<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Specifications								
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:			<input checked="" type="checkbox"/>	Agency. List the types of agencies:		
	Individuals who meet the prevocational services standards			Agencies that meet the prevocational services standards.				
Provider Qualifications								
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>					
Individuals who meet the prevocational services standards	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.							
Agencies that meet the prevocational services standards.	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.							
Verification of Provider Qualifications								
Provider Type:	Entity Responsible for Verification:				Frequency of Verification			
Individuals who meet the prevocational services standards	The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.				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.			
Agencies that meet the prevocational services standards.	The Minnesota Department of Human Services monitors individuals <u>agencies</u> holding a license under Minnesota Statutes, Chapter 245D.				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,			

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		severity, and chronicity of violations of law or rule.

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Service Specification	
Service:	
[delete]Supported Employment[end delete]	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>[delete]PLEASE NOTE: Supported employment is not provided after August 31, 2018.</p> <p>Supported employment services consist of paid employment for participants for whom competitive employment at or above the minimum wage is unlikely without supports, and who, because of their disabilities, need intensive ongoing support to perform in a community work setting. Supported employment is conducted in a variety of community settings in which people without disabilities are employed.</p> <p>Supported employment includes activities needed to sustain paid work by participants receiving waiver services, including supervision and training. When supported employment services are provided at a work site where people without disabilities are employed, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.</p> <p>Supported employment services can be authorized by the case manager as part of a participant's community support plan only when:</p> <p>1. the participant engages in paid employment in a setting or variety of settings in which people without disabilities are also employed, particularly existing businesses or industry sites;</p>	

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2. public funds are necessary for the purpose of providing ongoing training and support services throughout the period of employment; and
3. the participant has the opportunity for social interactions with people who do not have disabilities and who are not paid caregivers.

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

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

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

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

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

[delete]This service does not cover incentive payments, subsidies, or unrelated training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2. Payments that are passed through to users of supported employment programs; or 3. Vocational training that is not directly related to a participant's supported employment program.

Supported employment shall discontinue after June 30, 2019, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. Supported Employment will be replaced by employment exploration services, employment development services and employment support services. No new authorizations for supported employment will be allowed after June 30, 2018, or 180 days following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for Supported Employment for a participant who was not previously receiving Supported Employment before June 30, 2018. [end delete]

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	[delete] <input checked="" type="checkbox"/>	Provider managed [end delete]
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Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Category(s) <i>(check one or both):</i>	[delete] <input checked="" type="checkbox"/> Individual. List types:	[delete] <input checked="" type="checkbox"/> Agency. List the types of agencies:
	Individuals that meet the service standards for supported employment [end delete]	Agencies that meet the service standards for supported employment [end delete]

Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
[delete] Individuals that meet the service standards for supported employment [end delete]	[delete] Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services. [end delete]		
[delete] Agencies that meet the service standards for supported employment [end delete]	[delete] Providers must be licensed under Minnesota Statutes, Chapter 245D as a provider of intensive support services. [end delete]		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
[delete] Individuals that meet the service standards for supported employment [end delete]	[delete] The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D. [end delete]	[delete] Every one to three years. [end delete]
[delete] Agencies that meet the service standards for supported employment [end delete]	[delete] The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D. [end delete]	[delete] Every one to three years [end delete]

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Service Specification

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Service:	
Respite	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope): <p>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.</p> <p>Respite may be provided in the participant's home or place of residence, or one of the following out of home settings:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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</p>	

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waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

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

Respite care is not available to participants living in settings where Customized Living, 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.

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Child Foster Care		Child Foster Care
		Adult Foster Care		Adult Foster Care
		Individuals who meet the respite service standards		Agencies that meet the respite service standards
				Long Term Care Facilities [add] (also referred to as nursing facilities) [end add]
				Hospitals as defined in Minnesota Statutes, section 144.696, subd 3.
				Camps
				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

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individual: Child Foster Care	Must be licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.		[delete]Providers of Respite provided in a licensed child foster care setting, must also be licensed under Minnesota Statutes, Chapters 245D. [end delete]

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	<p>Providers that are not exempt <u>excluded</u> from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - 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. 		<p>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.</p> <p><u>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.</u></p> <p>Providers exempt <u>excluded</u> from licensure under Minnesota Statutes, <u>section</u> 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.</p>
<p>Agency: Child Foster Care</p>	<p>Must be licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.</p> <p>Providers that are not exempt <u>excluded</u> from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or - licensed for home care under Minnesota Statutes, 		<p>Providers of Respite provided in a licensed child foster care setting, must also be licensed under Minnesota Statutes, Chapters 245D.</p> <p>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.</p> <p><u>Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, sections Minnesota Statute, chapter 245D.</u></p> <p>Providers exempt <u>excluded</u> from licensure under Minnesota Statutes, <u>section</u> 245A.03, subd. 2(1) and (2) must meet the requirements of: sections</p>

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	sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.		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.
Individual: Adult Foster Care	<p>Adult foster care is licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 [add]or <u>Minnesota Statutes chapter 245D.21 to 245D.26.</u> [end add]</p> <p>Providers that are not [delete]exempt [end delete] [add]excluded[end add] from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - 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. 		<p>[delete]Providers of Respite provided in a licensed adult foster care setting, must also be licensed under Minnesota Statutes, Chapters 245D.-[end delete]</p> <p>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.</p> <p>[add]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. [end add]</p> <p>Providers [delete]exempt-[end delete] [add]excluded[end add] from licensure under Minnesota Statutes, [add]section[end add] 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.</p>
Agency: Adult Foster Care	<p>Adult foster care is licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 [add]or <u>Minnesota Statutes</u></p>		<p>[delete]Providers of Respite provided in a licensed adult foster care setting, must also be licensed under Minnesota Statutes, Chapters 245D.-[end delete]</p>

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	<p><u>chapter 245D.21 to 245D.26</u>[end add].</p> <p>Providers that are not [delete]exempt [end delete] [add]excluded[end add] from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - 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. 		<p>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.</p> <p>[add]Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, sections Minnesota Statute, chapter 245D. [end add]</p> <p>Providers exempt from licensure under Minnesota Statutes, [add]section[end add] 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.</p>
<p>Individuals who meet the respite service standards</p>	<p>Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - 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. 		<p>Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D.</p> <p>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.</p> <p>Adults and children: Related individuals that are excluded from licensure under</p>

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			<p>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.</p> <p>If the service is furnished in an unlicensed setting for adults 18 years of age or older, the case manager must assess whether the home setting is appropriate to meet the needs of the participant. Documentation will be in the person's community support plan.</p> <p>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.</p>
<p>Agencies that meet the respite service standards</p>	<p>Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(1) and (2) must be:</p> <ul style="list-style-type: none"> - 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 		<p>Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D.</p> <p>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.</p>

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	Minnesota Statutes, section 144A.484.		<p>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 community support plan.</p> <p>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.</p>
Long Term Care Facilities [add] (also referred to as nursing facilities) [end add]	Must be licensed in accordance with MN Statute 144A and must meet the definition under Minnesota Rules, part 9505.0175, subpart 23.	Medicare Certification	
Hospitals as defined in Minnesota Statutes, section 144.696, subd 3.	Licensed under Minnesota Statutes, sections 144.50 to 144.585 [end delete] [add]144.591[end add].	Medicare Certification	
Camps	Licensed under Minnesota Statutes, chapter 245D.	Certified by the American Camp Association	
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)	Licensed under Minnesota Statutes, sections 144A.75 to 144A.756.		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

State:	
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Individual: Child Foster Care	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Every five years
Agency: Child Foster Care	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Every five years
Individual: Adult Foster Care	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Every five years
Agency: Adult Foster Care	The Department of Human Services. Some licensing functions are delegated to counties to complete under department supervision.	Every five years
Individuals who meet the respite service standards	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.</p>	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.
Agencies that meet the respite service standards	<p>The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.</p>	Every five years
Long Term Care Facilities	Minnesota Department of Health	Long term care facilities are reviewed every two years by the state and receive federal certification annually.
Hospitals as defined in Minnesota Statutes, section 144.696, subd 3.	Minnesota Department of Health	Accredited hospitals are surveyed when CMS notifies MDH to conduct validation surveys or the state may survey based on complaint investigations.
Camps	Minnesota Department of Human Services, Provider Enrollment	Every five years
Residential hospice facilities as defined in Minnesota Statutes,	Minnesota Department of Health	Every one to three years

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section 144A.75, subd. 13 (a) (1) serving hospice patients as defined under Minnesota Statutes, section 144A.75, subd. 6 (2)		
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Service Specification	
Service:	
Live-in Caregiver	
Alternate Service Title:	
Caregiver Living Expenses	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
07 Rent and Food Expenses for Live-In Caregiver	07010 rent and food expenses for live-in caregiver
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope): <p>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, independent living skills training services; adult companion services; extended personal care assistance services; 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).</p> <p>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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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Caregiver living expenses are not available in situations in which the participant lives in a home that is owned by the caregiver or a residence owned or leased by a provider of Medicaid services. This service does not cover live-in expenses of 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 <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals and agencies that meet the live-in caregiver standards (receipt services)		Agencies that meet the live-in caregiver standards (receipt services)

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals and agencies that meet the live-in caregiver standards (receipt services)			<p>The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: [add]individualized home supports, [end add] independent living skills training services, adult companion services, extended personal care assistance services, personal support services, or consumer directed community supports. Refer to the qualifications for each of these services.</p> <p>Caregiver living expenses must provide a cost-effective means of meeting the needs defined in the participant's [delete]community[end delete] support plan.</p> <p>The standards in Minnesota Statutes, chapter 245C concerning criminal background studies must be applied to determine if the live-in caregiver is disqualified.</p>
Agencies that meet the live-in caregiver standards (receipt services)			<p>The live-in personal caregiver must meet the provider qualifications for the waiver service that they are providing: [add]individualized home supports, [end add] independent living skills training services, adult companion services; extended personal care assistance services;</p>

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			<p>personal support services; or consumer directed community supports. Refer to the qualifications for these services.</p> <p>Caregiver living expenses must provide a cost-effective means of meeting the needs defined in the participant's [delete]community[end delete] support plan.</p> <p>The standards in Minnesota Statutes, Chapter 245C concerning criminal background studies must be applied to determine if the live-in caregiver is disqualified.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals and agencies that meet the live-in caregiver standards (receipt services)	Lead agencies, or Minnesota Department of Human Services, Provider Enrollment .	Lead agency review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years
Agencies that meet the live-in caregiver standards (receipt services)	[delete]Counties / Tribes[end delete] [add]Lead agencies[end add], or Minnesota Department of Human Services[add], Provider[add] Enrollment	[delete]County/Tribe[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years

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Service Specification	
Service:	
24-Hour Emergency Assistance	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

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Category 4:		Sub-Category 4:	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.			
Service Definition (Scope):			
24-hour emergency assistance provides on-call counseling and problem solving and/or immediate response for assistance at the [delete]participants[end delete] [add]participant's[end add] home due to a health or personal emergency. This service includes provision of electronic personal emergency response systems, which [delete]includes[end delete] [add]include[end add] the device and monitoring. This service may be authorized as an integral component of the [delete]participants[end delete] [add]participant's[end add] [delete]community[end delete] support plan. If the service is initiated in response to unexpected needs, the authorization of the service must be followed by review of the [delete]community[end delete] support plan within five days of the first date of service initiation and amendment of the [delete]community[end delete] support plan as necessary to meet the on-going needs of the participant. The [delete]community[end delete] 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 [delete]participants[end delete] [add]participant's[end add] 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.			
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.			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
		Individuals that meet the 24-hour emergency assistance standards for services other than equipment	Agencies that meet the 24-hour emergency assistance (non-equipment) service standards

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	Providers that meet the 24-hour emergency assistance / equipment service standards (receipt services)	Providers that meet the 24-hour emergency assistance / equipment service standards (receipt service)	
Provider Qualifications			
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individuals that meet the 24-hour emergency assistance standards for services other than equipment	Providers that are not [delete]exempt [end delete] [add]excluded[end add] 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.		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.
Agencies that meet the 24-hour emergency assistance (non-equipment) service standards	Providers that are not [delete]exempt [end delete] [add]excluded[end add] 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		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.

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	with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.		
Individuals: Providers that meet the 24-hour emergency assistance / equipment service standards (receipt services)			<p>24-Hour Emergency Assistance equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's [delete]community[end delete] support plan.</p> <p>All items shall meet applicable standards of manufacture, design and installation.</p>
Agencies: Providers that meet the 24-hour emergency assistance / equipment service standards (receipt service)			<p>24-Hour Emergency Assistance equipment services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's [delete]community[end delete] support[add] plan[end add].</p> <p>All items shall meet applicable standards of manufacture, design and installation.</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals that meet the 24-hour emergency assistance standards for services other than equipment	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.</p>	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.
Agencies that meet the 24-hour emergency assistance (non-equipment) service standards	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For agencies who are excluded under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) the lead agency monitors the provider.</p>	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.

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Individuals: Providers that meet the 24-hour emergency assistance / equipment service standards (receipt services)	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services Provider Enrollment.	[delete]County/Tribe[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports. Enrolled provider DHS review - Every five years.
Agencies: Providers that meet the 24-hour emergency assistance / equipment service standards (receipt service)	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services, Provider Enrollment	[delete]County/Tribe[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years

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Service Specification	
Service:	
Adult Companion Services	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope): 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 [delete]community[end delete] 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.	

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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):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications				
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals who meet the standards to provide Adult Companion Services		Agencies that meet the standards to provide adult companion services
				Organizations that provide companion service under the Corporation for National and Community Service

Provider Qualifications

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Individuals who meet the standards to provide Adult Companion Services	Providers that are not exempt [end delete] [delete] [end delete] [add] excluded [end add] 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.		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.
Agencies that meet the standards to provide adult companion services	Providers that are not exempt [end delete] [delete] [end delete] [add] excluded [end add] from licensure under Minnesota Statutes,		Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, Chapter 245D.

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	<p>section 245A.03 subd. 2(2) must be:</p> <ul style="list-style-type: none"> - 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. 		<p>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.</p>
Organizations that provide companion service under the Corporation for National and Community Service			Providers must meet the standards established by the Corporation for National and Community Service

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals who meet the standards to provide Adult Companion Services	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For individuals who are excluded under Minnesota Statutes, section 245A.03, subd. 2(2) the lead agency monitors the provider.</p>	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.
Agencies that meet the standards to provide adult companion services	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For individuals who are excluded under Minnesota Statutes, section 245A.03, subd.2(2) the lead agency monitors the provider.</p>	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.
Organizations that provide companion service under the	Minnesota Department of Human Services, Provider Enrollment	Every five years

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Corporation for National and Community Service		
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Service Specification	
Service:	
Adult Day Service Bath	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<p><u>[add]Licensed adult foster care providers cannot provide adult day service baths to foster care participants residing in the adult foster care home. [end add]</u></p>	
<p>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.</p>	
<p>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:</p>	

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adult day services, day training and habilitation, prevocational services, structured day services, adult and child foster care, customized living and residential habilitation.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Family homes		Nursing homes
				Free-standing centers
				Medical clinics
				Hospitals

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Family homes	Must be licensed under [add]Minnesota Statutes, section 245A.143, or[end add] Minnesota Rules, parts [delete]9555.9600 to 9555.9730-[end delete] [add]9555.5050 to 9555.6265 with additional licensing authorization to provide family adult day services. [end add]		<p>[add]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. [end add]</p> <p>Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16-[end delete] [add]245A.24[end add].</p> <p>[add]Additional qualifications that are necessary to meet a participant's unique needs and preferences will be documented in the support plan.</p> <p>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.</p>

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			<u>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 residents legal representative documenting the residents informed choice to living in a home that provides adult day services. The informed consent must include a statement that the residents refusal to consent will not result in service termination.</u> [end add]
Nursing homes	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16-[end delete] [add]245A.24[end add], with the exception of section 245A.143.
Free-standing centers	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		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 [delete]individuals-[end delete] [add]individual's[end add] home. Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16-[end delete] [add]245A.24[end add], with the exception of section 245A.143.
Medical clinics	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16-[end delete] [add]245A.24[end add], with the exception of section 245A.143.
Hospitals	Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.		Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 to [delete]245A.16-[end delete] [add]245A.24[end add], with the exception of section 245A.143.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Family homes	Minnesota Department of Human Services[add], <u>Licensing Division. Some licensing functions are delegated to counties to complete under department supervision.</u> [end add]	Every five years.
Nursing homes	Minnesota Department of [delete]Health-[end delete] [add] <u>Human Services, Provider Enrollment</u> [end add]	[delete]One to three years-[end delete] [add] <u>Every five years</u> [end add]

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Free-standing centers	Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add]	Every five years.
Medical clinics	Minnesota Department of [delete]Health-[end delete] [add]Human Services, <u>Provider Enrollment</u> [end add]	[delete]One to three years-[end delete] [add]Every five years[end add]
Hospitals	Minnesota Department of [delete]Health-[end delete] [add]Human Services, <u>Provider Enrollment</u> [end add]	[delete]One to three years-[end delete] [add]Every five years[end add]

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Service Specification	
Service:	
Adult Foster Care	
Alternate Service Title:	
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:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope): Adult foster care is ongoing residential care and supportive services and includes personal care [delete]assistant [end delete] [add]assistance[end add] services, 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).	
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.	

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- 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 <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Adult Foster Care Providers		Adult Foster Care Providers

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Adult Foster Care Providers	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		Adult foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 [add]or Minnesota Statutes chapter 245D.21 to 245D.26[end add]. To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of qualified

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			professional provided by Minnesota Rules, part 9544.0020, subp. 47.
Agency: Adult Foster Care Providers	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		<p>Adult foster care providers must deliver the service in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 [add]or <u>Minnesota Statutes chapter 245D.21 to 245D.26</u>[end add].</p> <p>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.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Adult Foster Care Providers	<p>Some licensing functions are delegated to counties to complete under department supervision.</p> <p>The Minnesota Department of Human Services monitors individuals holding a license under [add]<u>Minnesota Statutes</u>, [end add] Chapter 245D.</p>	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.
Agency: Adult Foster Care Providers	<p>Some licensing functions are delegated to counties to complete under department supervision.</p> <p>The Minnesota Department of Human Services monitors agencies holding a license under [add]<u>Minnesota Statutes</u>, [end add] Chapter 245D.</p>	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.

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Service Specification	
Service:	
Child Foster Care	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02013 group living, other

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Category 2:	Sub-Category 2:
02 Round-the-Clock Services	02023 shared living, other
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 personal care [delete]assistant[end delete] [add]assistance[end add] services, 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 participants needs. Documentation of the determination must be maintained in the [delete]participants[end delete] [add]participant's[end add] record.

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 [delete]participants[end delete] [add]participant's[end add] immediate family.
- 2) Homemaker [add]and chore[end add] 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

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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 <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Child Foster Care Providers		Child Foster Care Providers

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Child Foster Care Providers	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		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.
Agency: Child Foster Care Providers	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Child Foster Care Providers	Some licensing functions are delegated to counties to complete under department supervision.	Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS

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	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	has concerns about the nature, severity, and chronicity of violations of law or rule.
Agency: Child Foster Care Providers	Some licensing functions are delegated to counties to complete under department supervision. The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.

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Service Specification	
Service:	
Chore Services	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>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 [delete]enrolled person[end delete] [add]participant[end add]. Chore services can include, but are not necessarily limited to:</p> <p>1) heavy household cleaning tasks; 2) indoor and outdoor general home maintenance work;</p>	

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- 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 [delete]community[end delete] support plan also includes homemaker services, the [delete]community[end delete] 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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Chore service providers (market services)		Chore service providers (market service)
		Structural pest control applicators		Structural pest control applicators

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Chore service providers (market services)			Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's [delete]community[end delete] support plan.

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Agency: Chore service providers (market service)			Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's [delete]community[end delete] support plan.
Individual: Structural pest control applicators			Must meet the standards and requirements of Minnesota Statutes, Chapter 18B.
Agency: Structural pest control applicators			Must meet the standards and requirements under Minnesota Statutes, Chapter 18B.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Chore service providers (market services)	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Non-enrolled providers: [delete]Counties/Tribes[end delete] [add]Lead agencies[end add]	Enrolled providers: Every five years Non-enrolled providers: Every five years
Agency: Chore service providers (market service)	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Non-enrolled providers: [delete]Counties/Tribes[end delete] [add]Lead agencies[end add]	Enrolled providers: Every five years Non-enrolled providers: Every five years
Individual: Structural pest control applicators	Minnesota Department of Human Services[add], Provider Enrollment[end add]	Every five years.
Agency: Structural pest control applicators	Minnesota Department of Human Services[add], Provider Enrollment[end add]	Every five years

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Service Specification	
Service:	
Consumer-directed community supports (CDCS): personal assistance	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	Sub-Category 3:

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Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>CDCS: personal assistance is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. CDCS: personal assistance includes a range of direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are typically covered under this category:</p> <ul style="list-style-type: none"> -Assistance with activities of daily living and incidental activities of daily living -Respite care -Homemaking <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A participant or the participant's representative may withdraw from participating in a shared services agreement at any time.</p> <p>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.</p> <p>Criteria for allowable expenditures</p> <p>The Purchase of goods and service must meet all of the following criteria:</p> <p>1. An individual written community support plan must be developed for each participant. Services included in the community support plan must be necessary to meet a need identified in the participant's assessment, 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 &</p>	

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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 ~~community~~ support plan that collectively represent a feasible alternative to institutional care. Services not included in the ~~community~~ support plan are not covered. In addition, goods and services are not covered when they:

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

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

- 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 ~~individual~~ participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the ~~individual~~ 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 ~~community~~ support plan.
- Services included in the ~~community~~ support plan must be necessary to meet a need identified in the participant's assessment and must be related to the participant's disability and/or condition.
- ~~FSE~~ 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

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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 [add]at the same time[end add] to participants who are sharing [add]personal assistance[end add] services; or
- For a child care program licensed under [add]Minnesota Statutes,[end add] chapter 245A or operated by a local school district or public school.

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 [delete]adds-[end delete] [add]add[end 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 <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Financial Management Services (FMS) providers

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
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Financial Management Services (FMS) providers			<p>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.</p> <p>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[add], chapter[end add] 245C, Department of Human Services Background Studies Act.</p> <p>People or organizations paid to assist in developing the [delete]community[end delete] 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 [delete]community[end delete] support plan for participants who are purchasing financial management services from them.</p> <p>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[add], [end add] [delete]or a[end delete] legal guardian or conservator can receive payment for support plan activities.</p> <p>Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The [delete]community[end delete] support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.</p>
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			<p>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.</p> <p>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.</p> <p>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 [delete]community[end delete] 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</p>
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			<p>disclose in writing the nature of that relationship, and must not develop the participant's [delete]community[end delete] support plan.</p> <p>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.</p> <p>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.</p> <p>The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.</p>
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			<p>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 [delete]participants²[end delete] [add]participant's CDCS[end add]-[delete]community[end delete] 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 [delete]community[end delete] support plan.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services (FMS) providers	The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.	Every three years

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Service Specification	
Service:	
Consumer-directed community supports (CDCS): self-direction support activities	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction

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Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an “X”) :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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 ~~community~~ support plan
- Monitoring the provision of services

~~Flexible case management is~~ 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 participants person-centered ~~community~~ support plan must: be 18 years of age or older; pass a certification test developed by the department on person-centered support planning approaches including the Vulnerable Adult and Maltreatment of Minors Acts; provide a copy of their training certificate to the participant; use the ~~community~~ support plan template or a ~~community~~ support plan format that includes all of the information required to authorize CDCS and, be able to coordinate their services with the ~~county~~ 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 ~~participants~~ participant’s ~~community~~ support plan. The provider must provide the participant or the ~~participants~~ 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 ~~community~~ support plan must be developed for each participant. Services included in the ~~community~~ support plan must be necessary to meet a need identified in the participant’s assessment, 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.

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

- a) are provided prior to the development of the [delete]community[end delete] support plan;
- b) duplicate other services in the [delete]community[end delete] 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 [delete]consumer[end delete] 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 [delete]goods and services that are[end delete]:

- 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 [delete]individual[end delete] [add]participant[end add] or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the [delete]individual[end delete] [add]participant[end add]

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 [delete]community[end delete] support plan. Services included in the [delete]community[end delete] 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.
- [delete]FSE[end delete] [add]FMS[end add] cost incurred to manage the participant's budget
- Maintenance of vehicle modifications (i.e. wheelchair lift)
- Costs related to internet access based on criteria established by the state

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

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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 ~~adds~~ 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 <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Financial Management Services (FMS) providers
Provider Qualifications				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Financial Management Services (FMS) providers			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	

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			<p>disqualified under the criminal background check according to the standards in Minnesota Statutes[add], chapter[end add] 245C, Department of Human Services Background Studies Act.</p> <p>People or organizations paid to assist in developing the [delete]community[end delete] 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 [delete]community[end delete] support plan for participants who are purchasing financial management services from them.</p> <p>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[add], [end add] [delete]or a[end delete] legal guardian or conservator can receive payment for support plan activities.</p> <p>[delete]Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.[end delete]</p> <p>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</p>
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			<p>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.</p> <p>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.</p> <p>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 [delete]community[end delete] 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 [delete]community[end delete] support plan.</p> <p>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.</p>
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			<p>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.</p> <p>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.</p> <p>The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.</p> <p>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 participants' <u>participant's CDCS</u> community support plan approved by the lead agency.</p>
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			Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the [delete]community[end delete] support plan.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services (FMS) providers	The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.	Every three years

[\[BACK to List of Services\]](#)

Service Specification	
Service:	
Consumer-directed community supports (CDCS): environmental modifications and provisions	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	

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CDCS: environmental modifications ~~is~~ 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 well-being. The following are typically covered under this category:

- Assistive technology*
- Home and vehicle modifications*
- Environmental supports (snow removal, lawn care, heavy cleaning)
- Supplies and equipment
- Special diets
- Adaptive clothing
- Transportation
- For adults, costs related to health clubs and fitness centers

* Costs exceeding \$5,000 may be negotiated with the county of financial responsibility and provided outside of the ~~consumers enrollees~~ participant's individual budget. The county of financial responsibility may authorize additional funding for assistive technology and home and vehicle modifications within the ~~counties~~ 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 ~~community~~ support plan must be developed for each participant. Services included in the ~~community~~ support plan must be necessary to meet a need identified in the participant's assessment, 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 ~~community~~ support plan that collectively represent a feasible alternative to institutional care. Services not included in the ~~community~~ support plan are not covered. In addition, goods and services are not covered when they:

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

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

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- 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 ~~goods and services that are~~:

- 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 ~~individual~~ participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the ~~individual~~ 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 ~~community~~ support plan. Services included in the ~~community~~ support plan must be necessary to meet a need identified in the participant's assessment and must be related to the participant's disability and/or condition.
- ~~FSE~~ FMS cost incurred to manage the participant's budget
- Maintenance of vehicle modifications (i.e. wheelchair lift)
- Costs related to internet access based on criteria established by the state

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

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

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 ~~adds~~ 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;

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- 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 <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications	
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/> Individual. List types: _____ <input checked="" type="checkbox"/> Agency. List the types of agencies: Financial Management Services (FMS) providers _____ _____

Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Financial Management Services (FMS) providers			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[add], chapter[end add] 245C, Department of Human Services Background Studies Act. People or organizations paid to assist in developing the [delete]community[end delete] 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 [delete]community[end delete] support plan for participants

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			<p>who are purchasing financial management services from them.</p> <p>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 [add], [end add] [delete] or a [end delete] legal guardian or conservator can receive payment for support plan activities.</p> <p>[delete] Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met. [end delete]</p> <p>[add] 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.</p> <p><u>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.</u></p> <p><u>Fitness and Exercise. Health clubs and fitness centers that provide fitness and</u></p>
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Appendix C: Participant Services
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			<p><u>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 county that they are using the health club or fitness center. [end add]</u></p> <p>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.</p> <p>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.</p> <p>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 [delete]community[end delete] support plan. FMS provider fees</p>
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			<p>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 [delete]community[end delete] support plan.</p> <p>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.</p> <p>FMS providers must successfully complete a readiness review prior to enrollment,</p>
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			<p>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.</p> <p>The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.</p> <p>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 [delete]participants' [end delete] [add]participant's CDCS[end add] [delete]community[end delete] 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 [delete]community[end delete] support plan.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services (FMS) providers	The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.	Every three years

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Service Specification	
Service:	
Consumer-directed community supports (CDCS): treatment and training	
Alternate Service Title:	

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HCBS Taxonomy	
Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-direction
Category 2:	Sub-Category 2:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

CDCS: ~~personal assistance~~ [add]treatment and training[end add] is one of four services that can be purchased in a consumer-directed manner within a global budget. See Appendix E. ~~CDCS: treatment~~ [add]Treatment[end add] 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 ~~community~~ support plan must be developed for each participant. Services included in the ~~community~~ support plan must be necessary to meet a need identified in the participant's assessment, 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 ~~community~~ support plan that collectively represent a feasible alternative to institutional care. Services not included in the

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[delete]community[end delete] support plan are not covered. In addition, goods and services are not covered when they:

- a) are provided prior to the development of the [delete]community[end delete] support plan;
- b) duplicate other services in the [delete]community[end delete] 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 [delete]consumer[end delete] 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 [delete]goods and services that are[end delete]:

- 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 [delete]individual[end delete] [add]participant[end add] or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the [delete]individual[end delete] [add]participant[end add]

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 [delete]community[end delete] support plan.
- Services included in the [delete]community[end delete] 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.
- [delete]FSE[end delete] [add]FMS[end add] cost incurred to manage the participant's budget
 - Maintenance of vehicle modifications (i.e. wheelchair lift)
 - Costs related to internet access based on criteria established by the state

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

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

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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 ~~adds~~ 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 <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Financial Management Services (FMS) providers

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Financial Management Services (FMS) providers			<p>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.</p> <p>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</p>

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			<p>Minnesota Statutes[add], chapter[end add] 245C, Department of Human Services Background Studies Act.</p> <p>People or organizations paid to assist in developing the [delete]community[end delete] 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 [delete]community[end delete] support plan for participants who are purchasing financial management services from them.</p> <p>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[add], [end add] [delete]or a[end delete] legal guardian or conservator can receive payment for support plan activities.</p> <p>[delete]Services and supports included in this category do not require a professional license, professional certification, or other professional credentialing. The following services are typically covered in this category: personal care services, home health aide, homemaking, and behavioral aide services. The community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.[end delete]</p> <p><u>[add]For services and supports that require the person or entity providing the service or support to be professionally licensed, credentialed, or otherwise certified to perform the service under state law, the provider must meet all applicable standards. The following service providers are typically covered in this category: therapists, physicians, nurses, and dieticians. The community support plan may identify additional qualifications that the person must meet to provide the service. For services and supports that do</u></p>
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			<p><u>not require professional licensing, credentialing, or certification, the community support plan will define the qualifications that the direct care worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.</u></p> <p><u>CDCS services do not require a license unless the CDCS participant used an identified service under Minnesota Statutes, section 245D.03 that requires a license under Minnesota Statutes, Chapter 245A. These identified services are subject to the standards under Minnesota Statutes, Chapter 245D. [end add]</u></p> <p>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.</p> <p>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.</p> <p>FMS providers must establish and make public the maximum rate(s) for their</p>
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			<p>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 [delete]community[end delete] 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 [delete]community[end delete] support plan.</p> <p>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,</p>
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			<p>and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.</p> <p>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.</p> <p>The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.</p> <p>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 [delete]participants²[end delete] [add]participant's CDCS[end add] [delete]community[end delete] 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 [delete]community[end delete] support plan.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial Management Services (FMS) providers	The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.	Every three years

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Service Specification	
Service:	
Crisis Respite	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>Crisis-respite services are specialized services that provide short-term care and intervention to an individual [end delete] [add] <u>a participant</u> [end add] 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:</p> <ol style="list-style-type: none"> 1. Assessment to determine the precipitating factors contributing to the crisis. 2. Development of a provider intervention plan in coordination with the support planning team. 3. Consultation and staff training to the provider(s) and/or caregiver(s) as necessary to assure successful implementation of the participant specific intervention plan. 4. Development and implementation of a transition plan to aid the participant in returning home if out-of-home crisis-respite was provided. 5. On-going technical assistance to the caregiver or provider in the implementation of the intervention plan developed for the participant. 6. Recommendations for revisions to the 24-hour plan of care (community [end delete] support plan [delete] [end delete] to prevent or minimize future crisis situations in order to increase the likelihood of maintaining the participant in the community. <p>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.</p> <p>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 [add] <u>or</u></p>	

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licensed community residential setting (for up to five people)[end add] 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 [add]or licensed community residential setting[end add] 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 [add]to DHS on a weekly basis[end add] [delete]of continued need for crisis respite to be provided in a licensed hotel to DHS-[end delete] for review and approval [delete]on a weekly basis-[end delete] [add]of the continued need for crisis respite to be provided in a licensed hotel[end add].

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 [delete]screened and authorized as-[end delete] [add]assessed and determined[end add] 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 [delete]community[end delete] support plan must occur within five working days of receiving crisis-respite services. However, no Medicaid payment will be made if the [delete]screening-[end delete] [add]assessment[end add] process determines that the individual is not eligible for home and community-based services. The [delete]screening-[end delete] [add]assessment[end add] 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.

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

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed		
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
Provider Specifications						
Provider Category(s)	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:		
	Out-of-home crisis respite providers		Out-of-home crisis respite providers			
	In-home crisis respite providers		In-home crisis respite providers			

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<i>(check one or both):</i>			
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Out-of-home crisis respite providers	[delete]Providers[end delete] [add]Individuals[end add] must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		<p>Out-of-home crisis respite providers, must deliver the service in one of the following licensed facilities:</p> <ul style="list-style-type: none"> • Minnesota Rules, parts [delete]9555.5105[end delete] [add]9555.5050[end add] to 9555.6265 • Minnesota Chapter 245D.21 to 245D.26 • Minnesota Rules, parts 2960.3000 to 2960.3340 <p>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 [delete]community[end delete] support plan.</p> <p>Providers who bill for crisis respite specialized staff must have staff who are either:</p> <ul style="list-style-type: none"> • Licensed, certified or credentialed, or • Have a four-year degree and be specially trained in crisis prevention, intervention and resolution <p>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.</p>
Agency: Out-of-home crisis respite providers	[delete]Providers[end delete] [add]Agencies[end add] must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		<p>Out-of-home crisis respite providers must deliver the service in one of the following licensed facilities:</p> <ul style="list-style-type: none"> • Minnesota Rules, parts [delete]9555.5105[end delete] [add]9555.5050[end add] to 9555.6265 • Minnesota Chapter 245D.21 to 245D.26 • Minnesota Rules, parts 2960.3000 to 2960.3340 <p>Providers of crisis respite must have the specific experience, skills and</p>

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			<p>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 [delete]community[end delete] support plan.</p> <p>Providers who bill for crisis respite specialized staff must have staff who are either:</p> <ul style="list-style-type: none"> • Licensed, certified or credentialed, or • Have a four-year degree and be specially trained in crisis prevention, intervention and resolution <p>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.</p>
Individual: In-home crisis respite providers	<p>[delete]Providers[end delete] [add]Individuals[end add] must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.</p>		<p>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 [delete]community[end delete] support plan.</p> <p>Providers who bill for crisis respite specialized staff must have staff who are either:</p> <ul style="list-style-type: none"> • Licensed, certified or credentialed, or • Have a four-year degree and be specially trained in crisis prevention, intervention and resolution <p>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.</p>
Agency: In-home crisis respite providers	<p>[delete]Providers[end delete] [add]Agencies[end add] must be licensed under Minnesota</p>		<p>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</p>

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	<p>Statutes, chapter 245D as a provider of intensive support services.</p>		<p>contributed to the crisis situation as identified in the person's [delete]community[end delete] support plan.</p> <p>Providers who bill for crisis respite specialized staff must have staff who are either:</p> <ul style="list-style-type: none"> • Licensed, certified or credentialed, or • Have a four-year degree and be specially trained in crisis prevention, intervention and resolution <p>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.</p>
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Out-of-home crisis respite providers	The Minnesota Department of Human Services monitors [delete]agencies[end delete] [add]individuals[end add] holding a license under Minnesota Statutes, Chapter 245D.	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.
Agency: Out-of-home crisis respite providers	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes, [end add] Chapter 245D.	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.
Individual: In-home crisis respite providers	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Agency: In-home crisis respite providers	The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.	Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent

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		monitoring occurs when DHS has concerns about the nature, severity, and chronicity of violations of law or rule.
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Service Specification	
Service:	
Customized Living	
Alternate Service Title:	
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
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>Customized living (CL) services are provided to adults 18 years of age or older in congregate settings by the management of the setting or a provider under contract with the management of the setting.</p> <p>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 [delete]community support plan developed with the case manager that includes all waiver services.</p> <p>Service plans that contain supervision of the participant must include documentation of the [delete]participants [end delete] [add]participant's[end add] specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact will occur. The participant must be given the opportunity to accept, revise, or reject the service plan and the case manager determines whether the plan is approved as part of the [delete]participants-[end delete] [add]participant's[end add] overall [delete]community[end delete] support plan. Service plans must document whether or not there is a need for 24-hr supervision of the participant and whether or not 24-hour supervision is included in the CL plan. Service plans must also include documentation of the participant's specific need(s) for supervision, and the plan to provide supervision including the frequency and mode of contact, and the time of day the contact with occur.</p>	

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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 ~~delegation~~ delegated nursing tasks may be provided as allowed by 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 ~~participants~~ 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 ~~participants~~ 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 ~~participants~~ participant's needs and activities
- ~~]~~ Be able to respond in-person to a participant within a time frame that meets the ~~participants~~ participant's needs and that does not exceed ten minutes.

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

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, 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

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developmental disabilities, or institution for mental disease. When more than one living setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants living in one of the settings.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	[delete] <input checked="" type="checkbox"/> [end delete]	Individual. List types:	[add] <input checked="" type="checkbox"/> [end add]	Agency. List the types of agencies:
	[delete]Home care providers[end delete]		[add]Home care providers[end add]	

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
[add]Agency: [end add] Home care providers	[add]Minnesota Department of Health[end add] Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484		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 [delete]that are not licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 (adult foster care), and [end delete] who provide services in settings with one to five residents, [add]and are not licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 (adult foster care) or Minnesota Statutes, chapter 245D.21 to 245D.26,[end add] 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

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			<p>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</p> <ul style="list-style-type: none"> - 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 [delete]individuals[end delete] [add]individual’s[end add] 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: <ul style="list-style-type: none"> [add]-[end add] An unexpected loss of an essential caregiver [add]-[end add] A sudden loss of housing due to closure [add]-[end add] Loss of services or housing due to a natural disaster [add]-[end add] Necessary to place siblings together <p>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.</p> <p>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</p>
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			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		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
[add]Agency:[end add] Home care providers	Minnesota Department of Health. [add]Minnesota Department of Human Services, Provider Enrollment[end add]	As scheduled by Minnesota Department of Health. Providers must renew their license annually. [add]Enrolled providers: Every five years[end add]

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Service Specification	
Service:	
Employment Development Services	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	

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Service Definition (Scope):

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

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

1. Individualized, strengths-based assessments and employment opportunity discovery strategies (employment discovery and assessment phase 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.

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

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initial authorization of employment development services [delete]not to exceed 12 months of service[end delete]. 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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (<i>check one or both</i>):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers who meet the service standards for employment development services		Providers that meet the service standards for employment development services

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individual: Providers who meet the service standards for employment development services	<p>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.</p> <p>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 [delete]credential [end delete] (DSP-S-ES)</p>		

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	[add]credential[end add].		
Agency: Providers that meet the service standards for employment development services	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 [delete]credential [end delete] (DSP-S-ES) [add]credential[end add].		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Providers who meet the service standards for employment development services	Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D	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

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Appendix C: Participant Services
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		<p>about the nature, severity, and chronicity of violations of law or rule.</p> <p>Provider Enrollment: Every five years</p>
<p>Agency: Providers that meet the service standards for employment development services</p>	<p>Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D</p>	<p>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.</p> <p>Provider Enrollment: Every five years</p>

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Service Specification	
Service:	
Employment Exploration Services	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>Employment exploration services are community-based services that introduce a person to competitive employment opportunities in their community and [delete]moves[end delete] [add]move[end add] a person</p>	

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

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

1. Educational visits to community businesses to learn about various employers, products, services and employment opportunities;
2. Career education activities to learn about specific types of occupations, job positions and work opportunities;
3. Ongoing educational information and counseling assistance about jobs/careers that interest the person;
4. Peer-to-peer mentoring opportunities to meet and learn from people with disabilities who are ~~competitively~~ ~~employed~~ ~~in~~ the community;
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.

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.

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- Employment exploration services are to occur as identified in the person’s support plan. Employment exploration services are time-limited and expected to end:
 - o When a person is interested in actively seeking competitively paid employment and starts receiving employment development services; or
 - o When a person obtains competitively paid employment; or
 - o After a maximum of 12 months 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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Specifications				

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Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers who meet the service standards for employment exploration services		Providers that meet the service standards for employment exploration services

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Providers who meet the service standards for employment exploration services	<p>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.</p> <p>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 [delete]credential [end delete] (DSP-S-ES) [add]credential[end add].</p>		Providers must have the capacity to provide a range of essential informed choice educational activities, learning opportunities, and work experiences.
Agency: Providers that	Providers must be licensed under		Providers must have the capacity to provide a range of essential informed

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<p>meet the service standards for employment exploration services</p>	<p>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.</p> <p>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 [delete]credential [end delete] (DSP-S-ES) [add]credential [end add].</p>		<p>choice educational activities, learning opportunities, and work experiences.</p>
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<p>Individual: Providers who meet the service standards for employment exploration services</p>	<p>Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, Chapter 245D</p>	<p>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.</p>

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		Provider Enrollment: Every five years
Agency: Providers that meet the service standards for employment exploration services	Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, Chapter 245D	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

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Service Specification	
Service:	
Employment Support Services	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>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.</p> <p>I. Employment support services– job support can include: 1. Job analysis and re-design;</p>	

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2. Arranging [add]for[end add] 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.

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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:
 - o Made to an employer as an incentive for participation in a person’s employment support services;
 - o Passed through to subsidize a person receiving employment support services;
 - o For vocational education and training that is not directly related to a person’s employment support services;
 - o For routine supervision and support rendered as a normal function of the business setting; or
 - o Used as supplemental capital to finance a self-employment or microenterprise business.

Service Delivery (microenterprise and group)

- Employment support services cannot be provided in congregate group arrangements greater than 6 people in a work crew or job enclave.
- Microenterprise businesses are restricted to 5 or fewer co-owners or partners.
- Service providers cannot be owners, partners, shareholders, operators, employees, independent contractors, subcontractors or otherwise a financial beneficiary of the 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 [add]day training and habilitation ([end add]DT&H[add])[end add], 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).

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• 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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers who meet the service standards for employment support services		Providers that meet the service standards for employment support services

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Providers who meet the service standards for employment support services	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		

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	Specialist in Employment Support [delete]credential [end delete] (DSP-S-ES) [add]credential[end add].		
Agency: Providers that meet the service standards for employment support services	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 [delete]credential [end delete] (DSP-S-ES) [add]credential[end add].		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification

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Individual: Providers who meet the service standards for employment support services	Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D	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
Agency: Providers that meet the service standards for employment support services	Minnesota Department of Human Services, Provider Enrollment [delete]Unit [end delete] Minnesota Department of Human Services Licensing Division monitors agencies holding a license under Minnesota Statutes, chapter 245D	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

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Service Specification	
Service:	
Environmental Accessibility Adaptations	
Alternate Service Title:	
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:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :	

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

Service Definition (Scope):

Environmental accessibility adaptations are physical adaptations to the participant’s home or primary vehicle, required by the participant's [delete]community[end delete] 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 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) and "vehicle" refers to the participant's primary vehicle. Exceptions to the requirement that home and vehicle modifications be limited to the [delete]participants[end delete] [add]participant’s[end add] primary place of residence or primary vehicle, may be authorized by the case manager when the following criteria are met and documented in the participant’s [delete]community[end delete] 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 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 [add]Minnesota Statutes,[end add] section 13.02; classification of the data on individuals as private under [add]Minnesota Statutes,[end add] section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to [add]Minnesota Statutes,[end add] 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 [add]Minnesota Statutes,[end add] section 13.04, in which the agency or individual is assigned the duties of the

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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 [delete]community[end delete] 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.

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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.

Environmental Accessibility Adaptations are limited to a maximum of \$40,000 per year per waiver participant. A case manager may request an exception to the annual limit of \$40,000 from the commissioner. Approval of an exception will allow an additional \$40,000 to be authorized from the person’s service allotment for the following year for a maximum of \$80,000 for a two-year time period. Exceptions over \$40,000 may be approved when 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.
- 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 [delete]participants [end delete] [add]participant’s[end add] [delete]community[end delete] support plan. The expert must have no financial interest in the delivery of the accessibility adaptation.
- The accessibility adaptation is reasonable given the value and size of the home and is limited to materials that are the least costly and of reasonable standards.

The lead agency will determine whether the above criteria are met and will submit all documentation to the department for the final determination.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Environmental Accessibility Adaptations/Vehicle Modification Assessments		Environmental Accessibility Adaptations/Vehicle Modification Assessments
		Environmental Accessibility Adaptations/Home Modification Assessments		Environmental Accessibility Adaptations/Home Modification Assessments

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	Environmental Accessibility Adaptations/Vehicle Installations	Environmental Accessibility Adaptations/Vehicle Installations	
	Environmental Accessibility Adaptations/Home Modification/Installations (market service)	Environmental Accessibility Adaptations/Home Modification/Installations (market service)	
Provider Qualifications			
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individual: Environmental Accessibility Adaptations/Vehicle Modification Assessments			Individuals 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
Agency: Environmental Accessibility Adaptations/Vehicle Modification Assessments			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

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			<p>3) Five years of full time experience in the field of driver rehabilitation</p> <p>4) Four year undergraduate degree in a health related field with</p> <p>a. One year full time experience in the degree area of study; and</p> <p>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</p> <p>c. Supervision by:</p> <p>i. A certified driver rehabilitation specialist; or</p> <p>ii. An occupational therapist with a specialty certification in driving and community mobility; or</p> <p>iii. A person with 2 years of full time experience in the field of driver rehabilitation</p>
<p>Individual: Environmental Accessibility Adaptations/Home Modification Assessments</p>			<p>Individuals who provide home modification assessments [add]must[end add] meet one of the following:</p> <ul style="list-style-type: none"> • An Occupational Therapists that is currently registered by the American Occupational Therapy Association to perform assessment functions and have at least 1 year of experience with home modification evaluations • A Physical Therapist that is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must be [delete]registered[end delete] [add]licensed[end add] under Minnesota Statutes, section [delete]148.70[end delete] [add]148.65 to 148.78[end add]. • A Certified Aging-in-Place Specialist with at least 1 year of experience with home modification assessments

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			<ul style="list-style-type: none"> • A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry with at least 1 year of experience with home modification assessments
Agency: Environmental Accessibility Adaptations/Home Modification Assessments			<p>Agencies that provide home modification assessments [add]must[end add] meet one of the following:</p> <ul style="list-style-type: none"> • An occupational therapist that is currently registered by the American Occupational Therapy Association to perform assessment functions and have at least one year of experience with home modification evaluations • A Physical Therapist that is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must be [delete]registered[end delete] [add]licensed[end add] under Minnesota Statutes, section [delete]148.70[end delete] [add]148.65 to 148.78[end add]. • A certified aging-in-place specialist with at least one year of experience with home modification assessments • A certified accessibility specialist, certified through the Minnesota Department of Labor and Industry with at least one year of experience with home modification assessments.
Individual: Environmental Accessibility Adaptations/Vehicle Installations			<p>People who provide vehicle installation services must:</p> <ul style="list-style-type: none"> • 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 CFR section 595.7)

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			<ul style="list-style-type: none"> • Follow the recommended practices of the Society of Automotive Engineers • Register as a “vehicle modifier” with the National Highway Traffic Safety Administration
Agency: Environmental Accessibility Adaptations/Vehicle Installations			<p>Agencies that provide vehicle installation services must:</p> <ul style="list-style-type: none"> • 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 CFR section 595.7) • Follow the recommended practices of the Society of Automotive Engineers • Register as a “vehicle modifier” with the National Highway Traffic Safety Administration
Individual: Environmental Accessibility Adaptations/Home Modification/Installations (market service)	<p>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.</p> <p>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.</p>		<p>The provider must be qualified, by professional certification or references, to install, repair and/or maintain the home modification defined in the participant's [delete]community[end delete] support plan. All installations shall be executed in accordance with applicable state and local building codes.</p>

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	<p>Limited Install Providers: Providers who do exclusively small install projects, such as grab bars [add]and ramps,[end add] [delete]ramps[end delete] are [delete]exempt[end delete] [add]excluded[end add] from licensure when the skills they perform meet the definition of “special skill” as defined in Minnesota Statutes Chapter 326B.802, subd. 15.</p>		
<p>Agency: Environmental Accessibility Adaptations/Home Modification/Installations (market service)</p>	<p>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.</p> <p>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.</p> <p>Limited Install Providers: Providers who do exclusively small</p>		<p>The provider must be qualified, by professional certification or references, to install, repair, and/or maintain the home modification defined in the participant’s [delete]community[end delete] support plan. All installations shall be executed in accordance with applicable state and local building codes.</p>

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	install projects, such as grab bars [add]and ramps,[end add] [delete]ramps[end delete] are [delete]exempt[end delete] [add]excluded[end add] from licensure when the skills they perform meet the definition of “special skill” as defined in Minnesota Statutes, Chapter [delete]326B.082[end delete] [add]326B.802[end add], subd. 15.		
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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Environmental Accessibility Adaptations/Vehicle Modification Assessments	Minnesota Department of Human Services, Provider Enrollment	Every five years
Agency: Environmental Accessibility Adaptations/Vehicle Modification Assessments	Minnesota Department of Human Services, Provider Enrollment	Every five years
Individual: Environmental Accessibility Adaptations/Home Modification Assessments	Minnesota Department of Human Services, Provider Enrollment	Every five years
Agency: Environmental Accessibility Adaptations/Home Modification Assessments	Minnesota Department of Human Services, Provider Enrollment.	Every five years.
Individual: Environmental Accessibility Adaptations/Vehicle Installations	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Non-enrolled providers: [delete]counties/tribes[end delete] [add]Lead agencies[end add]	Enrolled providers: Every five years Non-enrolled providers: every five years
Agency: Environmental Accessibility Adaptations/Vehicle Installations	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Non-enrolled providers: [delete]Counties/Tribes[end delete] [add]Lead agencies[end add]	Enrolled providers: Every five years Non-enrolled providers: every five years
Individual: Environmental Accessibility Adaptations/Home	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment	Enrolled providers: Every five years

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Modification/Installations (market service)	Non-enrolled providers: [delete]Counties/Tribes [end delete] [add]Lead agencies[end add]	Non-enrolled providers: Every five years
Agency: Environmental Accessibility Adaptations/Home Modification/Installations (market service)	Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Non-enrolled providers: [delete]Counties/Tribes [end delete] [add]Lead agencies[end add]	Enrolled providers: Every five years Non-enrolled providers: Every five years

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Service Specification	
Service:	
Family Training and Counseling	
Alternate Service Title:	
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:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>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 [delete]can not[end delete] [add]cannot[end add] be reimbursed for training and counseling activities that are the responsibility of their employer.</p> <p>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 [delete]the [end delete] application of [delete]principles of [end delete] person-centered [delete]planning [end delete] [add]principles [end add], information gathering [add]skills [end add] and [delete]summarization [end delete] [add]summary techniques [end add], instruction about treatment regimens, use of equipment specified in the [delete]community [end delete] support plan, and updates as needed to safely maintain the participant at home.</p>	

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Areas of training and intended outcomes will be documented in the [delete]participants[end delete] [add]participant's[end add] [delete]community[end delete] 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 [delete]participants[end delete] [add]participant's[end add] 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 [delete]participants[end delete] [add]participant's[end add] file.

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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)		Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)
		Nutritional therapists including licensed dietitians and licensed nutritionists		Home Health Agencies: Nurses, speech and language pathologists, and physical, occupational, and respiratory therapists
		Mental Health Professionals		[add]Providers that meet the Family Training and Counseling service standards[end add]
		Occupational Therapists		
		Physicians		
		Registered and Public Health Nurses		
		Social Workers		
		Medical equipment suppliers		
		Speech and language pathologists		
		Providers that meet the Family Training and Counseling service standards		

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Physical Therapists			
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)			<p>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 [delete]community[end delete] support plan.</p> <p>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.</p>
Agency: Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)			<p>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 [delete]community[end delete] support plan.</p> <p>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.</p>
Home Health Agencies: Nurses, speech and language pathologists, and physical, occupational, and respiratory therapists	Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484	Medicare certification	<p>Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.</p> <p>Individual practitioners employed by a home health agency must meet the standards in Minnesota Rules, part 9505.0290.</p> <p>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.</p> <p>Providers of family training[delete]--[end delete] [add]and[end add] 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</p>

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			defined in [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.
Nutritional therapists including licensed dietitians and licensed nutritionists			<p>A nutritional therapist must have a bachelor's or [delete]masters-[end delete] [add]master's[end add] 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.</p> <p>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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.</p>
Mental Health Professionals	Must be licensed and/or qualified according to Minnesota Statutes, sections 245.462, subd. 18, or 245.4871, subd. 27.		Providers of family training[delete]--[end delete] [add] and[end add] 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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.
Occupational Therapists			<p>Must be currently registered by the American Occupational Therapy Association as an occupational therapist.</p> <p>Providers of family training[delete]--[end delete] [add] and[end add] 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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.</p>
Physicians	Must be licensed under Minnesota Statutes, Chapter 147.		Providers of family training[delete]--[end delete] [add] and[end add] 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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.
Registered and Public Health Nurses	Must be licensed under Minnesota Statutes, sections 148.171 to 148.285.		Providers of family training[delete]--[end delete] [add] and[end add] 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

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			defined in [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.
Social Workers			<p>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.</p> <p>Providers of family training[delete]–[end delete] [add]and[end add] 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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.</p>
Medical equipment suppliers			<p>[add]State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310.[end add]</p> <p>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.</p>
Speech and language pathologists		Must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.	Providers of family training[delete]–[end delete] [add]and[end add] 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 [add]Minnesota Statutes,[end add] section 245C.02, subdivision 11.
Individual: Providers that meet the Family Training and Counseling service standards			Individuals, agencies or educational facilities who have demonstrated expertise as determined by the case manager, and based on the participant’s needs as [delete]outlined[end delete] [add]identified[end add] in the [delete]Community Support Plan[end delete] [add]support plan.[end add]
Physical Therapists			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 [delete]registered[end delete] [add]licensed[end add] under Minnesota Statutes [delete]148.70[end delete] [add]148.65 to 148.78[end add].

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			Providers of family training[delete]–[end delete] [add]and[end add] 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.
[add]Agency: Providers that meet the Family Training and Counseling service standards[end add]			[add]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. [end add]

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)	[delete]Counties / Tribes[end delete] [add]Lead agencies[end add], or Minnesota Department of Human Services, Provider Enrollment	[delete]County/Tribe[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review: Every five years
Agency: Providers offering person-centered planning, training or educational classes, courses or conferences (receipt service)	[delete]Counties / Tribes[end delete] [add]Lead agencies[end add], or Minnesota Department of Human Services, Provider Enrollment	[delete]County/Tribe[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review: Every five years
Home Health Agencies: Nurses, speech and language pathologists, and physical, occupational, and respiratory therapists	Minnesota Department of Human Services, Provider Enrollment	[delete]DHS verifies every[end delete] [add]Every[end add] five years
Nutritional therapists including licensed dietitians and licensed nutritionists	Minnesota Department of Human Services, Provider Enrollment	Nutritional therapists must renew their licenses every two years. DHS verifies every five years.
Mental Health Professionals	Minnesota Department of Human Services, Provider Enrollment	Mental health professionals that are psychologists, nurses, or social workers must renew their licenses every two years. Psychiatrist, and marriage and

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		<p>family [delete]therapist[end delete] [add]therapists[end add] must renew their license annually.</p> <p>DHS verifies every five years.</p>
Occupational Therapists	Minnesota Department of Human Services, Provider Enrollment	<p>Occupational therapists must renew their licenses every two years.</p> <p>DHS verifies every five years</p>
Physicians	Minnesota Department of Human Services, Provider Enrollment	<p>Medical licenses must be renewed annually.</p> <p>DHS verifies every five years</p>
Registered and Public Health Nurses	Minnesota Department of Human Services, Provider Enrollment	<p>Nurses must renew their licenses every two years.</p> <p>DHS verifies every five years.</p>
Social Workers	Minnesota Department of Human Services, Provider Enrollment	<p>Social workers must renew their licenses every two years.</p> <p>DHS verifies every five years.</p>
Medical equipment suppliers	Minnesota Department of Human Services, Provider Enrollment	<p>[delete]DHS verifies every[end delete] [add]Every[end add] five years.</p>
Speech and language pathologists	Minnesota Department of Human Services, Provider Enrollment	<p>Speech and language pathologists must renew their licenses every two years.</p> <p>DHS verifies every five years</p>
Individual: Providers that meet the Family Training and Counseling service standards	Lead agencies.	<p>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 [delete]Community Support Plan[end delete] [add]support plan[end add].</p>
Physical Therapists	Minnesota Department of Human Services, Provider Enrollment	<p>Physical therapists must renew their licenses annually.</p> <p>DHS verifies every five years.</p>
[add]Agency: Providers that meet the Family Training and Counseling service standards[end add]	[add]Lead agencies[end add]	<p>[add]Lead agencies are responsible to work with participants to assure that Family Training and Counseling services meet the participant's needs and are</p>

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		<u>directed at the outcomes identified in the support plan.</u> [end add]
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Service Specification			
Service:			
Home Delivered Meals			
Alternate Service Title:			
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:		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.			
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.			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
			Provider managed

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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (<i>check one or both</i>):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Hospitals, schools, restaurants or other entities that meet the provider standards		Hospitals, schools, restaurants or other entities that meet the provider standards

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individual: Hospitals, schools, restaurants or other entities that meet the provider standards			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, [delete]parts 4626.0010 to 4626.2025-[end delete] [add]Chapter 4626[end add]. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietitians and nutritionists must meet requirements as specified in Minnesota Statutes, 148.621 and Minnesota Rules, chapter 3250.
Agency: Hospitals, schools, restaurants or other entities that meet the provider standards			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, [delete]parts 4626.0010 to 4626.2025-[end delete] [add]Chapter 4626[end add]. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietitians and nutritionists must meet requirements as specified in Minnesota Statutes, 148.621 and Minnesota Rules, chapter 3250.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
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Individual: Hospitals, schools, restaurants or other entities that meet the provider standards	Minnesota Department of Human Services, Provider Enrollment	Every five years
Agency: Hospitals, schools, restaurants or other entities that meet the provider standards	Minnesota Department of Human Services, Provider Enrollment	Every five years

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Service Specification	
Service:	
Housing Access Coordination	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>Housing access coordination provides assistance in acquiring housing for participants moving to their own home from any of the following settings:</p> <p>1. Unlicensed settings;</p> <p>2. Hospitals licensed under Minnesota Statutes, sections 144.50 to [delete]144.585-[end delete] [add]144.591[end add];</p> <p>3. Adult foster care homes licensed under Minnesota Rules, parts [delete]9555.5105-[end delete] [add]9555.5050[end add] to 9555.6265 [add] or Minnesota Statutes chapter 245D.21 to 245D.26; [end add]</p> <p>4. Family and group [delete]family-[end delete] [add]child[end add] foster care licensed under Minnesota Rules, parts [delete]9560.0500 to 9560.0670-[end delete] [add]2960.3000 to 2960.3340[end add];</p> <p>5. Nursing facilities licensed under Minnesota [delete]Rules, part 9505.0175, subp. 23-[end delete] [add]Statutes, Chapter 144A[end add];</p>	

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6. Intermediate care facilities for persons with developmental disabilities (ICF/DD's) [add]as defined under Minnesota Rules, part 9525.1800, subp. 18 and[end add] licensed under Minnesota [delete]Rules, part 9525.1210, subpart 10[end delete] [add]Statutes, section 252.28[end add];
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 [add]Statutes,[end add] Chapter 144D

Housing access coordination services are provided to people moving into their own home. A person's own home [delete]is one[end delete] [add]means a setting that a participant owns, rents or leases[end add] that 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, [add]and[end add] 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 [delete]community[end delete] 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 [delete]unseen[end delete] [add]unforeseen[end add] reason, the participant does not enroll in the waiver (e.g., due to death or a significant change in condition), the [delete]local[end delete] [add]lead[end add] agency may bill for 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.

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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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals [delete] or agencies [end delete] that meet the housing access coordination service standards		[delete] Individuals who [end delete] [add] Agencies that [end add] meet the Housing Access Coordination service standards

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals [delete] or agencies [end delete] that meet the housing access coordination service standards			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.
[delete] Individuals who [end delete] [add] Agencies that [end add] meet the Housing Access Coordination service standards			[delete] Individual [end delete] [add] Agency [end add] providers of Housing Access Coordination must assure they have: [delete] 5) [end delete] [add] 1) [end add] Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects.

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			<p>[delete]6)[end delete] [add]2)[end add] Successfully passed online Housing Access Coordination training</p> <p>[delete]7)[end delete] [add]3)[end add] A valid driver's license and automobile insurance</p> <p>[delete]8)[end delete] [add]4)[end add] Completed mandated reporter training which includes training on Vulnerable Adult law</p> <p>Providers of Housing Access Coordination services must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals [delete]or agencies[end delete] that meet the housing access coordination service standards	Minnesota Department of Human Services, Provider Enrollment	Every five years.
[delete]Individuals who[end delete] [add]Agencies that[end add] meet the Housing Access Coordination service standards	Minnesota Department of Human Services, Provider Enrollment.	Every five years.

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Service Specification	
Service:	
In-Home Family Supports	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	Sub-Category 2:

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Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>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.</p> <p>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.</p> <p>In-home family support can be delivered in the participant's family home or community settings typically used by the general public.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
<ul style="list-style-type: none"> • In-home family support services are not covered for families, including extended family members[add],[end add] 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 <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Specifications	
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types: Individuals who meet the service standards for In-Home Family Supports
	<input checked="" type="checkbox"/> Agency. List the types of agencies: Agencies that meet the service standards for In-Home Family Supports
Provider Qualifications	
Provider Type:	License <i>(specify)</i> Certificate <i>(specify)</i> Other Standard <i>(specify)</i>

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Individuals who meet the service standards for In-Home Family Supports	Providers must be licensed under Minnesota Statutes, chapter 245D as an a provider of intensive support services.		[add]To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47. [end add]
Agencies that meet the service standards for In-Home Family Supports	Providers must be licensed under Minnesota Statutes, chapter 245D as an a provider of intensive support services.		[add]To complete a functional behavior assessment as required by Minnesota Rules, part 9544.0040, the provider must meet the definition of a qualified professional provided by Minnesota Rules, part 9544.0020, subp. 47. [end add]

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals who meet the service standards for In-Home Family Supports	The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D	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.
Agencies that meet the service standards for In-Home Family Supports	The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.	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.

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Service Specification	
Service:	
Independent Living Skills (ILS) Training Services	
Alternate Service Title:	
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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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :

Service is included in approved waiver. There is no change in service specifications.

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Independent Living Skills (ILS) Training services are directed toward the acquisition, retention, maintenance and improvement of a ~~participants~~ 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 ~~participants~~ participant's home or surrounding community settings used by the general public.

ILS Training Services are staff-intensive, instructional services, whereby ~~an enrolled person~~ 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 ~~community~~ support plan, as well as, regular written reviews of progress and periodic written reports.

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

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications				
Provider Category(s)	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers who meet the ILS training services standards.		Providers who meet the ILS training services standards.

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<i>(check one or both):</i>			
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Providers who meet the ILS training services standards.	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support 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, part 9544.0020, subp. 47.
Agency: Providers who meet the ILS training services standards.	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support 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, part 9544.0020, subp. 47.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Individual: Providers who meet the ILS training services standards.	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	[delete]One to three years.[end delete] [add]Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of violations of law or rule. [end add]	
Agency: Providers who meet the ILS training services standards.	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	[delete]One to three years.[end delete] [add]Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of violations of law or rule. [end add]	

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Service Specification	
Service:	
Individualized Home Supports	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an “X”) :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>Individualized home supports (IHS) include direct supports and training in categories of community living for adult participants who reside in their own home. Individualized home supports can be delivered in the participant’s own home or community settings typically used by the general public.</p> <p>The definition of support in a community living service area means staff providing direct supervision, cueing, skill maintenance, guidance, instruction, incidental 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 Individualized Home Supports service provider.</p> <p>The individualized home supports service requires a participant to receive training, at minimum, in one or more categories of community living service. The categories include, but are not limited to: community participation; health [delete]and[end delete] [add]_[end add] safety[delete];[end delete] and wellness; household management; and adaptive skills.</p> <p>For individualized home supports, “own home” means a setting in which the participant or, if applicable, legal guardian:</p> <ol style="list-style-type: none"> (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. <p>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</p>	

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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. In person service delivery will be scheduled a minimum of weekly.

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.

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

- For participants receiving individualized home supports, the following services are not covered: adult foster care, customized living, [add]and[end add] independent living skills (ILS) training[delete], and residential care[end delete].
- Individualized home supports is not delivered to provide supervision services during the participant's primary sleeping hours or delivered as a 24-hour on-site supervision service.
- The individualized home supports service provider cannot have any direct or indirect financial interest in the property or housing in which individualized home supports is 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. The remote support method of service delivery can be authorized as a 15-minute unit at a 1:1 staff-to-participant ratio.
- Individualized home supports is limited to a maximum of 16 hours of in person service per day.

Limitations applicable to remote support service delivery of individualized home supports:

- 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:
 - o Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature
 - o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered written electronic messaging)
 - o Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by (<i>check each that applies</i>):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) (<i>check one or both</i>):	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Providers who meet the service standards for Individualized Home Supports.		Providers who meet the service standards for Individualized Home Supports.	

Provider Qualifications

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individual: Providers who meet the service standards for Individualized Home Supports.	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support 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, part 9544.0020, subp. 47.
Agency: Providers who meet the service standards for Individualized Home Supports.	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support 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, part 9544.0020, subp. 47.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Providers who meet the service standards for Individualized Home Supports.	The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.	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.
Agency: Providers who meet the service standards for Individualized Home Supports.	The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, [delete]chapter[end delete] [add]chapter[end add] 245D	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.

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Service Specification			
Service:			
Night Supervision Services			
Alternate Service Title:			
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:		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.			
Service Definition (Scope): Night supervision services provide awake 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 is not licensed or operated by another entity <u>add]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[end add].</u> 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:			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
			Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
		Relative	<input type="checkbox"/>
			Legal Guardian
Provider Specifications			

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Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		[delete]Providers of[end delete] [add]Individuals who provide[end add] night supervision services		[add]Agencies that provide[end add] [delete]Night[end delete] [add]night[end add] supervision [delete]providers[end delete]

Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
[delete]Providers of[end delete] [add]Individuals who provide[end add] night supervision services	Providers that are not [delete]exempt [end delete] [add]excluded[end add] 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.		Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute[add]s, chapter[end add] 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.
[add]Agencies that provide[end add] [delete]Night[end delete] [add]night[end add] supervision [delete]providers[end delete]	Providers that are not [delete]exempt [end delete] [add]excluded[end add] 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		Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statute[add]s, chapter[end add] 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

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	Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.		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

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<p>[delete]Providers of [end delete] [add]Individuals who provide [end add] night supervision services</p>	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For individuals who are excluded [add]from licensure [end add] under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.</p>	<p>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.</p>
<p>[add]Agencies that provide [end add] [delete]Night [end delete] [add]night [end add] supervision [delete]providers [end delete]</p>	<p>The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, Chapter 245D.</p> <p>The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, Chapter 144A.</p> <p>For agencies who are excluded [add]from licensure [end add] under Minnesota Statutes, section 245A.03, subd.2 (1) and (2) the lead agency monitors the provider.</p>	<p>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.</p>

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Service Specification	
Service:	
Personal Support Services	
Alternate Service Title:	
HCBS Taxonomy	

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Appendix C: Participant Services
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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:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
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 [delete]community[end delete] 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.	
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):	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Specifications	
Provider Category(s) (check one or both):	<input checked="" type="checkbox"/> Individual. List types:
	<input checked="" type="checkbox"/> Agency. List the types of agencies:
	Individuals who meet the service standards for Personal Support Services
Providers that meet the service standards for Personal Support Services	

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Provider Qualifications			
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Individuals who meet the service standards for Personal Support Services	Providers [add]that are not excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2)[end add] 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 [delete]Statutes [end delete] [add]Statutes [end add], sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.		[add]Individuals licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D. [end add] [delete]Agencies exempt [end delete] [add]Individuals excluded [end add] from licensure under Minnesota Statutes, [add]section [end add] 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.
Providers that meet the service standards for Personal Support Services	Providers [add]that are not excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2)[end add] 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 [delete]Statutes [end delete] [add]Statutes [end add]		[add]Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D. [end add] [delete]Individuals exempt [end delete] [add]Agencies excluded [end add] from licensure under Minnesota Statutes, [add]section [end add] 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

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	add], sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.		manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals who meet the service standards for Personal Support Services	<p>The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.</p> <p>The Minnesota Department of Health monitors [delete]agencies[end delete] [add]individuals[end add] holding a home care license under Minnesota Statutes, chapter 144A.</p> <p>For [delete]agencies[end delete] [add]individuals[end add] who are excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.</p>	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.
Providers that meet the service standards for Personal Support Services	<p>The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.</p> <p>The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.</p> <p>For agencies who are excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(1) and (2) the lead agency monitors the provider.</p>	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.

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Service Specification	
Service:	
Positive Support Services	
Alternate Service Title:	

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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:
Category 4:	Sub-Category 4:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>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:</p> <p>1) Positive support professionals:</p> <ul style="list-style-type: none"> • 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 <p>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.</p> <p>2) Positive support analysts:</p> <ul style="list-style-type: none"> • 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 [add]and/or behavior support plan[end add] 	

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- 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.

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

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Positive Support Specialists		Positive Support Specialists
		Positive Support Analysts		Positive Support Analysts
		Positive Support Professionals		Positive Support Professionals

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Positive Support Specialists	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		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

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			<p>-20 hours of instruction in the understanding of the function of behavior; and [delete]-ten hours of instruction on design of positive practices behavioral support strategies;-[end delete] -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</p> <p>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.</p>
<p>Agency: Positive Support Specialists</p>	<p>Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.</p>		<p>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.</p> <p>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</p>

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			<p>-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</p> <p>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.</p>
<p>Individual: Positive Support Analysts</p>	<p>Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.</p>		<p>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 <u>[add]one of the following qualifications:[end add]</u></p> <p>1) [delete]Obtained[end delete] 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) [delete]Be[end delete] certified <u>[add]as a Behavior Analyst or Assistant Behavior Analyst[end add]</u> by the Behavior Analyst Certification Board [delete]as a Behavior Analyst or Assistant Behavior Analyst.[end delete]</p> <p>Additionally, positive support analysts must have:</p> <ul style="list-style-type: none"> - 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 [delete]plan[end delete] <u>[add]strategies[end add]</u>; 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

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			<p>behavioral interventions or failures in maintaining fidelity to intervention strategies, and recommending enhancements based on evaluation data; and</p> <ul style="list-style-type: none"> - eight hours of instruction on the principles of person-centered thinking; and - clinical supervision by a positive support professional. <p>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.</p>
<p>Agency: Positive Support Analysts</p>	<p>Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.</p>		<p>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 <u>[add]one of the following qualifications: [end add]</u></p> <ol style="list-style-type: none"> 1) Obtained 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) Be certified <u>[add]as a Behavior Analyst or Assistant Behavior Analyst[end add]</u> by the Behavior Analyst Certification Board [delete]as a Behavior Analyst or Assistant Behavior Analyst. [end delete] <p>Additionally, positive support analysts must have:</p> <ul style="list-style-type: none"> - ten hours of instruction in functional behavior assessment and functional analysis; and - twenty hours of instruction in the understanding of the function of behavior; and - ten hours of instruction on design of positive practices behavior support 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

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			<p>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</p> <ul style="list-style-type: none"> - eight hours of instruction on the principles of person-centered thinking; 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 [end delete] - clinical supervision by a positive support professional. <p>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.</p>
<p>Individual: Positive Support Professionals</p>	<p>Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. [delete]Mental health professionals must be licensed or certified, or meet the qualification criteria listed under Minn. Stat., see 245.462, subd.18. [end delete]</p>		<p>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:</p> <ol style="list-style-type: none"> 1) Psychologist licensed under Minnesota Statutes, sections 148.88 to [delete]148.98 [end delete] [add]148.99[end add]; or 2) Clinical social worker licensed as an independent clinical social worker under Minnesota Statutes, chapter [delete]148D [end delete] [add]148E[end add], 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

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			<p>delivery of clinical service in the above identified competency areas; or</p> <p>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</p> <p>4) Licensed professional clinical counselor licensed under Minnesota Statutes, sections [delete]148B.29 to 148B.39[end delete] [add]148B.50 to 148B.593[end add] 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</p> <p>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</p> <p>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 [delete]community[end delete] support plan; or</p> <p>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</p> <p>i. [delete]who[end delete] 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</p> <p>ii. [delete]who[end delete] 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</p>
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			<p>post-master’s supervised experience in the delivery of clinical services.</p> <p>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.</p>
<p>Agency: Positive Support Professionals</p>	<p>Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services. Mental health professionals must be licensed or certified, or meet the qualification criteria listed under Minn. Stat., sec. 245.462, subd. 18. [end delete]</p>		<p>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:</p> <ol style="list-style-type: none"> 1) Psychologist licensed under Minnesota Statutes, sections 148.88 to 148.98 [end delete] [add]148.99[end add]; or 2) Clinical social worker licensed as an independent clinical social worker under Minnesota Statutes, chapter 148D [end delete] [add]148E[end add], 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

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		<p>[delete]148B.29 to 148B.39[end delete] [add]148B.50 to 148B.593[end add] 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</p> <p>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</p> <p>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 [delete]community[end delete] support plan; or</p> <p>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</p> <p>i. [delete]who[end delete] 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</p> <p>ii. [delete]who[end delete] 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.</p> <p>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.</p>
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
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Individual: Positive Support Specialists	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Agency: Positive Support Specialists	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Individual: Positive Support Analysts	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Agency: Positive Support Analysts	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Individual: Positive Support Professionals	The Minnesota Department of Human Services monitors individuals holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.
Agency: Positive Support Professionals	The Minnesota Department of Human Services monitors agencies holding a license under [add]Minnesota Statutes,[end add] Chapter 245D.	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.

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Service Specification	
Service:	
[delete]Residential Care Services[end delete]	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	
<p>[delete]PLEASE NOTE: Residential care services are not provided after June 30, 2018.</p> <p>Residential care services are supportive services and up to 24-hour supervision and may include: meal preparation, individualized home management tasks, socialization, money management, assisting participants with arranging meetings and appointments for medical and social services, and coordinating or providing transportation.</p> <p>Residential care services may also include, minimal assistance with dressing, grooming and bathing, reminding participants to take medications and storing medications in accordance with Minnesota Statutes, section 157.17.</p> <p>Residential care services are provided to participants who reside in a residential care home. Residential care homes are licensed as board and lodging establishments and are registered with the Minnesota Department of Health as board and lodge with specialized services.</p> <p>Service direction must be provided by the participant or by residential care home staff with oversight by the case manager.</p> <p>The total number of individuals living in the setting shall not exceed four except when authorized by the commissioner. The commissioner may authorize services provided in settings serving up to five individuals, living in the setting who are unrelated to the principal care provider, in emergency situations when the setting is needed to avert an individual's placement in a regional treatment center or nursing facility and the following criteria are met. This exception for services delivered in a site with more than four individuals shall not exceed two years. For purposes of this provision, emergency situations are defined as:</p> <ul style="list-style-type: none"> • An unexpected loss of an essential caregiver • A sudden loss of housing due to closure 	

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- ~~Loss of services or housing due to a natural disaster~~
- ~~Necessary to place siblings together~~

~~This limit does not apply to settings that have continuously provided this service to a waiver participant prior to July 1, 2000. Provided means that this was an approved service for a participant in the setting on or prior to July 1, 2000. This size restriction does not apply to people who are 55 years of age or older.~~

~~The residential care service shall discontinue by June 30, 2018. The Department will work with lead agencies to begin the transition process for people to complete person-centered planning to determine alternative waiver supports that are more tailored to individual needs, such as homemaker, chore transportation and other services. No new authorizations for residential care services will be allowed starting July 1, 2017. A new authorization means approval for residential care services for a participant who was not receiving care services on June 30, 2017.~~

~~From July 1, 2017 to June 30, 2018, the commissioner may approve a new authorization for residential care services for a participant who is being discharged from an institutional setting (e.g. nursing facility, hospital, ICF/DD, or IMD) or short term crisis or stabilization program, and was receiving residential care services immediately prior to entering the institutional setting, crisis or stabilization program.~~

~~The commissioner may approve an adjustment to a participant's rate to assure continuity of services while transitioning to alternative services.~~

~~Transition Plan for Elimination of Residential Care: Beginning in July 2015, the Department conducted a comprehensive outreach effort to providers and lead agencies detailing the discontinuation of residential care. Specifically, the Department sent fact sheets to stakeholders and hosted two webinars for providers and lead agencies on July 15 and September 14, 2015. The webinars explained the decision to discontinue residential care and discuss transition options for providers and people receiving the service. Providers were also contacted between January through February 2016 via telephone to discuss the planned discontinuation of the service and business-related options for the providers. The Department plans to continue outreach efforts by conducting a series of trainings in the fall of 2016 and beginning of 2017 to support case managers in developing a person-centered transition plan with participants affected by the discontinuation of residential care.~~

~~Case managers will contact participants affected by the discontinuation of residential care. Case managers and care coordinators will use the "Person-Centered, Informed Choice & Transition Protocol" to develop transition plans for participants transitioning from residential care to alternative waiver services and settings. Specifically, the transition protocol will address the participant's choices and preferences while assuring the participant's health and welfare.~~

~~Each affected participant will receive a formal notice regarding the termination of residential care at least thirty days in advance. Providers also will communicate to participants that the service will terminate on June 30, 2018. Case managers and care coordinators are responsible for developing a community support plan for the participant, which includes a component addressing the participant's health and safety needs. During the transition period, case managers and care coordinators will update the community support plan to reflect how a person's health and safety will be ensured. Case managers and care coordinators are responsible for monitoring the implementation of the community support plans as well as assuring the health and safety of the person. [end delete]~~

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

[delete]Homemaker, chore, and respite services are not covered as separate services for participants who are receiving residential care services.

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

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

~~Services provided in a living setting on the same or adjoining property as an institution are not covered if the institution has any financial interest in the living setting or services provided in the setting. For purposes of this limitation, institution means a nursing facility, hospital, intermediate care facility for persons with developmental disabilities, or institution for mental disease. When more than one living setting is located on the same or adjoining property and the settings or property is owned or leased by a single provider, services may only be covered for participants living in one of the settings. [end delete]~~

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	[delete]☒ [end delete]	[delete]Provider managed [end delete]
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications				
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	[delete]☒ [end delete]	Agency. List the types of agencies:
				[delete]Board and lodge settings that are registered as housing with services establishments to provide specialized services [end delete]

Provider Qualifications			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
[delete]Board and lodge settings that are registered as housing with services establishments to provide specialized services [end delete]	[delete]Providers must be licensed as a board and lodging establishment and meet the standards in Minnesota Statutes, section 157.15 to 157.17 Providers must also meet standards of licensure, certification or registration where	[delete]Providers must be registered with the Minnesota Department of Health as providing specialized services and must meet applicable building codes. [end delete]	[delete]Residential services must be provided by the management of the residential care home. Staff who provide assistance with dressing, grooming, bathing, or reminders to take medications or store medication are required to have eight hours of training and orientation by a registered nurse. If medications are distributed or stored, a registered nurse must provide supervision. Staff must possess: (1) communication skills including the ability to read and write, follow written and verbal instructions, and converse on the telephone;

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	they exist either in state law or administrative rule[end delete]		(2) experience and/or training in caring for participants with functional limitations; (3) the ability to perform essential job functions; (4) the ability to follow the community support plan, work effectively under intermittent supervision, to deal with minor emergencies, and work under stress in a crisis situation; (5) understanding and respect regarding maintaining confidentiality; and, (6) a valid Minnesota driver's license and insurance coverage in accordance with state requirements, if they provide transportation to waiver participants. [end delete]

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
[delete]Board and lodge settings that are registered as housing with services establishments to provide specialized services[end delete]	[delete]Minnesota Department of Health[end delete]	[delete]Every one to three years. [end delete]

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Service Specification	
Service:	
Specialist Services	
Alternate Service Title:	
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:

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Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	
<p>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 [delete]community[end delete] support plan. This service is designed to promote competency of staff and caregivers.</p> <p>To be eligible for this service, a participant must have documented needs in the areas of [add];[end add] [add]-[end add] augmentative communication, [add]-[end add] personal health care, [add]-[end add] mental health symptom support to strengthen effective emotional and behavioral functioning, and manage harmful symptom expression and endangering conduct, [add]-[end add] functional motor skills, [add]-[end add] community safety training and support, [add]-[end add] social skills, [add]-[end add] leisure and recreational skills, or [add]-[end add] independent living skills.</p> <p>Behavior and mental health symptom support can occur when not covered within the scope of Positive Support Services.</p> <p>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.</p> <p>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.</p>	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Specifications	
<input checked="" type="checkbox"/>	Individual. List types: <input checked="" type="checkbox"/> Agency. List the types of agencies:

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Provider Category(s) <i>(check one or both):</i>	Individuals who meet the specialist service standards	Agencies that meet the specialist service standards	
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals who meet the specialist service standards	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		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 [delete]community[end delete] support plan.
Agencies that meet the specialist service standards	Providers must be licensed under Minnesota Statutes, chapter 245D as a provider of intensive support services.		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 [delete]community[end delete] support plan.
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Individuals who meet the specialist service standards	The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.		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.
Agencies that meet the specialist service standards	The Minnesota Department of Human Services monitors agencies holding a license under Minnesota Statutes, chapter 245D.		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.

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Service:	
Specialized Equipment and Supplies	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	Sub-Category 3:
14 Equipment, Technology, and Modifications	14032 supplies
Category 4:	Sub-Category 4:
17 Other Services	17010 goods and services
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
<p>Service Definition (Scope):</p> <p>Specialized equipment and supplies include devices, controls, or appliances, specified in the [delete]community [end delete] support plan, that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with their environment.</p> <p>This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not covered under the State plan. All items must meet applicable standards of manufacture, design and installation.</p> <p>Thickening agents may be covered when there is a determination of medical need.</p> <p>Equipment repair and upkeep can be covered, unless covered by the warranty. Training is not covered separately.</p> <p>An item is not covered if it restricts a participant's rights or restrains a participant and:</p> <p>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</p> <p>b. the items violate the provisions of Minnesota Rules, chapter 9544.</p>	
<p>Specify applicable (if any) limits on the amount, frequency, or duration of this service:</p> <p>Items that are not of direct medical or remedial benefit to the participant are not covered. Experimental treatments are not covered.</p> <p>All prescription and over-the counter medications, compounds and solutions, and related fees including premiums and co-payments are not covered.</p> <p>Oral nutritional products, electrolyte products, foods including organic or special diet needs, organ extracts, and over-the-counter food supplement products are not covered.</p>	

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Specialized equipment and supplies are limited to a maximum of \$3,909.00 per year per waiver participant.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Individuals who provide supplies or equipment (receipt services)		Agencies that provide supplies or equipment (receipt services)
				Pharmacies
				Medical suppliers (including wheelchair and oxygen vendors)
				Home health agencies

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individuals who provide supplies or equipment (receipt services)			Services must provide a cost-effective, appropriate means of meeting the needs [delete]defined[end delete] [add]identified[end add] in the participant's [delete]community[end delete] support plan.
Agencies that provide supplies or equipment (receipt services)			Services must provide a cost-effective, appropriate means of meeting the needs [delete]defined[end delete] [add]identified[end add] in the participant's [delete]community[end delete] support plan.
Pharmacies	Pharmacies are licensed by the Minnesota Board of Pharmacy in accordance with Minnesota Rules, parts 6800.0100 to 6800.9954		
Medical suppliers (including wheelchair and oxygen vendors)			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
Home health agencies		Medicare certification	Providers must meet the definition under Minnesota Rules, part 9505.0195

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individuals who provide supplies or equipment (receipt services)	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services, Provider Enrollment.	[delete]County/Tribe-[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years
Agencies that provide supplies or equipment (receipt services)	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services[add], Provider[add] Enrollment	[delete]County/Tribe-[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years
Pharmacies	Minnesota Department of Human Services, Provider Enrollment.	Every five years.
Medical suppliers (including wheelchair and oxygen vendors)	Minnesota Department of Human Services, Provider Enrollment.	Every five years.
Home health agencies	Minnesota Department of Health	One to three years.

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Service Specification	
Service:	
Transitional Services	
Alternate Service Title:	
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:
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.	
Service Definition (Scope):	

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Transitional services covers goods, housing-related deposits and moving expenses that are necessary and reasonable for a participant to transition to their own home from the following settings:

- [add]-[end add] unlicensed settings,
- [add]-[end add] hospitals licensed under Minnesota Statutes, sections 144.50 to [delete]144.586-[end delete] [add]144.591[end add];
- [add]-[end add] adult foster care homes licensed under Minnesota Rules, parts 9555.5050 to 9555.6265 [add]or Minnesota Statutes chapter 245D.21 to 245D.26[end add];
- [add]-[end add] family and group [delete]family-[end delete] [add]child[end add] foster care licensed under Minnesota Rules, parts [delete]9560.0500 to 9560.0670-[end delete] [add]2960.3000 to 2960.3340[end add];
- [add]-[end add] nursing facilities licensed under Minnesota Statutes, chapter 144A;
- [add]-[end add] intermediate care facilities for persons with developmental disabilities (ICF/DDs) [add]as defined under Minnesota Rules, part 9525.1800, subp. 18 and[end add] licensed under Minnesota Statutes, section 252.28;
- [add]-[end add] intensive rehabilitation treatment and rule 36 settings licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;
- [add]-[end add] institutions for mental diseases (IMDs); and
- [add]-[end add] housing with services establishments as defined under Minnesota Statutes, chapter 144D.

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 covered when the home does not include the provision of these items or services [add], and[end add] when they are inherent to the service being provided.

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, 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.

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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 [delete]community[end delete] 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 [delete]local[end delete] [add]lead[end add] 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.

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
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Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative	<input type="checkbox"/>	Legal Guardian
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Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
		Providers of items and expenses (receipt services)		Providers of items and expenses (receipt services)

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Individual: Providers of items and expenses (receipt services)	[delete]Maintain [end delete] [add]Providers must maintain[end add] all applicable licenses, permits, registrations as		Services must provide a cost-effective, appropriate means of meeting the needs [delete]defined[end delete] [add]identified[end add] in the participant's [delete]community[end delete] support plan.

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	required for their business.		
Agency: Providers of items and expenses (receipt services)	[delete]Maintain [end delete] [add]Providers must maintain [end add] all applicable licenses, permits, registrations as required for their business.		Services must provide a cost-effective, appropriate means of meeting the needs [delete]defined [end delete] [add]identified [end add] in the participant's [delete]community [end delete] support plan.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual: Providers of items and expenses (receipt services)	[delete]Counties / Tribes, [end delete] [add]Lead agencies [end add] or Minnesota Department of Human Services, Provider Enrollment	[delete]County/Tribe [end delete] [add]Lead agency [end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years
Agency: Providers of items and expenses (receipt services)	[delete]Counties / Tribes, [end delete] [add]Lead agencies [end add] or Minnesota Department of Human Services, Provider Enrollment.	[delete]County/Tribe [end delete] [add]Lead agency [end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years

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Service Specification	
Service:	
Transportation	
Alternate Service Title:	
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:

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Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.				
Service Definition (Scope): Transportation is covered in order to enable participants to gain access to waiver and other community services, activities, [add]resources.[end add] and employment as specified in the [delete]community[end delete] 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 <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed	
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian	
Provider Specifications				
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
	Special transportation [delete]may be required[end delete]-to transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.		Common carriers including buses, taxicabs, other commercial carrier, and county-owned or leased vehicles [add] (receipt service)[end add]	
	Individuals who are not common carrier providers (receipt services)		[delete]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.[end delete]	
Provider Qualifications				
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>	
Individual: Special transportation [delete]may be required[end delete] to	Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being	Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the	Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's [delete]community[end delete] support plan.	

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<p>transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.</p>	<p>provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.</p>	<p>Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.30 [end delete] [add]174.315 [end add].</p>	
<p>Individuals who are not common carrier providers (receipt services)</p>	<p>Drivers or carriers must have a valid Minnesota drivers [end delete] [add]driver's [end add] license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.</p>		<p>Services must provide a cost-effective, appropriate means of meeting the needs defined [end delete] [add]identified [end add] in the participant's community [end delete] support plan.</p>
<p>Common carriers including buses, taxicabs, other commercial carrier, and county-owned or leased vehicles [add] (receipt service) [end add]</p>	<p>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.</p>		<p>Services must provide a cost-effective, appropriate means of meeting the needs defined [end delete] [add]identified [end add] in the participant's community [end delete] support plan.</p>
<p><u>[add]Agency: Special transportation to transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not</u></p>	<p><u>[add]Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as</u></p>	<p><u>[add]Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes,</u></p>	<p><u>[add]Services must provide a cost-effective, appropriate means of meeting the needs identified in the participant's support plan. [end add]</u></p>

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<u>require ambulance transportation.</u> [end add]	<u>required under Minnesota Statutes, Chapter 65B.</u> [end add]	<u>sections 174.29 to 174.315.</u> [end add]	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Special transportation [delete]may be required[end delete] to transport a participant who, because of physical or mental impairment, is unable to use a common carrier and does not require ambulance transportation.	Minnesota Department of Human Services, Provider Enrollment.	Every five years	
Individuals who are not common carrier providers (receipt services)	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services, Provider Enrollment	[delete]County/Tribe-[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years	
Common carriers including buses, taxicabs, other commercial carrier, and county-owned or leased vehicles [add] (receipt service) [end add]	[delete]Counties / Tribes,[end delete] [add]Lead agencies[end add] or Minnesota Department of Human Services, Provider Enrollment.	[delete]County/Tribe-[end delete] [add]Lead agency[end add] review: Upon purchase of goods / supports Enrolled provider DHS review - Every five years	

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Service Specification	
Service:	
Extended Home Care Nursing	
Alternate Service Title:	
HCBS Taxonomy	
Category 1:	Sub-Category 1:
05 Nursing	05010 private duty nursing
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:

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Category 4:	Sub-Category 4:		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") : <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.			
Service Definition (Scope):			
Extended state plan 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 <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E <input checked="" type="checkbox"/> Provider managed		
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian		
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="checkbox"/> Individual. List types: Licensed practical nurses (LPN) Registered nurses	<input checked="" type="checkbox"/> Agency. List the types of agencies: Home health agencies Home care nursing agencies	
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Licensed practical nurses (LPN)	Must be licensed under Minnesota Statutes, sections 148.171 to 148.285. LPNs must also have a comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484.		LPNs must be supervised by a registered nurse and may only provide care that is delegated by the registered nurse.
Registered nurses	Must be licensed under Minnesota		

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	Statutes, sections 148.171 to 148.285.		
Home health agencies	Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484	Medicare certification.	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.
Home care nursing agencies	Comprehensive home care license in accordance with Minnesota Statutes, section 144A.43 through 144A.484		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed practical nurses (LPN)	Minnesota Department of Human Services Enrollment, Provider Enrollment.	Every five years
Registered nurses	Minnesota Department of Human Services, Provider Enrollment	Every five years
Home health agencies	Minnesota Department of Health and Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add].	Every five years
Home care nursing agencies	Minnesota Department of Health and Minnesota Department of Human Services[add], <u>Provider Enrollment</u> [end add]	Every five years

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Service Specification	
Service:	
Extended Home Health Care Services	
Alternate Service Title:	
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

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Category 4:		Sub-Category 4:	
11 Other Health and Therapeutic Services		11090 physical therapy	
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications. <input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified. <input type="checkbox"/> Service is not included in the approved waiver.			
Service Definition (Scope):			
<p>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.</p>			
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 <i>(check each that applies):</i>		<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>		<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Home health agencies
Provider Qualifications			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Home health agencies	Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484	[add]Medicare certification[end add]	<p>Must [delete]be Medicare certified and [end delete] meet the standards as specified under the Medicaid State plan and Minnesota Rules, part 9505.0290.</p> <p>[delete]Employees of the home health agency must meet the standards in Minnesota Rules, part 9505.0290.[end delete]</p> <p>Physical therapists must: [add]-[end add] be registered under Minnesota Statutes 148.65 and 148.78; and</p>

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			<p>[add]-[end add] meet the standards as specified under the Medicaid State plan; and [add]-[end add] 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.</p> <p>Physical therapy assistants must work under the direction and supervision of a physical therapist as indicated in Minnesota Statutes, section [delete]148.65 [end delete] [add]148.706[end add].</p> <p>Occupational therapists must: [add]-[end add] meet the standards as specified under the Medicaid State plan; and [add]-[end add] be currently registered by the American Occupational Therapy Association as an occupational therapist; and [add]-[end add] meet the standards as specified in Minnesota Statutes 148.6401 to [delete]148.6450-[end delete] [add]148.6449[end add]</p> <p>Occupational therapy assistants must work under the direction and supervision of [delete]a physical-[end delete] [add]occupational[end add] therapist as indicated in Minnesota Statutes, sections [delete]148.6401 to 148.6450-[end delete] [add]148.6432[end add].</p> <p>Speech-language pathologists must: [add]-[end add] meet the standards as specified under the Medicaid State plan; and [add]-[end add] have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association; and [add]-[end add] meet the standards as specified in Minnesota Statutes, sections 148.511 to 148.5198.</p> <p>Speech-language pathology assistants must work under the direction and supervision of a speech-language pathologist as</p>
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			<p>indicated in Minnesota Statutes, sections [delete]148.511 to 148.5198-[end delete] [add]148.5192[end add].</p> <p>Respiratory therapists must: [add]-[end add] meet the licensure requirements as defined in MN [delete]Statute-[end delete] [add]Statutes, chapter[end add] 147C; and [add]-[end add] meet the standards as specified under the Medicaid State plan.</p>

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Home health agencies	Minnesota Department of Health	Every one to three years

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Service Specification	
Service:	
Extended Personal Care Assistance Services	
Alternate Service Title:	
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:
<p>Complete this part for a renewal application or a new waiver that replaces an existing waiver. (Selection is marked by an "X") :</p> <p><input type="checkbox"/> Service is included in approved waiver. There is no change in service specifications.</p> <p><input checked="" type="checkbox"/> Service is included in approved waiver. The service specifications have been modified.</p> <p><input type="checkbox"/> Service is not included in the approved waiver.</p>	
Service Definition (Scope):	

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

The amount ~~of~~ and duration of the service is determined by the case manager or assessor based on completion of the MnCHOICES assessment or ~~PCA assessment tool~~ Supplemental Waiver PCA Assessment and Service Plan (DHS-3428D) ~~form 3428D~~.

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

Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative
	<input type="checkbox"/>		<input type="checkbox"/>	Legal Guardian

Provider Specifications

Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Medicare certified home health agencies
				Personal care provider agencies and personal care choice provider agencies.

Provider Qualifications

Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Medicare certified home health agencies	Must meet the standards and requirements under Minnesota Statutes, § 256B.0659, subd. 21 22 <u>and</u> 23.	Medicare certification	The <u>Must meet the</u> standards and requirements for PCA services <u>as specified</u> in the state plan and under Minnesota Statutes, section 256B.0659 must be met .
Personal care provider agencies and personal care choice provider agencies.	Must meet the standards and requirements under Minnesota Statutes, § 256B.0659, subd. 21 22 <u>and</u> 23.		The <u>Must meet the</u> standards and requirements for PCA services <u>as specified</u> in the state plan and under Minnesota Statutes, section 256B.0659 must be met .

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Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Medicare certified home health agencies	Minnesota Department of Health and [add]Minnesota[end add]_Department of Human Services[add]_Provider Enrollment[end add]	Every three years
Personal care provider agencies and personal care choice provider agencies.	[add]Minnesota[end add]_Department of Human Services[add]_Provider Enrollment[end add]	Every three years

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b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

<input type="radio"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants.
<input checked="" type="radio"/>	Applicable – Case management is furnished as a distinct activity to waiver participants. Check each that applies:
<input checked="" type="checkbox"/>	As a waiver service defined in Appendix C-3 <i>Do not complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a primary care case management system service under a concurrent managed care authority. <i>Complete item C-1-c.</i>

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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Appendix C-2: General Service Specifications

- a. **Criminal History and/or Background Investigations.** Specify the state’s policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- **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 [delete]Study[end delete] [add]Studies[end add] 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 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 [delete]13[end delete] [add]12[end add] 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
 - Consumer-directed community supports (personal assistance, treatment and training, self-directed support, and fiscal intermediary entity services)
 - Customized living
 - Crisis respite
 - Employment Exploration

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- Employment Development
- Employment Support
- Extended Home Health Care Services
- Extended Personal Care Assistance
- Extended Home Care Nursing
- Family Training and Counseling (for direct contact in the home)
- Homemaker services
- Housing Access Coordination
- In-home family supports
- Independent living skills (ILS) training
- Individualized home 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. ~~Disqualified providers do not have a provider identification number from DHS Provider Services Division (PSD), and cannot bill or be paid for their services.~~ [end delete] [add]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

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	<u>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.</u> [end add]
<input type="radio"/>	No. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (*select one*):

<input checked="" type="radio"/>	<p>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):</p> <p>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.</p> <p>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.</p>
<input type="radio"/>	No. The state does not conduct abuse registry screening.

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

<input type="radio"/>	No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. <i>Do not complete Items C-2-c.i – c.iii.</i>
<input checked="" type="radio"/>	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>Complete Items C-2-c.i –c.iii.</i>

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

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Facilities licensed to provide board and lodging	Customized Living	Four people unrelated to the caregiver, under age 55 years, with some exceptions.

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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.

Customized Living [~~delete~~]and Residential Care Services[~~end delete~~] may not be authorized for participants residing in a living setting if adjoined to or on the same property as an institution (nursing facility, hospital, ICF/DD) or institution for mental disease (IMD) if the institution or IMD has any financial interest in the living setting.

When more than one living setting is located on the same or adjoining property is leased or owned by a single provider, services may only be authorized for individuals living in one of the settings.

For persons under the age of 55 years, the total number of persons residing in a living setting cannot exceed four. This means 4 people unrelated to the principal care provider.

Exception - Residence was developed before May 1, 2001 and has continuously provided waiver services.

Temporary Exception to Capacity Limit

Short-term admission to a fifth bed in a licensed 4-bed setting may be requested in an emergency situation including:

- Sudden loss of caregiver, or
- Sudden closure of current living arrangement, or
- Floods or other natural disasters, or
- To keep siblings together when foster care is needed

In settings that hold a board and lodge license and that serve more than four people, the [~~delete~~]participants[~~end delete~~] [add]participant's[~~end add~~] [~~delete~~]community[~~end delete~~] support plan, licensing requirements (when licensed as a home care provider), and the home care bill of rights support the individuals control of the character of the setting.

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

iii. Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following (*check each that applies*):

Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>

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Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input type="checkbox"/>

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.

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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.
●	<p>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 <i>extraordinary care</i> 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. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.</i></p> <p>Extended personal care assistance (PCA)</p> <p>[add]For children: <u>Legally responsible individuals (parents and guardians) and step parents must not provide PCA services.</u> [end add]</p> <p>For adult participants: Non-paid legal guardians and parents and step parents who are not the [delete]participants [end delete] [add]participant's[end add] responsible party may provide extended PCA services. Spouses, paid guardians and responsible parties may not be paid to provide PCA services.</p> <p>PCAs must be employed by an enrolled agency and the PCA must: [add]-[end add] 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. [add]-[end add] Successfully complete training requirements. The provider is required to maintain documentation of the PCAs training. [add]-[end add] Be able to provide the PCA services according to [delete]participants-[end delete] [add]participant's[end add] [delete]community[end delete] support plan, respond appropriately to the needs of the participant, and report changes in the [delete]participants [end delete] [add]participant's[end add] condition as required. [add]-[end add] 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. [add]-[end add] Enroll as an individual PCA provider with the Minnesota Health Care Programs. [add]-[end add] Not be the [delete]participants-[end delete] [add]participant's[end add] paid legal guardian, guardian of a minor, or responsible party. [add]-[end add] Not be receiving PCA services. [add]-[end add] Effectively communicate with the person and the PCA provider agency.</p>

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[add]-[end add] Maintain daily written records including, but not limited to, time sheets.
[add]-[end add] Complete training and orientation on the needs of the participant within no more than 14 days after services begin.

[add]-[end add] Be supervised by the participant or the qualified professional.

[delete]For children:

Parents, step parents, guardians, or the participants responsible party must not provide PCA services.-[end delete]

The [delete]screening-[end delete] [add]assessment[end add] and [delete]community [end delete] support planning process is used to determine the [delete]participants-[end delete] [add]participant's[end add] PCA service needs and whether the service is appropriately provided by a legal guardian or parent. This includes use of the [delete]Long Term Care Consultation Assessment Form (DHS form 3428) or-[end delete] MnCHOICES assessment, [add]or the Long Term Care Consultation Services Assessment Form (DHS-3428)[end add] and Supplemental Waiver [delete]Personal Care Assistance-[end delete] PCA [delete] Assessment and Service Plan (DHS[add]-3428D[end add] [delete]-form 3428D[end delete]). The information from the [delete]PCA Assessment (DHS form 3428D)[end delete] [add]assessment[end add] identifies the amount of state plan PCA services that can be authorized. Additional time can be authorized as Extended PCA services based on the [delete]participants-[end delete] [add]participant's[end add] needs identified in the [delete]Long Term Care Consultation-[end delete] [add]assessment and support planning process. The case manager authorizes the PCA hours in the participant's waiver service agreement[end add].

The department uses several mechanisms to enforce appropriate billing procedures for PCA services including the following.

[add]-[end add] 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.

[add]-[end add] Every PCA is required to have [delete]an individual-[end delete] [add]a[end add] 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.

[add]-[end add] 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.

[add]-[end add] The department conducts quality assurance compliance inquiries. This includes reviewing the [delete]providers-[end delete] [add]provider's[end add] time sheets, other required documentation and participant interviews as needed.

[add]-[end add] 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, [delete]community[end delete] 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

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services, etc. Department staff will work with the provider and participant to ensure accurate billing and use of services.
 [add]-[end add] The department conducts random audits to evaluate [delete]providers-[end delete] [add]provider's[end add] billing practices and appropriate use of services, and case managers are responsible for monitoring the use of services and accurate billing for services authorized.

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:*

<input type="radio"/>	The state does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="radio"/>	<p>The state makes payment to relatives/legal guardians under <i>specific circumstances and only when the relative/guardian is qualified to furnish services.</i> 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. <i>Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.</i></p> <p>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.</p> <p>EXTENDED HOME CARE NURSING: Spouses, [delete]non-paid[end delete] 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:</p> <ul style="list-style-type: none"> • 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: <ol style="list-style-type: none"> (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. <p>The home care nursing hardship waiver is not available when a participant is using consumer directed community supports (CDCS).</p> <p>The spouse, non-paid legal guardian, family foster parent or parent of a minor must be a nurse licensed in Minnesota and pass a criminal background study in accordance with Minnesota Statutes, Chapter 245C. Individuals must have a current RN or LPN license with the State of Minnesota and be employed by a home health care agency. The service cannot be used in lieu of nursing services covered under and available through liable third-party payers nor does it</p>

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negate the individual's responsibilities as a primary caregiver or to provide emergency backup without payment.

The number of hours shall not exceed 50 percent of the total approved nursing hours, or eight hours per day, whichever is less, up to a maximum of 40 hours per week. The service shall not be covered if the home health agency, the case manager, or the physician determines that the home care nursing care provided by the spouse, legal guardian, or parent of a minor is unsafe.

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.

[delete]←[end delete]Refer to the CDCS service description and provider specifications for the criteria used to determine whether legally responsible individuals may be authorized for this service.

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 [add]other[end add] 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 [delete]community[end delete] support plan;
- be provided by a parent or spouse who meets the qualifications and training standards identified as necessary in the participant's [delete]community[end delete] support plan;
- be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care assistance (PCA) services;
- be related to the participant's disability and NOT be an activity that a parent of a minor or spouse would ordinarily perform or is responsible to perform;
- be necessary to meet at least one identified dependency in activities of daily living as assessed using the Long Term Care Consultation (LTCC) Screening Document or MnCHOICES assessment.*

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* The LTCC ~~screening~~ assessment or MnCHOICES assessment will be used to provide a means to identify activities in which the participant is dependent, to distinguish between activities that a parent or family member would ordinarily perform and those activities that go beyond what is normally expected to be performed, and to identify areas in which the level of assistance or supervision required exceeds what is typically required of a person of the same age.

In addition to the above:

- the parents (as defined above) of minor children and spouses may not provide more than 40 hours of service in a seven-day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
 - number of parents (as defined above),
 - combination of parent(s) of minors and spouse, or
 - number of children who receive CDCS;
- the parents of minors and spouses must maintain and submit time sheets and other required documentation for hours worked and covered by the waiver;
- married participants must be offered a choice of providers. If they choose a spouse as their care provider, it must be documented in the ~~community~~ support plan.
- Parents of minors and spouses may only be paid for providing supports that fall within the Personal Assistance service category
- Parents of minors and spouses may not be reimbursed for mileage expenses.

CDCS service is allowable for minor participants under age 18 who reside in, but do not receive residential services in a licensed residential setting with the following conditions:

- Parents of minor participants under age 18 who receive payment to 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 ~~county~~ lead agency on the expenditures and the health and safety status of the participant;
- face-to-face visits with the participant by the ~~county~~ lead agency on at least a semi-annual basis.

WAIVER SERVICES, OTHER THAN CDCS AND EXTENDED HOME CARE NURSING, PROVIDED TO ADULTS:

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	<p>Related individuals cannot provide adult companion services, caregiver living expenses, or case management.</p> <p>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.</p> <p>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 [delete]community[end delete] support plan and the relative, guardian or conservator must:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p><u>ALL WAIVER SERVICES[add], OTHER THAN EXTENDED HOME CARE NURSING[end add]:</u> 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.</p>
<input type="radio"/>	<p>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.</p>
<input type="radio"/>	<p>Other policy. <i>Specify:</i></p>

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- 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 ~~Departments~~ 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 ~~will be~~ are listed in an on-line directory (MinnesotaHelp.info) ~~directory as of 1/1/14~~. 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 ~~three~~ six basic services directed to a broad community market:

- ~~Chore~~;
- ~~cleaning only component of homemaker~~ services ~~and~~
- ~~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 ~~or the financial management service contractor will~~ 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 ~~consumer~~ 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 ~~tribes~~ 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 ~~tribes~~ 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.

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Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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.

i. 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.

[add] 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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of total CADI [delete]waiver[end delete] claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI [delete]waiver [end delete] claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI [delete]waiver[end delete] claims paid, per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

State:	
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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[NEW PERFORMANCE MEASURE]

Performance Measure:	[add]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[end add]		
Data Source (Select one) (Several options are listed in the on-line application):			
[add]Other[end add]			
If 'Other' is selected, specify:			
[add]Minnesota Health Care Program (MHCP) Quality Control Audit Record[end add]			
	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

State:	
Effective Date	

	<i>(check each that applies)</i>		
	[add] <input checked="" type="checkbox"/> <u>State Medicaid Agency</u> [end add]	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	[add] <input checked="" type="checkbox"/> <u>Monthly</u> [end add]	[add] <input checked="" type="checkbox"/> <u>Less than 100% Review</u> [end add]
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			[add] <input checked="" type="checkbox"/> <u>Other Specify:</u> [end add]
			[add] <u>MHCP program area random audit sample</u> [end add]

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
[add] <input checked="" type="checkbox"/> <u>State Medicaid Agency</u> [end add]	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[add] <input checked="" type="checkbox"/> <u>Annually</u> [end add]
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

i. 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.

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[add]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.[end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of total CADI [delete]waiver[end delete] claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI [delete]waiver[end delete] claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI [delete]waiver[end delete] claims paid, per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

State:	
Effective Date	

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[NEW PERFORMANCE MEASURE]

Performance Measure:	[add]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[end add]		
Data Source (Select one) (Several options are listed in the on-line application):			
[add]Other[end add]			
If 'Other' is selected, specify:			
[add]Minnesota Health Care Program (MHCP) Quality Control Audit Record[end add]			
	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)
	[add] <input checked="" type="checkbox"/> State Medicaid Agency[end add]	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	[add] <input checked="" type="checkbox"/> Monthly[end add]	[add] <input checked="" type="checkbox"/> Less than 100% Review[end add]
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			[add] <input checked="" type="checkbox"/> Other Specify: [end add]
			[add]MHCP program area random audit sample[end add]

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
[add] <input checked="" type="checkbox"/> <u>State Medicaid Agency</u> [end add]	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[add] <input checked="" type="checkbox"/> <u>Annually</u> [end add]
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	<p>Percent of non receipt CADI services delivered by non-enrolled providers (e.g. chore, cleaning, home modification installation) appropriately determined as qualified by lead agencies. Numerator: Number of non receipt services provided by non-enrolled providers appropriately determined as qualified by lead agencies. Denominator: Number of non receipt services provided by non-enrolled providers. [end delete]</p> <p>[add] <u>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.</u> [end add]</p>
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Data Source (Select one) (Several options are listed in the on-line application):

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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	[add] <input checked="" type="checkbox"/> <u>100% Review</u> [end add]
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	[delete] <input checked="" type="checkbox"/> <u>Less than 100% Review</u>

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	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		[add] <input checked="" type="checkbox"/> Other Specify: [end add]	
		[add] Data derived from most recent cycle of lead agency review. The department reviews lead agencies on a 4 year cycle. [end add]	[delete] <input checked="" type="checkbox"/> Other Specify: [end delete]
			[delete] Multi-stage sample: Case file sampling for lead agency reviews involves a complex, two-stage sampling plan. [end delete]

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

- 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.**

i. Performance Measures

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For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of total CADI [delete]waiver[end delete] claims paid to active MHCP providers, per calendar year. Numerator: Dollar amount of CADI [delete]waiver[end delete] claims paid to active MHCP providers, per calendar year. Denominator: Dollar amount of all CADI [delete]waiver[end delete] claims paid, per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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:	
Effective Date	

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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.

[add]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. [end add]

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

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

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***

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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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input checked="" type="checkbox"/> Other: Specify:	[delete] <input checked="" type="checkbox"/> <u>Annually</u> [end delete]
	Minnesota Department of Health Lead agencies	[add] <input checked="" type="checkbox"/> <u>Continuously and Ongoing</u> [end add]
		<input type="checkbox"/> 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.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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

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

<input type="radio"/>	Not applicable – The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
<input checked="" type="radio"/>	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; and, (f) how participants are notified of the amount of the limit.

<input checked="" type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p> <p>See Appendix C-3, and Appendix E.</p>
<input type="checkbox"/>	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>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. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The state employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>

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Appendix 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, ~~[add]HCB Settings Waiver Transition Plan[end add]~~ for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

~~[delete]As set forth in the statewide transition plan submitted to CMS on January 7, 2015, Minnesota has conducted an assessment of its current compliance with the home and community-based settings rule. The regulatory review was completed in April 2015 and a summary of its findings will be available in the near future. Remedial actions based on the findings of the regulatory view will be complete by December 2018.[end delete]~~

[add]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.[end add]

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Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Community Support Plan and Coordinated Services and Supports Plan
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a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the state
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under state law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input checked="" type="checkbox"/>	Case Manager (qualifications specified in Appendix C-1/C-3)
<input type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-1/C-3). <i>Specify qualifications:</i>
<input type="checkbox"/>	Social Worker <i>Specify qualifications:</i>
<input type="checkbox"/>	Other <i>Specify the individuals and their qualifications:</i>

b. **Service Plan Development Safeguards.**

Select one:

<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
<input checked="" type="radio"/>	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. <i>Specify:</i> 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 [delete]county or tribal public health agency[end delete] [add]public health department at a lead agency[end add] may provide personal care assistance services while the social service agency is responsible for case management. In

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small [delete]counties-[end delete] [add]lead agencies[end add], it is essential for service access to allow [delete]counties-[end delete] [add]lead agencies[end add] to provide both case management and other waiver services.

- 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 [delete]community[end delete] 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.

- 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

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

(b) Assessments

As part of the MnCHOICES assessment (or LTCC ~~screening~~ ~~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 ~~departments~~ ~~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

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- 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 ~~guardian~~ legal representative (if applicable), the case manager, and providers responsible for delivering services under the plan within 60 calendar days of the in-person assessment. The plan is distributed to the person, the person's ~~guardian~~ 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~~ participant's strengths and preferences in the community 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 participants ~~community~~ 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.

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If a ~~participants~~ 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 ~~participants~~ participant's CSSP and upon request, and CSSPs are updated when there is a change in the ~~participants~~ 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 ~~community~~ support plan development are available upon request.

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

Through the assessment and support planning process, case managers and assessors are responsible to identify issues that may affect the ~~participants~~ participant's health and safety. This includes identifying possible health and safety risks and addressing these through the ~~community~~ support plan. Case managers and assessors are also responsible to develop emergency back-up plans included in the required assessment and reassessment ~~form~~ 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, ~~end~~ 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;

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- 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.

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 [delete]community[end delete] 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, [add]cleaning only component of[end add] homemaker, [delete]and[end delete] [add]home construction and vehicle installation components of[end add] environmental accessibility adaptations[add], training component of family training and counseling, the non-commercial individual driver component of transportation service,[end add] and receipt-based services [delete]as appropriate[end delete];
- 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 participants needs.

Refer to Appendix B-7, Freedom of Choice.

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, [delete]community [end delete] support plans are reviewed during the lead agency reviews.

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:

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<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule <i>Specify the other schedule:</i>

- 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*):

<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input type="checkbox"/>	Other <i>Specify:</i>

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Appendix D-2: Service Plan Implementation and Monitoring

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

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

Case managers must meet face-to-face with participants at least twice within the twelve-month period and certified assessors must conduct reevaluations of level of care at least annually. ~~Community support~~ Support plans are to be updated any time there is a change in the ~~participants~~ 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 ~~community support plan and/or~~ CSSP.

- b. Monitoring Safeguards.** *Select one:*

<input type="radio"/>	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.
<input checked="" type="radio"/>	<p>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.</p> <p>The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i></p> <p>Case managers are responsible for monitoring the community support plan implementation including monitoring that the health and safety needs of the participant as identified in the community support plan are addressed. 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).</p> <p>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. <u>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).</u></p>

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance

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.

i. 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.

[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI participant files reviewed during the current lead agency review cycle where the [delete]community[end delete] support plan documents [add]services to address[end add] all (100%) domains of assessed need. Numerator: Number of CADI participant files reviewed where the support plan documents [add]services to address[end add] all domains of assessed need. Denominator: Number of CADI participant files reviewed during the current review cycle.		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

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	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval = <input type="checkbox"/> Stratified: Describe Group: <input checked="" type="checkbox"/> Other Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	
		<input type="checkbox"/> Other Specify:	

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[delete] <input checked="" type="checkbox"/> Annually[end delete]
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other Specify: [end add]
	[add]Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI participant files reviewed during the current lead agency review cycle where the [delete]community[end delete] 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
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		of assessed need. Denominator: Number of CADI participant files reviewed during the current review cycle.	
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify: Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[delete] <input checked="" type="checkbox"/> Annually [end delete]
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other Specify: [end add]

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[add]Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

[REVISED PERFORMANCE MEASURE]

Performance Measure: Percent of CADI participant files reviewed during the current lead agency review cycle where the [delete]community[end delete] support plan documents [delete]a participant's[end delete] [add]assessed[end add] health and safety issues. Numerator: Number of CADI participant files reviewed where the support plan documents [delete]participant[end delete] [add]assessed[end add] health and safety issues. Denominator: Number of CADI participant files reviewed during the current review cycle.

Data Source (Select one) (Several options are listed in the on-line application):

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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan

State:	
Effective Date	

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other Specify: [end add]
	[add] Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI participant files reviewed during the current lead agency review cycle where the [delete]community[end delete] 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) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

State:	
Effective Date	

	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other Specify: [end add]
	[add] Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

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

i. Performance Measures

State:	
Effective Date	

For each performance measure the state will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

[add]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. [end add]

<i>Performance Measure:</i>	NOTE FOR PUBLIC COMMENT PURPOSES: Sub-assurance eliminated per March 12, 2014 CMS Communication: Modifications to Quality Measures and Reporting in § 1915 (c) Home and Community-Based Waivers
------------------------------------	---

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

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

i. 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.

[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

<i>Performance Measure:</i>	Percent of CADI participant files reviewed during the current lead agency review cycle where the community 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.		
<i>Data Source (Select one) (Several options are listed in the on-line application):</i>			
Other			
<i>If ‘Other’ is selected, specify:</i>			
Lead Agency Waiver Review Database			
	<i>Responsible Party for data collection/generation</i>	<i>Frequency of data collection/generation: (check each that applies)</i>	<i>Sampling Approach (check each that applies)</i>

State:	
Effective Date	

	<i>(check each that applies)</i>		
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[delete] <input checked="" type="checkbox"/> Annually [end delete]
	[add] <input checked="" type="checkbox"/> Continuously and Ongoing [end add]
	<input checked="" type="checkbox"/> Other Specify:
	Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

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

[REVISED PERFORMANCE MEASURE]

State:	
Effective Date	

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 [delete]current[end delete] [add]current[end add] review cycle in which support plans were completed within [delete]50[end delete] [add]60[end add] days of assessment/ reassessment. Denominator: Number of CADI files reviewed during the current review cycle
-----------------------------	---

Data Source (Select one) (Several options are listed in the on-line application):

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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input type="checkbox"/> Annually

State:	
Effective Date	

Specify:	
	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>
	[add] <input checked="" type="checkbox"/> <i>Other</i> <i>Specify:</i> [end add]
	[add] <u>Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.</u> [end add]

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

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.

i. 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.

[add] 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. [end add]

[REVISED PERFORMANCE MEASURE]

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 encumbered for CADI waiver services [add] <u>claimed for CADI services provided to participants</u> [end add], per calendar year. Denominator: Dollar amount claimed for CADI waiver services provided to participants [end delete] [add] <u>encumbered for CADI services</u> [end add], per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
Other			
If 'Other' is selected, specify:			
MMIS			
	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

State:	
Effective Date	

	<i>(check each that applies)</i>		
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input checked="" type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of [delete]ease-[end delete] [add]CADI participant[end add] files reviewed [delete]over the most recent 3 years-[end delete] [add]during the current lead agency review cycle[end add] in which the support plan is signed[add], [end add] [delete] and-[end delete]dated[add], [end add] [delete] by [end delete] and disseminated to all relevant parties as required [delete]under the regulation[end delete]. Numerator: Number of [add]CADI[end add] case files reviewed in which the support plan is signed[add], [end add] [delete] and[end
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delete] dated and disseminated [add]to all relevant parties[end add].
Denominator: Number of [add]CADI[end add] case files reviewed during the current review cycle.

Data Source (Select one) (Several options are listed in the on-line application):

Other

If 'Other' is selected, specify:

[add]Lead Agency[end add] 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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sampling: case file sampling for lead agency reviews involves a complex, two-stage sampling plan.

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other

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	<u>Specify:</u> [end add]
	[add]Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

e. Sub-assurance: Participants are afforded choice between/among waiver services and providers.

i. 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.

[add] 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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI participant files reviewed during the current lead agency review cycle in which participant choice between/among waiver services [add]and providers[end add] 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) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

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	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	[delete] 95% <i>Representative Sample; Confidence Interval</i> =[end delete]
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	[delete]95%[end delete]
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			[add] <input checked="" type="checkbox"/> Other Specify: [end add]
			[add]Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan. [end add]

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[delete] 95% Annually [end delete]
	[add] <input checked="" type="checkbox"/> Continuously and Ongoing [end add]
	<input checked="" type="checkbox"/> Other Specify:
	Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.

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

- 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.

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b. Methods for Remediation/Fixing Individual Problems

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

Lead Agency Reviews, 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 [delete]were-[end delete] [add]was[end add] 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):
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.

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<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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

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State:	
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Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	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):

<input type="radio"/>	Yes. The state requests that this waiver be considered for Independence Plus designation.
<input checked="" type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

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

Consumer directed community supports (CDCS) may include traditional goods & services provided by the waiver, and alternatives that support participants. Four categories of CDCS are covered: personal assistance; treatment & training; environmental modifications & provisions; and, self-direction support activities. Refer to ~~Appx~~ 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

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Appendix E: Participant Direction of Services

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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 ~~participants~~ 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 ~~participants~~ participant's needs; safeguards to reasonably maintain the ~~participants~~ 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 ~~applicant~~ 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 ~~participants~~ participant's support plan.

In a 12 month service agreement period, the ~~participants~~ 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 ~~participants~~ participant's budget. ~~Flexible case management is~~ 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:

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Appendix E: Participant Direction of Services

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(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 [delete]community[end delete] 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 [delete]participants[end delete] [add]participant's[end add] disability when they are not covered by the State plan and are prescribed by a physician that is enrolled as a MHCP provider.

(4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the [delete]participants[end delete] [add]participant's[end add] physical condition. There must be no other reasonable alternative of meeting the [delete]participants[end delete] [add]participant's[end add] fitness or exercise need and the condition must be identified in the [delete]participants[end delete] [add]participant's[end add] support plan and monitored by a MHCP enrolled physician. 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 [delete]participants[end delete] [add]participant's[end add] 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 [delete]consumers[end delete] [add]participants[end add] 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 [delete]flexible case management[end delete] [add]support planner[end add] tasks are included in the participant's budget. A nonexclusive list of [delete]flexible direct[end delete] support [add]planner[end add] functions is included below.

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 [delete]below[end delete] [add]in Appendix E-1-j[end add].

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~~[delete] Required Lead Agency Functions (not included in the participant's CDCS budget)~~

- ~~1. Screen and determine if individuals are MA eligible.~~
- ~~2. Screen and assess to determine if the individual is eligible for waiver services including level of care requirements.~~
- ~~3. Provide the consumer with information regarding HCBS alternatives to make an informed choice.~~
- ~~4. If the consumer elects CDCS, provide them with their maximum budget amount.~~
- ~~5. Provide CDCS consumers with resources and informational tool kits to assist them in managing the service.~~
- ~~6. Evaluate that the consumer's health and safety needs are expected to be met given the community support plan including provider training and standards.~~
- ~~7. Evaluate if the plan is appropriate including that the goods and services meet the service description and provider qualifications, rates appear to be appropriate, etc.~~
- ~~8. Review the service plan and MMIS service agreement, review rates, and set limits by service category.~~
- ~~9. Authorize waiver services (prior authorized the MMIS service agreement).~~
- ~~10. Review and authorize additional funding for environmental modifications or assistive technology exceeding \$5,000 and additional quality assurance if it is manageable within the lead agency's overall waiver allocation.~~
- ~~11. Manage waiver spending within the lead agency's allowable waiver allocation.~~
- ~~12. Monitor and evaluate the implementation of the support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions (this includes taking action, when required to address suspected or alleged abuse, neglect, or exploitation of a participant as a mandated reporter according to the maltreatment of minors or vulnerable adults acts).~~
- ~~13. At a minimum, review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter. Monitoring requirements are increased when the provider is the parent of a minor or spouse of a participant.~~
- ~~14. Monitor the management of the budget and services.~~
- ~~15. 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.~~
- ~~16. Investigate reports related to vulnerability or misuse of public funds per jurisdiction.~~
- ~~17. Assist the state agency in completing satisfaction measurements as requested.~~
- ~~18. Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested.~~
- ~~19. Have a system for consumers to contact the local agency on a 24-hour basis in the case of a service emergency or crisis.~~

~~Flexible Case Management, Direct Support Functions (included in the participant's CDCS budget)~~

- ~~1. If the consumer elects waiver services, provide information about CDCS and provider options.~~
- ~~2. Facilitate the development of a person-centered support plan.~~
- ~~3. Monitor and assist with revisions to the support plan.~~
- ~~4. Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.~~
- ~~5. Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.).~~
- ~~6. Monitor the provision of services including such things as interviews or monitoring visits with the participant or service providers.~~

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~~7. Provide staff training that is specific to the participant's support plan.~~

~~Please refer to Appendix C 2 e for monitoring requirements of budget and spending when the provider is a parent of a minor or spouse of a participant. [end delete]~~

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , 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.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , 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.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input checked="" type="checkbox"/>	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.
[delete] <input checked="" type="checkbox"/> [end delete] [add] <input type="checkbox"/> [end add]	<p>The participant direction opportunities are available to persons in the following other living arrangements</p> <p><i>Specify these living arrangements:</i></p> <p>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. People receiving licensed foster care while residing in residential settings licensed by DHS or home care services while residing in a residential setting registered by the MDH as a housing with services establishment are not eligible for CDCS.</p>

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

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input type="radio"/>	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.
<input checked="" type="radio"/>	<p>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.</p> <p><i>Specify the criteria</i></p> <p>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 home care services while residing in a residential setting registered by the Minnesota Department of Health (MDH) as a housing with services establishment.</p>

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.

<p>Participants have had the option to self-direct their waiver services through the consumer directed community supports (CDCS) service, since 2004. Approximately 7% <u>8.9%</u> of CADI participants are currently using CDCS.</p> <p>CDCS allows participants to design an individualized set of supports to meet their needs. The service includes four categories of supports: personal assistance; treatment and training; environmental modifications and provisions; and, self-direction support activities. Participants</p>

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choose the level of support they want to assist them in developing [delete]community[end delete] 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 [add]participant's with[end add] information and [delete]consumer[end delete] education about the goods and services that may be purchased under CDCS; information that helps [delete]consumers[end delete] [add]participants[end add] 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 [delete]community[end delete] support plan development.

- f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The state does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The state provides for the direction of waiver services by representatives. Specify the representatives who may direct waiver services: (<i>check each that applies</i>):
<input type="checkbox"/>	Waiver services may be directed by a legal representative of the participant.
<input checked="" type="checkbox"/>	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.

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

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Consumer-directed community supports: self-direction support activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Consumer-directed community supports: treatment and training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Consumer-directed community supports: environmental modifications and provisions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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Consumer-directed community supports: personal assistance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
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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:*

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i).</i> Specify whether governmental and/or private entities furnish these services. <i>Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

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

<input checked="" type="radio"/>	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
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information</i>	
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 [delete]community[end delete] 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 <i>(check each that applies):</i> Supports furnished when the participant is the employer of direct support workers:	
	<input checked="" type="checkbox"/> Assists participant in verifying support worker citizenship status	
	<input checked="" type="checkbox"/> Collects and processes timesheets of support workers	
	<input checked="" type="checkbox"/> Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	
	<input type="checkbox"/> Other <i>Specify:</i>	

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		Supports furnished when the participant exercises budget authority:	
<input checked="" type="checkbox"/>		Maintains a separate account for each participant's participant-directed budget	
<input checked="" type="checkbox"/>		Tracks and reports participant funds, disbursements and the balance-of participant funds	
<input checked="" type="checkbox"/>		Processes and pays invoices for goods and services approved in the service plan	
<input checked="" type="checkbox"/>		Provide participant with periodic reports of expenditures and the status of the participant-directed budget	
<input type="checkbox"/>		Other services and supports <i>Specify:</i>	
		Additional functions/activities:	
<input checked="" type="checkbox"/>		Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency	
<input checked="" type="checkbox"/>		Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency	
<input checked="" type="checkbox"/>		Provides other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget	
<input type="checkbox"/>		Other <i>Specify:</i>	
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.	

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- 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*):

<input checked="" type="checkbox"/>	<p>Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.</p> <p><i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i></p> <p>This section delineates and distinguishes those mandatory functions of the lead agency (required case management), and those optional functions that are covered under CDCS: self-direction support activities, under the subcategory of flexible case management <u>support planner services</u>.</p> <p>Required Lead Agency Functions that are not included within the CDCS budget:</p> <ul style="list-style-type: none"> -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 <u>applicant or</u> participant with information regarding HCBS alternatives to make an informed choice -If the consumer <u>applicant or participant</u> elects CDCS, provide them with their maximum budget amount -Provide CDCS participants with resources and informational tool kits to assist them in managing the service -Determine whether <u>Evaluate that</u> the participant's health and safety needs are expected to be met through <u>given</u> the community support plan <u>including provider training and standards</u> -Determine <u>Evaluate</u> if the plan is appropriate, including that the goods and services meet the service description and provider qualifications, rates are appropriate, etc. -Review the service plan and MMIS service agreement, review rates, and set limits by service category -Authorize waiver services (prior authorize the MMIS agreement) -Review and authorize additional funding for environmental modifications or assistive technology exceeding \$5,000 and additional quality assurance if it is manageable within the lead agency's overall waiver allocation -Monitor and evaluate the implementation of the community support plan, including health and safety, satisfaction, and the adequacy of the current plan and the possible need for revisions. This includes taking action as a mandated reporter, when required to address suspected or alleged abuse, neglect, or exploitation of a participant according to the Vulnerable Adult and Maltreatment of Minors Acts. -At a minimum, review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter (monitoring requirements are increased when the provider is the parent of a minor participant or spouse of a participant. -Monitor 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,
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	<p>timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider.</p> <p>-Investigate reports related to participant vulnerability or misuse of public funds per jurisdiction</p> <p>-Assist the state agency in completing satisfaction measurements as requested</p> <p>-Provide satisfaction, utilization, budget, and discharge summary information to the state agency as requested</p> <p>-Have a system for participants to contact the local <u>lead</u> agency on a 24 hour basis in the case of a service emergency or crisis.</p> <p>Optional, direct support functions (flexible case management <u>support planning services</u>) that are included in the CDCS budget:</p> <p>-If the participant elects waiver services, provide information about CDCS and provider options</p> <p>-Facilitate development of a person centered community support plan</p> <p>-Monitor and assist with revisions to the community support plan</p> <p>-Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers</p> <p>-Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.)</p> <p>-Monitor the provision of services including such things as interviews or monitoring visits with the participant or service providers</p> <p>-Provide staff training that is specific to the participant's community support plan.</p>	
<input checked="" type="checkbox"/>	<p>Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-1/C-3 (check each that applies):</p>	
	Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	(list of services from Appendix C-1/C-3)	<input checked="" type="checkbox"/> Consumer-directed community supports: self-direction support activities
<input type="checkbox"/>	<p>Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.</p> <p><i>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:</i></p>	

k. Independent Advocacy (select one).

<input checked="" type="radio"/>	<p>No. Arrangements have not been made for independent advocacy.</p>
<input type="radio"/>	<p>Yes. Independent advocacy is available to participants who direct their services.</p> <p><i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i></p>

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- 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 [delete]community[end delete] 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.

- 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 is 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 home care services while residing in a residential setting registered by the MDH as a housing with services establishment.

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

- n. Goals for Participant Direction.** In the following table, provide the state’s goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants

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Year 1		[delete]1635[end delete] [add]3193[end add]
Year 2		[delete]1801[end delete] [add]3361[end add]
Year 3		[delete]1956[end delete] [add]3553[end add]
Year 4 (only appears if applicable based on Item 1-C)		[delete]2069[end delete] [add]3801[end add]
Year 5 (only appears if applicable based on Item 1-C)		[delete]2214[end delete] [add]3846[end add]

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Appendix E-2: Opportunities for Participant-Direction

a. **Participant – Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. **Participant Employer Status.** Specify the participant’s employer status under the waiver. *Select one or both:*

<input type="checkbox"/>	<p>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.</p> <p>Specify the types of agencies (a.k.a., “agencies with choice”) that serve as co-employers of participant-selected staff:</p>
<input checked="" type="checkbox"/>	<p>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.</p>

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:*

<input checked="" type="checkbox"/>	Recruit staff
<input type="checkbox"/>	Refer staff to agency for hiring (co-employer)
<input checked="" type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	<p>Obtain criminal history and/or background investigation of staff</p> <p>Specify how the costs of such investigations are compensated:</p> <p>Background checks are paid outside of the participant's CDCS budget.</p>
<input type="checkbox"/>	<p>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:</p>
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable state limits
<input checked="" type="checkbox"/>	Schedule staff
<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff

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<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input type="checkbox"/>	Discharge staff from providing services (co-employer)
<input type="checkbox"/>	Other Specify:

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:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget
<input checked="" type="checkbox"/>	Determine the amount paid for services within the state’s established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
<input checked="" type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for waiver goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other Specify:

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 [delete]community[end delete] support plan. CDCS Budgets for [delete]CCB [end delete] participants [add]on BI, CAC and CADI[end add] 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 [delete]under state law [end delete] [add]through legislation to all services[end add].

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Step 1: A base rate is determined for each participant using scores on [delete]11[end delete] [add]12[end add] assessment variables. Assessment scores are used in a formula that applies coefficients to [add]each then adds[end add] 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 [add]from year to year[end add] 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 [delete]11.15462[end delete] [add]11.54[end add]

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Effective Date: 7/1/15: percent change 2.53; cumulative percent change [delete]14.3832-[end delete] [add]14.37[end add]

Effective Date: 7/1/16: percent change 0.2; cumulative percent change [delete]14.6119-[end delete] [add]14.595[end add]

Effective Date 8/1/17: percent change 1.642; cumulative percent change 16.4938

[add]Effective Date 7/1/19; percent change 2.37; cumulative percent change 19.2547[end add]

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 [delete]community[end delete] support plan year, the participant is ineligible for CDCS for the remainder of their [delete]community[end delete] 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 [delete]on-[end delete] [add]in[end add] the [delete]community[end delete] 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 through 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 12 or more daily hours of personal care assistance
 - b. The individual's services are provided by a worker who has completed the required training.

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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

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.

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

<input checked="" type="radio"/>	Modifications to the participant directed budget must be preceded by a change in the service plan.
<input type="radio"/>	<p>The participant has the authority to modify the services included in the participant-directed budget without prior approval.</p> <p>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:</p>

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 [delete]community[end delete] 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 [delete]community[end delete] 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 [delete]participants[end delete] [add]participant's[end add] 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 [delete]community[end delete] support plan. This includes reviewing that health and safety needs are being adequately met, the [delete]participants[end delete] [add]participant's[end add] 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.

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(4) Review each ~~participants~~ participant's CDCS expenditures, at a minimum, within three months, six months, and twelve months of the ~~community~~ support plan being implemented and annually thereafter to evaluate if spending is consistent with the approved ~~community~~ support plan.

(5) Review expenditures and the ~~participants~~ 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 ~~community~~ support plan. This may include a corrective action plan. If efforts to resolve problems in using CDCS are unsuccessful, the CDCS authorization will be discontinued after providing the required notifications. The ~~participants~~ participant's ~~community~~ 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 ~~participants~~ participant's health and safety or misuse or abuse of public funds and report the concern to the appropriate local or state agency for investigation. The notice will include fair hearing rights and inform participants that their CDCS services are being terminated or suspended pending the outcome of the hearing if one is requested. The ~~participants~~ participant's ~~community~~ 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 ~~consumer~~ participant satisfaction measurements as requested. Provide ~~consumer~~ 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.

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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 ~~screened~~ assessed for home and community-based services and when a waiver service authorization is initiated or modified in MMIS. This includes ~~services~~ 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 ~~departments~~ 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.

- ~~Application for Title XIX home and Community Based Waiver Services and Alternative Care (135 Day Eligibility)~~ Long-Term Services and Supports Assessment and Program Information and Signature Sheet, (DHS-2727) ~~form 2727~~. This form is provided at the time an individual ~~initially applies for waiver services~~ 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 ~~form 2828~~. 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.

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- 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 [end add] [delete]when there is-[end delete] a denial, decrease, or termination [delete]in-[end delete] [add]of the person's[end add] waiver services.

These forms are available on the departments web site at:

[delete]http://www.dhs.state.mn.us/id_000100-[end delete]

[add]https://mn.gov/dhs/general-public/publications-forms-resources/edocs/[end add]

State Policies

The [delete]departments-[end delete] [add]department's[end add] 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.

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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:*

<input checked="" type="radio"/>	No. This Appendix does not apply
<input type="radio"/>	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.

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Appendix F-3: State Grievance/Complaint System

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

<input type="radio"/>	No. This Appendix does not apply
<input checked="" type="radio"/>	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 ~~the~~ Ombudsman for Mental Health and Developmental Disabilities
 The Office of ~~the~~ Ombudsman for Long-Term Care
 The Minnesota Department of Health, Office of Health ~~Facilities and~~ Facility Complaints
 The Minnesota Department of Human Services, Surveillance and Integrity Review ~~Unit~~ Section
 The Minnesota Department of Human Services, ~~Disabilities~~ 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 ~~Ombudsmans~~ Ombudsman's Office or regulatory agency. Depending upon the nature of the concern, local adult or child protection units may also be notified.

The ~~ombudsmans~~ 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 ~~Facilities and~~ Facility Complaints, addresses complaints and allegations concerning providers that they license (e.g., home care agencies ~~; residential care providers, etc.~~) to determine if an investigation is warranted. If there is an indication that an individual is in imminent jeopardy, the ~~local common entry point~~ county or tribal adult/child protection units may initiate immediate protective services for alleged victims.

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The Office of Health [delete]Facilities and[end delete] [add]Facility[end add] 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 [delete]Unit[end delete] [add]Section[end add] 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 [delete]participants[end delete] [add]participant's[end add] 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).

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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:*

<input checked="" type="radio"/>	Yes. The state operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
<input type="radio"/>	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[delete]-[end delete]. 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 [delete]delegates[end delete] [add]delegate[end add] 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.

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Maltreatment reports involving vulnerable adults are made to the ~~common entry point (CEP)~~ Minnesota Adult Abuse Reporting Center (MAARC) established, 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 ~~CEP~~ MAARC operates on a 24-hour basis. All reports of suspected maltreatment made to the ~~CEP~~ 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 ~~CEP~~ 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 ~~CEP~~ 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.91~~ 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,~~ section ~~245D.91~~ 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;

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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; [add] or [end add]
 - d. [delete] or [end delete] 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

[add]Minnesota Statutes, Chapter [end add] 245D license holders 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. [add]Minnesota Statutes, Chapter [end add] 245D license holders 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 service and support plan, up to and including a change in the service provider.

In addition to the above, providers [add]subject to Minnesota Rules, Chapter 9544 (which includes providers [end add] licensed under Minnesota Statutes [add], Chapter [end add] 245D to provide home and community based services [add], as well as all other providers licensed under Minnesota Statutes, Chapter 245A for services to people with developmental disabilities or related conditions) [end add] are required to report the following incidents via an electronic form, the Behavior Intervention Report Form [add] (DHS-5148) [end add], 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 [add]Minnesota Statutes, section [end add] 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. administration of PRN psychotropic medication in order to avert or in response to imminent risk of danger to a person;~~
- ~~4. 911 call in order to avert or in response to imminent risk of danger to person;~~
- ~~5. emergency hospitalizations in order to avert or in response to imminent risk of danger to a person. [end delete]~~
- [add]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;

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- 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[end add]

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[add], section[end add] 245.8251, subdivision 2 and the subsequent behavior intervention report form instructions issued by the Department [delete]. ~~The instructions can be accessed at: http://www.dhs.state.mn.us/dhs16_177490 [end delete]~~ [add]. Instructions and Definitions for the Behavior Intervention Reporting Form (DHS-5148A). [end add]

- 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 [delete]counties and tribes-[end delete] [add]lead agencies[end add], 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 [delete] "Help protect people who are frail or vulnerable" (DHS-2754)-[end delete] [add] "Report suspected abuse, neglect, self-neglect or financial exploitation of vulnerable adults" (DHS-6778E) [end add]. 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 [delete] "Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters" (DHS-2917) [end delete] [add] "Resource Guide for Mandated Reporters of Child Maltreatment Concerns" (DHS-2917). [end add]

The department publishes a handbook for [delete]enrollees-[end delete] [add]participants[end add] and families. "Older Minnesotans, Know Your Rights About Services," (DHS[add]-4134[end add]-[delete]form-4134[end delete]) includes information about [delete]enrollees'-[end delete] [add]participants'[end add] rights to "be safe and free from harm," including how to report a concern and information about advocacy assistance. "[delete]Families'-[end delete] [add]Family[end add] 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 [delete]screenings-[end delete] [add]assessments[end add]. All DHS forms, [delete]including consumer products-[end delete] [add]in addition to participant resources[end add], are available at [delete]http://www.dhs.state.mn.us/main/id_000100 [end delete] [add]<https://mn.gov/dhs/general-public/publications-forms-resources/edocs/>[end add]

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The ~~Long Term Care Consultation~~ LTC Screening Document (DHS-3428) or the MnCHOICES ~~MNCHOICES~~ assessment tool are ~~used~~ to determine waiver eligibility ~~(DHS 3428) contains~~ contain assessment questions intended to help discover any risk for maltreatment the applicant maybe experiencing. An assessor is required to report to the ~~CEP~~ MAARC reports of any suspected maltreatment. Actions taken would follow those outlined above related to the ~~CEP~~ MAARC and next steps related to investigation and the provision of protective services.

The Senior Linkage Line (SLL) and Disability ~~Linkage Lines (SLL and DLL)~~ 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 ~~DLL~~ Disability Hub can be viewed at http://www.mnaging.net/en/Advisor/SLL.aspx https://disabilityhubmn.org ~~http://www.mnaging.org/advisor/SLL.htm and at http://www.dhs.state.mn.us/main/id_056508 respectively.~~

Providers who furnish home care services are required to provide their clients with a copy of the Home Care Bill of Rights and information on how to report maltreatment concerns. The Bill of Rights is provided to waiver ~~enrollees~~ participants who receive services through a home health care agency. Routine licensing reviews of providers include monitoring that ~~enrollees~~ participants are informed of their rights as required. The Home Care Bill of Rights, including copies in other languages, can be accessed at ~~http://www.health.state.mn.us/divs/fpc/consumerinfo/0904MN_HCBOR_engreg.pdf~~ 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.

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INITIAL REPORT REVIEW AND RESPONSE:

The [delete]CEP[end delete] [add]MAARC[end add] receives reports of incidents of suspected abuse, neglect, or exploitation involving adults. [delete]CEP[end delete] [add]MAARC[end add] staff screen reports for immediate risks, making all necessary referrals before forwarding reports to the county or state lead investigative agency. [delete]CEP[end delete] [add]MAARC[end add] staff work with a standardized screening and decision-making framework in responding to reports. The [delete]CEP[end delete] [add]MAARC[end add] 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 [delete]CEP[end delete] [add]MAARC[end add] forwards reports of suspicious death to the medical examiner and the ombudsman for mental health and developmental disabilities. The [delete]CEP[end delete] [add]MAARC[end add] 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 [delete]Minnesota’s Child Maltreatment Screening Guidelines (<https://docs.dhs.state.mn.us/Hfs/Server/Public/DHS-5144-ENG>)[end delete] [add]Minnesota Child Maltreatment Intake, Screening and Response Path Guidelines (DHS-5144). [end add] Counties [add]and authorized tribal agencies[end add] 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 [add]to[end add] 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.)

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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. ~~Enrollees~~ 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. ~~Notification of substantiated maltreatment reports is made to licensing boards. Referrals for criminal prosecution may result.~~ 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:

~~<http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm> and~~

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

DHS Licensing Information Lookup: <http://licensinglookup.dhs.state.mn.us/>

REMEDICATION 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.

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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 ~~add~~to~~end add~~ use SSIS to support ~~delete~~maltreatment report~~end delete~~ intake, ~~delete~~report~~end delete~~ referral and management ~~add~~of maltreatment reports~~end add~~. Upon completion of a maltreatment investigation, the county ~~add~~ (or tribal nation in the case of minors)~~end add~~, 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. ~~delete~~Extraction of child maltreatment data from SSIS is a multi-step process. Supported in part by funding under a CMS Systems Change Grant, DHS retrieves adult waiver participant data, collected through CEP, more expediently.~~end delete~~ ~~add~~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.~~end add~~ Information entered in SSIS narrative data fields, whether for waiver child or waiver adult, cannot be extracted ~~delete~~on an aggregate basis~~end delete~~ ~~add~~in an aggregated format~~end add~~.

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 ~~delete~~CEP~~end delete~~ ~~add~~MAARC~~end add~~ 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.

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[delete]-(end delete) [add]-(end add) DHS Licensing [add]Information Lookup[end add]:
<http://licensinglookup.dhs.state.mn.us/> [delete]and[end delete]
[add]-(end add) MDH Licensing:
[delete]<http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm>-(end delete)
[add]<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>[end add]

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 [delete]be[end delete] checked against the DHS disqualified perpetrator registry.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

- 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.)*

<input type="radio"/>	<p>The state does not permit or prohibits the use of restraints</p> <p>Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:</p>
<input checked="" type="radio"/>	<p>The use of restraints is permitted during the course of the delivery of waiver services.</p> <p>Complete Items G-2-a-i and G-2-a-ii:</p>

- 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.

[add]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). [end add]

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Services licensed under Minnesota Statutes, Chapter 245D. Minnesota Statutes[add], section[end add] 245D.06, subdivisions 5 to 8 and section 245D.061[delete], subdivisions 1 to 9[end delete] 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. [add]Minnesota Statutes,[end add] 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 [add]Minnesota Statutes, Chapter[end add] 245D license holder 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 [delete]home and community based service[end delete] licensure (see Minnesota Statutes, section 245D.06, subdivision 5). [delete]In very limited circumstances[end delete] [add]Under Minnesota Statutes, section 245D.06, subd. 8[end add], the commissioner has [add]limited[end add] authority to authorize the use of a prohibited procedure for persons at risk of serious injury, defined in Minnesota Statutes[add], section[end add] 245.91, subdivision 6, due to self-injurious behavior [delete](see Minnesota Statutes section 245d.06, subdivision 8) [end delete]. The Department [delete], with authority provided by the Minnesota State Legislature, [end delete] created an [delete]Interim Review Panel[end delete] [add]External Program Review Committee[end add] to review plans seeking the use of a prohibited procedure and make recommendations to the commissioner regarding authorization. [delete]This panel has been reviewing plans and making recommendations to the commissioner since August of 2014.[end delete] [add]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. [end add]

[delete]In Minnesota Statutes 245.8251, the 2012 Minnesota Legislature required the Department to promulgate rules governing the use of positive support strategies that will apply to[delete] [add]On August 31, 2015, the Department promulgated Minnesota Rules, part 9544 governing the use of positive support strategies that apply to[end add] (a) all providers licensed under Minnesota Statutes[add], Chapter[end add] 245D, and (b) all other providers licensed by the Department under Minnesota Statutes[add], Chapter[end add] 245A for services to persons with a developmental [delete]disability[delete] [add]disabilities[end add] or related [delete]condition[delete] [add]conditions[end add]. [delete]Upon promulgation, the[delete] [add]The[add] conditions of Minnesota Statutes, Chapter 245D noted above [delete]will[delete] apply to all providers licensed by the Department under Minnesota Statutes[add], Chapter[end add] 245A for services to persons with [delete]a [end delete] developmental [delete]disability[delete] [add]disabilities[end add] or related [delete]condition[delete] [add]conditions[end add]. [delete]For purposes of the rule,

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~~“developmental disability or related condition” has the meaning given in Minnesota Rules, part 9525.0016, subpart 2, items A to E. [end delete]~~

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 [delete]and residential care services for children.

~~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 section 121A.67 (dealing with discipline in school) or section 245.825 (dealing with facilities and programs that provide services to persons with developmental disabilities). [end delete]~~

- 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 [add] (DHS-5148), [end add] 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 [delete]consumers-[end delete] [add]participants[end add] regarding functional assessment and [add]positive[end add]

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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, ~~local common entry point~~ 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 Interactive Informational Guide for Mandated Reporting (maltreatment of minors)~~ The online Mandated Reporter Training related to child maltreatment is available at:

~~<http://www.dhs.state.mn.us/media/flash/Training%20modules%20on%20guidelines%20for%20mandated%20reporting/>~~

<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 ~~(vulnerable adults)~~ 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.

All emergency use of manual restraints utilized by providers licensed under Minnesota Statute 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 ~~residential care homes,~~ board and lodge facilities and boarding care homes.

b. Use of Restrictive Interventions

<input type="radio"/>	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:

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●	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.

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- 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.

- 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.)*

<input type="radio"/>	<p>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:</p>
<input checked="" type="radio"/>	<p>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.</p>

- 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 in the specification 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 [delete]M.S.[end delete] [add]Minnesota Statutes, section[end add] 609.379.

For providers licensed under [delete]M.S.[end delete] [add]Minnesota Statutes, Chapter[end add] 245D, [add]section[end add] 245D.06, subdivision 5 further prohibits the

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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. [add]Minnesota Statutes, section[end add] 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 [delete]common entry point[end delete] [add]Minnesota Adult Protection Abuse Reporting Center[end add] or local welfare agency. Additionally, the use of restricted procedures identified in [add]Minnesota Statutes, section[end add] 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 [delete]common entry point[end delete] [add]Minnesota Adult Abuse Reporting Center[end add], 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 [add]Developmental[end add] Disabilities continuously monitors reports submitted via the behavior intervention report form or the serious injury or death reports.

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

<input type="radio"/>	No. This Appendix is not applicable <i>(do not complete the remaining items)</i>
<input checked="" type="radio"/>	Yes. This Appendix applies <i>(complete the remaining items)</i>

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 ~~community~~ support plan must address health and safety needs. This includes plans to address the need for medication assistance, and a determination by the case manager as part of ~~care~~ support planning of whether and which provider is able to reasonably meet the medication management needs identified in the participant's ~~community~~ support plan.

The waiver includes participants who receive ongoing services in foster care homes and community residential settings, and ~~customized living~~, ~~and residential care services~~. Providers have on-going responsibilities related to monitoring participants, which may include monitoring medication regimens.

~~Foster Care and Community Residential Setting~~ Services licensed under Minnesota Statutes, Chapter 245D

~~Foster Care and Community Residential Setting providers must have a 245D service license~~. 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 Minnesota Statutes, chapter 245D service license include:

- 24-hour emergency assistance
- Adult companion
- Adult foster care
- Child foster care
- Crisis respite
- Employment development
- Employment exploration
- Employment support
- Homemaker
- Independent living skills (ILS) training
- Individualized home support
- In-home family support
- Night supervision
- Personal support

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- Positive support services
- Prevocational services
- Respite
- Specialist services[end add]

Customized Living

Providers of Customized Living must maintain a home care license issued by the Minnesota Department of Health under Minnesota Statutes, Chapter 144A. [add]Minnesota Statutes, [end add] Section [delete]244A.4792 [end delete] [add]144A.4792[end add] addresses medication set-up, administration and monitoring.

~~Residential Care~~

~~Providers who furnish residential care must have a board and lodge license and be registered as housing with services establishment to provide specialized services. [end delete]~~

Home Care

For individuals who receive state plan home care, medication assistance may be provided through the licensed home health agency. Other medication management strategies include those made available through pharmacies, clinics, and primary care physicians. 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.

[add]Services that must have a Minnesota Statutes, chapter 245D service license include:

- 24-hour emergency assistance
- Adult companion
- Adult foster care
- Child foster care
- Crisis respite
- Employment development
- Employment exploration
- Employment support
- Homemaker
- Independent living skills (ILS) training
- Individualized home support
- In-home family support
- Night supervision
- Personal support
- Positive support services
- Prevocational services
- Respite
- Specialist services[end add]

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~~[delete]Adult foster care, child foster care and community residential settings must be licensed under Chapter 245D and [end delete]~~ [add]These services must[end add] follow medication standards ~~[delete]at [end delete]~~ [add]in Minnesota Statutes[end add], sections 245D.05 and 245D.051. The provider is required to document the administration of the medication in the individual's medication administration record. ~~[delete]They are [end delete]~~ [add]The provider is[end add] 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 service and support 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 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 or pharmacists.

Case managers are responsible to develop a ~~[delete]community [end delete]~~ support plan that identifies and addresses the ~~[delete]participants [end delete]~~ [add]participant's[end add] health and safety needs, and conduct monitoring reviews at least twice within the twelve-month period.

Physicians 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;

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- 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.

c. Medication Administration by Waiver Providers

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

<input type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)
<input checked="" type="radio"/>	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. (<i>complete the remaining items</i>)

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 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.

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

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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.

~~[delete]Adult foster care, child foster care, and community residential setting providers must meet the licensing standards in 245D.01 to 245D.26. The related state laws and rules are available upon request. [end delete]~~

[add]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
- Crisis respite
- Employment development
- Employment exploration
- Employment support
- Homemaker
- Independent living skills (ILS) training
- Individualized home support
- In-home family support
- Night supervision
- Personal support
- Positive support services
- Prevocational services
- Respite
- Specialist services[end add]

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iii. **Medication Error Reporting.** *Select one of the following:*

○	<p>Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies). <i>Complete the following three items:</i></p> <p>(a) Specify state agency (or agencies) to which errors are reported:</p> <p>_____</p> <p>(b) Specify the types of medication errors that providers are required to <i>record</i>:</p> <p>_____</p> <p>(c) Specify the types of medication errors that providers must <i>report</i> to the state:</p> <p>_____</p>
●	<p>Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.</p> <p>Specify the types of medication errors that providers are required to record:</p> <p>[delete]As described above, for participants residing in homes licensed under Minnesota Statutes, Chapter 245D as adult foster care, child foster care, or a community residential setting, the physician informs the foster care provider when he/she must be notified concerning a medication that was not taken as prescribed. The provider must also immediately report to the lead agency whenever the participant's physician is notified. [end delete]</p> <p><u>[add]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:</u></p> <ul style="list-style-type: none"> • <u>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</u> • <u>a person's refusal or failure to take or receive medication or treatment as prescribed; or</u> • <u>concerns about a person's self-administration of medication or treatment.</u> [end add] <p>Please reference Appendix G-3, a.ii. for additional information on <u>[add]Minnesota Statutes,</u>[end add] Chapter 245D requirements for license holders to document, track and review the administration of medications.</p>

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.

<p>DHS or MDH review all providers licensed under Minnesota Statutes, Chapter 245D every three years. The review includes requirements related to medication administration.</p>
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Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state 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 instances of 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.)

i. 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.

[add] 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. [end add]

[REVISED PERFORMANCE MEASURE]

<i>Performance Measure:</i>	Percent of CADI [delete]waiver[end delete] participants who are not victims of maltreatment per calendar year. Numerator: Number of CADI [delete]waiver[end delete] participants who were not the victims of county-substantiated maltreatment while on the CADI [delete]waiver[end delete] per calendar year. Denominator: Number of CADI [delete]waiver[end delete] participants per calendar year.
<i>Data Source (Select one) (Several options are listed in the on-line application):</i>	
Other	
<i>If ‘Other’ is selected, specify:</i>	
[delete]Social Services Information System; Common Entry Point (CEP)[end delete] [add]Minnesota[add] Adult Protection database[delete];[end delete] [add]and Minnesota[add] Child Protection database [add] (Social Service Information System [SSIS]) [end add]	

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	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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI participant files reviewed during the current lead agency review cycle where the community support plan documents assessed health and safety issues. Numerator: Number of CADI participant files reviewed where the support
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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) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[delete] <input checked="" type="checkbox"/> Annually [end delete]
	[add] <input checked="" type="checkbox"/> Continuously and Ongoing [end add]
	<input checked="" type="checkbox"/> Other Specify:

State:	
Effective Date	

	Individual local agency performance data is shared, monitored, and maintained on an ongoing basis.
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Add another Performance measure (button to prompt another performance measure)

[REVISED PERFORMANCE MEASURE]

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) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input checked="" type="checkbox"/> Other Specify:
			Multi-stage sample: Case file sampling for Lead Agency Reviews involves a complex, two-stage sampling plan.

Add another Data Source for this performance measure

Data Aggregation and Analysis

State:	
Effective Date	

Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	[add] <input checked="" type="checkbox"/> Other Specify: [end add]
	[add] Individual local agency performance data is shared, monitored, and maintained on an ongoing basis. [end add]

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

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of [add]CADI adult[end add] deaths [delete]of adults[end delete] associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per calendar year. Numerator: Number of [add]CADI adult[end add] deaths [delete]of adults[end delete] associated with alleged maltreatment reported to [delete]the CEP[end delete] [add]MAARC[end add] that were referred to the ME. Denominator: Number of [add]CADI adult[end add] deaths [delete]of adults[end delete] associated with alleged maltreatment reported to [delete]the CEP[end delete] [add]MAARC[end add].		
Data Source (Select one) (Several options are listed in the on-line application):			
Other			
If 'Other' is selected, specify:			
[delete]Social Service Information System (SSIS): CEP[end delete] [add]Minnesota[end add] Adult Protection database [add] (Social Service Information System [SSIS]) [end add]			
	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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

State:	
Effective Date	

	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =	
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually		
		<input checked="" type="checkbox"/> Continuously and Ongoing		<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:		
				<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[NEW PERFORMANCE MEASURE]

Performance Measure:	[add]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[end add]		
Data Source (Select one) (Several options are listed in the on-line application):			
[add]Other[end add]			
If 'Other' is selected, specify:			
[add]Minnesota Child Protection database (Social Service Information System [SSIS]) [end add]			
	Responsible Party for data collection/generation	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

State:	
Effective Date	

	<i>(check each that applies)</i>		
	[add] <input checked="" type="checkbox"/> <i>State Medicaid Agency</i> [end add]	<input type="checkbox"/> <i>Weekly</i>	[add] <input checked="" type="checkbox"/> <i>100% Review</i> [end add]
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		[add] <input checked="" type="checkbox"/> <i>Continuously and Ongoing</i> [end add]	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other Specify:</i>	
			<input type="checkbox"/> <i>Other Specify:</i>

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
[add] <input checked="" type="checkbox"/> <i>State Medicaid Agency</i> [end add]	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other Specify:</i>	[add] <input checked="" type="checkbox"/> <i>Annually</i> [end add]
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other Specify:</i>

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

- 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.**

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.

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[add]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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of reports of maltreatment of CADI adults submitted to [delete]the CEP [end delete] [add]MAARC[end add] 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 [delete]the CEP [end delete] [add]MAARC[end add] and referred to a LIA within two working days. Denominator: Number of allegations of maltreatment of CADI adults reported to [delete]the CEP [end delete] [add]MAARC[end add], per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
Other			
If 'Other' is selected, specify:			
[delete]Social Service Information System (SSIS): CEP [end delete] [add]Minnesota [end add] Adult Protection database [add] (Social Service Information System [SSIS]) [end add]			
	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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis	Frequency of data aggregation and analysis:
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State:	
Effective Date	

<i>(check each that applies)</i>	<i>(check each that applies)</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>

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

[NEW PERFORMANCE MEASURE]

Performance Measure:	[add]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. [end add]		
Data Source (Select one) (Several options are listed in the on-line application):			
[add]Other[end add]			
<i>If 'Other' is selected, specify:</i>			
[add]Minnesota Adult Protection database and Minnesota Child Protection database (Social Service Information System [SSIS]) [end add]			
	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)
	[add] <input checked="" type="checkbox"/> <i>State Medicaid Agency</i> [end add]	<input type="checkbox"/> <i>Weekly</i>	[add] <input checked="" type="checkbox"/> <i>100% Review</i> [end add]
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
	<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample; Confidence Interval =</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	<input type="checkbox"/> <i>Annually</i>	
		[add] <input checked="" type="checkbox"/> <i>Continuously and Ongoing</i> [end add]	<input type="checkbox"/> <i>Stratified: Describe Group:</i>
		<input type="checkbox"/> <i>Other</i> <i>Specify:</i>	

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Effective Date	

			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input type="checkbox"/> [add] <input checked="" type="checkbox"/> State Medicaid Agency [end add]	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	[add] <input checked="" type="checkbox"/> Annually [end add]
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

- c. **Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.**

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.

[add] 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. [end add]

[NO CHANGES TO PERFORMANCE MEASURE]

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) (Several options are listed in the on-line application):	
Other	

State:	
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If 'Other' is selected, specify:

Behavior Intervention Report Form database			
	Responsible Party for data collection/generation <i>(check each that applies)</i>	Frequency of data collection/generation: <i>(check each that applies)</i>	Sampling Approach <i>(check each that applies)</i>
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

[NO CHANGES TO PERFORMANCE MEASURE]

State:	
Effective Date	

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) (Several options are listed in the on-line application):

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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

State:	
Effective Date	

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

[NO CHANGES TO PERFORMANCE MEASURE]

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) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

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	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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.

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.

[add]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.

[REVISED PERFORMANCE MEASURE]

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 [add]≥1yr[end add], per calendar year. *AAP – Adults’ Access to Preventative/Ambulatory Health Services **CAP – Children and Adolescents’ Access to Primary Care		
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =

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	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

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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 [delete]participants[end delete] [add]participant's[end add] 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 [delete]community[end delete] 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 [delete]were[end delete] [add]was[end add] 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 Departments Waiver Lead Agency Review Database.

ii. Remediation Data Aggregation

	Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> 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.

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<input checked="" type="radio"/>	No
<input type="radio"/>	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.

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Appendix H: Quality Improvement Strategy

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.

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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 QIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. 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.

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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 ([add]“[end add]monitoring data[add]”[end add]) according to the following process (below). Problems or concerns requiring intervention beyond existing remediation processes (i.e., system improvement) are directed to the appropriate [~~Policy Review Team~~] [add]policy team[end add] (working with QET) for more advanced analysis and new/improved policy and/or procedure development, testing, and implementation.

Input (all identified data sources)
 Performance Measure and Remediation (monitoring) data

Analysis (QET)

1. Is there a problem (single instance or trend) indicated by the monitoring data?
 If yes test data (step 2).
 If no return to monitoring.
2. Is the problem real (e.g., not a statistical artifact)?
 If yes Identify what type of problem is indicated (i.e., policy, process, and/or “bad actor”).
 If no return to monitoring.
3. Do existing remediation processes address the identified problem?
 If yes remediate and return to monitoring.
 If no enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement ([~~Policy Review Team~~] [add]policy team[end add] & QET)
 Policy Analysis Realm

1. Can the [~~problems~~] [add]problem's[end add] 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 [add]“[end add]best[add]”[end add] 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 [add]“[end add]best[add]”[end add] process alternative.
5. Enact new process(es) and return to monitoring.

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ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of monitoring and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	[add] <input checked="" type="checkbox"/> Annually [end add]
<input type="checkbox"/> Other Specify:	[delete] Other Specify:
	Twice a year [end delete]

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 [delete]Policy Review Team[end delete] [add]policy team[end add], 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:

[delete]•January 15, 2016
 •January 15, 2017
 •January 15, 2019 [end delete]
 [add]• January 15, 2021 [end add]

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

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- 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.

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*):
 - o No
 - Yes (*Complete item H.2b*)
- b. Specify the type of survey tool the state uses:
 - o HCBS CAHPS Survey;
 - o NCI Survey;
 - o NCI AD Survey;
 - Other (*Please provide a description of the survey tool used*):

We conduct the NCI and NCI-AD surveys annually.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

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

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 [delete]participants[end delete] [add]participant's[end add] [delete]community[end delete] 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 [delete]departments[end delete] [add]department's[end add] 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 personal care assistance
- Extended home health care
- Homemaker - assistance with activities of daily living
- In-home family support
- Night supervision

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- 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.

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability 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.)

a.i. 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.

[add] 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. [end add]

[NO CHANGES TO PERFORMANCE MEASURE]

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.
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Denominator: Dollar amount of all paid CADI waiver claims, per calendar year.			
Data Source (Select one) (Several options are listed in the on-line application):			
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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI waiver claims paid that align to Disability Waiver Rates System (DWRS) [end delete] [add]Rate Management System (RMS) [end add] records, per calendar year. Numerator: Dollar amount of CADI waiver claims paid for services with service agreement lines matching the DWRS [end delete] [add]RMS [end add] record, per calendar year. Denominator: Dollar amount of CADI waiver claims paid for services with service agreement lines requiring a DWRS [end delete] [add]RMS [end add] record, per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
Other			
If 'Other' is selected, specify:			
DWRS [end delete] [add]RMS [end add] 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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	[add]<input checked="" type="checkbox"/> Annually [end delete]	
		[add]<input checked="" type="checkbox"/> Continuously and Ongoing [end add]	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

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)
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

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	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i>
	<i>Specify:</i>

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

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.

[add] 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. [end add]

[REVISED PERFORMANCE MEASURE]

Performance Measure:	Percent of CADI waiver service authorizations that align to Disability Waiver Rates System (DWRS) <u>Rate Management System (RMS)</u> records, per calendar year. Numerator: Dollar amount of authorized CADI waiver service agreement lines that have a matching DWRS <u>RMS</u> record, per calendar year. Denominator: Dollar amount of authorized CADI waiver service agreement lines requiring a DWRS <u>RMS</u> record, per calendar year.		
Data Source (Select one) (Several options are listed in the on-line application):			
Other			
If 'Other' is selected, specify:			
DWRS <u>RMS</u> 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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

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<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
<input type="checkbox"/> Other Specify:	[delete] <input checked="" type="checkbox"/> Annually[end delete]	
	[add] <input checked="" type="checkbox"/> Continuously and Ongoing[end add]	<input type="checkbox"/> Stratified: Describe Group:
	<input type="checkbox"/> Other Specify:	
		<input type="checkbox"/> Other Specify:

Add another Data Source for this performance measure

Data Aggregation and Analysis

Responsible Party for data aggregation and analysis <i>(check each that applies)</i>	Frequency of data aggregation and analysis: <i>(check each that applies)</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

- 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 [delete]Continuing Care Management Reporting System (CCMRS)-[end delete] [add]Management Reporting System (MRS) [end add]. The Department manages waiver cost neutrality through allocations (amounts) to [delete]counties and tribes-[end delete] [add]lead agencies[end add]. [delete]Counties and tribes-[end delete] [add]Lead agencies[end add]

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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 [delete]counties and tribes[end delete] [add]lead agencies[end add] 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 [delete]counties and tribes[end delete] [add]lead agencies'[end add] authorization patterns.

Department staff also monitor regularly (e.g., quarterly, ad hoc) generated encumbrance and payment summary reports that are downloaded into the [delete]CCMRS[end delete] [add]MRS[end add] 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 state’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

Surveillance and Integrity Review Section (SIRS). When individual problems are identified, SIRS is able to address them through various methods as appropriate, including:
 [add]-[end add] Recovering overpayments due to error, abuse, or fraud;
 [add]-[end add] Suspending or terminating provider participation in the MHCP; and/or
 [add]-[end add] 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)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
	<input type="checkbox"/> Other	<input type="checkbox"/> Annually
	Specify:	<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other

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		<i>Specify:</i>

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.

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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

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APPENDIX I-2: Rates, Billing and Claims

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

Minnesota pays for services in 3 ways.

1. DHS sets rates for state plan services, including home care, home care nursing & PCA services. These rates are approved in the state plan. Personal care for participants who elect CDCS are not state-set rates.

DHS establishes rates for case mgmt, ext PCA, 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 ~~[\$4.35, \$3.26 and \$2.86]~~ ~~add~~ \$4.45, \$3.34 and \$2.93 ~~end add~~ respectively per 15-min units. For persons eligible for 12 or more hours of daily PCA, ext PCA rates are increased by 7.5% when the service is provided by persons who have completed the required training. Homemaker (home mgmt & w/ADLs) is paid at \$4.61/15-min unit, home-delivered meals are paid at \$6.53/meal, and chore services are paid at \$3.76/15-min unit. These rates are subject to COLA increases as enacted by the Legislature.

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

- 24-hr emergency assistance
- Caregiver Living Expenses
- Crisis Respite
- Environmental Accessibility Adaptations
- Family Training & Counseling
- Homemaker (cleaning component)
- Respite (daily)
- Specialized Equipment & Supplies
- Transitional Services ~~[delete]~~ ~~(Expenses)~~ ~~[end delete]~~
- ~~[delete]~~ ~~Public~~ ~~[end delete]~~ 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:

- Customized living
- Foster Care

Payment for day program services:

- Adult Day Service/Adult Day Service Bath
- Prevocational Services

Payments for unit-based services w/programming:

- Independent Living Skills Training

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- 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 [delete]disability[end delete] 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

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an added customization rate for assisting those in need of deaf/hard of hearing support. All ~~of~~ those ~~providers'~~ ~~provider's~~ expenses are multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits and client programming, including transportation. Client programming costs, including transportation, to provide individuals access to the community or care in their home as ~~defined in a~~ ~~identified in the~~ support plan are also considered.

Within the 4 ~~different~~ 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, beginning ~~with~~ 7/1/22. COLAs (after-model rate increases) enacted by the legislature will also impact these component values prior to the implementation of the automatic inflationary adjustments (rebase) within the model. When the inflationary adjustments within the model are updated using BLS and CPI, the COLAs enacted by the legislature will be replaced by the inflationary adjustments within the model. If a legislative COLA occurs in the years between rebasing, they will add to component values prior to and until the next rebase.

DHS maintains a document with these values at ~~mn.gov/dhs/assets/2019-DWRS-component-values_tcm1053-356458.pdf~~ ~~https://mn.gov/dhs/assets/01012020%20DWRS%20component%20values%2008212019_tcm1053-404438.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 ~~screening~~ ~~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 ~~screening~~ ~~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.

Implementation of ~~new~~ ~~the~~ RMS system began 1/1/14 and was completed in 1 year. All service plans were entered into the RMS during individual annual reviews by 12/31/14.

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. ~~The department~~ ~~DHS~~ sets

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rate file limits for all services, regardless of payment methodology, as found in the Long-Term Services & Supports ~~[add]Service[end add]~~ Rate Limits document:
~~[delete]www.dhs.state.mn.us/dhs16_151043.pdf[end delete]~~
~~[add]https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3945-ENG[end add]~~

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 ~~[delete]included[end delete]~~ ~~[add]include[end add]~~ lead agency reviews and ~~by~~ 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 program services, the licensing process under ~~[add]MN Statutes,[end add]~~ 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 ~~[delete]community[end delete]~~ 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 ~~[add]MN Statutes,[end add]~~ Chapter 245D. ~~[delete]This process began with technical assistance visits in July 2014, with a 2-yr licensing review cycle beginning January 2015.[end delete]~~

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.

~~[delete]Beginning 2012 and every 2 yrs thereafter,[end delete]~~ ~~[add]Every 2 years[end add]~~ 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:

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Providers bill Medical Assistance directly through MMIS and claims are processed through MMIS.

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

<input checked="" type="radio"/>	No. State or local government agencies do not certify expenditures for waiver services.
<input type="radio"/>	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. <i>Select at least one:</i>
<input type="checkbox"/>	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). <i>(Indicate source of revenue for CPEs in Item I-4-a.)</i>
<input type="checkbox"/>	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). <i>(Indicate source of revenue for CPEs in Item I-4-b.)</i>

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- 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 ~~participants~~ participant’s ~~community~~ 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 ~~participants~~ participant’s MA and waiver eligibility date spans).

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

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APPENDIX I-3: Payment

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

<input checked="" type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="radio"/>	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:
<input type="radio"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input checked="" type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	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:
<input type="checkbox"/>	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.

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- 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:*

<input checked="" type="radio"/>	No. The state does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	<p>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.</p>

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

<input type="radio"/>	<p>No. State or local government providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i></p>
<input checked="" type="radio"/>	<p>Yes. State or local government providers receive payment for waiver services. <i>Complete item I-3-e.</i></p> <p>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. <i>Complete item I-3-e.</i></p>
	<p>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.</p>

- 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:*

<input checked="" type="radio"/>	The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
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<input type="radio"/>	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.
<input type="radio"/>	The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input checked="" type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

g. **Additional Payment Arrangements**

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

<input checked="" type="radio"/>	No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
<input type="radio"/>	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:*

<input checked="" type="radio"/>	No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
<input type="radio"/>	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

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	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.** *Select one:*

<input checked="" type="radio"/>	The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
<input type="radio"/>	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.
<input type="radio"/>	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.
<input type="radio"/>	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.

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APPENDIX I-4: Non-Federal Matching Funds

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. *Select at least one:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid Agency
<input type="checkbox"/>	<p>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:</p>
<input type="checkbox"/>	<p>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:</p>

- 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:*

<input type="radio"/>	Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
<input type="radio"/>	<p>Applicable <i>Check each that applies:</i></p>
<input type="checkbox"/>	<p>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:</p>
<input type="checkbox"/>	<p>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:</p>

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- 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:

<input type="radio"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="radio"/>	The following source(s) are used. <i>Check each that applies.</i>
<input type="checkbox"/>	Health care-related taxes or fees
<input type="checkbox"/>	Provider-related donations
<input type="checkbox"/>	Federal funds
	For each source of funds indicated above, describe the source of the funds in detail:

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APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual.
<input checked="" type="radio"/>	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:

<p>Costs related to room and board in residential settings are excluded from the statewide rate setting frameworks.</p>

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

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

Select one:

<input type="radio"/>	<p>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.</p>
<input checked="" type="radio"/>	<p>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.</p> <p>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:</p> <p>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.</p> <p>(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).</p> <p>(b) the method used to reimburse these costs: Claims are paid via MMIS.</p>

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

- a. **Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The state does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

i. **Co-Pay Arrangement**

Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

<i>Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>Specify:</i>

ii **Participants Subject to Co-pay Charges for Waiver Services.**

Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

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- iii. **Amount of Co-Pay Charges for Waiver Services.** The following table lists the waiver services defined in C-1/C-3 for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Charge	
	Amount	Basis

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iv. Cumulative Maximum Charges.

Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

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*:

<input checked="" type="radio"/>	No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	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[delete];[end delete] and (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix 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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care (<i>specify</i>):							
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1							
2							
3							
4							
5							

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Appendix J-2: Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1			
Year 2			
Year 3			
Year 4 (only appears if applicable based on Item 1-C)			
Year 5 (only appears if applicable based on Item 1-C)			

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.

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:

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:

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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:

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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:

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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	
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>
	<u>manage components</u>

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d. Estimate of Factor D.

i. Estimate of Factor D – Non-Concurrent Waiver. 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. 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	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Total Cost
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

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Waiver Year: Year 2					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

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Waiver Year: Year 3					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

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Waiver Year: Year 4 (only appears if applicable based on Item 1-C)					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

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Waiver Year: Year 5 (only appears if applicable based on Item 1-C)					
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
GRAND TOTAL:					
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					
FACTOR D (Divide grand total by number of participants)					
AVERAGE LENGTH OF STAY ON THE WAIVER					

State:	
Effective Date	

ii. Estimate of Factor D – 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 1						
	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col.6	Col. 7
Waiver Service / Component	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input type="checkbox"/>						
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	<input type="checkbox"/>						
GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

Waiver Year: Year 2							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	<input type="checkbox"/>						
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

Waiver Year: Year 3							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

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	Waiver Year: Year 4 (only appears if applicable based on Item 1-C)						
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
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GRAND TOTAL:							
Total: Services included in capitation							
Total: Services not included in capitation							
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)							
FACTOR D (Divide grand total by number of participants)							
Services included in capitation							
Services not included in capitation							
AVERAGE LENGTH OF STAY ON THE WAIVER							

State:	
Effective Date	

	Waiver Year: Year 5 (only appears if applicable based on Item 1-C)							
Waiver Service / Component	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost	
	<input type="checkbox"/>							
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GRAND TOTAL:								
Total: Services included in capitation								
Total: Services not included in capitation								
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)								
FACTOR D (Divide grand total by number of participants)								
Services included in capitation								
Services not included in capitation								
AVERAGE LENGTH OF STAY ON THE WAIVER								

State:	
Effective Date	