

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

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

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

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

	Not applicable				
	Applicable				
	<p>Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. <i>Specify:</i></p> <p>(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);</p> <p>(b) the geographic areas served by these plans;</p> <p>(c) the specific 1915(i) State plan HCBS furnished by these plans;</p> <p>(d) how payments are made to the health plans; and</p> <p>(e) whether the 1915(a) contract has been submitted or previously approved.</p>				
	<p>Waiver(s) authorized under §1915(b) of the Act.</p> <p><i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i></p>				
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><input type="checkbox"/> §1915(b)(1) (mandated enrollment to managed care)</td> <td style="width: 50%;"><input type="checkbox"/> §1915(b)(3) (employ cost savings to furnish additional services)</td> </tr> <tr> <td><input type="checkbox"/> §1915(b)(2) (central broker)</td> <td><input type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)</td> </tr> </table>	<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 type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)
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<input type="checkbox"/> §1915(b)(2) (central broker)	<input type="checkbox"/> §1915(b)(4) (selective contracting/limit number of providers)				
	<p>A program operated under §1932(a) of the Act.</p> <p><i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</i></p>				
	<p>A program authorized under §1115 of the Act. <i>Specify the program:</i> Alternative Care (AC)</p>				

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

	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <i>(select one)</i> :	
	The Medical Assistance Unit <i>(name of unit)</i> :	
	Another division/unit within the SMA that is separate from the Medical Assistance Unit <i>(name of division/unit)</i> <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.</i>	
	The State plan HCBS benefit is operated by <i>(name of agency)</i>	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

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

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

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

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

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

Managed care organizations contracted with the SMA perform functions No. 1-4 above.

Local county/regional entities and tribes under interagency agreement with the SMA perform functions No. 1-4 above.

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

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

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

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	SFY 2022	SFY 2023	1,100
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

Evaluation/Reevaluation of Eligibility

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

<input type="radio"/>	Directly by the Medicaid agency
<input checked="" type="radio"/>	By Other (<i>specify State agency or entity under contract with the State Medicaid agency</i>): Entities under contract with the State Medicaid agency, local non-state entities under interagency agreement with the State Medicaid agency

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

Each lead agency (i.e., county agency, tribal nation managed care organization) uses an assessor to perform evaluations/reevaluations. Assessors complete training and a certification processes determined by the DHS commissioner. Assessors shall demonstrate best practices in assessment and support planning, including person-centered planning principles and having a common set of skills that ensure consistency and equitable access to services statewide. A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency. Certified assessors must use person-centered planning principles to conduct an interview that identifies what is important to the person, what the person's needs for supports are, what health and safety concerns exist and what the person's abilities, interests and goals are.

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

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

The term “comprehensive assessment” or “assessment” will be used throughout the 1915i plan, and defined as: A standardized, comprehensive and person-centered tool used to determine program eligibility and identify long-term services and support needs.

A participant interested in receiving Community First Services and Supports (CFSS) must receive an assessment of need from a certified assessor who will complete the comprehensive assessment. Initial assessments for CFSS are completed when the participant requests an assessment from the lead agency where they are located, or another person requests the assessment on their behalf. The lead agency schedules and conducts the assessment in person.

The assessment tool is a comprehensive, conversation-based assessment that supports person-centered practices. The assessment includes the health, psychological, functional, environmental and social needs of the individual necessary to develop a person-centered support plan that meets the individual's needs and preferences.

The comprehensive assessment tool includes assessment of activities of daily living, instrumental activities of daily living, medical service needs, safety/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.

After completion of the assessment process, the CFSS service delivery plan is developed and evaluated through a person-centered planning process by the participant or the participant's representative or legal representative (who may be assisted by a consultation services provider).

Reassessments are completed using the same comprehensive assessment tool that is used for the initial assessment in the same manner and many times by the same lead agency as the initial assessment. A different lead agency may complete the reassessment if, during the CFSS service delivery plan year, the participant moved to a different area of the state or changed MCOs.

Reassessment must be completed at least every 12 months and when a significant change in the participant's condition warrants a comprehensive review. Annually, the financial management services (FMS) provider (under the CFSS budget model) or the CFSS agency (under the CFSS provider-agency model) requests a reassessment at least 60 days before the end of the participant's service agreement.

When a participant has a significant change in condition, the participant, CFSS agency (CFSS provider-agency model) or FMS provider (CFSS budget model) can request a reassessment using the [Referral for Reassessment for PCA services form, DHS-3244P \(PDF\)](https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3244P) (<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3244P-ENG>).

After receiving the request for reassessment due to a significant change in the participant's condition, the lead agency determines if it should complete:

- A 45-day temporary increase in CFSS services
- A full reassessment

4. ✓ **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.
5. ✓ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

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

CFSS is available to participants who:

- Are determined eligible for medical assistance
- Require assistance
- Are determined, based on the comprehensive assessment, to be dependent in at least one activity of daily living and/or as having a Level 1 behavior (meaning physical aggression toward self, others or destruction of property that requires the immediate response of another person).

6. **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*
7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). *(Specify target group(s)):*

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

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

8. **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, **and** (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

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

Home and Community-Based Settings

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

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

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

The Community First Services and Supports (CFSS) service provider (HCBS service provider) does not own/control the setting in which the participant resides. Therefore this does not meet the definition of provider-owned or controlled. As such:

- The CFSS provider does not have a direct or indirect financial relationship with the property owners in the settings described below, therefore the nature of the relationship does not affect either the care provided or the financial conditions applicable to tenants.
- CFSS services are not part of the package of services that may be provided by the residential setting. Participants do not need to use a specific CFSS provider in order to live in the residence.

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

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

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

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

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

2. Participants may receive CFSS in residential settings that are not controlled by the provider of CFSS services. Such as:

- Settings registered by the Minnesota Department of Health (MDH) as a board and lodge establishment (e.g. hotel, VRBO, etc.)
- Medical homes for children and adults, owned and operated by the home care/nursing provider

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

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

- Support workers complete required person-centered training as part of worker training and development for both the agency and budget models
- Agency providers complete initial CFSS training which includes person-centered practices, as well as service- and protection-related rights
- Consultation service providers offer choices to the participant regarding the services and supports they receive (and from whom) and record the alternative home and community-based settings that were considered by the participant in their service plan
- Consultation service providers educate participants on CFSS service expectations and person-centered practices and their service/protection related rights upon initial orientation and annual review
- Participants are surveyed annually on their experience with CFSS services to assure person-centered practices are being followed and their rights are asserted and protected. (DHS will use survey results to trigger remediation at an individual level when a participant's experience differs from HCBS requirements).
- Agency providers attest to compliance with home and community based services requirements as part of new enrollment (new provider record), re-enrollment (inactive to active) or revalidation every five years (review of enrollment documents of currently active record) as a Medicaid provider.

CFSS program-monitoring metrics are cited in other quality assurance sections (beginning on page 49) that assure compliance with HCBS settings requirements.

Person-Centered Planning & Service Delivery

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

1. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.
2. Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).
3. The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.
4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. (*Specify qualifications*):

Each lead agency (county agency, tribal nation, managed care organization) uses an assessor to perform face-to-face evaluations/reevaluations. Assessors complete training and a certification processes determined by the DHS commissioner and are required to be recertified every three years.

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

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

The term "CFSS service delivery plan" will be used throughout the 1915i plan. It is defined as: The individualized, person-centered service delivery plan developed by the participant/representative and, if needed, the consultation services provider.

The participant, or their representative, are responsible for developing the CFSS service delivery plan with assistance of consultation services as requested. All people who use CFSS, regardless of service delivery method, must select a consultation services provider. Certain functions of consultation services are required to be provided to the participant, and some functions are optional depending on the participant's choice. Consultation service providers assist the participant with understanding CFSS, planning for services, choosing a model, creating and implementing the participant's CFSS service delivery plan.

DHS and lead agencies determine if consultation services providers meet the qualifications through a request for proposal (RFP) process at a frequency determined by DHS. All consultation services providers must have a contract with the state to provide consultation services.

See the qualifications for consultation services provider in the services section on Page 25.

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

(a) The CFSS service delivery plan is based on the comprehensive assessment, which includes the health, psychological, functional, environmental and social needs of the individual necessary to develop a person-centered support plan that meets the their needs and preferences.

The lead agency's assessor must determine and communicate (within 10 business days) the results of the assessment and any recommendations and authorizations for CFSS (as defined in section 256B.0911) to the participant, or the participant's representative, and chosen CFSS providers. The written communication from the lead agency allows the person to begin developing the CFSS service delivery plan as soon as possible.

After the assessment, the participant chooses a consultation service provider who provides them with information about CFSS service models and rights and responsibilities (including appeal rights, choice in providers, budget information for those who choose the budget model and CFSS policies). The consultation service provider also provides the participant with the CFSS service delivery plan template.

The assessor will provide assessment results to the consultation service provider, FMS and/or CFSS agency, as applicable.

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

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

The consultation services provider shares information on how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers. Consultation service providers will also direct CFSS participants to MinnesotaHelp.info (https://MinnesotaHelp.info) or the MCO provider network. This site contains a listing of qualified CFSS agencies and support workers. The consultation services provider will answer any questions and help perform a search of available providers.

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

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

The consultation services provider will submit the service delivery plan to the lead agency responsible for conducting the face to face assessment. The CFSS service delivery plan must be approved by the consultation services provider and authorized by the lead agency (county, managed care organization, tribal nation).

The lead agency will input the service delivery plan information into MMIS for approval by the Medicaid Agency.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

<input type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other <i>(specify)</i> :	The service delivery plan is maintained by the lead agency for a minimum of three years			

Services

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

Service Specifications <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</i>	
Service Title:	
Service Definition (Scope):	
1. Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs) and	
Identify the activities to be provided by applicable provider type and describe any service limitations related to such activities.	
Personal attendant services. Describe: Personal attendant services (i.e., personal care assistance services) provided by a support worker include assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision/cueing to accomplish the task. Personal care assistance services may also include observation and redirection to the participant for episodes of behavior that need redirection (as identified in the CFSS service delivery plan).	
ADLs include dressing, grooming, bathing, eating, transfers, mobility, positioning and toileting.	
IADLs include activities related to living independently in the community, such as attending medical appointments, providing or assisting with transportation, paying bills, communicating by telephone or other media and completing household tasks necessary to support the participant with an assessed need (such as planning and preparing meals or shopping for food, clothing and other essential items).	
Health-related procedures and tasks are procedures and tasks performed by a support worker that can be delegated or assigned by a health care professional licensed under Minnesota state law.	
Health-related procedures and tasks may include assistance with self-administered medications, interventions for seizure disorders, range-of-motion and passive exercise, clean tracheostomy suctioning and services to a participant who uses ventilator support or other activities within the scope of CFSS that meet the definition of health-related procedures or tasks.	
Personal care assistance services may be delivered individually (1:1) or as shared care (1:2 or 1:3). CFSS support workers are limited to providing 310 hours of care per calendar month, regardless of the number of participants being served or the number of agencies or participants the support worker is employed by.	
Personal care assistance services do not include:	
<ul style="list-style-type: none">• CFSS services provided by a participant's representative or paid legal guardian• Services that are used solely as a child care or babysitting service	

- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules
- Sterile procedures
- Giving of injections into veins, muscles or skin
- Homemaker services that are not an integral part of the assessed CFSS service
- Home maintenance or chore services
- Home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant
- Services to other members of the participant's household
- Services not specified as covered under medical assistance as CFSS
- Application of restraints or implementation of deprivation procedures
- Independently determining the medication dose or time for medications for the participant.

2. The acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks.

Identify the activities to be provided by applicable provider type and any describe any service limitations related to such activities:

Personal attendant services (personal care assistance services) provided by a support worker as described in item No. 1 may include activities that allow time for skills training through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-related tasks. When an assessment shows that a person needs assistance to acquire, maintain and/or enhance the skills necessary to accomplish ADLs, IADLs, and health-related tasks, the person will receive this support concurrently (with hands-on assistance, or constant supervision and/or cueing) to accomplish the task. This will be done as described under the personal attendant services description.

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

Support workers may provide assistance under the following conditions:

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

3. Individual back-up systems or mechanisms to ensure continuity of services and supports.

Identify the systems or mechanisms to be provided and limitations for:

[selected] Personal Emergency Response

- Systems Pagers
- Other Mobile Electronic Devices
- Other. Describe: persons identified by an individual to be included as backup supports

Describe any limitations for the systems or mechanisms provided:

Personal emergency response (PERS) covers:

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

Personal emergency response does not cover:

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

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

- The participant's assessed need for a personal emergency response system
- The type of personal emergency response equipment the participant will use
- How the personal emergency response equipment will meet the participant's assessed need
- Backup system for personal emergency response equipment during electrical outages or other equipment malfunctions
- Training for the participant and their paid and/or informal caregivers (if applicable) on the use of the equipment
- Fees for equipment purchase, installation and monthly monitoring.

Individual backup supports:

Participants can identify a person (or people) to provide backup supports and the circumstances when they would need the backup support. The person(s) chosen to provide individual backup supports will be identified in the participant's CFSS service delivery plan. The CFSS service delivery plan will also include a description of how the participant will communicate with or summon the designated backup supports.

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

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

4. Goods and Services -Services or supports for a need identified in the individual's person-centered plan of services that increase an individual's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

Include a service description including provider type and any limitations for each service provided

CFSS may cover the costs of goods and services that either:

- Increase a participant's independence
- Decrease a participant's need for assistance (with an assessed need) from another person.

Expenditures for goods and services must:

- Relate to a need identified in a participant's CFSS service delivery plan
- Be priced at fair market value
- Increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed need
- Fit within the annual limit of the participant's approved service allocation or budget
- Be something that can fit within the participant's budget without compromising the participant's health or safety.

Examples of covered goods and services include, but are not limited to:

- Grab bars
- Wheelchair ramps
- Smart phone applications
- Specialized devices for dressing or grooming
- A microwave
- Laundry service
- Assistive technology
- Environmental modifications.

When a participant uses CFSS funds to purchase goods and services, the consultation services provider must review the CFSS service delivery plan and, if the good(s) meet the requirements for a covered item, approve the request. The consultation services provider submits the plan to the lead agency. All goods must be purchased through the FMS provider.

When a participant is using the agency-provider model and they choose to purchase goods through CFSS, the cost for the goods is covered using a portion of the approved number of service delivery units (service allocation). When a participant is using the budget-model and they choose to purchase

goods through CFSS, the cost for the goods is covered using the participant's service budget as described on Pages 34-35.

5. Consultation services

Consultation services are an integral part of the CFSS program. Consultation services are separated into three main categories that provide different functions:

- CFSS orientation/annual review
- Ongoing support
- Remediation.

All participants using CFSS, regardless of service delivery method, must select a consultation services provider. Certain functions of consultation services are required to be provided to the participant, and some functions are optional depending on the participant's choice. Consultation service providers assist the participant with understanding CFSS, planning for services, choosing a model, creating and implementing the CFSS service delivery plan by providing information about:

- Service options
- Choices in providers
- Rights and responsibilities (including appeal rights).

Consultation services: CFSS orientation/annual review

Consultation services for CFSS orientation and annual review is a required service for all CFSS participants. After the participant's assessment is complete, the consultation services provider supports the participant in the next step in their CFSS experience. Under this activity category, the consultation service provider will:

- Educate the participant about CFSS
- Educate the participant about the agency model and budget model
- Assure a person-centered planning process
- Help the participant or the participant's representative write, implement and evaluate their CFSS service delivery plan (to the extent the participant desires)
- Assist participants who have chosen the budget model with outlining a budget
- Approve the service delivery plan or do the initial approval of the service delivery plan if the participant is on a waiver or a person older than 65 years old who is enrolled in managed care
- Provide a notice of action or denial, termination or reduction (DTR) notice when denying the CFSS service delivery plan or items in the CFSS service delivery plan (only for people who use an MCO)
- Provide the participant with a list of CFSS agency providers (if the participant chooses the agency model) or financial management services (FMS) providers (if the participant chooses the budget model).

Consultation services: Ongoing support

Ongoing support is offered and available to participants who use CFSS services, in either model, as an optional service. Consultation services ongoing support includes:

- Training the participant to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers

- Responding to participant’s questions related to self-directed tasks or other concerns throughout the CFSS service delivery plan year
- Completing a semi-annual review if the participant does not have a case manager/care coordinator and their spouse or parent (if a minor) serves as their support worker
- Revise a person-centered CFSS service delivery plan to achieve quality service outcomes.

When a participant uses the budget model, the consultation services provider will:

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

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

Consultation services: QA/remediation

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

Additional responsibilities and expectations of consultation service providers

- Help DHS/lead agency with surveys and data collection, at request
- Document complaints received for possible audit
- Have policies and procedures to meet the needs of culturally diverse participants receiving services
- Review their grievance policy annually
- Pass on information from DHS/lead agency (e.g., policy clarifications or changes) to participants using CFSS when requested by DHS
- Comply with all requirements, as applicable.

6. Worker training and development

Worker training and development is a function of CFSS that pays for the training, observation, monitoring and coaching of CFSS support workers. These activities help CFSS support workers expand their skills to support the participant's specific needs. Under the agency-provider model, the CFSS agency is the employer of the support worker. Under the budget model, the participant (or their representative) is the employer of the support worker. The support worker's employer is responsible to train, supervise and evaluate the support worker's competency. The employer must orient each support worker to the participant's needs and train them on the tasks the participant needs.

All participants using CFSS must have a worker training and development plan included in their CFSS service delivery plan. The plan must describe:

- What training the participant's support workers need
- Who will provide the training and what license(s), education, training or work experience the trainer needs
- Who will determine the support worker is competent to provide the service the participant needs
- A plan to supervise and evaluate the support workers
- A plan to evaluate if the overall service delivery is meeting the participant's needs.

The employer must update the worker training and development plan in all of the following situations:

- At reassessment
- When a new support worker begins providing services to the participant
- When there are significant changes to the participant's service delivery plan
- When a performance review indicates a support worker needs additional training.

In the CFSS agency model, a CFSS agency staff with a background relevant to the needed task, trains and ensures the support worker is competent.

In the CFSS budget model, the participant is responsible to train and ensure the support worker is competent to perform the needed task. The participant or their representative cannot use the worker training and development budget to pay themselves to meet their employer responsibilities. The participant or their representative cannot hire another individual to supervise their support workers.

In both the CFSS agency and budget models, the support worker's employer can use the CFSS worker training and development budget to pay the fees for a support worker attending a class or workshop on topics related to the participant's assessed needs. A class can take place in a variety of settings and have varying numbers of learners (e.g., one-on-one training, traditional classroom course, online class, etc.).

Worker training and development has a minimum annual allocation credited to each participant who receives CFSS, which is separate from the participant's service delivery budget. People can request additional funds for the participant's worker training and development, but it is subject to DHS/lead agency approval.

7. Financial management services (FMS)

Participants who use the budget model must select a financial management services (FMS) provider.

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

The role of the FMS provider is to support the participant as they fulfill their responsibilities of being the employer of their support workers. The FMS provider is responsible to:

- Collect and process timesheets of the participant’s support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Separately track budget funds and expenditures for each participant
- Track and report disbursements and balances of each participant’s funds
- Process and pay invoices for services in the person-centered CFSS service delivery plan
- Provide individual, periodic reports of expenditures and the status of the approved service budget to the participant or their representative and DHS, as well as the consultation service provider and lead agency, as applicable
- Initiate background studies for CFSS support workers
- Help the participant obtain support workers’ compensation
- Educate the participant on how to employ support workers
- Ensure what the participant spends their funds on follows the rules of the program and the approved CFSS service delivery plan

Participants who use the agency-provider model and choose to purchase goods with their CFSS service allocation must use an FMS provider to purchase the goods.

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

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

(Choose each that applies):

Categorically needy (*specify limits*):

Services are limited to service units or service budget amounts available, as determined through the assessment of the participant’s needs.

Worker training and development services and consultation services are not subject to the participant’s individual service authorization limit. The worker training and development service will be determined as per the participant’s need with a minimum of 96 units a year. Each CFSS participant will have six consultation services sessions annually (including when the participant’s authorization is for less than 12 months). The participant, along with the consultation service

<p>provider, can request additional sessions. The request must include an explanation for how the previous six sessions were used and justification for why additional sessions are needed. People who use CFSS under this attachment of the state plan are not eligible to receive personal care assistance services as described in Item 26 of Attachments 3.1-A and 3.1-B.</p>			
<p><input checked="" type="checkbox"/> Medically needy (<i>specify limits</i>):</p> <p>Services are limited to service units or service budget amounts available, as determined through the assessment of the participant’s needs.</p> <p>Worker training and development services and consultation services are not subject to the participant’s individual service authorization limit. The worker training and development service will be determined as per the participant’s need with a minimum of 96 units per year. Each CFSS participant will have six consultation services sessions annually (including when the participant’s authorization is for less than 12 months). The participant, along with the consultation service provider, can request additional sessions. The request must include an explanation for how the previous six sessions were used and a justification for why the additional sessions are needed.</p> <p>People who use CFSS under this attachment of the state plan are not eligible to receive personal care assistance services as described in Item 26 of Attachments 3.1-A and 3.1-B.</p>			
<p>Provider Qualifications (<i>For each type of provider. Copy rows as needed</i>):</p>			
Provider Type (<i>Specify</i>):	License (<i>Specify</i>):	Certification (<i>Specify</i>):	Other Standard (<i>Specify</i>):
1-2: Support workers	N/A	N/A	<p>All CFSS support workers, regardless of service delivery model must:</p> <ul style="list-style-type: none"> • Complete the standardized certification training and pass the test named “Personal Care Assistance (PCA) and Community First Services and Supports (CFSS) Training and Test” • Pass a background study initiated by the provider agency/FMS provider, as required under Minnesota Statutes, Chapter 245C • Enroll with Minnesota Health Care Programs as a PCA/CFSS support worker • Be able to communicate effectively with the participant and the provider agency/FMS provider • Have the skills and ability to provide the services and supports according to the participant's CFSS service delivery plan and respond appropriately to the participant's needs. <p>The participant may establish additional CFSS support worker qualifications.</p>
3. Personal emergency	N/A	N/A	PERS vendors can be either:

Effective: June 1, 2022

Approved:

Supersedes: NEW

<p>response equipment (PERS) vendor</p>			<p>1) Minnesota Health Care Programs (MHCP) enrolled vendors or providers enrolled in MCO network (s) that meet one of the following qualifications:</p> <ul style="list-style-type: none"> ○ State medical equipment provider, as defined under Minn. R. 9515.0195 ○ Pharmacy licensed by the Minnesota Board of Pharmacy in accordance with Minn. R. 6800.0100 to 6800.9954 ○ Medicare-certified home health agency, as defined under Minn. R. 9505.0195. <p>2) Non-MHCP enrolled vendors that meet both of the following qualifications:</p> <ul style="list-style-type: none"> ○ Demonstrate to the participant that they have the capability to perform the requested work and the ability to successfully communicate with the participant ○ Have all the necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable. <p>The participant or their representative is responsible to verify provider qualifications under the budget model. DHS provider enrollment or the lead agency is responsible to verify provider qualifications under the agency model.</p> <p>The participant determines qualifications for individual backup supports.</p>
<p>4. Goods and services providers</p>			<p>Entities providing goods or services covered by CFSS must bill through the Financial Management Services provider. All individuals/vendors that provide individual directed goods and services must have:</p> <ul style="list-style-type: none"> ● The capability to perform the requested work ● The ability to successfully communicate with the participant ● All the necessary professional and/or commercial licenses required by federal, state and local laws and regulations, if applicable.

<p>5. Consultation services contractor</p>	<p>N/A</p>	<p>N/A</p>	<p>A consultation services provider must meet all of the following qualifications:</p> <ul style="list-style-type: none"> • Enrolled with Minnesota Health Care Programs (MHCP) or enrolled through MCO provider network(s) • Employ at least one lead staff member who meets the qualifications for the lead employee • Have the ability to provide services statewide (either in person or remotely) • Have an office located in Minnesota • Have a toll-free phone number and secure fax number • Have never had a lead agency contract or provider agreement discontinued due to fraud • Have never had any owners, managers or board members who have been disqualified under the criminal background check system • Ensure employees complete all DHS-mandated training applicable to their roles. <p>Consultation services providers are required to employ a lead professional staff member that meets certain education criteria. The lead employee must meet at least one of the following education requirements:</p> <ul style="list-style-type: none"> • Be a doctor of medicine or osteopathy • Be a registered nurse; or • Have a bachelor’s degree or higher in one of the following fields: <ul style="list-style-type: none"> ○ Occupational therapist ○ Physical therapist ○ Psychologist ○ Social worker ○ Speech-language pathologist or audiologist ○ Professional recreation staff ○ Professional dietitian ○ Have a designation as a human services professional • Have at least one year of experience working directly with people who have an intellectual disability or other developmental disability and have a degree in a discipline associated with at least one of the following fields of study: <ul style="list-style-type: none"> ○ Human behavior (e.g., psychology, sociology, speech communication, gerontology, etc.)
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			<ul style="list-style-type: none"> ○ Human skill development (e.g., education, counseling, human development) ○ Humans and their cultural behavior (e.g., anthropology) ○ The human condition (e.g., literature, art) ○ Any other study of services related to basic human care needs (e.g., rehabilitation counseling). <p>Additionally the lead employee must:</p> <ul style="list-style-type: none"> • Be 18 years old or older • Clear a background study as required under Minnesota Statutes, Chapter 245C • Have a minimum of two years of full-time experience in the field of self-direction.
6. Worker training and development worker	N/A	N/A	A person who does worker training and development must have a background relevant to the needed task so they can train to ensure the support worker is competent. (A participant's representative must not be the worker training and development service provider).
7. Financial Management Services contractor	N/A	N/A	<p>DHS contracts with all FMS providers to provide FMS services. DHS determines if FMS providers meet the qualifications through a Request for Proposal (RFP) process at a frequency determined by DHS.</p> <p>All FMS providers shall:</p> <ul style="list-style-type: none"> • Enroll as a Medical Assistance/Minnesota Health Care Programs (MHCP) provider and meet all applicable provider standards and requirements • Comply with background study requirements under Minnesota Statutes, Chapter 245C and maintain documentation of background study requests and results • Successfully complete a readiness review before enrollment, conducted by a participant or organization that meets the qualifications required by the state • Have knowledge of and compliance with Internal Revenue Service (IRS) requirements • Provide services statewide • Meet the requirements under a collective bargaining contract.
Agency provider	N/A	N/A	An agency provider must meet the following qualifications:

			<ul style="list-style-type: none"> Enrolled as a Medical Assistance/Minnesota Health Care Programs (MHCP) provider or enrolled in an MCO network Meet all applicable provider standards and requirements Comply with background study requirements under Minnesota Statutes, chapter 245C and maintain documentation of background study requests and results.
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Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed):*

Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>	Frequency of Verification <i>(Specify):</i>
Support worker	State Medicaid Agency	DHS must check the Office of Inspector General (OIG) exclusion list at enrollment and then monthly thereafter.
Consultation services contractor	State Medicaid Agency	Every 5 years
Financial Management Services contractor	State Medicaid Agency	Every 5 years
CFSS agency-provider	State Medicaid Agency	Every 3 years

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

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

(a) – (b) Any provider who meets the qualifications above may provide CFSS services with the following limitations:

- If a parent(s), stepparent(s), unpaid legal guardian(s) of a participant under age 18 or the participant's spouse works as a person's support worker, they may not provide CFSS in excess of 40 hours per seven-day period.
 - For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
 - Number of parents
 - Combination of parent(s) and spouse
 - Number of children who receive CFSS.
- Paid legal guardians are not allowed to be the support worker, whether the participant is a minor or an adult.

(c) The CFSS budget model allows the participant to choose the provider of support services. This allows the recipient to choose a provider whom:

- They believe best meets their needs
- They feel comfortable working with.

This concept is the hallmark of self-direction. People who choose to receive services through an agency-provider while having a lesser role in the selection of their service provider, still retain a significant role in the selection and dismissal of their support workers.

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

(f) The person-centered assessment accounts for age appropriate dependencies and natural supports. It only authorizes services that exceed those levels. Therefore, all authorized services are extraordinary.

Participant-Direction of Services

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

Election of Participant-Direction. (Select one):

<input type="radio"/>	The state does not offer opportunity for participant-direction of State plan HCBS.
<input checked="" type="checkbox"/>	Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. <i>(Specify criteria):</i>

- 1. Description of Participant-Direction.** *(Provide an overview of the opportunities for participant direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

<p>Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers and obtain other supports and goods as defined in the CFSS service package.</p> <p>Participants will use a financial management services contractor for the billing and payment of services; for ensuring accountability of CFSS funds; for management of spending and to serve as a vendor/fiscal employer agent in order to maintain compliance with employer related duties, including federal and state labor and tax regulations. Participants may use the consultation service for assistance while developing a person-centered service delivery plan and budget and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.</p>
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- 2. Limited Implementation of Participant-Direction.** *(Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

<input checked="" type="checkbox"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
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<input type="radio"/>	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the state affected by this option):</i>

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

Participant-Directed Service	Employer Authority	Budget Authority
Community First Services and Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input checked="" type="checkbox"/>	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

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

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

Termination of services

An agency-provider must provide written notice when it intends to terminate services with a participant at least 30 calendar days before the proposed service termination is to become effective, except in cases where:

- 1) The participant engages in conduct that significantly alters the terms of the CFSS service delivery plan with the agency-provider
- 2) The participant or other persons at the setting where services are being provided engage in conduct that creates an imminent risk of harm to the support worker or other agency-provider staff;
- 3) An emergency or a significant change in the participant's condition occurs within a 24-hour period that results in the participant's service needs exceeding the participant's identified needs in the current CFSS service delivery plan so that the agency-provider cannot safely meet the participant's needs.
 - b) When a participant initiates a request to terminate CFSS services with the agency-provider, the agency-provider must give the participant a written acknowledgment of the participant's service termination request that includes the date the request was received by the agency-provider and the requested date of termination.
 - c) The agency-provider must participate in a coordinated transfer of the participant to a new agency-provider to ensure continuity of care.

Voluntary change

A participant can elect to switch service-delivery models (agency-provider model or budget model) at any time, unless they are not allowed to use the budget model (i.e., the person is on the Minnesota Restricted Recipient Program [MRRP]).

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

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

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

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

If the participant is not on a waiver, DHS is responsible to update the person’s service agreement when they switch models

Involuntary change

If a person who used the budget model is in the MRRP program by DHS/the lead agency, the person must switch to the agency-provider model.

If the participant is not meeting the requirements of the budget model (including the required participant-employer activities) the CFSS consultation service provider must attempt to reeducate the person before the recommendation to remove them from the budget model. If the person is not succeeding as a participant employer (i.e., the budget model), the consultation services provider is responsible to:

- Recommend the lead agency (if the person is on a waiver) or DHS/MCO (if the person is not on a waiver) disallow the person from using the budget model, if necessary
- Help the person switch models if DHS or the lead agency removes them from the budget model.

DHS is responsible to:

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

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

8. Opportunities for Participant-Direction

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

<input type="radio"/>	The state does not offer opportunity for participant-employer authority.
<input type="checkbox"/>	Participants may elect participant-employer Authority (<i>Check each that applies</i>):
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.

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

<input type="radio"/>	The state does not offer opportunity for participants to direct a budget.
<input checked="" type="checkbox"/>	Participants may elect Participant–Budget Authority. Participant-Directed Budget. (<i>Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.</i>): A CFSS service budget amount is based on an objective assessment of the participant’s personal care needs as defined under Minnesota Statutes, Chapter 256B.85, subd. 8. The assessment must be conducted by an assessor according to the criteria established in Minn. Stat., Ch. 256B.0911, subd. 3a. A statistical model is applied to arrive at a total dollar and service amount. Once the total benefit amount is determined, the lead agency develops/tailors a detailed spending plan that meets the person preferences, as established in the service plan. After the assessment is completed, the assessor will provide, by mail or in person, the participant with a written summary outlining their needs for care and options for services and supports, including the total dollar amount for CFSS. The participant works with their consultation services provider to understand how they will use funds. If the participant is on a waiver, the Alternative Care program (AC) or a senior enrolled in managed care, the participant would work with their case manager or care coordinator to finalize their service delivery plan. Participants may use their service budget to: <ul style="list-style-type: none">• Directly employ and pay qualified support workers• Obtain covered goods, as defined under the optional services and supports• Select and pay for financial management services• Purchase backup systems. A person’s budget is recalculated annually at reassessment. The budget also may be recalculated at any time during the year if the person has a change in need. Approval CFSS service delivery plans must be approved by the consultation services provider for participants without a case manager or care coordinator. A case manager or care coordinator must approve the plan for a waiver or alternative care program participant or for a senior who is enrolled in managed care. Consultation services and worker training/development are authorized on a per diem basis and do not count against a participant’s CFSS service budget. The rate for consultation services is up to \$100.00 per session. Each CFSS participant get six consultation services sessions, consisting of a total of up to \$600.00 annually. The six sessions apply for each eligible participant, including when the participant’s authorization is for less than 12 months. The participant, along with the consultation service provider, can request additional

sessions, however. The request must include an explanation for how the previous six sessions were used and justification for why additional sessions are needed..

A separate budget is available to people who employ their own CFSS workers (i.e., CFSS agency or person/representative on budget model). This is used to pay for training, observation, monitoring and coaching of CFSS workers. These activities help CFSS workers expand their skills to support the participant's specific needs.

Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

The consultation service provider works with the participant to develop a person-centered service delivery plan that recognizes risk factors and develops measures/strategies to mitigate them. Risk factors include premature depletion and underutilization of the assessed budget.

Participants who choose to use the budget model will need a fiscal management service (FMS) provider to assist with managing their budget. The FMS will:

- Review the risk mitigation plan and track expenditures accordingly
- Bill and make payments for expenditures
- Maintain records and provide participants with a monthly written summary of the spending for services and supports that were billed against the spending budget
- Work with the participant and the consultation services provider to monitor and mitigate risk.

Quality Improvement Strategy

Quality Measures

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

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

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

Table 1a

<i>Requirement</i>	<i>Service plans address assessed need of 1915(i) participants</i>
<i>Discovery</i>	
Discovery Evidence <i>(Performance Measure)</i>	Percent of agency model participant CFSS service delivery plans that document services to address ADL and IADL domains of assessed need. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS agency model participant plans that document services to ADL and IADL domains of assessed need. ▪ Denominator: Number of agency model CFSS participant plans reviewed.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS will review a representative sample of agency model participant service delivery plans and assess the extent to which participant needs identified at assessment were addressed.

	Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: 8/30 Methodology ¹ within the agency model subpopulation
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze service-plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers’ performance until the issue(s) is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider’s contract.
Frequency (of Analysis and Aggregation)	Annual

Table 1b

Requirement	Service plans: (a)address assessed need of 1915(i) participants
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of budget model CFSS participant service delivery plans that document services to address ADL and IADL domains of assessed need. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS budget model participant plans that document services to address ADL and IADL domains of assessed need. ▪ Denominator: Number of budget model CFSS participant plans reviewed.

¹ 8/30 file review methodology is used by the National Committee for Quality Assurance (NCQA) of health plans in evaluating health plan accreditation. Through this methodology, a random sample of 30 files are selected. Eight files are reviewed for the particular standard. If all eight files meet the standard, then the standard has passed. If fewer than 8 meet the standard, an additional 22 files are reviewed to evaluate the standard.

https://www.ncqa.org/Portals/0/Programs/Accreditation/8_30%20Methodology.pdf?ver=2018-01-10-154243-267

Discovery Activity <i>(Source of Data & sample size)</i>	DHS will review a representative sample of budget model participant service plans and assess the extent to which participant needs identified at assessment were addressed. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: 8/30 methodology within budget model subpopulation
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 1c

Requirement	Service plans address assessed need of 15(i) participants
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who reported that they were satisfied with their CFSS service plan adequately addressing their needs. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who reported satisfaction with their service plan. ▪ Denominator: Number of participants who received CFSS services in the review period.

Discovery Activity <i>(Source of Data & sample size)</i>	DHS directs collection of a participant CFSS satisfaction data annually through a DHS survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: CFSS participants receiving services/supports for at least three months under their current service plan.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze the CFSS participant satisfaction data • Conduct root-cause analysis, investigating situations where participants reported that their service plan is not meeting their needs • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider’s contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 1d

Requirement	<i>Service plans are updated annually</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participant service delivery plans reviewed that are updated annually. <ul style="list-style-type: none"> ▪ Numerator: Number of plans reviewed in which the most recent plan has been updated within the past 12 months. ▪ Denominator: Number of CFSS participants re-evaluated in the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS will review a representative sample of participant service plans, assessing the extent to which service plans were updated annually. Data source: Desk audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: 8/30 methodology

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers’ performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider’s contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 1e

Requirement	Service plan documents choice of services and provider
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS service delivery participant plans reviewed that document the participant’s choice between/among services and providers. <ul style="list-style-type: none"> ▪ Numerator: Number of plans reviewed in which participant choice was documented. ▪ Denominator: Number of CFSS participant plans reviewed during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS will review a representative sample of participant service plans and assess the extent to which a choice of services and provider was offered to the participant and documented. Data source: Desk Audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider. Sample size: 8/30 methodology

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider's contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 2a

Requirement	<i>Eligibility requirements: An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who received a functional assessment that included a determination of medical need. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who received a functional assessment that included a determination of medical need. ▪ Denominator: Number of CFSS participants in the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	Upon request, all people in Minnesota are entitled to a functional assessment. They will be assessed for the needs they have at the time of assessment. DHS reviews MMIS data to determine whether all CFSS participants received a functional assessment that included a determination of medical need. Data source: MMIS Sample size: All CFSS participants

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS is responsible to assure that every CFSS participant received an equitable, person-centered functional assessment that included a determination of medical need. Where this did not occur, DHS will ensure remediation within 30 days.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 2b

Requirement	<i>Eligibility requirements: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of new CFSS recipients with a determination of medical need that included a review of all criteria. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participant records that included a review of all medical need criteria. ▪ Denominator: Number of CFSS participants in the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS monitors the administration of functional assessments. Data source: MMIS Sample size: All CFSS participants
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	

<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>MMIS edits direct CFSS service/support eligibility in alignment with program requirements. For an increasing number of participants, MnCHOICES drives the assessment via a series of rules-driven screens that the assessor completes in sequence. MnCHOICES determines CFSS program eligibility based on assessor responses and CFSS program requirements. The MnCHOICES printout directs the entry of determination data into MMIS.</p> <p>DHS’s appeals process preserves the ability of those receiving assessments to challenge adherence to the processes/application of the instruments in making determinations. Appeals judges direct remediation of due appeals.</p> <p>CFSS program staff monitor trends in appeals that suggest program policies are not being properly implemented or need refining. DHS may address the situation with clarifying technical assistance or policy refinements and other system improvements.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Annual</p>

Table 2c

<p>Requirement</p>	<p><i>Eligibility requirements: The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.</i></p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Percent of CFSS participant reassessments completed annually</p> <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participant reassessments conducted annually. ▪ Denominator: Number of CFSS participant reassessments.
<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>DHS monitors the frequency of the administration of functional assessments.</p> <p>Data source: MMIS</p> <p>Sample size: All CFSS participants</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>State Medicaid Agency</p>
<p>Frequency</p>	<p>Ongoing</p>
<p>Remediation</p>	

Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS: <ul style="list-style-type: none"> Prevents the payment of CFSS services where a recipient has not received an assessment within the previous year. Monitors claims on a continuous basis to confirm MMIS system edit functionality.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 3a

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS claims paid to active CFSS providers. <ul style="list-style-type: none"> Numerator: Number of CFSS claims paid to active CFSS providers. Denominator: Number of all CFSS claims paid during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS reviews all provider applications before approval. It maintains MMIS system edits to ensure that payment is made only to enrolled, active MHCP providers authorized to provide the service(s) for which they have billed. It routinely monitors system functionality with CFSS services. Data source: MMIS Sample size: All CFSS claims paid during the review period
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS: <ul style="list-style-type: none"> Verifies that providers initially and continually meet required certification and other service standards before being approved to deliver CFSS services. Providers that do not meet and maintain required standards will not be authorized to provide CFSS services. Routinely reviews claims reports to assure the ongoing functionality of system edits that prevent non-qualified providers from being approved to deliver CFSS services.

Frequency <i>(of Analysis and Aggregation)</i>	Annual
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Table 3b

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent completion of support worker training directed by the support worker training and development plan of CFSS agency model participants. <ul style="list-style-type: none"> ▪ Numerator: Number of agency model participants for whom support worker training was completed as directed by the support worker training and development plan of CFSS agency model participants. ▪ Denominator: Number of agency model participants for whom support worker training was due to be completed during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS requires CFSS agencies to submit annual reports on the person-centered training activity of CFSS support workers serving agency model participants. Data source: Annual CFSS agency provider reports Sample size: CFSS agency model participants with current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze support worker training reports received from agency CFSS agencies. Where it identifies that a support worker did not complete training as required in the training and development plan, it will review the agency’s plan to assure that the support worker receives the training necessary to meet the participant’s service needs. • Work with CFSS agency providers to assure that the necessary support worker training occurs. • Work with consultation service providers to make any adjustments needed to the service delivery plan, including the support worker’s training and development plan.

	<ul style="list-style-type: none"> Address a pattern of substandard CFSS agency performance through the provision of technical assistance and, where needed, reassessment of the CFSS agency’s enrollment status.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 3c

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent completion of support worker training directed by the support worker training and development plan of CFSS budget model participants. <ul style="list-style-type: none"> Numerator: Number of budget model participants for whom support worker training was completed as directed by the support worker training and development plan. Denominator: Number of budget model participants for whom support worker training was due to be completed during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS requires consultation services providers to submit annual reports on the person-centered training activity of CFSS support workers serving budget model participants. Data source: Annual CFSS consultation services provider reports Sample size: CFSS budget model participants current service plans completed before or within the third quarter of the review year
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> Aggregate and analyze support worker training reports received from consultation services providers. Where it identifies a potential support worker competency issue, it will review the participant’s service plan. Work with consultation services providers to assure that the necessary support worker training occurs and accurate documentation is maintained.

	<ul style="list-style-type: none"> Address a pattern of substandard consultation services provider performance through the provision of technical assistance and, where needed, modification reassessment to the provider’s contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 3d

Requirement	Providers meet required qualifications
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS budget model participants served by support workers determined at performance review to adequately preform job functions. <ul style="list-style-type: none"> Numerator: Number of budget model participants served by support workers determined to adequately perform job functions. Denominator: Number of CFSS budget model participants where support worker performance was evaluated during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS directs collection of a participant CFSS satisfaction data annually through a DHS survey tool administered by consultation services providers. Data source: Annual participant survey Sample size: CFSS budget model participants who receive services/supports for at least three months under their current service plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> Aggregate and analyze the CFSS participant satisfaction data. Conduct root-cause analysis, investigating situations where participants reported that their service plan is not meeting their needs. Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider’s contract.

Frequency <i>(of Analysis and Aggregation)</i>	Annual
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Item 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Community First Services and Supports (CFSS) is a participant-directed method of selecting and providing services and supports. It allows the participant maximum control over the services and supports. CFSS services, by their nature, are individualized and provided in the community, the member’s private home or non-disability-specific setting. CFSS allows full access to the broader community according to a person's needs and preferences. People choose which services and supports they receive and who provides them.

A CFSS service provider cannot own/control the setting:

- The CFSS provider does not have a direct or indirect financial relationship with the property owners in the settings described below. Therefore the nature of the relationship does not affect either the care provided or the financial conditions applicable to tenants.
- CFSS services are not part of the package of services that may be provided by a residential setting. Participants do not need to use a specific CFSS provider in order to live in the residence.

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

DHS will use several strategies at the provider and participant level to assure ongoing compliance with the home and community-based service requirements:

- Support workers complete required person-centered training as part of worker training and development for both the agency and budget models.
- Agency providers complete initial CFSS training, which includes person-centered practices, as well as service- and protection-related rights.
- Consultation service providers:
 - Offer choices to the participant regarding the services and supports they receive and from whom.
 - Document in the person’s service plan which alternative home and community-based settings the person considered.
 - Educate participants on CFSS service expectations and person-centered practices and their service/protection-related rights upon initial orientation and annually upon participant request.
- Participants are surveyed annually on their experience with CFSS services to assure person-centered practices are being followed and their rights are asserted/protected. DHS will use the survey results to trigger remediation at an individual level when a participant’s experience differs from HCBS requirements.

- Agency providers attest to compliance with home and community based services requirements as part of new enrollment (new provider record), re-enrollment (inactive to active) or revalidation every five years (review of enrollment documents of currently active record) as a Medicaid provider.

The following are the CFSS Program Monitoring Metrics cited in the measure tables that assure ongoing compliance with HCBS Settings requirements:

Percent completion of support worker training as directed by the support worker training and development plan of CFSS agency model participants.

Percent completion of support worker training as directed by the support worker training and development plan of CFSS budget model participants.

Percent of CFSS participants who reported that they were satisfied with the training/assistance provided them by consultation services providers in developing their service plan.

Percent of CFSS participants who reported that their consultation services provider informed them adequately of the program’s person-centered practices and their service/protection related rights.

Percent of CFSS participant plans reviewed that document the recipient’s choice between/among services and providers.

Percent of CFSS participants who reported that they were satisfied with their CFSS service delivery plan adequately addressing their needs.

Percent of CFSS participants who reported that their CFSS support worker assisted them in meeting their service goals.

Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection related rights.

Table 5a

<i>Requirement</i>	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who reported that they were satisfied with the training/assistance provided them by consultation services providers toward developing their CFSS service delivery plan. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who reported that they were satisfied with the training provided them toward developing their CFSS service delivery plan. ▪ Denominator: Number of CFSS participants who providing response during the review period.
Discovery Activity <i>(Source of Data &</i>	DHS directs collection of a participant CFSS satisfaction data annually through a DHS survey tool administered by consultation services providers.

<i>sample size)</i>	Data Source: Annual participant survey Sample size: CFSS participants receiving services/supports for at least three months under their current service plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze the CFSS participant satisfaction data. • Conduct root-cause analysis, investigating situations where participants reported that their service plan is not meeting their needs. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5b

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who reported that they were satisfied with their service delivery plan as adequately addressing their health and safety needs. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who reported that their service delivery plan adequately addressed their health and safety needs. ▪ Denominator: Number of participants providing response during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS directs: <ul style="list-style-type: none"> • Annual assessment of the CFSS service plan meeting the participants' health and safety needs as a part of routine reassessment and service planning. • Collection of a participant CFSS satisfaction data annually through a DHS survey tool administered by consultation services providers.

	Data Source: Annual participant survey Sample size: CFSS participants receiving services/supports for at least three months under their current service plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> • Aggregate and analyze the CFSS participant satisfaction data. • Conduct root-cause analysis, investigating situations where participants reported that their service plan is not meeting their needs. • Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. • Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider’s contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5c

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who reported that their consultation services provider adequately informed them of the program’s person-centered practices and their service/protection rights. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who reported that their consultation services provider informed them adequately of the person-centered practices and their service/protection related rights. ▪ Denominator: Number of participants providing response during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS: <ul style="list-style-type: none"> • Monitors the consultation services provider’s provision of person-centered practice and service/protection rights information to CFSS participants.

	<ul style="list-style-type: none"> DHS directs collection of CFSS participant satisfaction data annually through a DHS survey tool administered by consultation services providers. <p>Data Source: Annual participant survey</p> <p>Sample size: CFSS participants receiving services/supports for at least three months under their current service plan</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>DHS will:</p> <ul style="list-style-type: none"> Aggregate and analyze the CFSS participant satisfaction data. Conduct root-cause analysis, investigating situations where participants reported that they received inadequate information involving person-centered practices and/or their service/protection rights. Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider’s contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5d

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Percent of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection related rights.</p> <ul style="list-style-type: none"> Numerator: Number of CFSS participants who reported that their CFSS support worker adequately safeguarded their service/protection related rights. Denominator: Number of participants providing response during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	<p>DHS:</p> <ul style="list-style-type: none"> Monitors the safeguarding of participant service/protection related rights.

	<ul style="list-style-type: none"> Directs collection of a participant CFSS satisfaction data annually through a DHS survey tool administered by consultation services providers. <p>Data Source: Annual participant survey</p> <p>Sample size: CFSS participants receiving services/supports for at least three months under their current service plan</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>DHS will:</p> <ul style="list-style-type: none"> Aggregate and analyze the CFSS participant satisfaction data. Conduct root-cause analysis, investigating situations where participants reported that their support worker is not safeguarding their service/protection related rights. Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to consultation services provider’s contract (budget model) or reassessment of the CFSS agency’s enrollment status (agency model.)
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5e

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Percent of CFSS participants who reported that their support worker helped them meet their service goals.</p> <ul style="list-style-type: none"> Numerator: Number of participants who reported that their CFSS support worker helped them meet their service goals. Denominator: Number of participants providing response during the review period.

Discovery Activity <i>(Source of Data & sample size)</i>	DHS directs: <ul style="list-style-type: none"> Annual assessment of CFSS service plan goal attainment as a part of routine reassessment and service planning. Collection of a participant CFSS satisfaction data annually through a Department survey tool administered by consultation services providers. Data Source: Annual participant survey Sample size: CFSS participants receiving services/supports for at least three months under their current service plan
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Annual
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	DHS will: <ul style="list-style-type: none"> Aggregate and analyze the CFSS participant satisfaction data. Conduct root-cause analysis, investigating situations where participants reported that their service plan is not meeting their needs. Follow up with the consultation services provider to assure that identified programmatic shortfalls have been/are being addressed. Address a pattern of substandard performance through the provision of technical assistance and, where it persists, modification to the provider's contract.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5f

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent difference between the dollar amount encumbered for CFSS services compared to the dollar amount claimed for CFSS services provided to participants. <ul style="list-style-type: none"> Numerator: Dollar amount claimed for CFSS fee-for-service (FFS) services. Denominator: Dollar amount encumbered for CFSS services provided to FFS participants during the review period.

Discovery Activity <i>(Source of Data & sample size)</i>	DHS monitors service delivery through the MMIS service authorization data that compares services claimed (i.e., paid claims) to services authorized (i.e., encumbered services.) Comparing aggregated claimed service dollars to aggregated encumbered service dollars provides a reliable indicator of the extent to which CFSS services are delivered to participants in accordance with their service plans. Data source: MMIS Sample size: All CFSS services authorized during the review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Differences between authorized and claimed services reflect historical patterns. DHS aggregates and analyzes claims and authorization data. Where it detects an uncharacteristically low rate of CFSS service utilization, it conducts root-cause analysis, identifying and implementing program improvements needed.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 5g

Requirement	<i>The SMA retains authority and responsibility for program operations and oversight.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	Percent of CFSS participants who did not file an appeal that progressed to a hearing before an appeals judge. <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participants who did not file an appeal that progressed to a hearing before an appeals judge. ▪ Denominator: Number of CFSS participants during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS monitors CFSS appeals activity. Data source: Community Supports Administration appeals database

	Sample size: CFSS participants who receives services/supports during the review period.
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	The Department maintains an appeals process where appeal judges direct remediation. CFSS program staff monitor appeals activity, including appeals determinations. Where staff detect appeal trends indicating policies are not being properly implemented or need refining, they may addresses the situation by providing clarifying technical assistance or directing policy refinements and/or system improvements.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 6a

Requirement	<i>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	For participants enrolled through FFS, percent of CFSS claims paid for which there is corresponding prior authorization. <ul style="list-style-type: none"> ▪ Numerator: Dollar amount paid for CFSS claims with a corresponding prior authorization, per calendar year. ▪ Denominator: Dollar amount of all paid CFSS claims during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	DHS reviews CFSS claims paid during the reporting period. Data source: MMIS Sample size: All CFSS claims paid during the review period

Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	<p>Claims without prior authorization are rejected. Many potential claims and coding problems are averted through interactive MMIS edits, including edits related to eligibility, screening data, authorization criteria and other provider status. Payment of CFSS claims is made only after alignment of a number of records in MMIS, including all of the following:</p> <ul style="list-style-type: none"> • Service was authorized in the service agreement the lead agency entered into MMIS. (The service agreement includes the rate, time span, units, type of service, and provider for each service to be provided) • A screening document identifies the enrollee to whom services were delivered as CFSS- eligible • The enrollee for whom services were delivered was eligible for Medical Assistance • An active provider number on the claim matches the provider number on the service authorization and corresponds to a provider that is enrolled to deliver this service (category of service) • Services are claimed within service authorization parameters and limits.
Frequency <i>(of Analysis and Aggregation)</i>	Annually

Table 7a

Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Percent of CFSS participant plans reviewed that include an emergency back-up plan.</p> <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS participant files that include an emergency back-up plan. ▪ Denominator: Number of CFSS participant files reviewed during the review period.

<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>DHS will review a representative sample of participant service plans, assessing the extent to which emergency back-up plans are complete. An emergency back-up plan assures a concrete approach to managing unanticipated situations that might otherwise result in maltreatment.</p> <p>Data Source: Desk audit, MMIS MnCHOICES data and participant plans submitted by consultation services provider</p> <p>Sample size: 8/30 Methodology</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>State Medicaid Agency</p>
<p>Frequency</p>	<p>Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>DHS will:</p> <ul style="list-style-type: none"> • Aggregate and analyze service plan audit data. • Work with consultation services providers to achieve remediation of substandard performance within 60 days. Remediation will entail submission of a remediation plan within 30 days. • Review and approve all corrective action plans and will continuously monitor providers’ performance until the issue is resolved. • Address a pattern of substandard performance through the provision of technical assistance and, where needed, modification to the provider’s contract.
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Annual</p>

Table 7b

<p>Requirement</p>	<p><i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i></p>
<p>Discovery</p>	
<p>Discovery Evidence <i>(Performance Measure)</i></p>	<p>Percent of CFSS support workers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters.</p> <ul style="list-style-type: none"> ▪ Numerator: Number of CFSS providers that completed training on child protection, maltreatment of vulnerable adults and responsibilities as mandated reporters.

	<ul style="list-style-type: none"> Denominator: Number of providers approved to deliver CFSS services during the review period.
Discovery Activity <i>(Source of Data & sample size)</i>	<p>DHS reviews the training received by support workers to report suspected maltreatment.</p> <p>Data source: MMIS</p> <p>Sample size: All CFSS support workers approved to deliver services during the reporting period.</p>
Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i>	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Minnesota has established processes for reporting abuse, neglect and exploitation of vulnerable adults and minors. DHS requires all providers that deliver direct care services to CFSS participants to take complete training on how to prevent, recognize and report suspected maltreatment.
Frequency <i>(of Analysis and Aggregation)</i>	Annual

Table 7c

Requirement	<i>The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</i>
Discovery	
Discovery Evidence <i>(Performance Measure)</i>	<p>Percent of reports of maltreatment involving adults that receive CFSS that were submitted to the MAARC and referred to a lead investigative agency (LIA) in a timely manner.</p> <ul style="list-style-type: none"> Numerator: Number of allegations of maltreatment involving adults that receive CFSS that were reported to the MAARC and referred to a LIA within two working days. Denominator: Number of allegations of maltreatment involving adults that receive CFSS that were reported to the MAARC during the review period.

<p>Discovery Activity <i>(Source of Data & sample size)</i></p>	<p>DHS monitors the timely response to reports of alleged maltreatment involving vulnerable adults that receive CFSS services and supports. Data source: SSIS Sample size: All reports of alleged maltreatment involving adults that received CFSS services and supports during the review period.</p>
<p>Monitoring Responsibilities <i>(Agency or entity that conducts discovery activities)</i></p>	<p>State Medicaid Agency</p>
<p>Frequency</p>	<p>Ongoing</p>
<p>Remediation</p>	
<p>Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i></p>	<p>DHS operates the Minnesota Adult Abuse Reporting Center (MAARC). MAARC staff screen reports for immediate risks, referring all cases involving an identified safety issue to county and tribal social services. MAARC immediately forwards reports containing information involving an alleged crime to law enforcement. Within two working days, the MAARC refers all reports to lead investigative agency (LIA) responsible for review and investigation of such reports. It has performance measures and a system of quality review for the MAARC. Identified issues are remediated with system enhancements, coaching and training.</p>
<p>Frequency <i>(of Analysis and Aggregation)</i></p>	<p>Annually</p>

System Improvement

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

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

DHS routinely will analyze CFSS program process data and the response data amassed through annual CFSS participant surveys. CFSS participant satisfaction data. Complimentary analysis measures the extent to which key functions assigned to program providers occurred and the extent to which they were effective in maximizing participant independence, safeguarding participant health and safety, and assisting the participant in meeting his/her goals. Performance trends will identify the need for further analysis, prioritizing improvement initiatives based on analytic findings and the opportunity for targeted intervention.

2. Roles and Responsibilities

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

3. Frequency

DHS will review and analyze program process and outcome data on an ongoing basis. Policy staff will meet quarterly with the CFSS Implementation Council to review and assess findings, contemplating program improvement initiatives where applicable.

4. Method for Evaluating Effectiveness of System Changes

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

State: MINNESOTA

<p>All services listed in Attachments 3.1-A, 3.1-B, 3.1-i, <u>3.1-i.A, and 3.1-k</u> are included, with the following exceptions:</p> <ul style="list-style-type: none"> • Abortions • Child welfare targeted case management • Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults, adults with developmental disabilities or related conditions, or adults without a permanent residence. • Services provided pursuant to an individualized education plan (IEP) or individual family service plan (IFSP). • Nursing facility services • Relocation coordination services • Officer-involved, community-based care coordination. • FQHC services • Services provided by an IHS or 638 facility. <p><u>For managed care plans for the elderly, all services listed in Attachments 3.1-i.A and 3.1-k are included.</u></p>	<p>3.1-A, 3.1-B, 3.1-i, <u>3.1-i.A,</u> <u>3.1-k</u></p>		
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1932(a)(5)(D)(b)(4) J. The state assures that each MCO has established an internal grievance and

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<input type="checkbox"/>	HCBS Case Management						
<input type="checkbox"/>	HCBS Homemaker						
<input type="checkbox"/>	HCBS Home Health Aide						
<input checked="" type="checkbox"/>	HCBS Personal Care						
<p>Payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized in the participant’s approved service allocation:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 10px 2px 20px;">Personal Care 1:1 unit</td> <td style="padding: 2px 10px 2px 20px; text-align: right;">\$4.78</td> </tr> <tr> <td style="padding: 2px 10px 2px 20px;">Personal Care 1:2 unit</td> <td style="padding: 2px 10px 2px 20px; text-align: right;">\$3.59</td> </tr> <tr> <td style="padding: 2px 10px 2px 20px;">Personal Care 1:3 unit</td> <td style="padding: 2px 10px 2px 20px; text-align: right;">\$3.15</td> </tr> </table> <p>NOTE: One unit is equal to 15 minutes.</p> <p>Participants receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above.</p> <p>Shared care: For two participants sharing services, payment is one and one-half times the payment for serving one participant. For three participants sharing services, payment must not exceed two times the payment for serving one participant. This paragraph applies only to situations in which all participants were present and received shared services on the date for which the service is billed.</p> <p>Direct staffing wage costs were the main driver of rates. The rate methodology consisted of:</p> <ul style="list-style-type: none"> • A base wage index was established using Minnesota-specific wages taken from job descriptions and standard occupational classification codes from the BLS Occupational Handbook. 		Personal Care 1:1 unit	\$4.78	Personal Care 1:2 unit	\$3.59	Personal Care 1:3 unit	\$3.15
Personal Care 1:1 unit	\$4.78						
Personal Care 1:2 unit	\$3.59						
Personal Care 1:3 unit	\$3.15						

- A competitive workforce factor multiplier was applied to the direct staffing wage to address the difference in average wages for direct care staff and other occupations with similar education, training, and experience requirements, as identified by the BLS Occupational Handbook.
- The average wages were adjusted to differentiate between shared and individual staffing.
- Shared staffing was taken into account, when staff are available to provide services to more than 1 person and individual staffing, when direct care staff are available to solely provide support as a 1-to-1 interaction with a specific individual.
- These wage expenses are multiplied by factors for relief staffing, ancillary staff needs, employee-related taxes and benefits, and client programming.

Budget Model:

Under the budget model, an amount equal to the participant’s authorized service units multiplied by the amount listed above for a 1:1 unit (@ \$4.78), is authorized for use by the participant.

An enhanced rate of 107.5 percent of the rate paid for CFSS must be paid for services provided to persons who qualify for ten or more hours of CFSS per day when provided by a support worker who meets the training requirements.

<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input type="checkbox"/>	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)

X	Other Services (specify below)
	<p>Consultation Services: The rate for consultation services is up to \$100.00 per session. Each CFSS participant will be authorized 6 (six) Consultation Services sessions, consisting of a total of up to \$600.00 annually. The 6 (six) sessions are granted for each eligible participant including when the participant’s authorization is for less than 12 months. The participant along with the Consultation Service provider can request additional sessions from DHS. The request will be required to include justification to how the previous 6 (six) sessions were used and what the need is for the additional sessions.</p>
	<p>Back-up systems: Personal emergency response systems include three parts. Each part has its own limit per service agreement year:</p> <ul style="list-style-type: none">• Purchase of the PERS equipment, including necessary training or instruction on use of the equipment (\$1,500 maximum)• Installation, setup and testing of the PERS equipment (\$500 maximum)• Monthly monitoring fees (\$110 monthly maximum). <p>The CFSS participant may receive up to \$3,000 total of personal emergency response equipment and related services per service agreement year.</p>
	<p>Worker Training and Development: The budget for worker training and development is up to \$ 1,124.16 annually.</p>