Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

December 2021

v1.0

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Application for Section 1915(b) (4) Waiver
Fee-for-Service (FFS) Selective Contracting Program

Facesheet

The **State** of Minnesota requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Case Management Waiver (List each program name if the waiver authorizes more than one program.).

Type of request. This is:
___ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
_x_ a renewal request

Section A is:
_ _ replaced in full
___ carried over with no changes
_x_ changes noted in **BOLD**.

Section B is:
_x_ replaced in full
__ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of __5__ years beginning April 1, 2022 and ending March 31, 2027.

State Contact: The State contact person for this waiver is Jan Kooistra and can be reached by e-mail at jan.kooistra@state.mn.us. (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally-recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

State Response: On November 29, 2021, a letter, along with a copy of the proposed waiver renewal application, was sent via email to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic requesting their comment on the Minnesota Department of Human Service's intent to submit a request to the Centers for Medicare & Medicaid Services for a renewal of the 1915(b) Case Management waiver. A copy of the November 29, 2021 notice to Tribal officials is provided at Attachment A.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

State Response: Minnesota administers many health and human services programs through its county and tribal nation human service agencies. This includes established infrastructures for such things as adult and child protection, as well as provider recruitment and licensing. Counties have delegated responsibilities for certain administrative activities such as Medicaid eligibility and utilization review. Counties also have access to state computer systems for purposes of completing assessments, determining eligibility and authorizing waiver services.

MnChoices is a comprehensive online application that integrates assessment and support planning for people who need long-term services and supports. The MnChoices application also incorporates other processes including rate determination for services and a tool to gather feedback on the person's satisfaction with services. It uses an electronic rules-based system which ensures consistency and equity while providing data to analyze impact, inform policy decisions and maintain federal approval of waiver funds.

MnChoices implementation was deployed in phases to allow lead agencies time to train staff, reorganize their departments, and build staff capacity. This project is moving into its final phase. During this phase, the legacy assessment will be eliminated and all future reassessments will be completed in MnChoices.

Counties, and tribes under contract, are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services.

Restricting case management in the §1915(c) waiver to counties and tribes under contract with DHS is a core component of Minnesota's waiver programs because counties have existing service infrastructure, knowledge of local resources, proximity to enrollees and providers to arrange and monitor services, and the ability to provide continuity as the sole entity responsible for all aspects of case management (i.e., administrative activities and waiver case management services).

Through this selective contracting arrangement with counties and tribes, communication is streamlined and duplication minimized for enrollees, because one entity is responsible for all aspects of case management (i.e., administrative activities and waiver case management services). For example, administrative activities carried out by counties such as data entry and service agreements are closely associated with and sometimes inextricably linked to waiver case management services.

The case management waiver was initially approved effective January 1, 2007 and expired on December 31, 2008. From January 1, 2007 to June 31, 2007, the waiver applied only to case management services covered under the Brain Injury (BI) waiver. An amendment, effective July 1, 2007, expanded the waiver authority to case management services covered under all of Minnesota's Section 1915(c) home and community-based waiver programs. The waiver applies only to enrollees whose waiver services are covered fee-for-service and who receive services under one of the following Section 1915(c) home and community-based (HCBS) waiver programs:

- Developmental Disabilities Waiver (DD)
- Elderly Waiver (EW)
- Community Access for Disability Inclusion (CADI)
- Brain Injury Waiver (BI)
- Community Alternative Care (CAC)

The current case management waiver was approved effective April 1, 2017 and expires on March 31, 2022. A request to renew the waiver was submitted to CMS in January 2022.

The following table shows the average monthly persons served by state fiscal year (SFY) in each of the home and community based services (HCBS) waiver programs.

Home and Community Based Services (HCBS) Waivers
Average Monthly Persons Served

	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21(est)
BI	1,301	1,239	1,190	1,141	1,104	1,099
CAC	394	443	502	548	605	669
CADI	19,936	22,598	24,934	27,009	29,493	32,521
DD	16,606	17,498	18,615	19,777	20,817	22,089
EW	23,300	24,195	25,222	26,099	27,037	29,111
Total	61,537	65,937	70,463	74,574	79,056	85,489

*Includes §1915(c) waiver enrollees whose waiver services are covered fee-for-service.

Waiver Services:
Please list all existing State Plan services the State will provide through this selective contracting waiver.

Case management services authorized through the following HCBS §1915(c) waivers:

- Developmental Disabilities (DD) Waiver, CMS control number 0061
- Elderly Waiver (EW), CMS control number 0025
- Community Access for Disability Inclusion (CADI), CMS control number 0166
- Brain Injury Waiver (BI), CMS control number 4169
- Community Alternative Care (CAC), CMS control number 4128

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _x_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c._x_ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   __ the same as stipulated in the State Plan
   _x_ is different than stipulated in the State Plan (please describe)

   Case management is a waiver service that is billed in 15 minute unit increments. The Minnesota State Legislature can authorize rate changes for waiver services for continuing care providers. Case management services under the 1915(c) waivers are not paid the same rate as the targeted case management (TCM) services under the state plan.

2. **Procurement**. The State will select the contractor in the following manner:

   ___ **Competitive** procurement

___ **Open** cooperative procurement
___ **Sole source** procurement
_x_ **Other** (please describe)

State Response: Minnesota has a county-based infrastructure for case management services. State law specifies that counties or tribes provide case management services (see Minnesota Statutes, section 256B.49, subdivision13 and section 256S, subdivision 1. All counties are enrolled providers and have a Medicaid provider agreement with DHS.

Federally recognized tribes who contract with DHS may also provide case management services. The tribes must be enrolled providers and have a Medicaid provider agreement with DHS.

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_x _ Beneficiaries will be limited to a single provider in their service area.
__ Beneficiaries will be given a choice of providers in their service area.

Waiver participants are limited to using a single provider in their service area, referred to as the lead agency, (which may be a tribal or county entity or an entity contracted with the lead agency as the provider of case management services). Lead agencies can contract with multiple case management providers and are required under Minnesota Statutes, section 256B.0911, subdivision 3a, paragraph (e), clause (2) and Minnesota Statutes, section 256B.49, subdivision 13, paragraph (a), clause (3) to provide a different case manager upon request. Minnesota Statutes, section 256S.09, subdivision 1 allows eligible recipients choice among any qualified provider of case management services within the agency. The waiver program operates statewide.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

2. **State Standards.**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

Case management is a service that assists participants in gaining access to waiver and state plan services, as well as medical, social, educational and other necessary services, regardless of the funding source for such services. In accordance with 42 C.F.R.part 441.301(c) the case manager or case aide shall not have a personal financial interest in the services provided to the participant. Minnesota Statutes, section 256B.092,

subdivision 1a, paragraph (c), section 256B.49, subdivision 13, paragraph (c) and section 256S.08, subdivision 1 prohibit the provision of case management services to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's support plan. Duplicate payments will not be made for case management services to the same participant by more than one provider.

Case managers shall initiate and oversee the process of reassessment of the participant's level of care.

All lead agencies are now using MnCHOICES for initial assessments. In January, 2017, MnCHOICES began implementation statewide for reassessments. DHS is working with lead agencies on a timeline for all reassessments to be completed in MnCHOICES.

Counties, and tribes under contract, are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services.

Case managers are responsible for ongoing monitoring of the provision of services included in the participant's Support Plan. Case managers are required to conduct a face-to-face visit with participants a minimum number of times. For the EW program, participants must receive a face-to-face visit at least once every 12 months. CAC, CADI, DD and BI participants must receive a minimum of two face-to-face visits every 12 months. The participant's annual reevaluation may be counted as one face-to-face contact. Case aides shall perform only administrative tasks delegated and supervised by the case manager that do not involve professional expertise or judgment (e.g., case filing, contacts to vendors to schedule services, phone contacts). Case aides shall not conduct participant assessments, reassessments, or service plan development. Case aides must understand, respect and maintain confidentiality in regard to all details of their work.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
_x_ Blind/Disabled Adults and Related Populations
_x_ Blind/Disabled Children and Related Populations
_x_ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children

State Response: This §1915(b)(4) waiver applies only to §1915(c) waiver enrollees whose waiver services are covered fee-for-service.

This waiver operates concurrently with the following HCBS §1915(c) waivers:

- Developmental Disabilities (DD) Waiver, CMS control number 0061
- Elderly Waiver (EW), CMS control number 0025
- Community Access for Disability Inclusion (CADI), CMS control number 0166
- Brain Injury Waiver (BI), CMS control number 4169
- Community Alternative Care (CAC), CMS control number 4128

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_x__ Other (Please define):

This waiver does not apply to §1915(c) waiver enrollees whose waiver services are covered through managed care organizations.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

State Clarification: The case management service and provider standards are described in Appendix C of the §1915(c) waivers.

1. DHS measures timeliness of beneficiary access to services in the following ways:

a. Minnesota's Medicaid Management Information System (MMIS)
Case management is a required service for all enrollees in Minnesota's HCBS waiver programs. DHS monitors access to case management through claims data collected in MMIS. All HCBS waiver services, including case management, are authorized in the form of a service agreement with an enrollee that is entered into MMIS. Each service agreement includes the identification number of the enrollee's case manager. The authorization of services is based on a comprehensive, individualized assessment of need and the service plan to address those needs. Case managers are required under Minnesota Statutes, sections 256S, 256B.49 and 256B.092 to reevaluate enrollee needs, assist in planning and arranging services, and authorize and monitor services. The amount of case management included in a service plan is based on the enrollee's needs and the level of involvement the enrollee wishes the case manager to have in his or her support plan implementation.

b. Lead Agency Reviews.
In accordance with the State's approved HCBS waivers, DHS conducts onsite reviews of counties and tribes to monitor their compliance with HCBS waiver policies and procedures and to evaluate how the programs are meeting local needs. ~~At the conclusion~~ Upon completion of a review DHS issues a summary report with recommendations for program improvements (i.e., sharing best practice ideas) and, if needed, corrective actions. DHS issues corrective actions if the county or tribe is found to have a pattern of non-compliance with state waiver policies and procedures. The county or tribe is then required to submit a corrective action plan to DHS within 10 days of receiving the final report. The county or tribe is also required to bring all cases deemed out of compliance into full compliance within 60 days of the original site visit.

DHS is currently halfway through the fourth round of HCBS lead agency reviews (44 of the 90 lead agencies reviewed as of June 30, 2021). Note: This review process was previously referred to as the "waiver site reviews" and/or the "waiver review initiative" in previous CMS waiver submissions.

c. HCBS Assurance Plans and MMIS
DHS also ensures access to case management services through regular monitoring of lead agencies through HCBS Assurance Plans and MMIS subsystems. Counties and tribes are required to complete a survey that includes a HCBS Assurance attestation (previously referred to as the Quality Assurance Plan Survey) to DHS as part of the lead agency review activities prior to a site review. This occurs every four years. The ~~plan~~ survey is a self-assessment of compliance with waiver policies and procedures, some of which directly apply to case management activities. Our MMIS design supports HCBS waiver policies and procedures, including those related to case management. DHS uses data from MMIS to monitor case management activities. DHS reports on the HCBS Assurance Plans and MMIS subsystems in accordance with the §1915(c) waiver requirements.

2. DHS provides the following remedies in the event that Medicaid beneficiaries are unable to access services in a timely fashion:

Remediation and Corrective Action Plans

a. During the HCBS lead agency reviews, staff review a sample of client files and documentation to evaluate the frequency of face-to-face contacts with enrollees. Counties that do not have documentation to show compliance with the required number of face-to-face visits are identified as not meeting the required standard. Information from the case file reviews, which includes ~~this~~ visitation frequency and other measures, is maintained in a database. This measure does not include phone or other contacts that may be made on behalf of the enrollee or client visits that are not documented by the case manager. If any of the client files reviewed in the sample during the site review do not meet the requirements for face-to-face contacts, the county or tribe is required to remediate the issue by visiting those clients within 60 days of the site visit.

If a county or tribe is found to have a pattern of non-compliance with the visit requirements, a corrective action is issued in a report and the county or tribe must submit a corrective action plan within 10 business days of its final report being issued. This plan will show the steps the county or tribe will take to improve its practices and ensure that case managers are completing the required visits for all clients in the future. The plan may include additional training, adjusting case load sizes, and/or setting up a system to monitor the visits.

DHS has not encountered any difficulties collecting the corrective action plans from lead agencies or ensuring that lead agencies remediate issues with client visits. DHS review staff maintain regular communication with lead agency representatives to ensure that both requirements are promptly met. As of date, the compliance rate for both the submission of corrective action plans and case file remediation is 100 percent. If a case is closed within 60 days of the site visit (e.g. change in county of financial responsibility or death), remediation by country or tribe is not required.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

State Response:

1. State law requires that all 87 counties provide case management services to §1915(c) waiver enrollees. To manage staff capacity and workload issues, counties and tribal lead agencies may subcontract with qualified private vendors for case management services. State law also allows federally recognized tribal lead agencies to contract with DHS to provide case management services. Members of these tribes may choose to receive case management through their tribe or the county. Currently, three tribes provide case management services under contracts with the state. They include Red Lake, White Earth and Leech Lake.

2. DHS monitors the number of enrollees receiving case management through MMIS data. DHS uses the lead agency review process, as described in the state's response to Part II, question A, to monitor and evaluate access to case management, compliance with program requirements, and the quality of the service received, including lead agency use of person-centered practices. Case management service and provider standards under Minnesota Statutes, section 256B.092, subdivision 1a and section 256S.08 are described in Appendix C of the §1915(c) waivers.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

DHS monitors beneficiary utilization of the case management program through MMIS. DHS uses MMIS claims data to measure the hours of waiver case management provided. This data is used to determine the average amount of waiver case management received annually per enrollee. The data includes enrollees who are covered fee-for-service in an HCBS waiver.

DHS uses a 12-month period because utilization of case management by enrollees varies from month to month. For enrollees who elect consumer-directed services and supports (CDCS), we include the amount of case management provided by counties. This includes such things as conducting reevaluations and authorizing services. Enrollees using CDCS may also receive supports akin to case management from entities that are not county agencies. These supports may include assistance in developing a service plan, arranging for or scheduling services, or other case management related services.

The data show that on average 22.2 hours of case management were provided per member, per year in fiscal year 2019. The data also show that on average 22.4 hours of case management were provided per member, per year in fiscal year 2020. The table below shows the averages separately by waiver. We expect some variation in the amount of case management between waivers related to such things as the target population served by the waiver and their related level of care. For example, the waivers that serve people at risk of hospital level of care (BI and CAC) show higher amounts of case management compared to the waivers that serve people at risk of nursing facility level of care (CADI and EW).

	BI	CADI	DD	EW	CAC	TOTAL
Average number of hours FY 2019	29.3	22.45	24.2	9.9	21.8	22.2
Number of enrollees for FY 2019	1,236	31,328	21,014	5,220	644	59,145
Average number of hours for FY 2020	29.4	22.9	23.9	10.55	23.1	22.4
Number of enrollees for FY2020	1,167	34,177	22,027	5,306	700	63,094

Remedies include:

1) Fair Hearings.

Annually and when there is an increase, decrease, suspension or termination of service, HCBS waiver enrollees receive information about their right to a fair hearing and instructions for requesting a hearing. The Appeals and Regulations Division of DHS maintains data regarding appeals in a central database. Waiver staff review fair hearing requests in resolving individual issues and tracking patterns and trends for waiver appeals. The waiver policy areas report on activity with respect to appeals both to CMS and the state legislature.

2) Lead Agency Reviews. In Part II, Item A, we described the lead agency reviews. Compliance with many requirements is monitored during the on-site reviews and the information is maintained in a database. Corrective actions are issued if the county or tribe being reviewed is found to have a pattern of non-compliance with waiver policies and procedures. The county or tribe is then required to submit a corrective action plan.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.
        ii. Take(s) corrective action if there is a failure to comply.

State Response: In Part II, Item C, we noted that DHS monitors participants' access to waiver services through fair hearings, MMIS data, and lead agency reviews. Further review and analysis of compliance with quality standards occurs through the following:

1) Lead Agency Reviews

Data collected
During a lead agency review, DHS representatives review a sample of client files to evaluate the frequency of face-to-face contacts with enrollees. Counties or tribes that do not have documentation of a face-to-face visit are identified as not meeting the required standard. DHS has conducted on-site reviews in all of Minnesota's 87 counties and 3 tribes that administer HCBS waiver programs from 2015 to 2021. Lead agency reviews are continuous and ongoing. They occur approximately every four years per agency. If a corrective action had been issued based on the information gathered during a site visit, the county or tribe is responsible for developing and implementing a corrective action plan and ensuring that ~~it~~ the plan results in a compliant practice. DHS formally reviews compliance with the corrective action plan during future site visits. Please also refer to Attachment B for a copy of Appendix H: Quality Improvement Strategy for the 1915(c) waivers.

All lead agencies are asked to self-report the status of any corrective action plans 18 months after the site visit. Approximately 18 months after the site visit, DHS follows-up with a survey that asks the lead agency to report on several things, including progress on their corrective action plans. DHS asks if the lead agency is now in compliance with the issues identified in their corrective action plan and what techniques it uses for ongoing monitoring. If the lead agency has not demonstrated progress, DHS requires the lead agency to submit an updated corrective action plan.

DHS follows up and closely monitors lead agencies with programs that appear to be struggling to comply with quality standards. If a lead agency is found to have an excessive number of corrective actions and/or is unable to bring problem performance areas into compliance after several years, DHS will conduct a condensed site visit and case file review one year after the formal review.

Information from case file reviews is maintained in a database. We use the "frequency of case manager face-to-face contact" as a measure to monitor access to case management. The results are based on an unduplicated count of enrollees. This measure does not include phone or other contacts that may be made on behalf of the enrollee or visits that are not formally documented.

Please refer to Part II. A. Timely Access Standards for a more detailed description of the corrective action plan process.

Analysis

Below is data collected from the lead agency reviews through the end of state fiscal year 2021 (June 30, 2021).

Round I: From May 2006 to April 2012, all 87 counties and two tribes that administer HCBS waiver programs were reviewed. The summary information shows that 91.3% of enrollees included in the sample were visited by a case manager at least once during the year, while 76% were visited by a case manager at least every six months. Overall, 84% of enrollees included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. In 8.8% of cases reviewed, the findings were coded as indeterminate. Indeterminate is used, for example, to code cases in which the person has been enrolled on the waiver for less than one year. For counties with patterns of non-compliance for face-to-face visit requirements, a corrective action was issued.

Round II: From July 2012 to May 2015, all 87 counties and two tribes that administer HCBS waiver programs were reviewed. The frequency of case manager contacts was again collected. The summary information shows that 94.4% of enrollees included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. DHS followed up with all counties who had cases out of compliance at the time of the review, and 100% of cases were brought into compliance. In many cases, case managers are visiting participants more often than is required by the waiver program. The average number of visits within an 18-month period across all waivers was 3.9.

Round III: From August 2015 to November 2018, all 87 counties and three tribes that administer HCBS waiver programs were reviewed. The frequency of case manager contacts was again collected. The summary information shows that 95% of enrollees included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. DHS followed up with all counties and tribes who had cases out of compliance at the time of review, and 100% of all the cases were brought to compliance. The average number of visits within an 18-month period across all waiver programs was 4.2.

Round IV: DHS is currently halfway through Round IV reviews of lead agencies. From April 2019 to June 2021, 44 lead agencies were reviewed. The frequency of case manager contacts continued to be monitored and collected. The summary information shows that 98% of enrollees included in the sample were visited by a case manager in accordance with the applicable waiver program requirements. DHS followed up with all counties and tribes who had cases out of compliance at the time of review, and 100% of all the cases were brought into compliance. The average number of visits within an 18-month period across all waiver programs was 3.6.

System Improvements

The DHS Continuing Care for Older Adults and Community Supports Administration's Quality Essentials Team (QET) provides ongoing monitoring of lead agency review data and quality performance measures. It evaluates trends and emerging issues, employing a variety of improvement strategies (e.g., policy refinements, tool development) where needed. It evaluates improvement efforts and tracks the extent of remediation required of lead agencies. These initiatives are reviewed by CMS as part of the HCBS quality review and renewal process.

CMS's current quality assurance benchmark is set at a compliance threshold of 86 percent. Of the 21 items in general case files reviewed for technical compliance, three items fell below the 86 percent compliance benchmark. This was after data for all six HCBS programs was aggregated statewide for Round IV. They are: the ICF/DD Related Condition Checklist, timeliness between assessment and support plan and the needs that were identified in the assessment/screening process are documented in the support plan.

ICF/DD Related Condition Checklist

Overall, 24 percent of all case files reviewed between April 2019 through June 2021 did not contain this information. The following is an example of the corrective action issued to each county or tribe found to be out of compliance with this item: *Ensure that case files include the current "Related Condition Checklist" for all people on the DD waiver with a related condition. This is a requirement of Minnesota Rules, part 9525.0016. XX percent of cases for the developmentally disabled with a related condition did not have the required documentation. This form is used to confirm eligibility for case management for a person with a condition related to developmental disability and it must be completed annually.*

Timelines between assessment and support plan

The criteria for this item was refined in Round IV to evaluate the timeliness between assessment and support plan. Overall, 31 percent of all case files sampled between April 2019 and June 2021 did not meet the timeline requirements. The following is an example of the corrective action issued to each county or tribe that is found to be out of compliance with this item: *Per Minnesota Statutes, section 256B.0911, subdivision 3a (e) the certified assessor and the individual responsible for developing the coordinated service and support plan must complete the community support plan and coordinated services and support plan no more than 60 calendar days from the assessment visit or Eligibility Update. XX percent of case files reviewed were not compliant with the required timeline between assessment and support plan.*

Needs identified in the assessment/screening process are documented in the support plan

Overall, 22 percent of case files sampled between April 2019 and June 2021 did not contain this information. This is an area that continues to perform below the compliance standard set by CMS. The following is an example of the corrective action issued to each county or tribe that is found to be out of compliance with this item: *Minnesota Statutes, section 256.0911, subdivision 3a (g) (1) requires that the written community support plan include a summary of assessed needs identified during the assessment/screening. XX percent of cases reviewed did not document a person's assessed needs within the support plan.*

2) MMIS Case management services covered by HCBS waivers are authorized in MMIS. The authorization is based on a comprehensive and individualized assessment of need and the service plan developed to address those needs. Case managers are required by law to provide reevaluations, assist in planning and arranging services, authorize needed services and monitor the services being provided. The amount of additional case management included in a service plan is determined based on the enrollee's needs and the level of involvement the enrollee wishes the case manager to have. DHS monitors access to case management through claims data.

3) Fair Hearings

Data collected

The Appeals and Regulation's Division of DHS maintains a database of fair hearing requests that have been filed by waiver participants. The database captures information that includes the data of filing, appeal issue, all subsequent actions, dates of action, and the final disposition of the appeal. Disability Services Division staff review fair hearing requests in resolving individual issues and tracking waiver appeal patterns and trends involving the BI, CAC, CADI, and DD waivers. The Aging and Adult Services Division reviews fair hearings involving the EW waiver.

Analysis

Review and analysis of the disability waiver and the elderly waiver appeals data indicate that there were no adjudicated fair hearing requests filed that identified a case management issue. Thus, there are no trends involving case management-related challenges to report.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

State Response: Minnesota administers many health and human services programs through its county human service agencies. This includes established infrastructures for such things as adult and child protection, and provider recruitment and licensing. Counties have delegated responsibilities for certain administrative activities such as Medicaid eligibility and utilization review. Counties also have access to state computer systems for purposes of determining eligibility and authorizing waiver services.

Tribes under contract and counties are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services. Counties and tribes are also expected to manage spending for waiver services.

Restricting case management in the §1915(c) waiver to counties and tribes under contract with DHS utilizes the existing service infrastructure, knowledge of local resources, proximity to enrollees and providers to arrange and monitor services, and the continuity of one entity being responsible for all aspects of case management (i.e., administrative activities and waiver case management services).

Administrative activities carried out by counties and tribes are closely associated with and sometimes inextricably linked to waiver case management services. Dividing these functions between counties or tribes and an unlimited number of non-lead agency providers under our current case management structure would cause duplication and increase costs to the program.

As provided in Part II, Item C, DHS monitors participants' access to waiver services through lead agency review data, MMIS claims, and fair hearings.

1) Lead Agency Reviews. Site reviews have been conducted in all 87 counties and three tribes that administered HCBS waiver programs from 2006 to 2021. The lead agency reviews now occur once every four years with the fourth round of waiver reviews now underway. Data on the frequency of case manager face to face contacts continues to be collected.

2) MMIS. Case management services covered by HCBS waivers are authorized in MMIS. The authorization is based on a comprehensive and individualized assessment of need and the service plan to address those needs. Case managers are required by law to provide reevaluations, assist in planning and arranging services, and authorize needed services and

monitor the services being provided. The amount of additional case management included in a service plan is determined based on the enrollee's needs and the level of involvement the enrollee wishes the case manager to have. DHS monitors access to case management via claims data.

3) Fair Hearings. When a fair hearing involves an HCBS waiver the Appeals and Regulations Division forwards the request to the applicable policy division. Staff from the waiver policy divisions review fair hearing requests concerning HCBS waivers to monitor for trends and patterns, and identify case issues that may require follow-up. The Disabilities Services Division of DHS reviews fair hearings related to the DD, CADI, TBI, and CAC waivers. The Aging and Adult Services Division of DHS reviews fair hearings related to the EW.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

State Response: Waiver enrollees receive information about fair hearing rights when they are enrolled in Medicaid, are assessed for HCBS waiver services, receive their Support Plan, or experience a denial or termination or reduction in benefits. If enrollees are concerned with their waiver case management services, they may request a fair hearing. Participants will be informed of what choices they have among case managers within the county or tribe at the time of enrollment. The DHS public web site at Health Care Waivers provides the public with information about Medicaid waivers in Minnesota, including the case management 1915(b)(4) waiver. The website is updated on a regular basis and includes information about new waiver requests and proposed renewals. The page includes links to copies of waiver applications and approval documents.

On November 29, 2021 an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the proposed waiver renewal and the opportunity to provide comment and directing them to the Health Care Waivers web page. A second email will be sent to provide notice of any federal decision related to the State's request for approval.

B. Individuals with Special Needs.

___ The State has special processes in place for persons with special needs (Please provide detail).

State Response: This waiver operates concurrently with the §1915(c) waivers listed in Part I, Item D.

Participants who are enrolled in these waiver programs all meet an institutional level of care. A requirement of the waivers is that an individual, person-centered Support Plan be developed for each participant. This plan lists the services that are necessary to meet the needs identified in the participant's assessment that directly benefit the participant and support them in community-based living.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

Minnesota administers many health and human services programs through its county human service agencies. This includes established infrastructures for such things as adult and child protection, as well as provider recruitment and licensing. Counties have delegated responsibilities for certain administrative activities such as Medicaid eligibility and utilization review. Counties and tribes under contract with DHS also have access to state computer systems for purposes of determining eligibility and authorizing waiver services.

Tribes, under contract with DHS, and counties are responsible for §1915(c) waiver eligibility determinations, level of care evaluations and reevaluations, needs assessments, and authorization and monitoring of waiver services.

Restricting case management in the §1915(c) waiver to counties and tribes under contract with DHS is a component of Minnesota's waiver programs. Counties and tribes have existing service infrastructure and knowledge of local resources. Their proximity to enrollees and providers allows them to arrange and monitor services and provide continuity in all aspects of case management (i.e., administrative activities and waiver case management services).

Through the use of counties and tribes as lead agencies for the provision of case management, communication is streamlined and duplication minimized. Administrative activities carried out by counties and tribes are closely associated with and sometimes inextricably linked to waiver case management services.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from: 4/1/2022 to 3/31/2023

Trend rate from current expenditures (or historical figures): 4.32 %

Projected pre-waiver cost	_	
Projected Waiver cost	_	$187,143,930
Difference:	_	

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment C for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated based on both the Medical Assistance service total expenditures and on the actual caseload per member, per month (PMPM) projections for the five-year period. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the

course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost effectiveness projections.

P1 Aggregate PMPM $226.75

P1 PMPM-Projected Waiver Costs by MEG
BI 241.32
CADI 238.95
DD 211.13
CAC 228.12
EW 184.89

Year 2 from: 4/1/2023 to 3/31/2024

Trend rate from current expenditures (or historical figures): 4.32 %

Projected pre-waiver cost _
Projected Waiver cost _ $211,119,610
Difference: __

Please refer to the Case Management Waiver Cost Effectiveness spreadsheet at Attachment C for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated based on both the Medical Assistance service total expenditures and on the actual caseload per member, per month (PMPM) projections for the five-year period. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost effectiveness projections.

P2 Aggregate PMPM $236.53

P2 PMPM-Projected Waiver Costs by MEG
BI 241.69
CADI 249.28
DD 219.52
CAC 235.75
EW 193.26

Year 3 (if applicable) from: 4/1/2024 to 3/31/2025
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 4.32%

Projected pre-waiver cost _____
Projected Waiver cost _____ $238,364,872

Difference: _____

Please refer to Attachment C for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P3 Aggregate PMPM $246.75

P3 PMPM-Projected Waiver Costs by MEG
BI 242.06
CADI 260.07
DD 228.24
CAC 243.63
EW 202.01

Year 4 (if applicable) from: _4/1/2025_ to _3/31/2026_
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 4.32%

Projected pre-waiver cost _____
Projected Waiver cost _____ $269,340,436
Difference: _____

Please refer to Attachment C for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P4 Aggregate PMPM $257.45

P4 PMPM-Projected Waiver Costs by MEG
BI 242.42
CADI 271.31
DD 237.30
CAC 251.78
EW 211.15

Year 5 (if applicable) from: 4 /1/2026 to 3/31/2027
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Trend rate from current expenditures (or historical figures): 4.32%

Projected pre-waiver cost _____
Projected Waiver cost _____ $304,573,439
Difference: _____

Please refer to Attachment C for additional information regarding the basis of the calculations and trend rates.

Cost-effectiveness will be evaluated for the five-year period based on Medical Assistance service total expenditures and actual caseload per member, per month (PMPM) projections. In this way, the state is able to describe any caseload changes between Medicaid Eligibility Groups or overall changes in the magnitude of the state's caseload over the course of the waiver. The state is able to amend the waiver at any point in time to account for changes in the cost-effectiveness projections.

P5 Aggregate PMPM $268.64

P5 PMPM-Projected Waiver Costs by MEG
BI 242.79
CADI 283.05
DD 246.73
CAC 260.19
EW 220.71