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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: 21-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 23, 2021

Patrick Hultman, Deputy Medicaid Director
Minnesota department of Human Services
540 Cedar Street
PO Box 64983
St. Paul, MN 55164

RE: MN 21-0004 Housing Stabilization and Consultation Services §1915(i) home and community-based services (HCBS) state plan amendment (SPA)

Dear Mr. Hultman:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its 1915(i) state plan home and community-based services (HCBS) benefit, transmittal number TN 21-00004. The effective date for this amendment is July 1, 2021. With this amendment, the state is updating the provision of housing support services to include the addition of person-centered language and broaden the remote contact policy for direct service delivery.

Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Attachment 3.1-I, pages 7, 15, 17-18, 21-48

It is important to note that CMS approval of this change to the state's 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Jemima Drake at Jemima.Drake@cms.hhs.gov or (410) 786-8312.

Sincerely,

[redacted]
Digitally signed by George P. Failla Jr -S
Date: 2021.06.23 19:26:46 -04'00'

George P. Failla, Jr., Acting Director
Division of HCBS Operations and Oversight

Enclosure

cc:
Sandra Porter, CMS
Lynell Sanderson, CMS
Kathryn Poisal, CMS
Deanna Clark, CMS
Katherine Berland, CMS
Cynthia Nanes, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0004

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTER FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1915(i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY '21 $ 0
b. FFY '22 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-i, pages 7, 15, 17, 18, 21 ~~42~~ 48
(pages 43-48 are new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 7, 15, 17, 18, 21 ~~48~~ 42

10. SUBJECT OF AMENDMENT:
Providing housing support services remotely

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

16. RETURN TO:
Patrick Hultman
Minnesota Department of Human Services
540 Cedar Street, PO Box 64983
St. Paul, MN 55164-0983

13. TYPED NAME:
Patrick Hultman

14. TITLE:
Deputy Medicaid Director

15. DATE SUBMITTED:
March 26, 2021

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 26, 2021

18. DATE APPROVED:
June 23, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by George P. Failla Jr -S
Date: 2021 06.23 19:27 08 -04'00'

21. TYPED NAME:
George P. Failla Jr.

22 [redacted]

23. REMARKS: Pen & Ink change made to Box 8 & 9 to correct pages numbers of approved and superseded pages.

FORM CMS-179 (07-92)

- Demonstrate an understanding of how housing instability can affect the health of people with disabilities.

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 state Medicaid agency will review assessment outcomes and disability documentation through a secure web-based platform to determine medical need for these services. Department staff will use the results of the independent assessment to determine whether the beneficiary is over 18, has a disability or disabling condition, and meets the needs- based criteria to receive this service. The evaluator will be familiar with the medical necessity criteria and will use those criteria and the individual's assessment information to determine medical need.

Once the evaluator has determined medical necessity, the person will update MMIS and notify both the provider and recipient that services may commence.

This same process is used for both evaluation and reevaluation.

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):*

A person is eligible for state plan HCBS if the person meets the following needs-based criteria:

Is assessed to require assistance with at least one need in the following areas resulting from the presence of a disability and/or a long term or indefinite condition:

- Communication
- Mobility;
- Decision-making; and/or
- Managing challenging behaviors

And is experiencing housing instability, which is evidenced by one of the following risk factors:

Transition and consultation services, by their nature, are individualized, provided in the community, the individual's private home or non-disability-specific setting and allow 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. Providers of these services will not undergo the site-specific assessment/validation process. This aligns with the assessment of 1915(c) Housing Access Coordination services in the transition plan.

Person-Centered Planning & Service Delivery

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

1. X 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. X 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. X 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):*

Applicants can be assessed through one of three processes: a LTCC, a Professional Statement of Need, or a Coordinated Entry Assessment. The qualifications for the professionals conducting these assessments are as follows:

Long Term Care Coordination (LTCC)

Lead agencies use certified assessors or Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) care coordinators. Certified assessors and MSHO/MSC+ care coordinators 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, with at least one year of home and community-based experience; or a registered nurse without public health certification with at least two years of home and community-based experience. Assessors and MSHO/MSC+ care coordinators receive training specific to assessment and support planningfor long-term services and supports in the state. The LTCC is a comprehensive assessment process that encompasses more than needs related to institutional level of care. It looks at a person's whole life and determines potential need for a variety of services and support, including housing-related needs. Because the

For recipients receiving Medicaid-funded case management or MSHO/MSC+ care coordination, the recipient's case manager and MSHO/MSC+ care coordinator will be responsible for the development of the person-centered service plan. The qualifications for case managers providing targeted case management are described in Supplement 1, to Attachments 3.1-A/B. The qualifications for case managers and MSHO/MSC+ care coordinators providing services to recipients of home and community-based services are defined in the state's waivers approved under Section 1915(c).

If the recipient does not have a case manager MSHO/MSC+ care coordinator, they will receive housing-focused, person-centered planning through the Housing Consultation services provided as part of this benefit. Further information on Housing Consultation services is in the Services section of this attachment.

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):*

Person-centered planning principles are used in the development of the service plan, which creates a process that:

- Engages recipients, their representatives and other people chosen by the recipient;
- Provides information necessary for the participant to make informed choices and decisions in order direct the process to the maximum extent possible;
- Is timely and occurs at a time and location convenient to the participant;
- Reflects cultural considerations and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;
- Includes clear conflict of interest guidelines and strategies for solving conflict;
- Offers choices to the participant regarding the services and supports they receive and from whom;
- Includes methods for updating the service delivery plan; and
- Records the alternative HCBS settings considered by the participant.

The Department's web site offers a considerable amount of information and training for case managers, MSHO/MSC+ care coordinators, participants, and families regarding person-centered service delivery and individual choice, and offers links to applicable resources. Specifically, the Department offers access to:

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

- Housing Benefits 101 (helps people who need affordable housing, and supports to maintain that housing, understand the range of housing options and support services available)
- Disability Linkage Line (referral and assistance service for people with disabilities)
- Veterans Linkage Line, LinkVet (referral and assistance service for veterans)

6. **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):*

Case managers, MSHO/MSC+ care coordinators and providers of housing consultation services will assist the recipient in developing a person-centered plan by providing information regarding service options and choice of providers. Case managers MSHO/MSC+ care coordinators and consultation services providers offer information regarding:

1) Service types that would meet the level of need and frequency of services required by the recipient and the location of services;

2) Enrolled service providers listed in the on-line, MinnesotaHelp.Info directory and, as needed, additional local providers qualified to deliver Housing Stabilization Services;

3) Provider capacity to meet assessed needs and preferences of the recipient, or to develop services if they are not immediately available; and,

4) Other community resources or services necessary to meet the recipient's needs.

7. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service is made subject to the approval of the Medicaid agency):*

The State Medicaid Agency will review a sample of approved service plans to assess whether the needs of the participants are being addressed, identify best practices and quality improvement opportunities, and identify areas of technical assistance. A sample of each provider's service plans will be reviewed at least once every three years. Additional reviews will occur as needed to address issues of quality improvement that develop.

8. **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):*

X	Medicaid agency	☐	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

Housing Stabilization-Transition services are limited to 150 hours per transition. Additional hours beyond this threshold may be authorized by the Department.

Recipients must be planning to transition from their current setting to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. This service will only be provided to individuals transitioning to a less restrictive setting, and for individuals transitioning from provider-operated settings, the service is only provided to those transitioning to a private residence where the individual will be directly responsible for his or her own living expense. For persons residing in an institutional setting, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the recipient has transitioned to a community-based setting.

Transition services are not covered when a recipient is concurrently receiving sustaining services.

Limitations applicable to remote support service delivery of housing stabilization services:

- Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support at any time.
- A person requiring a higher level of remote support annually may be granted an exception through a provider request for prior authorization for up to 75% of the direct service provision.
- Prior authorization for higher remote support is not required during the period of a federal or state public health emergency or disaster declaration affecting the person or the person's geographic area.
- A person on Transition services may use remote support in a flexible manner that meetshis/her/their needs within the total yearly authorized units.

In order for providers to provide more than half of the direct service hours annually remotely, DHS must provide authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include:

- a person engages more readily with the provider via remote means due to their disabling condition
- The person is transient and difficult to physically locate but remains in contact remotely

	• The person works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing. • The person and provider are physically distant from one another and the person consents to additional remote support Providers need to outline remote support delivery methods agreed upon with the person. The housing support plan must also document: • why those methods were chosen and detail why remote support better meets the person's needs, • how remote support will support the person to live and work in the most integrated community settings • the needs that must be met through in-person support • a plan for providing in-person and remote supports based on the person's needs to ensure their health and safety. The direct staff or caregiver responsible for responding to a person's health, safety, and other support needs through remote support must: • Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public; • Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety, and other support needs for personal care; • Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to develop record keeping systems which identify when a service was provided remotely, and track the number of remote hours utilized. • Providers may not: o Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; o Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronicmessaging); o Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.
X	Medically needy *(specify limits):*

Housing Stabilization-Transition services are limited to 150 hours per transition. Additional hours beyond this threshold may be authorized by the Department.

Recipient must be planning to transition from their current setting to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the recipient has transitioned to a community-based setting.

Transition services are not covered when a recipient is concurrently receiving sustaining services.
Limitations applicable to remote support service delivery of housing stabilization service:
• Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support any time.

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- The person is transient and difficult to physically locate but remains in contact remotely
- The person works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing.
- The person and provider are physically distant from one another and the person consents to additional remote support

Providers need to outline remote support delivery methods agreed upon with the person. The housing support plan must also document:

- why those methods were chosen and detail why remote support better meets the person's needs

- how remote support will support the person to live and work in the most integrated community settings
- the needs that must be met through in-person support
- a plan for providing in-person and remote supports based on the person's needs to ensure their health and safety.

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

- Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;
- Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety, and other support needs for personal cares;
- Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA).

It is the provider's responsibility to develop record keeping systems which identify when a service was provided remotely, and track the number of remote hours utilized.

• Providers may not:

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

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency: agencies that meet the housing stabilization service standards			

Individual: Individuals that meet the housing stabilization service standards			Individuals providing housing stabilization services must have: • Knowledge of local housing resources. • Completed housing stabilization services training approved by the Commissioner. • Completed mandated reporter training which includes training on vulnerable adult law. Additionally, providers of housing stabilization services must pass a criminal background study.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency ofVerification *(Specify):*
Agency: Agencies that meet theHousing Stabilization service standards	Minnesota Department of HumanServices	Every five years
Individual: Individuals that meet thehousing stabilization service standards	Minnesota Department of HumanServices	Every five years

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

☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Housing Stabilization Service - Sustaining

Service Definition (Scope):

Community supports that help a person to maintain living in their own home in the community including:

- Developing, updating and modifying the housing support and crisis plan on aregular basis
- Prevention and early identification of behaviors that may jeopardize continuedhousing
- Education and training on roles, rights, and responsibilities of the tenant andproperty manager
- Coaching to develop and maintain key relationships with property managers and neighbors
- Advocacy with community resources to prevent eviction when housing is at risk
- Assistance with the housing recertification processes
- Continuing training on being a good tenant, lease compliance, and householdmanagement
- Supporting the person to apply for benefits to retain housing
- Supporting the person to understand and maintain income and benefits to retainhousing
- Supporting the building of natural housing supports and resources in the community
- Remote support when required to help the person retain their housing

Remote support is real-time, two-way communication between the provider and the participant. The service meets intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in person service delivery. Remote support is limited to check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of housing stabilization services. Remote support may be utilized when it is chosen by the participant as a method of service delivery. To meet the real-time, two-way exchange definition, remote support includes the following methods: telephone, secure video conferencing, and secure written electronic messaging, excluding e-mail and facsimile. All transmitted electronic written messages must be retrievable for review. Providers must document the staff who delivered services, the date of service, the start and end time of service delivery, length of time of service delivery, method of contact, and place of service (i.e. office or community) when remote support service delivery occurs.
Sustaining services **do not** include:

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses

Sustaining services cannot duplicate other services or assistance available to the person.

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):	
X	Categorically needy *(specify limits):*
	Housing Stabilization-Sustaining services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Department. Limitations applicable to remote support service delivery of housing stabilization services: • Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support at any time. • A person requiring a higher level of remote support annually may be granted an exception through a provider request for prior authorization for up to 75% of the direct service provision. • Prior authorization for higher remote support is not required during the period of a federal or state public health emergency or disaster declaration affecting the person or the person's geographic area. • A person on Sustaining services may use remote support in a flexible manner that meets his/her/their needs within the total yearly authorized units. In order for providers to provide more than half of the direct service hours annually remotely, DHS must provide authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include: • a person engages more readily with the provider via remote means due to their disabling condition • The person is transient and difficult to physically locate but remains in contact remotely • The person works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing. • The person and provider are physically distant from one another and the person consents to additional remote support Providers need to outline remote support delivery methods agreed upon with the person. The housing support plan must also document: • why those methods were chosen and detail why remote support better meets the person's needs • how remote support will support the person to live and work in the most integrated community settings

	• the needs that must be met through in-person support • a plan for providing in-person and remote supports based on the person's needs to ensure their health and safety. The direct staff or caregiver responsible for responding to a person's health, safety, and other support needs through remote support must: • Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public; • Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety, and other support needs for personal cares • Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to develop record keeping systems which identify when a service was provided remotely, and track the number of remote hours utilized. Providers may not: • Bill direct support delivered remotely when the exchange between the service participant and the provider is social in nature; • Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronicmessaging); • Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.
X	Medically needy *(specify limits):*

Housing Stabilization-Sustaining services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Department.

Limitations applicable to remote support service delivery of housing stabilization service:

- Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support at any time.
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- A person on Sustaining services may use remote support in a flexiblemanner that meets his/her/their needs within the total yearly authorized units.

In order for providers to provide more than half of the direct service hours annually remotely, DHS must provide authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include:

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- The person works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing.
- The person and provider are physically distant from one another and the person consents to additional remote support

Providers need to outline remote support delivery methods agreed upon with the person. The housing support plan must also document:

- why those methods were chosen and detail why remote support better meets the person's needs,
- how remote support will support the person to live and work in the most integrated community settings,
- the needs that must be met through in-person support
- a plan for providing in-person and remote supports based on the person's needs to ensure their health and safety.

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

- Respect and maintain the person's privacy at all times, including when the person is in settings typically used by the general public;

	• Respect and maintain the person's privacy at all times, including when scheduled or intermittent/as-needed support includes responding to a person's health, safety, and other support needs for personal cares • Ensure the use of enabling technology complies with relevant requirements under the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to develop record keeping systems which identify when a service was provided remotely, and track the number of remote hours utilized. • Providers may not: ○ Bill direct support delivered remotely when the exchange between the serviceparticipant and the provider is social in nature; ○ Bill direct support delivered remotely when real-time, two-way communication does not occur (e.g. leaving a voicemail; unanswered electronicmessaging); ○ Bill for the use of Global Positioning System (GPS), Personal Emergency Response System (PERS) and video surveillance to provide remote check-ins or consultative supports.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency: agencies that meet the housing stabilization service standards			Agency providers of housing stabilization services must assure all staff providing the service have: • Knowledge of local housing resources. • Completed housing stabilization service training approved by the Commissioner. • Completed mandated reporter training which includes training on Vulnerable Adult law. Additionally providers of Housing stabilization services must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.
Individual: Individuals that meet the housing stabilization service standards			Individuals providing housing stabilization services must have: • Knowledge of local housing resources. • Completed housing stabilization services training approved by the Commissioner. • Completed mandated reporter training which includes training on vulnerable adult law. Additionally, providers of housing stabilization services must pass a criminal background study.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):			
Provider Type *(Specify)*:		Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Agency: Agencies that meet the Housing Stabilization service standards		Minnesota Department of Human Services	Every five years
Individual: Individuals that meet the housing stabilization service standards		Minnesota Department of Human Services	Every five years
Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	X	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Housing Consultation Services
Service Definition (Scope):	
Housing Consultation: planning services that are person-centered and assist a person with the creation of the person-centered plan. Recipients may also receive referrals to other needed services and supports based on the person-centered plan. The consultant monitors and updates the plan annually or more frequently if the person requests a plan change or experiences a change in circumstance. This service shall be separate and distinct from all other services and shall not duplicateother services or assistance available to the participant. Housing consultation services may only be billed after approval of the plan by the Department. Systems edits will be in place to prevent the payment of targeted case management services in the same month in which housing consultations services are billed.	
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):

X	Categorically needy *(specify limits):*

Housing consultation services are available one time, annually. Additional sessions may be authorized by the Department if the recipient becomes homeless or experiences a significant change in a condition that impacts their housing, or when a person requests an update or change to their plan. To avoid conflict of interest, an individual cannot receive housing consultation services and housing stabilization services from the same provider.

Recipient must be living in, or planning to transition to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, providers may not bill for services until the recipient has transitioned to a community-based setting.

Remote support- Housing Consultation

- Remote support: A real-time, two-way communication between the provider and the person. For housing consultation, remote support can only be performed through telephone or secure video conferencing.
- Providers must document that the plan was completed remotely and why it was a remote planning session. The case notes must also identify the staff who delivered services, the date of service, the method of contact and place of service (i.e. office or community).

X	Medically needy *(specify limits):*

Housing consultation services are available one time, annually. Additional sessions may be authorized by the Department if the recipient becomes homeless or experiences a significant change in a condition that impacts their housing, or when a person requests an update or change to their plan. To avoid conflict of interest, an individual cannot receive housing consultation services and housing stabilization services from the same provider.

Recipient must be living in, or planning to transition to a new home in a community-based setting. These services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting, providers may not bill for services until the recipient has transitioned to a community-based setting.

Remote support- Housing Consultation

- Remote support: A real-time, two-way communication between the provider and the person. For housing consultation, remote support can only be performed through telephone or secure video conferencing.
- Providers must document that the plan was completed remotely and why it was a remote planning session. The case notes must also identify the staff who delivered services, the date of service, the method of contact and place of service (i.e. office or community).

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Agency: Agencies that meet the housing consultation service standards			Agency providers of Housing Consultation services must assure staff providing the service have: • Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects. • Completed training approved by the Commissioner. Additionally, providers of Housing Consultation services must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.
Individual: Individuals that meet the housing			Individual providers of housing consultation services must assure they have:

consultation service standards			• Knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the participant selects. • Completed training approved by the Commissioner. Additionally providers of Housing Consultation services must pass a criminal background study.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Agency: Agencies that meet the housing consultation service standards	Minnesota Department of Human Services	Every five years
Individual: Individuals that meet the housing consultation service standards	Minnesota Department of Human Services	Every five years

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

☐	Participant-directed	X	Provider managed

2. ☐ **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):*

Participant-Direction of Services

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

1. **Election of Participant-Direction**. (*Select one):*

X	The state does not offer opportunity for participant-direction of State plan HCBS.
○	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.
○	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. *(Specify criteria):*

2. **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):**

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	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. (*Specify the areas of the state affected by this option)*:

4. **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
	☐	☐
	☐	☐

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

X	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **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):*

8. **Opportunities for Participant-Direction**

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

X	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.
	☐	**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):*

X	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(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.):*
	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.*

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.)

Requirement	***Service plans address assessed needs of 1915(i) participants***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that document services to address all of the person's assessed needs. • Numerator: Number of plans reviewed that address all of the assessed needs. • Denominator: Number of plans reviewed by Department staff.
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System.

	Sample Size: 8/30 Methodology[1] of all provider files. Performance Standard: 90%.[2]
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Department will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Department will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that are updated annually. • Numerator: Number of plans reviewed in which the most recent plan has been updated within the past 12 months. • Denominator: Number of cases re-evaluated. Performance Standard: 90%.
Discovery Activity	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All cases with an annual re-evaluation.

[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. 8 files are reviewed for the particular standard. If all 8 files meet the standard, then the standard has passed. If less 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

[2] When applicable performance standards are listed. The Department reserves the right to adjust standards after initial baseline data is collected.

(Source of Data & sample size)	
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Department will work with providers to ensure remediation compliance takes place within 30 days of being informed about the find. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Department will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans document choice of services, and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of plans reviewed that document the recipient's choice between/among services and providers. • Numerator: Number of plans reviewed in which participant choice was documented • Denominator: Number of plans reviewed by Department staff. Performance Standard: 90%
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: 8/30 methodology
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency

Frequency	every 5 years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for monitoring service plans. For those service plans that do not comply with the performance indicators, the Department will work with providers to ensure remediation compliance takes place within 30 days of notice of the finding. Performance issues that require remediation will result in corrective action plans developed by the provider within 30 days of being informed of the finding. The Department will review and approve all corrective action plans and will continuously monitor providers' performance until the issue is resolved.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of provider applications that meet required qualifications. • Numerator: Number of provider applications that meet all required standards • Denominator: Number of providers who have applied for 1915(i) services. Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	All provider agency applications are reviewed prior to approval. Data Source: Provider enrollment data tracked by Department staff through MMIS. Sample Size: All providers applying to deliver 1915(i) services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Every 5 years
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department verifies that providers initially and continually meet required certification standards and adhere to other standards prior to their furnishing housing stabilization services. The Department will review provider qualifications upon initial enrollment, and every five years thereafter, to ensure providers meet compliance standards. Providers who do not meet required certification standards will not qualify to provide housing stabilization services.
Frequency	Annually

	(of Analysis and Aggregation)	

Requirement		***Settings meet the HCBS setting requirements as specified in this SPA***
Discovery		
	Discovery Evidence *(Performance Measure)*	In order to provide housing stabilization-sustaining services, providers must submit documentation attesting that the recipient lives in a HCBS-compliant setting. Measure #1: Percentage of recipients determined eligible in the past 12 months that have a provider attestation that recipient lives in an HCBS-compliant setting. • Numerator: Number of recipient files with the provider attestation. • Denominator: Number of recipient files reviewed. Performance Standard: 100% Measure #2: Percentage of recipients who had a recertification in the past 12 months that have a provider attestation that meets HCBS settings requirements. • Numerator: Number of recipient files with the provider attestation. • Denominator: Number of recipient files reviewed. Performance Standard: 100%
	Discovery Activity *(Source of Data & sample size)*	Department staff will review service plans to verify the recipient lives in a compliant setting. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All recipients of state plan HCBS.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	Recipients residing in settings that do not meet the requirements described in this plan may not receive housing stabilization- sustaining services.

timeframes for remediation)	
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight***
Discovery	
Discovery Evidence *(Performance Measure)*	Percent of corrective actions that were resolved over the course of the most recent review cycle. Numerator: Number of corrective actions that were resolved. Denominator: Number of corrective action plans issued/approved in the most recent review cycle. Performance Review: 90%
Discovery Activity *(Source of Data & sample size)*	The Department will collect & review regular reports as well as conduct random monitoring of service providers. Data Source: Data manually tracked by Department staff through the Housing Stabilization Data System.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will work with provider to ensure remediation compliance takes place within a designated period. The corrective action plan includes a timeline and describes how service plans will be corrected.
Frequency *(of Analysis and Aggregation)*	Quarterly

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to active providers during the review period in accordance with the published rate on the date of service. • Numerator: Number of claims paid to active providers at the correct rate. • Denominator: Number of housing stabilization service claims paid in the sample. • Performance Review: 90%
Discovery Activity *(Source of Data & sample size)*	Department staff will review a sample of paid claims from MMIS/MCO data. Data Source: MMIS Claims data; and MCO data Sample Size: 8/30 file methodology for file review.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will engage in continuous and on-going review and development of MMIS claims edits/MCO claims payments to ensure claims are properly paid.
Frequency *(of Analysis and Aggregation)*	Semi-annual reports of MMIS claims/MCO claims and edit development

Requirement	***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of providers who complete training on child protection, maltreatment of vulnerable adults, and responsibilities as mandated reporters. • Numerator: Number of providers who have completed training on child protection, maltreatment of vulnerable adults, and responsibilities as mandated reporters. • Denominator: Number of enrolled providers of housing stabilization services. • Performance Review: 100%

	• Denominator: Number of enrolled providers of housing stabilization services. • Performance Review: 100%
Discovery Activity *(Source of Data & sample size)*	All provider agency applications are reviewed prior to approval. Data Source: Provider enrollment and eligibility data manually tracked by Department staff. Sample size: All provider applications are reviewed for mandated training.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency and contracted entity
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department has a process in place for reporting abuse and neglect that will be applied to the provider working with beneficiaries. All providers working directly with beneficiaries are required to take training addressing issues when working with vulnerable adults and how to report instances of maltreatment.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***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.***
Discovery	
Discovery Evidence *(Performance Measure)*	Measure #1: Percentage of applications for 1951(i) services in which the Department completed a determination of medical need. • Numerator: Number of applications with a completed determination of medical need. • Denominator: Number of applications to the Department for 1915(i) services. • Performance Standard: 90%

Discovery Activity *(Source of Data & sample size)*	Department staff will review data from MMIS and the Housing Stabilization Data System to determine whether all recipients who submitted an application also received a determination of medical need. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All recipients of state plan HCBS.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for determinations of medical need. For those determinations that do not comply, the Department will work to ensure remediation takes place within 30 days.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of new recipients with a determination of medical need that included a review of all criteria. • Numerator: Number of cases reviewed that included a review of all medical need criteria. • Denominator: Number of new recipients' cases reviewed. • Performance Standard: 90%
Discovery Activity *(Source of Data & sample size)*	Department staff will review a sample of applications and compare the outcome of the medical need determinations to program policies to determine whether requirements were applied appropriately. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System.

	Sample Size: 8/30 Methodology
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will be responsible for determinations of medical need. The Department will review the processes and instruments used for determinations annually, and ensure remediation actions for changing these processes and instruments take place within a designated period.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***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***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of annual reevaluations for 1951(i) service in which the Department completed a determination of medical need. • Numerator: Number of reevaluations with a completed determination. • Denominator: Number of reevaluations submitted to the Department. Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All cases with an annual re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency

Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department will prevent payment of services if the recipient has not received an assessment within the previous 365 days. The Department will continuously monitor systems edits to ensure claims are properly paid or denied.
Frequency *(of Analysis and Aggregation)*	Annually

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

Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
The state Medicaid agency will regularly survey recipients, stakeholders, providers and organizations regarding the quality, design, and implementation of the services. A team of program and policy staff from the State Medicaid Agency will review and analyze collected survey, performance measure, and remediation data. This team will make recommendations for systems and program improvement strategies. Problems or concerns requiring intervention beyond existing remediation processes will be targeted for new/improved policy and/or procedure development, testing, and implementation.			