DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

John Connolly
Deputy Commissioner and Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55167-0983

Dear Director Connolly:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Minnesota Reform: Pathways to Independence (Project Number 11-W-00286/5) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section

1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Minnesota Reform Pathways to Independence demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on December 29, 2025, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 8.6, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

The demonstration STCs include requirements to submit a Home and Community Based Services (HCBS) Quality Improvement Strategy (QIS) Report (STC 8.4), HCBS Performance Measure Report (STC 8.4), HCBS Evidentiary Report (STC 8.5.b) and HCBS Deficiency Report (STC 8.5.a) that previously may have been included as part of the quarterly or annual monitoring reports. The state is still required to submit the HCBS specific deliverables and reports stipulated in the STCs, but separately from the structured monitoring reports. CMS will provide applicable instructions in the coming weeks.

Demonstration Monitoring Calls

As STC 8.9 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to), any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Minnesota Reform section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Sandra Porter, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00286/5

TITLE: Minnesota Reform: Pathways to Independence Section 1115 Demonstration

AWARDEE: Minnesota Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the "Act"), expenditures made by Minnesota (the "state') for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period from February 1, 2025 through January 31, 2030, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Minnesota to operate the above-identified section 1115(a) demonstration.

1. **Alternative Care Program (AC Program).** Expenditures to provide a targeted set of home and community-based services (HCBS), as described in the accompanying Special Terms and Conditions (STCs), to individuals aged 65 and older: (1) who are in need of a nursing facility level of care; (2) who are not eligible for Medicaid coverage because their income and assets exceed eligibility limits for the state's Medicaid program, including the state's Medicaid HCBS programs under section 1915 of the Act; and (3) whose income and/or assets are insufficient to pay for 135 days of nursing facility care. These authorized expenditures are provided under the Alternative Care program component of the demonstration as set forth in the accompanying STCs.

Title XIX Requirements Not Applicable to Demonstration Population

All requirements of the Medicaid program expressed in law, regulation and policy statement, not

expressly identified in the list below, shall apply to the above named demonstration populations.

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to mandatorily enroll the Alternative Care program's (AC program) demonstration population into a delivery system that restricts the free choice of provider.

2. Cost Sharing Requirements **Section 1902(a)(14) so far as it incorporates Section 1916**

To the extent necessary to permit the state to impose premiums, deductions, cost sharing, and similar charges for individuals in the AC population that exceed the statutory limitations.

3. Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To the extent necessary to permit the state to offer benefits to the AC demonstration population that differ from the benefits offered under the Medicaid state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00286/5

TITLE: Minnesota Reform: Pathways to Independence Section 1115(a) Demonstration

AWARDEE: Minnesota Department of Human Services

1. PREFACE

The following are the special terms and conditions (STC) for the "Minnesota Reform: Pathways to Independence" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Minnesota Department of Human Services (hereinafter "state"), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from February 1, 2025 through January 31, 2030, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Benefits

6. Cost Sharing
7. Delivery Systems
8. Monitoring and Reporting Requirements
9. Evaluation of the Demonstration
10. General Financial Requirements
11. Monitoring Budget Neutrality for the Demonstration
12. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Reserved for Evaluation Design
- Attachment D: Alternative Care Program Benefits

2. PROGRAM DESCRIPTION AND OBJECTIVES

Historical Context

On October 18, 2013, the Centers for Medicare & Medicaid Services (CMS) initially approved Minnesota's Reform 2020: Pathways to Independence (Reform) 1115(a) demonstration for a five-year period through June 30, 2018. The initial goals of this demonstration were to support independence, increase community integration and reduce reliance on institutional care for older adults with limited income and/or assets who are at risk of nursing home placement. The initial demonstration provided Medicaid funding for the Alternative Care (AC) program, which covers home and community-based services (HCBS) to older adults who have limited income and/or assets but are not yet financially eligible for Minnesota's Medicaid program, including Medicaid HCBS programs. It is managed by the Minnesota Department of Human Services (DHS).

On July 21, 2017, the state submitted a request to extend the demonstration. After operating under a temporary extension, CMS approved an extension on January 31, 2020 that included coverage for a targeted group of children under the age of 21 who would have lost coverage of personal care attendant services due to a change in Medicaid State Plan eligibility. The children

were assessed to have needs related to activities of daily living (ADL) but were no longer eligible for Medicaid State Plan personal care attendant services. This expenditure authority continued through October 31, 2020 until it was no longer needed, as all participants aged out of this authority by the end of 2020.

The state originally sought with this demonstration federal authority under sections 1915(i) and 1915(k) of the Social Security Act to expand self-directed options under a new Community First Services and Supports (CFSS) benefit to replace personal care assistance (PCA) services for seniors enrolled in the AC program. On February 27, 2024 CMS approved CFSS under section 1915(i) and 1915(k) authorities as a state plan service.

On July 30, 2024, the state submitted a request to extend the demonstration for a five-year period beyond its scheduled expiration date of January 31, 2025. This extension request included the following changes:

1. Remove the year 2020 from the demonstration name; and
2. Add transitional services as a covered service for AC program's qualifying participants.[1]

Goals and Objectives

In this demonstration, Minnesota will further the objectives of Title XIX of the Act to improve health outcomes of older adults with low income and/or assets in Minnesota by increasing their access to community-based services and supporting service delivery. The Alternative Care (AC) program covers home and community-based services for individuals aged 65 years or older who have limited income and/or assets but are not yet financially eligible for Minnesota's Medicaid program, including its Medicaid HCBS programs. The goals and objectives of the AC program under this demonstration are generally similar to those of Minnesota's Elderly Waiver (CMS control number MN.0025.91), which is authorized under section 1915(c) of the Social Security Act and covers home and community-based services to individuals aged 65 and older who require the level of care provided in a nursing facility and meet certain financial eligibility

[1] The 2024 Minnesota State Legislature authorized the addition of transitional services as a covered service for AC program participants. The law permits the service to be available upon federal approval. The service description, provider qualifications, and rates parallel those in Minnesota's Elderly Waiver. DHS' objective for adding transitional services is to provide support to participants who are transitioning from a licensed setting to independent or semi-independent community-based housing, and the desired outcome is increased community integration.

criteria, as specified therein.

During the demonstration period, the state seeks to achieve the following goals:

- Provide access to coverage for home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing facility use over time.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as

needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. State Plan Amendments. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of

the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. Extension of the Demonstration. States that intend to request an extension of the demonstration must submit an application to CMS at least 12 months in advance from the Governor of the state in accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 3.9.

3.9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as

well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR 431, Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including

services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will

be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain as set forth under the state plan and the state's Medicaid Home-and Community-Based Services (HCBS) programs under section 1915 of the Act.

4.2 Eligibility for the Alternative Care Program. The Alternative Care program (AC program) covers a targeted set of home and community-based services to individuals aged 65 and older: (1) who are in need of a nursing facility level of care; (2) who not eligible for Medicaid coverage because their income and/or assets exceed eligibility limits for the state's Medicaid program, including the state's Medicaid HCBS programs under section 1915 of the Act; and (3) whose income and/or assets are insufficient to pay

for 135 days of nursing facility care. Individuals who meet these criteria are Medicaid eligible for the services defined in the demonstration.

The AC program is a payor of last resort and other insurance is primary. If long term care (LTC) insurance has paid for all the individual's assessed needs, the individual would not be eligible for the Alternative Care program. If other insurance benefits and /or payments are sufficient to meet all the individual's assessed needs, the individual would not be eligible for Alternative Care program. If the LTC insurance only paid for a portion of the beneficiary's assessed needs, the Alternative Care program would pay for other assessed unmet needs.

4.3 Benefits under the Alternative Care Program. The state will cover services under its AC program for qualifying individuals (specified in STC 4.2) as set forth in this STC 4.3, STC 5.1, and Attachment D, which is appended to and incorporated into these STCs. The service definitions, provider qualifications , and other applicable requirements for coverage of services under the Alternative Care program are set forth in Attachment D. The majority of the home and community-based services available under the AC program are the same as those covered under the federally approved 1915(c) Elderly Waiver program (CMS control number 0025.91.R07.00), except for the following differences:

- Alternative Care covers nutrition services and discretionary benefits that address special or unmet needs of a participant or family caregiver that are not otherwise defined in the Alternative Care program service menu.
- Alternative Care covers conversion case management.
- Alternative Care does not cover adult foster care and customized living services.
- Alternative Care covers the personal care assistance (PCA) services that mirror those offered under the state's 1915(k).

The monthly cost of the Alternative Care program's services the state covers for a qualifying individual must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program.

4.4 Alternative Care Program Enrollment. Unless otherwise provided, the state must ensure its enrollment procedures for the Alternative Care program are consistent with the

state's enrollment for its Medicaid HCBS waiver programs, except that Alternative Care enrollees do not need to select a health plan. Lead agencies (which may be a county or tribal health agency) administer both the Alternative Care program and the 1915(c) Elderly Waiver. Lead agencies determine financial and program eligibility.

a. **Comprehensive Assessment.** Each individual will receive a comprehensive assessment under the Long Term Care Consultation process. The certified assessor/case manager also evaluates financial eligibility. Applicants who would be eligible for medical assistance under Medicaid State Plan categorical eligibility standards are referred for medical assistance. The certified assessor/case manager also discusses with applicants the option of qualifying medical assistance under a medically needy basis.

b. **Service Plan.** If the individual is eligible for the AC program as described in STC 4.2, the assessor/case manager develops a person-centered service plan that identifies the amount, frequency and duration of services needed by the individual and, where appropriate, caregiver supports. The state will authorize any approved AC program services prior to service delivery in the Medicaid Management Information System (MMIS) system. Reassessments are done at least annually or sooner if individual needs change.

4.5 Alternative Care Eligibility Process. Applicants must submit applications to lead agencies as identified by the state. Lead agencies must annually re-determine financial and service eligibility. Applicants may be required to provide all information necessary to determine eligibility for Alternative Care and potential eligibility under the Medicaid State Plan. Applicants for Alternative Care who appear to be categorically eligible under the Medicaid State Plan shall receive Alternative Care while their eligibility is determined. Eligibility for Alternative Care will be effective no earlier than the date of completion of the comprehensive assessment as provided in STC 4.4(a).

4.6 Application and Eligibility Determination Process. The state assures that the eligibility process for the AC program is integrated with other programs that receive federal Medicaid matching funds so that individuals applying for the AC program or long term care services are appropriately screened for the most appropriate program and category of eligibility, and that individuals who apply through the on-line, streamlined

application process are directed to the appropriate program for services. The state will integrate eligibility and application processes for the AC program when other long term care programs are integrated into the eligibility system operated by the state for Medicaid State Plan coverage in accordance with section 1943 of the Act.

The Medicaid eligibility process for Alternative Care participants is the same as the State Plan. The state will not make a final determination of ineligibility based on lack of citizenship/qualified immigration status documentation as provided by the applicant until the state completes pre- and post-enrollment to verify this information through the electronic data sources used for Medicaid state plan eligibility.

4.7 HCBS Beneficiary Protections.

a. **Person-Centered Service Planning.** The state assures there is a person–centered service plan for each beneficiary determined to be eligible for HCBS. The person–centered service plan is developed using a person–centered service planning process in accordance with 42 CFR 441.301(c)(1) and the written person–centered service plan will meet federal requirements at 42 CFR 441.301(c)(2). The person–centered service plan is reviewed and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the beneficiary.

b. **HCBS Conflict of Interest**. The state assures compliance with the HCBS conflict of interest protections at 42 CFR 441.301(c)(1)(vi). The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

c. **HCBS Settings Requirements.** The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) in accordance with implementation/effective dates as published in the Federal Register.

d. **Self-Direction.** Each individual eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options.

e. **Community Participation.** The state must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

5 BENEFITS

5.1 Alternative Care Program Benefits. The state will cover a targeted set of home and community-based services under its AC program for qualifying individuals (specified in STC 4.2) as set forth in STC 4.3, this STC 5.1, and Attachment D, which is appended to and incorporated into these STCs. The service definitions, provider qualifications, and other applicable requirements for coverage of services under the Alternative Care program are set forth in Attachment D. The state will authorize coverage of these services, prior to delivery of such services, based on a participant's assessed needs and included in their person-centered support plan.

AC program services that may be authorized in the participant's individualized support plan include the following.

- Adult companion services
- Adult day services, including family adult day services
- Adult day services bath
- Case management, case management aide, and conversion case management
- Chore services
- Consumer-directed community supports, including:
    - Community integration and support
    - Environmental modifications and provisions

    - Environmental modifications – home modifications
    - Environmental modifications – vehicle modifications
    - Financial management services
    - Individual-directed goods and services
    - Personal assistance
    - Self-direction support activities
    - Support planning
    - Treatment and training
- Discretionary services
- Environmental accessibility adaptations – home modifications
- Environmental accessibility adaptations – vehicle modifications
- Family caregiver services, including caregiver counseling and caregiver training
- Home delivered meals
- Home health services, including home health aide, home care nursing, skilled nursing, and tele- home care
- Homemaker
- Individual Community Living Supports
- Nutrition services
- Personal care
- Respite
- Specialized equipment and supplies, including Personal Emergency Response Systems
- Transitional services
- Transportation (non-medical)

The majority of the home and community-based services available under the AC program are the same as those covered under the 1915(c) Elderly Waiver, except for the following differences:

- Alternative Care covers nutrition services and discretionary benefits that address special or unmet needs of a participant or family caregiver that are not otherwise defined in the Alternative Care program service menu.
- Alternative Care covers conversion case management.
- Alternative Care does not cover adult foster care and customized living services.
- Alternative Care covers the personal care assistance (PCA) services that mirror

those offered under the state's approved 1915(k).

Additionally, AC is fee-for-service only. There is no managed care authorization. The monthly cost of AC program's services that the state covers for a qualifying individual must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the state's Elderly Waiver program. The state will approve coverage of AC program services for qualifying participants in MMIS based on the state's review of the comprehensive assessment as provided in STC 4.4(a) prior to delivery of the services. To be covered, services must be provided by qualified enrolled providers or as otherwise permitted as provided in Attachment D.

Details about all services in the AC program are published on the Alternative Care (AC) page of the Community-Based Services Manual, which is published on the website of the Minnesota Department of Human Services. The manual meets plain language and accessibility standards and is updated when there are program changes.

5.2 Transition to CFSS. Minnesota has redesigned its Medicaid State Plan personal care assistance (PCA) benefit to expand self-directed options for beneficiaries under a new service called Community First Services and Supports (CFSS). CFSS provides the same coverage as what is available under Minnesota's state plan PCA service, but CFSS additionally provides increased consumer control, and permits funding for certain goods and services. CFSS also permits spouses to be paid caregivers.

Currently PCA services are covered under the AC program. If during completion of annual reassessments the state determines that an AC program participant is eligible for CFSS under the state's Medicaid state plan, then the state will transition the AC program participant to the Medicaid state plan, where they may receive coverage of their PCA services under CFSS. The support planning process is used to determine whether a participant's spouse may provide the service. The determination considers the care and services needed by the participant, the availability and ability of the spouse, and whether the participant's needs would be met.

5.3 Electronic Visit Verification System (EVV). The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care

services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

5.4 Minimum Essential Coverage (MEC). This demonstration is limited to the provision of services for the individuals eligible for the AC program, as described in STC 4.2 and, consequently, is not recognized as Minimum Essential Coverage (MEC) as outlined in section 5000A(f)(1)(A)(ii) of the Internal Revenue Code of 1986. The state shall adhere to all applicable Internal Revenue Service reporting requirements with respect to MEC for demonstration enrollees in the AC program.

6 COST-SHARING

6.1 Alternative Care Program Cost-Sharing. Individuals in the Alternative Care program pay cost-sharing fees up to 30 percent of the average monthly cost of the individual's Alternative Care services. Cost sharing imposed upon individuals enrolled in the demonstration is consistent with state law.

6.2 Determining Fees. To determine monthly cost-sharing fees, Minnesota uses adjusted income and gross assets and the average monthly amount of services authorized for the beneficiary. Adjusted income for a married applicant who has a community spouse is calculated by subtracting the following amounts from gross income: the monthly spousal income allowance to the community spouse (which is calculated using the spousal impoverishment rules applicable under the 1915(c) Elderly Waiver); recurring and predictable medical expenses; and the federally indexed clothing and personal needs allowance. Adjusted income for all other applicants is calculated by subtracting the following amounts from gross income: recurring and predictable medical expenses and the federally indexed clothing and personal needs allowance. Table 1 reflects the monthly fees that the state may charge the AC program participant, based on calculation of their adjusted income and gross assets.

Table 1: Monthly Fees		
Alternative Care Adjusted Income	**Gross Assets**	**Monthly Fee Charge (percentage of average monthly cost of services)**
Less than 100% of the FPL	Less than $10,000	No monthly fee
Between 100% and 149% of the FPL	Less than $10,000	5 percent
Between 150% and 199% of the FPL	Less than $10,000	15 percent
At or greater than 200% of the FPL	At or greater than $10,000	30 percent

6.3 Billing and Non-payment of Fees. Enrollee fees are billed the month after services begin. If enrollee fees are not paid within 60 days, the lead agency works with the enrollee to arrange a payment plan. The lead agency can extend the enrollee's eligibility as necessary while making arrangements to rectify nonpayment of past due amounts and facilitate future payments. If no arrangements can be made, a notice is issued 10 days prior to termination stating that the enrollee will be dis-enrolled from the program. The enrollee may appeal the disenrollment under the state's Fair Hearing process, which must comply with 42 CFR Part 431, Subpart E. Following disenrollment due to nonpayment of a monthly fee, eligibility may not be reinstated for 30 days.

7 DELIVERY SYSTEM

7.1 AC program Delivery System. These program services are provided on a fee-for-service basis and are administered by counties and tribal human service agencies. Approved services are prior authorized in the MMIS system. The state must ensure that services authorized and covered by the AC program are provided by qualified providers

who are enrolled Medicaid providers. Minimum provider qualifications for each covered service are further specified in Attachment D.

8 MONITORING AND REPORTING REQUIREMENTS

8.1 Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due, if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverables.

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps that the state has taken to address such issue, and state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

8.2 Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

8.3 Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

8.4 Quality Strategy for 1915(c)-like HCBS Service. For services that could have been authorized to individuals under a 1915(c) HCBS waiver the state must have an accepted Quality Improvement Strategy that reflects how the state will assess and improve performance to demonstrate compliance with applicable federal assurances at 42 CFR 441.301 and 441.302 and is required to develop performance measures to address the following requirements:

a. **Administrative Authority**. The state must have performance measures to demonstrate that the State Medicaid Agency (SMA) retains ultimate administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.

b. **Level of Care.** The state must have performance measures to demonstrate each of the following: a) that an evaluation for level of care is provided to all applicants for whom there is reasonable indication that 1915(c)-like HCBS services may be needed in the future, and b) that the process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine initial participant level of care. While the state is required to conduct annual re-evaluations for level of care, a performance measure is not required to demonstrate compliance with this requirement.

c. **Qualified Providers.** Qualified Providers: The state must have performance measures to demonstrate each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing 1915(c)-like HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

d. **Service Plans.** The state must have performance measures to demonstrate each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of 1915(c)-like HCBS services or through other means, b) service plans are

updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among 1915(c)-like HCBS services and providers.

e. **Health and Welfare.** The state must have performance measures to demonstrate each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

f. **Financial Accountability.** The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the 1915(c)-like HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period.

The state must submit the Quality Improvement Strategy (QIS) and performance measures to CMS for review and acceptance within 90 days following approval of the demonstration.

8.5 1915(c)-like HCBS Reporting Requirements.

a. The state must report annually to CMS on the deficiencies found during the monitoring and evaluation of the HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect,

exploitation and/or unexplained death in the HCBS demonstration, the actions taken regarding the incidents and how they were resolved. Submission to CMS is due 6 months following the end of each Demonstration Year.

b. The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO), no later than 21 months prior to the end of the approved demonstration period, which includes evidence on the status of the approved HCBS quality performance measures and requirements that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will review and assess the evidentiary report to determine whether the performance measures and requirements have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

8.6 Monitoring Reports. The state must submit three Quarterly Reports and one Annual Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates** – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operational and challenges, underlying causes of challenges, how challenges are being addressed, as

well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics** – Per applicable CMS guidance and technical assistance, the performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals of the demonstration. Metrics in the state's Monitoring Reports must cover key policies under this demonstration, including but not limited to the AC program. Additionally, per 42 CFR § 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on beneficiaries' utilization and outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, as well as grievances and appeals. As applicable, the state must also report monitoring metrics stratified by key demographic subpopulations of interest (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography) and by demonstration component, to the extent feasible. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements** – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. **Evaluation Activities and Interim Findings**. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

8.7 Corrective Action Plan Related to Demonstration Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.8 Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 9.7 and 9.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30calendar days after receipt of CMS' comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

8.9 Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

8.10 Post Award Forum. Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

9 EVALUATION OF THE DEMONSTRATION

9.1 Cooperation with Federal Evaluators and Learning Collaborative. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

9.2 Independent Evaluator. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

9.3 Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of

the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

9.4 Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 9.7 and 9.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

9.5 Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment C to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

9.6 Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must cover outcomes, such as enrollment, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. The state must evaluate that beneficiaries' needs for transportation to and from demonstration-covered services are being met. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of AC services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by National Quality Forum (NQF).

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

The state should ideally undertake a well-designed beneficiary survey, for instance, to beneficiary understanding of and experience with access to and quality of care related to the services covered in the demonstration, which would significantly strengthen the demonstration's evaluation. Finally, to the best extent feasible, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography). Such stratified analyses will provide a fuller understanding of existing shortcomings or disparities in access to and quality of care and health outcomes and help inform how the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

9.7 Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expires prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to

the end of the demonstration, whichever is sooner. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

9.8 Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. Once approved by CMS, the state must post the final Summative Report to the state's Medicaid website within 30 calendar days.

9.9 Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased

difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

9.10 State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

9.11 Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

9.12 Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

10 GENERAL FINANCIAL REQUIREMENTS

10.1 Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

10.2 Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

10.3 Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

10.4 State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the

demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

10.5 Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

10.6 Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

10.7 State Monitoring of Non-federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 8.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

10.8 Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in STC 11:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

10.9 Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

10.10 Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and

other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart					
MEG	**Which BN Test Applies?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Alternative Care	Hypo	X		X	Adults ages 65 and over who are 1) in need of a nursing facility level of care; 2) not eligible for Medicaid coverage because their income and/or assets exceed eligibility limits; and 3) their income and/or assets are insufficient to pay for 135 days of nursing facility care.

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

10.11 Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00286/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in STC 11, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in STC 8, the state must report the actual number of "eligible member

months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which individuals enrolled in the demonstration are eligible to receive services. For example, an individual who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per individual, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Alternative Care	Individuals ages 65 and older who are: 1) in need of a nursing facility level of care; 2) not eligible for Medicaid coverage because their income and/or assets exceed eligibility limits; and 3) their income and/or assets are	*N/A*	Report on customary lines by category of service	Date of service	MAP	Y	2/1/2025	1/31/2030

	insufficient to pay for 135 days of nursing facility care.							

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group

10.12 Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 4: Demonstration Years		
Demonstration Year 13	February 1, 2025 to June 30, 2025	5 months
Demonstration Year 14	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 15	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 16	July 1, 2027 to June 30, 2028	12 months
Demonstration Year 17	July 1, 2028 to June 30, 2029	12 months
Demonstration Year 18	July 1, 2029 to January 31, 2030	7 months

10.13 Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in STC 11. CMS will provide technical assistance, upon request.[2]

[2] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration.

10.14 Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

10.15 Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require

CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

state legislation. The changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

10.16 Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 10.12.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as

reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;
ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
vi. High cost innovative medical treatments that states are required to cover; or
vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and
ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

11 MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

11.1 Limit on Title XIX Funding. The state will be subject to limits on the amount of federal

Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with this test will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

11.2 Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 2, Master MEG Chart and Table 3, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

11.3 Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

11.4 Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of a Hypothetical Budget

Neutrality Test. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

11.5 Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

11.6 Hypothetical Budget Neutrality Test 1: Alternative Care. The table below identifies the MEG that is used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit.

Table 5: Hypothetical Budget Neutrality Test 1									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY 17**	**DY 18**
Alternative Care	PC	Both	4.9%	$2,113.26	$2,186.09	$2,293.21	$2,405.58	$2,523.45	$2,631.32

11.7 Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

11.8 Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from February 1, 2025 to January 31, 2030. If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

11.9 Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and

approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 13	Cumulative budget neutrality limit plus:	2.0 percent
DY 13 through DY 14	Cumulative budget neutrality limit plus:	1.5 percent
DY 14 through DY 15	Cumulative budget neutrality limit plus:	1.0 percent
DY 15 through DY 16	Cumulative budget neutrality limit plus:	0.5 percent
DY 16 through DY 17	Cumulative budget neutrality limit plus:	0.0 percent
DY 17 through DY 18	Cumulative budget neutrality limit plus:	0.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	0.0 percent

12 SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

Table 7: Schedule of Deliverables for the Demonstration Period		
Timeline	**Deliverable**	**STC Reference**
30 calendar days after demonstration approval	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter

180 calendar days after approval of the demonstration extension	Evaluation Design	STC 9.4
One year prior to the expiration of the demonstration	Interim Evaluation Report	STC 9.7
Within 18 months after approval period ends	Summative Evaluation Report	STC 9.8
60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 8.6
	Quarterly Budget Neutrality Reports	STC 8.6
90 calendar days after end of each demonstration year	Annual Monitoring Reports	STC 8.6
If applicable, 120 calendar days after the end of the demonstration	Close-Out Report	STC 8.8

ATTACHMENT A

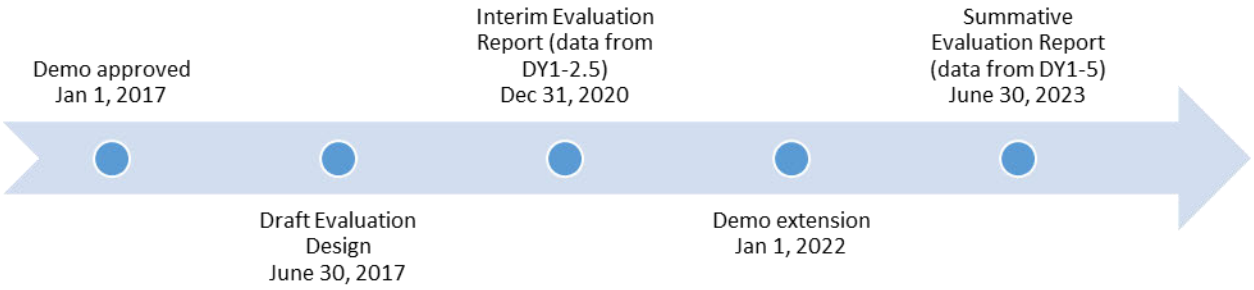
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs
CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;

E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for

the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of

Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–

standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft

Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

ATTACHMENT B

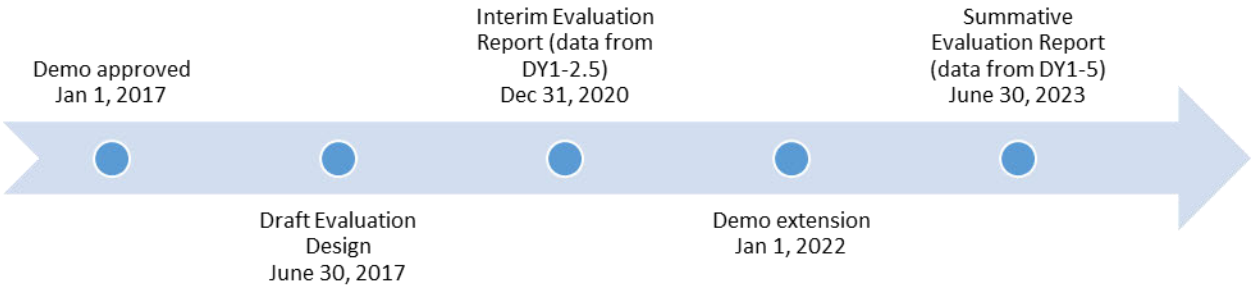
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    2. If the state did not fully achieve its intended goals, why not?
    3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the

implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

ATTACHMENT C

Reserved for Evaluation Design

ATTACHMENT D

Alternative Care Program Benefits

Reform 2020: Pathways to Independence

Section 1115 Demonstration Waiver No. 11-W-00286/5

Attachment D

December 27, 2024

Attachment D

This attachment to Minnesota's Reform section 1115 waiver application provides the service definitions and provider qualifications for the services covered under the Alternative Care (AC) program.

The Minnesota Department of Human Services (DHS) submitted a request (on August 2, 2024) to the Centers for Medicare and Medicaid Services (CMS) to extend the state's Reform 2020: Pathways to Independence Section 1115 waiver. Once approved, the waiver title will be Reform: Pathways to Independence. On December 5, 2024, CMS directed DHS to provide the service definitions and provider qualifications for the services covered under the AC program.

Section V – Covered Services and Information for Participants

Covered Services

All services covered under AC must be authorized by a county or tribal human services agency case manager. The case manager is responsible to assure there is no duplication in services and to authorize the services in MMIS. All AC services are covered fee-for-service.

In addition, goods and services are not covered when they:

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

The following services are available under AC. Service descriptions and provider qualifications are detailed in this attachment.

Covered Only Under AC

- Conversion case management (NOTE: Included in the service description under case management)
- Discretionary services
- Nutrition services

Covered Under AC – Mirrors the Definition and Provider Qualifications in Minnesota's §1915(c) Elderly Waiver

- Adult companion services
- Adult day services, including family adult day services
- Adult day services bath
- Case management and case management aide
- Chore services
- Consumer-directed community supports, including:
    - Community integration and support

    - Environmental modifications and provisions
    - Environmental modifications – home modifications
    - Environmental modifications – vehicle modifications
    - Financial management services
    - Individual-directed goods and services
    - Personal assistance
    - Self-direction support activities
    - Support planning
    - Treatment and training

- Environmental accessibility adaptations – home modifications
- Environmental accessibility adaptations – vehicle modifications
- Family caregiver services, including caregiver counseling and caregiver training
- Home delivered meals
- Homemaker
- Individual Community Living Supports
- Respite
- Specialized equipment and supplies, including Personal Emergency Response Systems
- Transitional services
- Transportation (non-medical)

Covered Under AC – Mirrors the Definition and Provider Qualifications in Minnesota's §1905(a) and §1915(k)

- Home care services, including home health aide, home care nursing, skilled nursing, and tele-home care
- Personal care services

Service Title: Adult Companion Services

Service Definition (*scope*):
Adult companion services are non-medical care, supervision and socialization, provided to a participant. This service must be provided in accordance with a therapeutic goal identified in the support plan and must not be solely diversional in nature.

Providers may assist or supervise the participant with tasks such as meal preparation, laundry and shopping when the tasks are incidental to the companion service, but may not perform these activities as discrete services.

Providers may complete light housekeeping tasks that are incidental to the care and supervision of the participant.

Provider may provide verbal instructions or cues to help the person complete a task.

Activities that support therapeutic socialization could be associated with a support plan goal to reduce social isolation, or help the individual maintain the most inclusive community life. Socialization activities that is therapeutic is directly tied to the individual's goal(s) in the support plan. Companion services are also specifically intended to support an individual to maintain and enhance community integration and social relationships, and can be used to support community relationships. Companion services are not limited to remediation of a medical condition.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult companion services do not include:

- hands-on nursing care, but may include verbal instruction or cuing;
- services provided by people related to the participant by blood, marriage, or adoption; except as allowed for individuals excluded from licensure under Minnesota Statutes, section 245A.03 subd 2(a) (1) and (2)
- activity fees (e.g. movie or event fees)
- socialization that is not directly tied to a participant's goal(s) in the support plan

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services; Environmental Accessibility Adaptations - Home Modifications; or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Individuals who meet the standards to provide adult companion services
2. Agency	Organizations that provide companion service under the Corporation for National and Community Service Senior Companion Programs
3. Agency	Agencies that meet the service standards for adult companion services

1. **Provider Category:** Individual
   Provider Type(s): Individuals who meet the standards to provide adult companion services
   Provider Qualifications
   License *(specify)*:
   Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a) (1) and (2) must be:
   - licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or

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

Certificate *(specify)*:

Other standard (*specify*):
Individuals who provide adult companion services must have:
1) Communication skills; be able to read, write, follow written and verbal instruction, and effectively converse on the telephone.
2) Homemaking skills; must have experience and/or training in homemaking skills, and/or in caring for people with cognitive or physical limitations, or other functional impairments.
3) The ability to perform essential job functions as identified in the participant's support plan.
4) Good physical and mental health and maturity of attitude toward work assignments, and may be required to pass a job related physical examination.
5) The ability to work under intermittent supervision and to manage minor emergencies. Individuals who provide companion services must be aware of their own limitations to handle crisis situations and report these to the case manager.
6) An understanding of, respect for, and ability to maintain confidentiality and data privacy.

The case manager determines whether the individual meets these standards.

Apply the standards in Minnesota Statutes, chapter 245C concerning criminal background checks.

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of Minnesota statutes section 245D.04, subd. 1(4), subd 2 (1), (2), (3), (6) and subd. 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D.

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03,subd 2(a) (1) and (2) the county or tribal human service agency monitors the provider.

Frequency of Verification:
Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A – Every one to three years

County or tribal human service agency – Every five years

Provider Eligibility and Compliance – every 5 years

2. **Provider Category:** Agency
   Provider Type(s): Organizations that provide companion service under the Corporation for National and Community Service Senior Companion Programs
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must meet the standards established by the Corporation for National and Community Service National and Community Service Senior Companion program grantees must undergo a National Service criminal history check. This check includes: A National Sex Offender Public Registry check (NSOPR, also known as the NSOPW); a statewide criminal history repository check of the state of residency and the state where the individual will work/serve (FBI checks will no longer substitute for state checks); and a fingerprint-based FBI criminal history repository check.

   If the provider of Adult Companion Services is a National Community Services Senior Companion Program grantee, they are exempt from the background study requirements of MN Statute 245C.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Federal Corporation for National and Community Service And Minnesota Department of Human Services, Provider Eligibility and Compliance

   Frequency of Verification:
   Every five years

3. **Provider Category:** Agency
   Provider Type(s): Agencies that meet the service standards for adult companion services
   Provider Qualifications
   License *(specify)*:
   Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a) (1) and (2) must be:
   - licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
   - licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

   Certificate *(specify)*:

   Other standard (*specify*):

Providers must assure that individual workers have:

1) Communication skills including the ability to communicate with the participant(s) use a telephone (or comparable device);
2) Experience or training in homemaking skills or in caring for people with functional limitations
3) The ability to perform essential companion tasks as identified in the participant's support plan;
4) The ability to work effectively under intermittent supervision, and to appropriately address emergencies that may arise; and,
5) Understand and maintain confidentiality and data privacy.

Apply the standards in Minnesota Statutes, chapter 245C concerning criminal background checks.

Understand and maintain confidentiality and data privacy.

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2)must meet the requirements of Minnesota statutes, section 245D.04, subd. 1(4), subd 2 (1), (2), (3),(6) and subd. 3 regarding rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03, the county or tribal human service agencies monitor the provider

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D –Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

County or tribal human service agency – Every five years

Provider Eligibility and Compliance – every 5 years

Service Title: Adult Day Services

Service Definition (*scope*):

The purpose of adult day service is to provide supervision, care, assistance, training and activities based on the participant's needs and directed toward the achievement of specific outcomes as identified in the support plan. Services must be designed to meet both the health and social needs of the participants.

In order to be covered as a waiver service, the adult day service must:

A. Comply with all requirements for home and community-based settings set forth in 42 CFR 441.301(c);
B. Offer a variety of meaningful and age-appropriate activities that are responsive to the goals, interests and needs of participants;
C. Maximize opportunities for community inclusion by offering or providing activities designed to increase and enhance each participant's social and physical interaction with people in their community who are not paid caregivers or staff members; and
D. Afford flexible scheduling of adult day services to accommodate a participant's work schedule.

Meals provided as part of this service shall be in accordance with 42 CFR 441.310(a)(2)(ii).

Adult day services, remote support is a provision of adult day services by a staff or caregiver from a remote location who is engaged with a person through the use of enabling technology* that utilizes live two-way communication**. Remote support can include offsite supervision and support by direct staff or caregiver responsible for responding to a person's health, safety and other support needs as needed when the method of support is appropriate, chosen and preferred by the person. A person has a right to refuse, stop, or suspend the use of remote support at any time. Remote support is initiated by the person or the caregiver on a scheduled basis as documented in the person's support plan. A participant who receives remote services must receive services in person at least quarterly. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult day services must be furnished two or more hours per day on a regularly scheduled basis, for one or more days per week. A person can receive a combination of in-person adult day services and remote adult day services on the same day but not at the same time. A participant who receives remote services must receive in person services at least quarterly.

In a 24-hour period, a participant may receive:
(1) up to six hours of remote adult day services and
(2) a combination of in-person and remote adult day services that does not exceed 12 hours in total.

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

Adult day services remote support cannot be delivered by family adult day services (FADS) providers.

Remote support does not fund the enabling technology. Technology may be covered through CDCS-Environmental Modification and Provisions, CDCS-Environmental Modifications-Home Modifications, CDCS-Individual directed goods and services, Environmental Accessibility Adaptations-Home Modification or Specialized Equipment and Supplies.

Provider Specifications

Provider Category	Provider Type
1. Individual	Family Adult Day Services (FADS)
2. Agency	Boarding Care Providers, Hospitals, and Nursing Homes
3. Agency	Adult Day Centers

1. **Provider Category:** Individual
   Provider Type(s): Family Adult Day Services (FADS)
   Provider Qualifications
   License *(specify)*:
   Must be licensed under Minnesota Statutes, section 245A.143 or Minnesota Rules, parts 9555.5050 to 9555.6265 with additional licensing authorization to provide family adult day services.

   Certificate *(specify)*:

   Other standard (*specify*):
   The service must be provided in the license holder's primary residence and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

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

Licensed adult foster care providers cannot provide family adult day services to foster care participants residing in the adult foster care home.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services-Licensing Division.

Frequency of Verification:
Every five years.

2. **Provider Category:** Agency
Provider Type(s): Boarding Care Providers, Hospitals, and Nursing Homes
Provider Qualifications

License *(specify)*:
Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730 with the exception of multifunctional organizations; nursing homes, hospitals, and boarding care settings that serve five or fewer people who are not residents or patients in the setting are exempted from the licensing requirement to provide adult day care.

Certificate *(specify)*:

Other standard (*specify*):
The provider must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.24, with the exception of section 245A.143. Providers providing Adult day services remotely must also meet requirements in Minnesota sections 245A.70 through 245A.75.

For the purposes of this service, multifunctional organization is defined in Minnesota Rule 9555.9600 Subp. 21. as an organization such as a nursing home that operates a center licensed under parts 9555.9600 to 9555.9730 as well as one or more other programs or facilities simultaneously and within the same administrative structure.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Licensing Division

Frequency of Verification:
Every five years.

3. **Provider Category:** Agency
   Provider Type(s): Adult Day Centers
   Provider Qualifications
   License *(specify)*:
   Must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.24, with the exception of section 245A.143. Providers providing Adult day services remotely must also meet requirements in Minnesota sections 245A.70 through 245A.75. For purposes of this service, a center is defined as a free-standing setting that is only licensed to provide adult day services and is not an individual's home.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services-Licensing Division.

   Frequency of Verification:
   Every five years.

Service Title: Adult Day Services Bath

Service Definition (*scope*):
A bath may be provided by an adult day or a family adult day services (FADS) provider when the bath is not able to occur in the person's home. In order to receive an Adult Day Bath, the participant must be receiving Adult Day Services. The reason for not providing the bath in the participant's home must be documented in the participant's support plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service is limited to two 15 minute units of service per day. A person cannot receive an adult day services bath and foster care waiver services from the same provider.

Provider Specifications

Provider Category	Provider Type
1. Agency	Nursing Homes, Hospitals, Medical Clinics
2. Individual	Family Adult Day Services (FADS)
3. Agency	Adult Day Centers

1. **Provider Category:** Agency
   Provider Type(s): Nursing Homes, Hospitals, Medical Clinics
   Provider Qualifications

License *(specify)*:
Licensed under Minnesota Rules, Parts 9555.9600-9730 with the exception of nursing homes, hospitals, and board and care settings that serve five or fewer people who are not residents or patients in the setting are exempted from the licensing requirement to provide adult day services.

Certificate *(specify)*:

Other standard (*specify*):
The provider must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.16, with the exception of section 245A.143.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Health

Frequency of Verification:
Every five years.

2. **Provider Category:** Individual
   Provider Type(s): Family Adult Day Services (FADS)
   Provider Qualifications

   License *(specify)*:
   Must be licensed under Minnesota Statutes, section 245A.143. or Minnesota Rules, parts 9555.5105 to 9555.6265 with additional licensing authorization to provide family adult day services.

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must meet the standards as provided in Minnesota Statutes, sections 245A.01 to 245A.16. The service must be provided in the license holder's primary residence and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

   Licensed adult foster care providers cannot provide family adult day services to foster care participants residing in the adult foster care home.

   Verification of Provider Qualifications

   Entity Responsible for Verification:
   Minnesota Department of Human Services-Licensing Division.

   Frequency of Verification:
   Every five years.

3. **Provider Category:** Agency
   Provider Type(s): Adult Day Centers

Provider Qualifications

License *(specify)*:
Adult day centers must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730.

Certificate *(specify)*:

Other standard (*specify*):
Providers must also meet the requirements and standards in Minnesota Statutes, sections 245A.01 through 245A.16, with the exception of section 245A.143.

For purposes of this service, a center is defined as a free-standing setting that is only licensed to provide adult day services and is not an individual's home.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Human Services- Licensing Division.

Frequency of Verification:
Every five years.

Service Title: Case Management

Service Definition (*scope*):
Services to assist participants in accessing needed waiver and other state plan services, assist individuals in appeals under Minnesota Statutes, section 256.045, as well as needed medical, social, educational and other services, regardless of the funding source for the services.

Case aides may assist the case manager in carrying out administrative activities of case management. Case aides must not assume responsibilities that require professional judgment, including assessments, reassessments, and support plan development. The case manager is responsible for providing oversight of the case aide.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the participants' support plans. When the case manager is not the assessor, case managers shall refer the participant for a reassessment of participants' level of care and provide necessary information to the assessor. Case managers shall review their support plans at least annually, or more frequently as warranted by changes in participants' conditions.

Case managers shall develop the support plan, inform the participant of service options, assist in identifying potential service providers, assist in accessing services, coordinate services, evaluate and monitor services identified in the support plan, provide participants with information concerning their rights, and review support plans at least annually.

The case manager or case aide shall not have a personal financial interest in the services provided to the participant. Case management must not be provided to a participant by a private agency that has a financial interest in the provision of any other services included in the participant's support plan.

Conversion case management
The service definition, limitations, and provider qualifications are the same for conversion case management as for case management services. Conversion case management is available to people who:

- Reside in a qualified setting (i.e. certified boarding care home, hospital, intermediate care facility, or nursing home);
- Will relocate to the community; and
- Will receive services through the AC program.

Access to this service is limited to 180 consecutive days per admission to a qualified setting. People may receive another 180-days of service if they are readmitted to a qualified setting.

Activities include, but are not limited to:

- Developing and implementing a relocation plan.
- Coordinating referrals and helping people access services.
- Coordinating and monitoring the overall implementation of a relocation plan.
- Coordinating with the discharge planner and others.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Minnesota holds a section 1915(b) waiver that restricts the provision of case management services to employees and contractors of counties and tribal human service agencies that are enrolled as a medical assistance provider.

Provider Specifications

Provider Category	Provider Type
1. Agency	Case Aides
2. Agency	Case Managers

1. **Provider Category:** Agency
   Provider Type(s): Case Aides
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

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

   Case aides must be employed by or under contract with agency providing case management.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   County and Tribal Human Service Agencies

Frequency of Verification:
For case aides that are employees of the county or tribal human service agency, verification occurs at hire. For case aides under contract with the county or tribal nation, verification occurs with contract cycles, which can be from one to three years.

2. **Provider Category:** Agency
Provider Type(s): Case Managers
Provider Qualifications
License *(specify)*:
Public health or registered nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Certificate *(specify)*:

Other standard (*specify*):
Social workers must be graduates from an accredited four-year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate of an accredited four-year college with a major in any field and one year experience as a social worker/case manager/care coordinator in a public or private social service agency. Social workers must also pass an assessment process through the Minnesota Merit System or another county merit system in Minnesota.

For counties that use the Minnesota Merit System or a county civil service system, social workers must:
- Apply to the Merit System to be considered for an open social worker position and be put on an eligible employment list
- Meet the minimum qualifications of a social worker under MN Rule 9575 or the county civil service system

Authority to set personnel standards is granted to the commissioner of human services under Minnesota Statutes, section 256.012.

Alternative credentialing standards may be applied to services provided by Tribal Governments if accepted by the Commissioner of Human Services under Minnesota Statutes, section 256B.02, subd. 7.

Standards for the Minnesota Merit System are authorized under Minnesota Rules, parts 9575.0010 to 9575.0090.

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

Verification of Provider Qualifications
Entity Responsible for Verification:

County and Tribal Nation agencies: The department verifies that case management activities are conducted in accordance with policies and regulations during county and tribal nation site reviews.

Frequency of Verification:
County and Tribal Nation Agencies: For case managers that are employees of the county or tribal nation, verification occurs at hire. For case manages under contract with the county or tribal nation, verification occurs at the time of hire and every one to three years. RN licenses are renewed every 2 years.

Service Title: Chore Services

Service Definition (*scope*):
Chore services support or assist a participant or his/her primary caregiver to maintain a clean, sanitary, and safe home environment. Chore services can be provided when the participant or their primary caregiver is not capable of performing the household tasks, neither the person nor anyone else in the household is financially able to provide chore services, or when the provision of chore services work allows for the caregiver to provide other needed supports to the participant.

Chore services may include, but are not necessarily limited to:
1) heavy household chores such as washing floors, windows and walls;
2) indoor and outdoor general home maintenance work;
3) moving or removal of large household furnishings and heavy appliances to provide safe access and egress from the home;
4) rearrangement of the home furnishings or the securing of household fixtures and items in order to or prevent falls or injuries;
5) extermination and pest control;
6) customary service charges made for the delivery of grocery store products when these products represent the majority of the participant's total grocery needs for at least seven days;
7) dumpster rental and refuse disposal;
8) packing the participant's belongings.

In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service shall not be covered in licensed settings or rental situations in which the lease agreement identifies the chore services as the responsibility of the landlord.

If the support plan also includes homemaker or Individual Community Living services, the support plan must be specific enough to assure that there is no duplication.

Extermination and pest control services are limited to reasonable number of treatments required to alleviate the pest problem.

Provider Specifications

Provider Category	Provider Type
1. Individual	Structural Pest Control Applicators
2. Agency	Structural Pest Control Applicators
3. Individual	Chore Service Providers
4. Agency	Chore Service Providers

1. **Provider Category:** Individual
   Provider Type(s): Structural Pest Control Applicators
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Must meet the standards and requirements under Minnesota Statute, chapter 18B.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

   Frequency of Verification:
   Enrolled providers: Every five years

   Non-enrolled providers: Every five years

2. **Provider Category:** Agency
   Provider Type(s): Structural Pest Control Applicators
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Must meet the standards and requirements under Minnesota Statutes, chapter 18B.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

   Frequency of Verification:
   Enrolled providers: Every five years

   Non-enrolled providers: Every five years

3. **Provider Category:** Individual
   Provider Type(s): Chore Service Providers
   Provider Qualifications
   License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non-enrolled providers: every five years

4. **Provider Category:** Agency
Provider Type(s): Chore Service Providers
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Chore services must provide a cost-effective, appropriate means of meeting the needs defined in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non-enrolled providers: Every five years

Service Title: Consumer-Directed Community Supports: Community Integration and Support

Service Definition (*scope*):

CDCS Community Integration and support focuses specifically on successful participation in community membership that offer the opportunity for meaningful, ongoing interactions with members of the broader community. This service provides the participant with development and maintenance of skills related to community membership through engagement in community-based activities.

This service will provide the participant access and supports to engage in acquisition, training and maintenance of skills to increase the participant's independence related to community integration through community-based activities.

CDCS Community Integration and support promotes positive growth and develop the skills and social supports necessary for the participant to:

a. Acquire, improve, or retain living skills necessary to live in and be a member of the community safely;
b. Develop and pursue meaningful day supports and community engagement for individuals who have elected not to pursue further employment opportunities;
c. Improve social skills and community behavior through social skills development and relationship building training; and,
d. Improve positive behavior skills and improve mental health.

CDCS Community Integration and support includes caregiver assistance, training and accompaniment to support the person while participating or engaging in the following activities:

1. Engaging in activities that facilitate, develop, and strengthen personal relationships with community members chosen by the person;
2. Self-designing day support services that provide the person with opportunities for regular connections to members of the broader community
3. Self-designing independent living skills training based on the persons assessed needs
4. Participating in local community events;
5. Assisting with a person's preferred volunteer experiences focused on community contribution rather than preparation for employment; and,
6. Participating in community support groups, organizations and clubs, formal and informal community associations and neighborhood groups.

CDCS Community Integration and Support cannot be used to cover expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;

- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of the CDCS services must be within the participant's individual budget.

Unallowable Expenditures.
The participant's budget shall not be used for Community Integration and Support for the following:

- Insurance except for insurance costs related to direct support worker employee coverage;
- CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
- Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
- Vacation expenses other than the cost of direct services;
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers;
- Tickets and related costs to attend sporting or other recreational events; and,
- Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS-Individual directed

goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Individual selected by the participant

1. **Provider Category:** Individual
   Provider Type(s): Individual selected by the participant
   Provider Qualifications
   License *(specify)*:
   Valid business license in good standing if applicable.

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

   All individuals providing CDCS-Community Integration and Support must:
   a. Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
   b. Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
   c. Receive customized training provided by the participant and/or his/her representative
   d. Be able, willing and have the capacity to perform the requested work outlined in the participant's support plan
   e. Have the ability to successfully communicate with the person

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Counties or tribal human service agencies are responsible for verifying the qualifications of providers of community integration and support.

   Frequency of Verification:
   At time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Service Title: Consumer-Directed Community Supports: Environmental Modifications and Provisions

Service Definition (*scope*):
Consumer directed community supports (CDCS) may include traditional goods and services provided by the waiver and alternatives that support participants. Environmental modifications and provisions is one of the four categories of CDCS that can be purchased within an established budget. Participants or their representative hire, fire, manage and direct their support workers.

CDCS: environmental modifications and provisions includes supports, services, and goods provided to the participant to maintain a physical environment that assists the person to live in and participate in the community or are required to maintain health and well-being. The following are typically covered under this category:

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

Providers of modifications must have a current license or certificate if required by Minnesota statutes or administrative rules to perform their service. A provider of modification services must meet all professional standards and or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes.

Participants or their representatives have control over the goods and services to be provided through developing the support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state. Prior to the development of a CDCS support plan, the county or tribal human service agency will inform the participant of the amount that will be available for implementing the plan over a one-year period. The county or tribal human service agency is responsible for reviewing and approving final spending decisions in the participant's CDCS support plan. The cost of background studies is not included in the individual budget amount. In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Individual Budget Methodology: Participants' budgets may not exceed the length of their service agreement span (i.e., a maximum of 12 months). If the span is less than 12 months, the budget amount will be prorated. Participants shall not carry forward unspent budgeted amounts from one plan year to the next. If a participant experiences a significant change in need or condition that requires a reassessment, or they are otherwise reassessed, and their case mix classification changes, their budget amount will be adjusted. Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's maximum case mix amount that is set by the state. These supports must be identified in the CDCS support plan.

Required case management functions are provided by counties or tribal human service agencies and are not included in the participant's budget. Required case management functions are:

1. Assess whether the individual is eligible for Alternative Care services including level of care requirements.
2. Provide the participant with information regarding HCBS alternatives to ensure that they make an informed choice.
3. Determine the maximum budget amount for participants who elect CDCS;

4. Provide CDCS participants with resources and informational tool kits to assist them in managing services.
5. Ensure that the CDCS support plan addresses the participant's health and safety needs.
6. Evaluate if the plan is appropriate including that the goods and services meet the service description and provider qualifications
7. Review the CDCS support plan and service rates
8. Authorize Alternative Care services
9. Monitor and evaluate the implementation of the CDCS support plan, including health and safety, satisfaction, the adequacy of the current plan and the possible need for revisions (this includes taking action to address suspected or alleged abuse, neglect, or exploitation of a participant as a mandated reporter according to the Vulnerable Adults Act)
10. Review the participant's budget and spending before the third, sixth, and twelfth month of the first year of CDCS services and at least annually thereafter. Monitoring requirements are increased when the provider is the spouse of a participant.
11. Monitor the management of the budget and services.
12. Provide technical assistance regarding budget and fiscal records management and take corrective action if needed. "Budget and fiscal records management" refers to the participant's ability to manage budget and recordkeeping tasks such as retaining and submitting receipts, invoices, timesheets, reimbursement requests, mileage sheets, and other documentation that is required to pay expenditures, as reported by the FMS provider.
13. Assist the state agency in completing satisfaction measurements as requested.

An individualized written CDCS Support Plan must be developed for each participant. The participant or their representative will direct the development and revision of the CDCS support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the participant's strengths, needs, and preferences. The support plan may include a mix of paid and non-paid services and may include traditional goods and services provided by the waiver as well as alternatives that support participants. The support plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS support plan identifies:

- the goods and services that will be provided purchased to meet the participant's assessed needs;
- safeguards that are required to reasonably maintain the participant's health and safety;
- the participant's emergency needs and how they will be met.
- overall outcome(s) of the participant's plan
- how monitoring of the plan will occur
- qualifications including training requirements of staff and
- who is responsible to assure that the qualification and training requirements are met

Criteria for allowable expenditures:

- The waiver shall cover only those goods and services authorized in the support plan and must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant.
- Goods and services are not covered when they are provided prior to the development of the CDCS support plan.
- Do not duplicate other services in the CDCS support plan,

- Do not supplant natural supports and
- Are the least costly and effective means appropriately meeting the participant's needs and are not available through other funding sources.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the county or tribal human service agency when the revision does not change or modify parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the participant or their representative will work with the county or tribal human service agency to have the CDCS community support plan reviewed and re-authorized.
Goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:

- Maintain the ability of the participant to remain in the community;
- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the participant
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures, it cannot be authorized and the case manager must provide the participant or the participant's representative a notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities. Additionally budgets may include:

1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are included in the CDCS support plan.
2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
3) Therapies, special diets, thickening agents and behavioral supports that are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CDCS support plan and monitored by a MHCP enrolled physician.
5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. Services included in the CDCS support plan must be necessary to meet a need identified in the participant's assessment. This may include hiring a support planner. The CDCS support plan must include specific tasks to be performed by a paid support planner. Support planner functions are:
    a. Provide information about CDCS and provider options.
    b. Facilitate the development of a person-centered CDCS support plan.
    c. Monitor and assist with revisions to the CDCS support plan.
    d. Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.

e. Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.).
f. Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers.
g. Provide staff training that is specific to the consumer's CDCS support plan.

6) FMS costs incurred to manage the budget; advertise and train staff;
7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
8) Costs related to internet access based on criteria established by the state.
9) Maintenance of vehicle modifications (i.e. wheelchair lift)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
CDCS cannot be used to cover goods and services that:

- Are provided prior to the development of the CDCS support plan
- Duplicate other goods and services in the CDCS support plan
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Goods and services that shall not be purchased within the participant's budget are:

- Any fees incurred by the participant such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items;
- Home modifications that add any square footage with the exception of an accessible bathroom-the county or tribal human service agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-Home Modifications)
- Home modifications for a residence other than the primary residence of the participant
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS support plan
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs;

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

TRANSITION PLAN: CDCS: environmental modifications and provisions under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS:

environmental modifications and provisions will be replaced by CDCS: environmental modifications-home modifications, CDCS: environmental modifications-vehicle modifications and CDCS: individual-directed goods and services. No new authorizations for CDCS: environmental modifications and provisions will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: environmental modifications and provisions for a participant who was not previously receiving CDCS: environmental modifications and provisions before December 2023.

Provider Specifications

Provider Category	Provider Type
1. Agency	Financial Management Services (FMS) providers

1. **Provider Category:** Agency
   Provider Type(s): Financial Management Services (FMS) providers
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

   People or organizations paid to assist in developing the CDCS support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a CDCS support plan for participants who are purchasing financial management services from them.

   A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for support plan activities.

   The CDCS support plan will define the qualifications that the worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

   Providers of modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by

Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Transportation. Standards for common carrier transportation are bus, taxicab, other commercial carrier, or county owned or leased vehicle. Private individuals may be designated to provide transportation when they meet the participant's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

Fitness and Exercise. Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant's actual and projected use of the health club or fitness center. Participants must periodically provide verification to the county or tribal human service agency that they are using the health club fitness center or fitness center.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the CDCS support plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, individual directed goods and services, community integration and support or environmental modifications (home or vehicle) provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's CDCS support plan.

The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information

technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.

The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participants' CDCS support plan approved by the county or tribal human service agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the CDCS support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years.

Service Title: Consumer-Directed Community Supports: Environmental Modifications – Home Modifications

Service Definition (*scope*):

CDCS: Environmental Modifications-Home Modifications can be purchased in a consumer directed manner within a global budget. CDCS: Environmental Modifications-Home Modifications include modifications or items to maintain the person's home that assists the person to live in and participate in the community or are required to maintain health and well-being. For purposes of home modifications, 'home' refers to the participant's primary place of residence (i.e.) not vacation homes)

The following are covered under this category:

- Home modifications

- Monitoring technology

Monitoring technology is defined as monitoring including cameras, motion detectors, GPS trackers, home security systems, and door and window alarms. A CDCS participant that wants to use their funds to purchase monitoring technology must follow service guidelines for monitoring technology usage as described in "Environmental Accessibility Adaptations – home modifications" as follows:

(a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:
    (1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
    (2) the Minnesota Government Data Practices Act as codified in Minnesota Statutes, chapter 13.

(b) The agency or individual shall be monitored for compliance as follows:
    (1) the agency or individual must control access to data on participants according to the definitions of public and private data on individuals under Minnesota Statutes, section 13.02; classification of the data on individuals as private under Minnesota Statutes, section 13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to Minnesota Statutes, section 13.05, in which the agency or individual is assigned the duties of a government entity;
    (2) the agency or individual must provide each participant with a notice that meets the requirements under Minnesota Statutes, section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;
    (3) In accordance with Minnesota Statutes, section 245A.11, Subd. 7a(f)(5) "a resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring." If an existing resident does not consent to electronic monitoring, the application for an alternative overnight technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant's needs are met by alternative means.
    (4) The use of environmental accessibility adaptations for monitoring technology requires a process for obtaining and maintaining informed consent. To ensure informed consent, the case manager and the participant or legal guardian must collaborate and determine:
        i. how the monitoring technology will be used;
        ii. how their needs will be met if they choose not to use monitoring technology;
        iii. possible risks created by the use of the technology;
        iv. who will have access to the data collected and how their personal information will be protected; and
        v. their right to refuse, stop, or suspend the use of monitoring technology at any time.
    (5) The participant's community support plan must describe how the use of monitoring technology:
        i. is the least restrictive option and the person's preferred method to meet an assessed need;

ii. achieves an identified goal or outcome; and
iii. addresses health, potential individual risks and safety planning.

(6) Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.
(7) cameras used for electronic monitoring must not be installed in bathrooms;
(8) cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Department approval is not required when parents are monitoring minor children living in their home using cameras in bedrooms for purposes of health and safety. Electronic monitoring cameras must not be concealed from the participant;
(9) equipment that is bodily invasive, auto door or window locks, and concealed cameras are not allowed;
(10) the state must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs; and
(11) electronic video and audio recordings of participants shall be stored for five days unless:
i. a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or
ii. the recording captures an incident or event of alleged maltreatment under Minnesota Statutes, Chapters 260E or 626.557 or a crime under Minnesota Statutes, chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section Minnesota Statutes, 626.557, subdivision 12b.

A provider of modification services must meet all professional standards and or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of CDCS services must be within the participants individual budget.
Unallowable Expenditures- CDCS Environmental modifications: home modifications that shall not be purchase with the participants budget are:

- Provided prior to the development of the CDCS support plan
- Home modifications that add any square footage with the exception of the addition of square footage necessary to make an accessible bathroom. The county or tribal human service agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-home modifications)
- Home modifications for a residence other than the primary residence of the participant

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Provider Specifications

Provider Category	Provider Type
1. Agency	Providers of CDCS Environmental Modifications – Home Modifications
2. Individual	Providers of CDCS Environmental Modifications – Home Modifications

1. **Provider Category:** Agency
   Provider Type(s): Providers of CDCS Environmental Modifications – Home Modifications
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing CDCS: Environmental Modifications-Home Modifications must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

   Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Home Modifications.

   Frequency of Verification:
   Upon authorization of the provider and prior to services being delivered.

2. **Provider Category:** Individual
   Provider Type(s): Providers of CDCS Environmental Modifications – Home Modifications
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing CDCS Environmental Modifications-Home Modifications must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal

background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

Providers of home modifications or monitoring technology must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide. Home modifications must meet building codes and be inspected by the appropriate building authority.

Verification of Provider Qualifications

Entity Responsible for Verification:
Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS environmental modifications-home modifications.

Frequency of Verification:
Upon authorization of the provider and prior to services being delivered.

Service Title: Consumer-Directed Community Supports: Environmental Modifications – Vehicle Modifications

Service Definition (*scope*):
CDCS Environmental Modifications-Vehicle Modifications can be purchased in a consumer directed manner within a global budget. CDCS Environmental Modifications–Vehicle Modifications are physical adaptations to the participant's primary vehicle required by the participant's support plan that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence.

Examples of adaptations include: adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions and wheelchair securing devices. The service may also cover installation, maintenance and repairs of vehicle modifications and equipment. Repairs may only be covered when they are cost effective given the condition of the item and compared to the replacement of the item.

Additionally, CDCS Environmental modifications – vehicle modifications can cover maintenance of vehicle modifications (i.e. wheelchair lift).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of the CDCS services must be within the participant's individual budget..
The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

CDCS Environmental Modifications-Vehicle Modifications cannot cover general vehicle maintenance.

Provider Specifications

Provider Category	Provider Type
1. Agency	Providers of CDCS Environmental Modifications-Vehicle Modifications

2. Individual	Providers of CDCS Environmental Modifications-Vehicle Modifications

1. **Provider Category:** Agency
   Provider Type(s): Providers of CDCS Environmental Modifications-Vehicle Modifications
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing CDCS Environmental Modifications-Vehicle Modifications must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

   Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Vehicle Modifications.

   Frequency of Verification:
   Upon authorization of the provider and prior to services being delivered.

2. **Provider Category:** Individual
   Provider Type(s): Providers of CDCS Environmental Modifications-Vehicle Modifications
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing CDCS Environmental Modifications-Vehicle Modifications must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act

Providers of vehicle modifications must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform their service. A provider of modification services must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide.

Verification of Provider Qualifications

Entity Responsible for Verification:

Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS Environmental Modifications-Vehicle Modifications.

Frequency of Verification:

Upon authorization of the provider and prior to services being delivered.

Service Title: Consumer-Directed Community Supports: Financial Management Services

Service Definition (*scope*):

Financial management services (FMS) provide help with financial tasks, billing and employer-related responsibilities for people who self-direct their services through consumer directed community supports (CDCS). These services are provided by financial management services (FMS) providers.

FMS providers perform vendor fiscal/employer agent (VF/EA) tasks. This means the FMS provider's role is to support the person to fulfill his/her responsibilities in being the employer of his/her workers. The FMS provider's tasks include:

- Billing DHS and paying vendors or the person's individual workers for authorized goods and services
- Ensuring what the person spends his/her funds on follows the rules of the program and the plan approved by the county or tribal human service agency
- Helping the person obtain workers' compensation
- Educating the person on how to employ workers
- Documenting and reporting all spending of program funds
- Initiating background studies for workers
- Filing federal and state payroll taxes for workers on the person's behalf

Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the support plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants' service budget, and may not include

set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, community integration and support, individual-directed goods and services, support planning services or environmental modifications and provisions, environmental modifications – home modifications, or environmental modifications – vehicle modifications provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's support plan.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS-Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS-individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Agency	Financial Management Services (FMS) Providers

1. **Provider Category:** Agency
   Provider Type(s): Financial Management Services (FMS) Providers
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable.

   The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

   FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.

The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participant's CDCS support plan approved by the county or tribal human service agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years

Service Title: Consumer-Directed Community Supports: Individual-Directed Goods and Services

Service Definition (*scope*):

Individual-Directed Goods and Services can be used to purchase items within a global budget. Individual-directed goods and services includes services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the support plan (including improving and maintaining the participant's opportunities for full membership in the community) and the item or services meets all of the following requirements:

- Decreases the need for other Medicaid services;
- Promotes inclusion in the community;
- Increases the participant's safety in the home environment; and
- The participant does not have the funds to purchase the item or service and the item or service is not available through another source.

Participants may purchase individual-directed goods and services that are included in their support plan, meet the criteria for allowable expenditures described below, and are within the means of their CDCS budget to purchase.

Allowable Expenditures: Consumer directed community supports may include traditional goods and services provided by the waiver as well as alternatives that support participants. Individual directed goods and services also covers special diets and thickening agents not otherwise available through the State plan that mitigate the participants disability or condition when prescribed by a physician, advanced practice registered nurse or physician assistant who is enrolled as a MHCP provider.

Individual-directed goods and services remote support, is the following:

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of the CDCS services must be within the participant's individual budget. Unallowable Expenditures. Goods and services that shall not be purchased within the participant's budget are:

- Any fees incurred by the participant such as MHCP fees and co-pays;
- Attorney costs or costs related to advocate agencies;
- Room and board and personal items;

- CDCS services to any participant who is placed in the Minnesota Restricted Recipient Program (MRRP). A participant is prohibited from using the CDCS option during the time period the person is in the MRRP;
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise for adults as specified in the support plan;
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS Environmental Modifications and Provisions, CDCS individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications, or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Individual/Vendor as selected by the participant

1. **Provider Category:** Individual
   Provider Type(s): Individual/Vendor as selected by the participant
   Provider Qualifications

   License *(specify)*:
   Valid Business license in good standing, if applicable.

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

   All individuals/vendors providing individual-directed goods and services must be able to:
   1) demonstrate to the waiver participant that they have the capacity to perform the requested work and the ability to successfully communicate with him/her; and
   2) have all necessary professional and/or commercial licenses required by federal, state and local statutes and regulations, if applicable.

   Private individuals may be designated to provide transportation when they meet the participant's needs and preferences in a cost-effective manner. Drivers must have a valid driver's license and meet state requirements for insurance coverage.

   Health clubs and fitness centers that provide fitness and exercise programs must meet all applicable state regulations for operation. If authorized, the payment structure shall be based on the most cost effective payment option (e.g., daily rates, annual memberships, etc.) depending on the participant's actual and projected use of the health club or fitness center. Participants

must periodically provide verification to the county or tribal human service agency that they are using the health club or fitness center.

Verification of Provider Qualifications

Entity Responsible for Verification:
Counties or tribal human service agencies are responsible for verifying the qualifications of providers of individual-directed goods and services.

Frequency of Verification:
Upon purchase of goods/support.

Service Title: Consumer-Directed Community supports: Personal Assistance

Service Definition (*scope*):
Consumer Directed Community Supports (CDCS) Personal Assistance can be purchased in a consumer directed manner within an established budget.

CDCS Personal Assistance includes direct assistance provided in the participant's home or community. Participants determine the provider qualifications. The assistance may be hands-on or cueing. The following are covered under CDCS Personal Assistance:

- Assistance with activities of daily living
- Assistance with instrumental activities of daily living (i.e. meal planning and preparation; basic assistance with paying bills; shopping for food, clothing and other essential items; performing household tasks integral to the personal assistance services)
- Caregiver Relief

The participant or his/her designated representative as applicable, is the employer of the worker providing personal assistance services. These workers are recruited, selected, employed and managed by the participant or his/her representative. Supports are available to assist the participant or his/her representative with employer related responsibilities through the Financial Management Services (FMS) provider.

Services provided under CDCS personal assistance are provided on a one-to-one basis unless the county or tribal human service agency approves the use of shared services. Shared services can only be authorized for services in the personal assistance category and within the scope of personal assistance services.

Shared services are defined as services provided simultaneously to no more than three participants by the same direct care worker. The participants must jointly develop and enter into an agreement to share services.

The need for shared services must be identified in each participant’s support plan. Each participant’s county or tribal human service agency must authorize the use of shared services based on a determination that the shared service is appropriate to meet the assessed needs of its participant.

Participants sharing services must use the same provider of FMS to ensure program integrity and simplify the processing of worker time sheets claims. The use of one FMS provider will ensure there is no duplication of services or overlapping of worker shifts. This safeguard will also ensure that workers are receiving overtime for applicable hours worked.

A participant or the participant's representative may withdraw from participating in a shared services agreement at any time.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of CDCS services must be within the participants individual CDCS budget.

Shared services cannot be provided:
- To more than three participants by one worker at one time;
- When more than one worker is providing services at the same time to participants who are sharing personal assistance services;

Unallowable Expenditures
Services under CDCS Personal Assistance that shall not be purchased within the participant's budget are:
Goods and services that shall not be purchased within the participant's budget are:
- Attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Vacation expenses other than the cost of direct services;
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs;

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications and Provisions, CDCS Environmental Modifications–Home Modifications, Environmental Accessibility Adaptations–Home Modifications, CDCS-individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Provider Specifications

Provider Category	Provider Type
1. Individual	CDCS Worker

1. **Provider Category:** Individual
   Provider Type(s): CDCS Worker
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   CDCS workers must meet the following qualifications:
   a) Comply with the criminal background study standards in Minnesota Statutes, Chapter 245C
   b) Meet all Minnesota Health Care Programs (MHCP) individual provider enrollment requirements as identified in the MHCP manual
   c) Receive customized training provided by the participant and/or his/her representative
   d) Be able and willing to provide the service-related responsibilities outlined in the participant's support plan

Providers of CDCS-Personal Assistance excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of Minnesota Statutes section 245D.06, regarding incident reporting and prohibited and restricted procedures; and section 245D.061 regarding the emergency use of manual restraint.

Verification of Provider Qualifications

Entity Responsible for Verification:

The participant or authorized representative if designated as the employer of the worker and the FMS provider determine if the worker has met the minimum qualifications.

Frequency of Verification:

At the time of the worker recruitment prior to hire, and thereafter, once hired, as necessary. The FMS provider verifies that the worker's background study qualifications are met during the employment process. During the enrollment process, MHCP executes an individual provider agreement with each worker on behalf of the participant.

Service Title: Consumer Directed Community Supports (CDCS): Self-direction Support Activities

Service Definition (*scope*):

CDCS: self-direction support activities includes services, supports and expenses incurred for administering or assisting the participant or their representative in administering CDCS. The following are typically covered under this category:

- liability insurance and workers compensation,
- payroll expenses including FICA, FUTA, SUTA and wages, processing fees,
- employer shares of benefits, assistance in securing and maintaining workers,
- development and implementation of the CDCS support plan,
- monitoring and provision of services.

Support Planner services are covered under this CDCS category. Participants may select who they want to provide this service. People reimbursed through CDCS to assist with the development of the participant's person-centered CDCS support plan must: be 18 years of age or older; pass a certification test developed by the department on person-centered support planning approaches including the Vulnerable Adult Act; provide a copy of their training certificate to the participant; use the CDCS support plan template or a community support plan format that includes all of the information required to authorize CDCS and, be able to coordinate their services with the county or tribal human service agency case manager to assure that there is no duplication between functions. Participants may require additional provider qualifications tailored to their individual needs. These will be defined in the participant's CDCS support plan. The provider must provide the participant or the participant's representative with evidence that they meet the required qualifications. This includes providing a copy of training completion certificate(s) for any related training.

Participants or their representatives have control over the goods and services to be provided through developing the support plan, selecting vendors, verifying that the service was provided, evaluating the provision of the service, and managing the CDCS budget. The individual budget maximum amount is set by the state. Prior to the development of a CDCS support plan, counties or tribal human service agencies will inform the participant of the amount that will be available for implementing the plan over a one-

year period. The county or tribal human service agency is responsible for reviewing and approving final spending decisions in the participant's CDCS support plan. The cost of background studies is not included in the individual budget amount. In a 12-month service agreement period, the individual budget will include all goods and services to be purchased through the waiver and state plan home care services except required case management and criminal background studies.

Expenses covered outside of the individual budget (i.e., required case management and criminal background checks) must be managed within the individual's maximum case mix amount that is set by the state. These supports must be identified in the CDCS support plan. Required case management functions are provided by counties or tribal human service agencies and are not included in the participant's budget.

An individualized written CDCS Support Plan must be developed for each participant. The participant or their representative will direct the development and revision of the CDCS support plan and delivery of the CDCS services. The support plan must be designed through a person-centered process that reflects the participant's strengths, needs, and preferences. The support plan may include a mix of paid and non-paid services and may include traditional goods and services provided by the waiver as well as alternatives that support participants. The support plan must define all goods and services that will be paid through CDCS. The participant or their representative must agree to and verify that the good or service was delivered prior to a Medicaid claim being submitted.

The CDCS support plan identifies:
- the goods and services that will be provided purchased to meet the participant's assessed needs;
- safeguards that are required to reasonably maintain the participant's health and safety;
- the participant's emergency needs and how they will be met.
- overall outcome(s) of the participant's plan
- how monitoring of the plan will occur
- qualifications including training requirements of staff and
- who is responsible to assure that the qualification and training requirements are met

Criteria for allowable expenditures:
- The waiver shall cover only those goods and services are not covered when they are provided prior to the development of the support plan and must be necessary to meet a need identified in the participant's assessment and be for the direct benefit of the participant.
- Do not duplicate other services in the CDCS support plan,
- do not supplant natural supports and
- Are the least costly and effective means appropriately meeting the participant's needs and are not available through other funding sources.

The participant or their representative may revise the way that a CDCS service or support is provided without the involvement or approval of the county or tribal human service agency when the revision does not change or modify parameters of the CDCS support plan authorized by the case manager. If a revision results in a change or modification of the approved CDCS community support plan parameters, the participant or their representative will work with the county or tribal human service agency to have the CDCS community support plan reviewed and re-authorized.
Goods and services are appropriate purchases when they are reasonably necessary to meet the following consumer outcomes:
- Maintain the ability of the participant to remain in the community;

- Enhance community inclusion and family involvement;
- Develop or maintain personal, social, physical, or work related skills;
- Decrease dependency on formal support services;
- Increase independence of the participant
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

If a service, support, or item does not meet the criteria or is included in the list of unallowable expenditures, it cannot be authorized and the case manager must provide the participant or the participant's representative a notice of appeal rights.

CDCS may include traditional goods and services provided by the waiver as well as alternatives that support participants. The goods and services need to fit into the four categories of Personal Assistance, Treatment and Training, Environmental Modifications and Provisions and Self-direction Support Activities.

Additionally budgets may include:

1) Goods or services that augment State plan services, or provide alternatives to waiver or state plan services. The rates for these goods and services are included in the CDCS support plan.
2) Goods or services provided by MA providers. The rates for these goods and services cannot exceed the rates established by the state for a similar service.
3) Therapies, special diets, thickening agents and behavioral supports that are not covered by the state plan and are prescribed by a physician that is enrolled as a MHCP provider.
4) Fitness or exercise programs when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant’s physical condition. The condition must be identified in the participant's CDCS support plan and monitored by a MHCP enrolled physician.
5) Expenses related to the development and implementation of the CDCS support plan will be included in the budget. Services included in the CDCS support plan must be necessary to meet a need identified in the participant’s assessment. This may include hiring a support planner. The CDCS support plan must include specific tasks to be performed by a paid support planner. Support planner functions are:
    a. Provide information about CDCS and provider options.
    b. Facilitate the development of a person-centered CDCS support plan.
    c. Monitor and assist with revisions to the CDCS support plan.
    d. Assist in recruiting, screening, hiring, training, scheduling, monitoring, and paying workers.
    e. Facilitate community access and inclusion (i.e., locating or developing opportunities, providing information and resources, etc.).
    f. Monitor the provision of services including such things as interviews or monitoring visits with the consumer or service providers.
    g. Provide staff training that is specific to the consumer's CDCS support plan.
6) FMS costs incurred to manage the budget; advertise and train staff;
7) Environmental modifications and adaptations up to the amount allowed in the waiver plan under the environmental accessibility adaptations service. This amount includes all environmental modifications and adaptations to be paid for by the waiver per service agreement year.
8) Costs related to internet access based on criteria established by the state.
9) Maintenance of vehicle modifications (i.e. wheelchair lift)

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

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

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

CDCS cannot be used to cover goods and services that:

- Are provided prior to the development of the CDCS support plan
- Duplicate other goods and services in the CDCS support plan
- Services covered by the State plan, Medicare, or other liable third parties including education, home based schooling, and vocational services
- Expenses for travel, lodging, or meals related to training the individual or his/her representative or paid or unpaid caregivers
- Services, goods or supports provided to or directly benefiting persons other than the participant

Goods and services that shall not be purchased within the participant's budget are:

- Any fees incurred by the participant such as MHCP fees and co-pays, attorney costs or costs related to advocate agencies;
- Insurance except for insurance costs related to direct support worker employee coverage;
- Room and board and personal items;
- Home modifications that add any square footage with the exception of an accessible bathroom-the county or tribal human service agency can seek approval to build or modify a wheelchair accessible bathroom (see Environmental Accessibility Adaptations-Home modifications)
- Home modifications for a residence other than the primary residence of the participant
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Membership dues or costs except those related to fitness or physical exercise as specified in the CDCS support plan
- Vacation expenses other than the cost of direct services;
- General vehicle maintenance
- Tickets and related costs to attend sporting or other recreational events;
- Animals, including service animals, and their related costs

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

TRANSITION PLAN: CDCS: self-direction support activities under this waiver shall discontinue after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. CDCS: self-direction support activities will be replaced by CDCS: financial management services and CDCS: support planning. No new authorizations for CDCS: self-direction support activities will be allowed after December 2023, or 18 months following CMS approval of this waiver amendment package and the completion of system updates by the Department, whichever is later. A new authorization means approval for CDCS: self-direction support activities for a participant who was not previously receiving CDCS: self-direction support activities before December 2023.

Provider Specifications

Provider Category	Provider Type
1. Agency	Financial Management Services (FMS) providers

1. **Provider Category:** Agency
   Provider Type(s): Financial Management Services (FMS) providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
CDCS direct care workers and other people or entities providing supports are selected by the participant. People or entities providing goods or services covered by CDCS must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

People or organizations paid to assist in developing the CDCS support plan (e.g., certified support planners) must not have any direct or indirect financial interest in the delivery of services in that plan. FMS providers or their representatives cannot participate in the development of a CDCS support plan for participants who are purchasing financial management services from them.

A parent, spouse or legal representative can provide many of the same types of support to the participant that a support planner can provide. However, neither a parent of a minor nor a spouse or a legal guardian or conservator can receive payment for support plan activities.

The CDCS support plan will define the qualifications that the worker or provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

FMS providers are the CDCS Medicaid enrolled provider for all CDCS services. The FMS providers function as statewide Vendor Fiscal/Employer Agent (VF/EA) FMS organizations in accordance with section 3504 of the Internal Revenue Code and Revenue Procedure 2013-39 as applicable. Tasks include, but are not limited to, training participants on their legal obligations as employers of their workers, disbursing and accounting of all MHCP funds for each participant served including payroll of individual workers and vendor payments, initiating criminal background studies, and filing federal and state payroll taxes for support workers on behalf of participants. The FMS provider may not in any way limit or restrict the participant's choices of services or support providers.

FMS providers must have a written agreement with the participant or their legal representative that identifies the duties and responsibilities to be performed and the related charges. The FMS must provide the participant on a monthly basis, and county of financial responsibility, on a quarterly basis, a written summary of what CDCS services were billed including charges from the FMS provider.

FMS providers must establish and make public the maximum rate(s) for their services. The rate and scope of financial management services is negotiated between the participant or the participant's representative and the FMS provider, and included in the CDCS community plan. FMS provider fees must be on a fee-for-service basis other than a percentage of the participants'

service budget, and may not include set up fees or base rates or other similar charges. Maximum FMS provider fees may be established by the state agency. FMS providers who have any direct or indirect financial interest in the delivery of personal assistance, treatment and training, individual-directed goods and services, community integration and support or environmental modifications (home and vehicle) provided to the participant must disclose in writing the nature of that relationship, and must not develop the participant's CDCS support plan.

The FMS provider must be knowledgeable of and comply with Internal Revenue Service requirements necessary to: process employer and employee deductions; provide appropriate and timely submission of employer tax liabilities; and maintain documentation to support the MA claims. The FMS provider must have current and adequate liability insurance and bonding, be a financially solvent organization with sufficient cash flow, and have on staff an information technology security officer and certified payroll professional, or a certified public accountant or an individual with a bachelor's degree in accounting. The FMS provider must use an electronic tracking, reporting, and verification software product for required controls and reports that rely on analyzing data on participants and support workers across FMS providers. The FMS provider must have the capacity to provide services statewide and to meet the requirements for VF/EA FMS organizations under a collective bargaining contract. The FMS provider must have an established customer service system, information technology system that complies with the requirements for data privacy set forth in the Health Insurance Portability and Accountability Act of 1996, and a quality assurance and program integrity system to prevent, detect and report suspected fraud, abuse or errors.

FMS providers must successfully complete a readiness review prior to enrollment, which includes a review of their Minnesota specific policies and procedures manual. Enrolled FMS providers will be subject to a performance review every three years.

The Department determines if these criteria and the provider standards are met through a written readiness review submitted by the FMS provider or applicant.

The FMS provider must maintain records to track all CDCS expenditures, including time records of people paid to provide supports and receipts for any goods purchased (i.e., a clear audit trail is required). The records must be maintained for a minimum of five years from the claim date, and available for audit or review upon request. The FMS provider must also receive a copy of the participants' CDCS support plan approved by the county or tribal human service agency. Claims submitted by the FMS provider must correspond with services, amounts, time frames, etc. as authorized in the CDCS support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department conducts performance reviews that include verification of provider qualifications, demonstration of effective service delivery, and compliance with the program standards.

Frequency of Verification:

Every three years.

Service Title: Consumer-Directed Community Supports: Support Planning

Service Definition (*scope*):
CDCS support planning is an optional service that is available to help participants develop and implement their person-centered CDCS Support Plan. The cost of support planning services is included in the participant's budget. When selected, support planning services are provided by certified CDCS support planners. The CDCS support planner is selected by the participant.

CDCS support planning services include tasks outlined in the written work agreement between the support planner and the participant

Tasks include:
- Providing information about CDCS and provider options
- Applying person-centered thinking and planning principles to facilitate the development of a person-centered CDCS support plan
- Developing a quality CDCS support plan that includes all required components and information required to authorize CDCS services
- Ensuring the CDCS support plan is developed based on assessed needs identified in the person's assessment
- Submitting the CDCS support plan to the county or tribal human service agency for approval
- Implementing, monitoring and evaluating the approved CDCS support plan and budget on an ongoing basis
- Modifying the CDCS support plan as needed, including revisions and addendums
- Helping and teaching the person to recruit, screen, hire, train, schedule and monitor workers
- Providing information about community resources related to the CDCS support plan.

A CDCS support planner performs support planning services according to established CDCS policy, self-direction principles, federally approved waiver plans and the written work agreement established between the individual and the support planner. The CDCS support planner helps the individual comply with DHS policies, waiver regulations and all applicable Minnesota rules and statutes.

A CDCS support planner must ensure that support planning service are provided within the scope of DHS support planner service standards and are related to an approved CDCS Community Support Plan (CSP). The CDCS support planner must also ensure that support planning services do not duplicate services provided under CDCS required case management or other services available to the person (e.g., services provided by certified assessors, FMS providers, Office of the Ombudsman, advocacy organizations, free civil legal assistance with appeals and other direct services covered under Minnesota Health Care Programs)

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

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

CDCS Support planners cannot:

- Be the employer of people or legal representatives to whom they are delivering support planner services
- Be the parent of a minor child or spouse of the person receiving services
- Have any direct or indirect financial interest in the delivery of the services in the CDCS Support Plan beyond support planning (e.g., a person receiving payment to help develop a support plan cannot employ others or hire independent contractors to deliver services and supports, even if chosen by the CDCS participant).

A parent of a minor or adult, spouse or legal representative can provide many of the same types of support to the person that a support planner can provide. However payment for support planning activities cannot be made to a parent of a minor or adult, spouse, or legal representative.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications–Home Modifications, CDCS-Environmental Modifications and Provisions, Environmental Accessibility Adaptations–Home Modifications, CDCS-individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	CDCS Support Planners

1. **Provider Category:** Individual
   Provider Type(s): CDCS Support Planners
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:
   For initial certification, a person must:
   - Be at least 18 years old
   - Complete a minimum of six hours of person-centered planning coursework within three years before taking the initial certification test
   - Successfully pass the Support Planner Initial Certification for CDCS test (TrainLink course DS651) with at least 80% correct.

   A CDCS Support planner must be recertified every two years. A CDCS support planner must:
   - Complete and document 20 hours of training or education if providing support planner services to more than one family.
   - Successfully pass the Support Planner Recertification for CDCS test (TrainLink course DS651C) with at least 80% correct.

   Support planners must maintain their own training documentation. This documentation must include:
   - Name of the trainer
   - Course outline
   - Course objectives
   - Length of training.

   Documentation of training is subject to DHS audit.

   A person providing support planning services (i.e. CDCS support planners) must:
   - Comply with the DHS support planner service standards
   - Establish a written work agreement with the person outlining the tasks they are hired to perform
   - Provide a copy of the training certificate to the person/legal representative and county or tribal human service agency as requested
   - Provide evidence they meet any additional required training and qualifications requested by the person and defined in the CDCS support plan

- Coordinate services with the county or tribal human service agency case manager to ensure there is no duplication of functions/tasks
- Have effective written communication skills sufficient to write a CDCS support plan that includes all required components.

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
DHS is responsible for verifying the qualifications of CDCS support planners.

Frequency of Verification:
Every two years

Service Title: Consumer-Directed Community Supports: Treatment and Training

Service Definition (*scope*):
CDCS Treatment and Training can be purchased in a consumer directed manner within an established budget.

CDCS: treatment and training includes services that promote the person's health and ability to live in and participate in the community. The following are covered under this category:
- * Specialized therapies or behavioral supports
- Training and education to paid or unpaid caregivers
- Training and education to participants to increase their ability to manage CDCS services

* Specialized therapies and behavioral supports are services that a Minnesota Health Care Program (MHCP) medical provider prescribes to relieve the person's disability and/or condition that are not included in the Medical Assistance State Plan or waiver plans. This includes therapies in the CDCS plan as an alternative to state plan services. These services are not intended to be used to either replace medical treatment or services available through Medical Assistance (MA) or exceed current Medical Assistance coverage limits.

Additionally, treatment and training includes supports that provide alternatives to waiver or state plan services, such as alternative therapies and behavioral supports, when those supports:
- Are not otherwise available through the State Plan;
- Mitigate the participants disability or condition; and
- Are prescribed by an MHCP medical provider.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agrees to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of the CDCS services must be within the participant's individual CDCS budget.

Unallowable Expenditures
Services under CDCS: Treatment and Training that shall not be purchased are:

- Services available through other funding sources
- Any fees incurred by the participant such as MHCP fees and co-pays.
- Experimental treatments;
- All prescription and over-the-counter medications, compounds, and solutions, and related fees including premiums and co-payments;
- Animals, including service animals, and their related costs.

Remote support does not fund the enabling technology. Technology may be covered through assistive technology, CDCS Environmental Modifications and Provisions, CDCS Environmental Modifications-

Home Modifications, Environmental Accessibility Adaptations–Home Modifications, Individual directed goods and services or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

The CDCS option cannot be used by a participant during the time period that the participant is in the Minnesota Restricted Recipient Program (MRRP).

Provider Specifications

Provider Category	Provider Type
1. Agency	Providers of CDCS Treatment and Training
2. Individual	Providers of CDCS Treatment and Training

1. **Provider Category:** Agency
   Provider Type(s): Providers of CDCS Treatment and Training
   Provider Qualifications
   License *(specify)*:
   Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the services being provided.

   Providers of training and education must meet the qualifications as specified in the participants CDCS Support Plan. For services and supports that do not require professional licensing, credentialing or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

   Certificate *(specify)*:

   Other standard (*specify*):
   People or entities providing specialized therapies, behavior supports, or training and education to caregivers or participants covered by CDCS must bill through the financial management services (FMS) provider.

   Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS Treatment and Training.

   Frequency of Verification:
   Upon authorization of the provider and prior to services being delivered.

2. **Provider Category:** Individual
   Provider Type(s): Providers of CDCS Treatment and Training

Provider Qualifications

License *(specify)*:
Providers of specialized therapies or behavioral support must meet the certification or licensing requirements in state law related to the services being provided.

Providers of training and education must meet the qualifications as specified in the participants CDCS Support Plan. For services and supports that do not require professional licensing, credentialing or certification, the support plan will define the qualifications that the provider must meet. Documentation must be maintained by the participant or their designee indicating how the qualifications are met.

Certificate *(specify)*:

Other standard (*specify*):
People or entities providing specialized therapies, behavior supports, or training and education to caregivers or participants services must bill through the financial management services (FMS) provider.

Providers may not be paid with CDCS funds if they have had state or county agency contracts or provider agreements discontinued due to fraud or been disqualified under the criminal background check according to the standards in Minnesota Statutes, chapter 245C, Department of Human Services Background Studies Act.

Verification of Provider Qualifications

Entity Responsible for Verification:
Counties or tribal human service agencies are responsible for verifying the qualifications of providers of CDCS Treatment and Training.

Frequency of Verification:
Upon authorization of the provider and prior to services being delivered.

Service Title: Discretionary Services

Service Definition (*scope*):
Discretionary services allow county and tribal human service agencies to use AC program funds to address special or unmet needs of an AC participant or their family caregiver if the service is not otherwise defined in the AC program service menu and if the service is prior authorized by DHS. These services may be used to improve access, choice, and/or cost effectiveness of the AC program by addressing the chronic care needs of the participant. Discretionary services must not duplicate other services or other funding that covers the service. Discretionary services must be necessary to delay or prevent nursing facility admission and must be identified in the participant's support plan.

County and tribal human service agencies that wish to use the discretionary services option must complete the Alternative Care Program Application for Discretionary Services and submit it to DHS. DHS staff review and approve requests, as applicable, and coverage amounts based on the above criteria.

To be eligible for AC discretionary services, a person must:

- Participate in the AC program.
- Have a specific need that cannot be met by another AC service.
- Have the discretionary service included in their support plan.
- County and tribal human service agencies must receive annual approval from DHS to offer discretionary services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
AC discretionary services do not cover services that:

- Are not approved by DHS.
- Do not address a person's chronic care needs.
- Do not prevent or delay nursing facility admissions.
- Duplicate services already provided by the AC program.
- Replace or duplicate services available through other funding sources (e.g., Medicare, Medicaid, private insurance).

Provider Specifications

Provider Category	Provider Type
1. Agency	Discretionary service providers
2. Individual	Discretionary service providers

1. **Provider Category:** Agency
   Provider Type(s): Discretionary service providers
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*): Discretionary services must improve participant access, expedite transfers into the community from nursing facilities, or support family caregivers in providing care.

   County and tribal human service agencies that wish to use the discretionary services option must complete the Alternative Care Program Application for Discretionary Services and submit it to DHS. DHS staff review and approve requests and coverage amounts based on the above criteria.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

   Non-enrolled providers: County or tribal human service agency

   Frequency of Verification:
   Enrolled providers: Every five years

   Non-enrolled providers: Annually

2. **Provider Category:** Individual
   Provider Type(s): Discretionary service providers
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*): Discretionary services must improve participant access, expedite transfers into the community from nursing facilities, or support family caregivers in providing care.

   County and tribal human service agencies that wish to use the discretionary services option must complete the Alternative Care Program Application for Discretionary Services and submit it to DHS. DHS staff review and approve requests and coverage amounts based on the above criteria.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

   Non-enrolled providers: County or tribal human service agency

   Frequency of Verification:
   Enrolled providers: Every five years

   Non-enrolled providers: Annually

Service Title: Environmental Accessibility Adaptations – Home Modifications

Service Definition (*scope*):
Environmental Accessibility Adaptations-Home Modifications are physical adaptations to the participant's primary home, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or that enable participants to function with greater independence in the home. For purposes of the waiver, "home" means the participant's primary place of residence (i.e., not vacation homes).

Exceptions to the requirement that home modifications be limited to the participant's primary place of residence, may be authorized by the case manager when the following criteria are met and documented in the participant's support plan. The accessibility adaptation:
1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, counties tribal human service agencies may authorize home modifications in separate payment amounts, for example:

- Line 1: Materials and permits
- Line 2: Down payment
- Line 3: Completion and inspection, or final payment.

This service also covers the necessary assessments to determine the most appropriate adaptation or equipment and oversight of the project by an assessment provider to assure ADA requirements or accessibility needs are met.

EAA also covers the installation, purchase, maintenance and repairs of portable or permanent equipment, materials, devices and systems that are integral to the home modification project. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

Modifications and adaptations to the home may include, but are not limited to: the installation of ramps, grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate medical equipment and supplies and modifications to adaptive equipment such as adaptive furniture, adaptive positioning devices, and utensils. EAA also includes the installation, maintenance and repairs of monitoring systems, and motion detectors when the equipment installation requires modifications to the physical structure of the home that are not easily removed.

Environmental Accessibility Adaptations-Home Modifications may not be furnished as a separate waiver service for participants that live in settings that are owned or leased by providers of waiver services, such as:

1) homes that are licensed to provide foster care, or
2) in a licensed assisted living facility as defined in Minnesota Statute 144G; or
3) in an affordable housing setting, as defined under Minnesota Statutes, section 256S.20 subd. 1 or subsequent provisions.

Adaptations that add to the square footage of the home may be covered when it is necessary to build a new bathroom or modify an existing bathroom when the following criteria are met:

- The accessibility adaptation is necessary to accommodate a wheelchair or scooter.
- The accessibility adaptation is to an unlicensed private residence of the individual and is owned by the individual or a family member
- At least two comparison bids were received.
- An evaluation by an expert in the field of home modifications must be completed to determine whether the accessibility adaptation is necessary based on the health and safety needs identified in the participant's support plan. The expert must have no financial interest in the delivery of the accessibility adaptation.
- The accessibility adaptation is reasonable and is limited to materials that are the most cost effective and of reasonable standards.

The county or tribal human service agency will determine whether the above criteria are met and will submit all documentation to the department for the final determination.

If, for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), the county or tribal human service agency may bill for environmental accessibility adaptations - home modification as a Medicaid administrative cost.

If the individual unexpectedly exits the waiver prematurely (due to death, or due to a move to a nursing facility or institution) after the completion of an environmental accessibility home modification, the provider shall be paid for the full cost of work completed, up to the amounts prior authorized by the county or tribal human service agency.

When EAA is used to authorize monitoring technology installation, maintenance or repair, the following requirements under (a) and (b) must be met:

(a) Any agency or individual who creates, collects, records, maintains, stores, or discloses any individually identifiable participant data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:
    (1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and
    (2) The Minnesota Government Data Practices Act as codified in chapter 13.
(b) The agency or the individual shall be monitored for compliance as follows:
    (1) The agency or the individual must control access to data on participants according to the definition of public and private data on individuals under section 13.02; classification of the data on individuals as private under section 13.46, subd.2; and control over the collection, storage, use, access, protection, and contracting related to data according to section 13.05, in which the agency or individual is assigned the duties of a government entity.
    (2) The agency or individual must provide each participant with a notice that meets the requirements under section 13.04, in which the agency or individual is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the participant that the agency or individual uses electronic monitoring and, if applicable, that recording technology is used;
    (3) In accordance with Minn. Stat. § 245A.11, Subd. 7a (f) “a foster care recipient may not be removed from a program under this subdivision for failure to consent to electronic monitoring.” If an existing resident does not consent to electronic monitoring, the application for an alternative overnight supervision technology license will not be approved. If the participant does not consent, the case manager and the support planning team are responsible to ensure that the participant’s needs are met by alternative means.
    (4) The use of environmental accessibility adaptations - home modifications for monitoring technology requires an informed consent process. To ensure informed consent, the case manager and the participant or legal guardian must collaborate and determine:
        i. how the monitoring technology will be used;
        ii. how their needs will be met if they choose not to use monitoring technology;
        iii. possible risks created by the use of the technology;
        iv. who will have access to the data collected and how their personal information will be protected; and
        v. their right to refuse, stop, or suspend the use of monitoring technology at any time.
    (5) The participant’s support plan must describe how the use of monitoring technology:

i. is the least restrictive option and the person's preferred method to meet an assessed need;
ii. achieves an identified goal or outcome; and
iii. addresses health, potential individual risks and safety planning.

(6) Additional consent is not required for door and window alarms that do not record data, when used to supplement the supervision provided by an on-site caregiver and documented in the support plan as needed for health and safety.
(7) cameras used for electronic monitoring must not be installed in bathrooms;
(8) cameras will only be permitted in bedrooms as the least restrictive alternative for complex medical needs or other extreme circumstances as approved by the Department. Electronic monitoring cameras must not be concealed from the participant;
(9) Equipment that is bodily invasive, concealed cameras, and auto door or window locks are not allowed.
(10) The State must review support plans of waiver participants with a proposed need for cameras in their bedroom. Support planning teams may consist of individuals with expertise in areas appropriate to meet the individual's needs.
(11) Electronic video and audio recordings of participants shall be stored for five days unless:
i. a participant or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or
ii. the recording captures an incident or event of alleged maltreatment under Chapter 260E or 626.557 or a crime under chapter 609. When requested by a participant or when a recording captures an incident or event of alleged maltreatment or a crime, the recordings must be maintained in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in Minnesota Statutes section 626.557, subdivision 12b.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Modifications and adaptations to the home that are of general utility, and are not of direct medical or remedial benefit to the participant, such as roof repair, central air conditioning, major household appliances, etc. and modifications that add to the total square footage of the home are not covered.

Coverage is limited to modifications and adaptations to the participant's primary residence.

For new construction or unfinished rooms in existing homes, the waiver will only pay for the additional costs directly related to the participant's accessibility needs and not the typical costs related to building or finishing a room.

An assessment provider completing an evaluation of the person's home and collecting comparison bids cannot also bid on the same project unless there are no other installation providers within the participant's region as documented by the county or tribal human service agency in the support plan.

Provider Specifications

Provider Category	Provider Type
1. Agency	Environmental Accessibility Adaptations/Home Modification/Installations
2. Individual	Environmental Accessibility Adaptations/Home Modification Assessments
3. Agency	Environmental Accessibility Adaptations/Home Modification Assessments

4. Individual	Environmental Accessibility Adaptations/Home Modification/Installations

1. **Provider Category:** Agency
   Provider Type(s): Environmental Accessibility Adaptations/Home Modification/Installations
   Provider Qualifications
   License *(specify)*:
   Providers who meet the definition of residential building contractor as defined in Minnesota Statutes, section 326B.802, subd. 11, must be licensed as a residential building contractor.

   As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

   Limited Install Providers: Providers who provide only one "special skill" as defined in Minnesota Statutes, Chapter 326B.802, subd. 15 are exempt from licensure.

   Certificate *(specify)*:

   Other standard (*specify*):
   The provider must be qualified, by professional certification or references, to install, repair, and/or maintain the home modification defined in the participant's support plan. All installations shall be executed in accordance with applicable state and local building codes.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

   Non-enrolled providers: County or tribal human service agency

   Frequency of Verification:
   Enrolled providers: Every five years

   Non-enrolled providers: Every five years

2. **Provider Category:** Individual
   Provider Type(s): Environmental Accessibility Adaptations/Home Modification Assessments
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Individuals that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
   - An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, sections 148.6401 to 148.6449

- A Physical Therapist licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
- A Certified Aging-in-Place Specialist
- A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry under Minnesota Statutes, section 326B.133, Subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
Enrolled providers: Every five years

3. **Provider Category:** Agency
Provider Type(s): Environmental Accessibility Adaptations/Home Modification Assessments
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Agencies that provide home modification assessments must have at least one year of experience with home modification evaluations and meet one of the following:
- An Occupational Therapist that is currently licensed by the Minnesota Board of Occupational Therapy under Minnesota Statutes, sections 148.6401 to 148.6449
- A Physical Therapist licensed by the Minnesota Board of Physical Therapy under Minnesota Statutes, section 148.65 to 148.78.
- A Certified Aging-in-Place Specialist
- A Certified Accessibility Specialist, certified through the Minnesota Department of Labor and Industry under Minnesota Statutes, section 326B.133, Subd. 3a, paragraph (d).

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
Enrolled providers: Every five years

4. **Provider Category:** Individual
Provider Type(s): Environmental Accessibility Adaptations/Home Modification/Installations
Provider Qualifications

License *(specify)*:
Providers who meet the definition of residential building contractor as defined in Minnesota Statutes section 326B.802, subd. 11, must be licensed as a residential building contractor.

As otherwise required by state law related to the trade area or item being furnished for example, the plumbing required for a bathroom modification must be provided by an appropriately licensed person or company.

Limited Install Providers: Providers who provide only one “special skill” as defined in Minnesota Statutes, Chapter 326B.802, subd. 15 are exempt from licensure.

Certificate *(specify)*:

Other standard (*specify*):
The provider must be qualified by professional certification or references, to install, repair, and or maintain the home modification defined in the participant’s support plan. All installations shall be executed] in accordance with applicable state and local building codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency.

Frequency of Verification:
Enrolled providers: Every five years Non-enrolled providers: Every five years

Service Title: Environmental Accessibility Adaptations – Vehicle Modifications

Service Definition (*scope*):
Environmental accessibility adaptations – vehicle modifications are physical adaptations to the participant’s primary vehicle, required by the participant's support plan, that are necessary to ensure the health and safety of the participant or enable the participant to function with greater independence. Examples of adaptations include adapted seat devices, door handle replacements, door widening, handrails and grab bars, lifting devices, roof extensions, wheelchair securing devices. The service also covers the necessary assessments to determine the most appropriate adaptation or equipment. The service may also cover installation, maintenance and repairs of vehicle modifications, and equipment. Repairs may only be covered when they are cost-effective given the condition of the item and compared to replacement of the item.

For purposes of the waiver, "vehicle" refers to the participant's primary vehicle. Exceptions to the requirement that vehicle modifications be limited to the participant's primary vehicle may be authorized by the case manager when the following criteria are met and documented in the participant’s support plan. The accessibility adaptation:
1) will enable active involvement of the participant in the community and/or with family members; and
2) is portable and can be used in a number of settings unless there is documentation that portable methods are not appropriate; and
3) is cost-effective compared to other services that would be provided in an environment that is inaccessible.

To ensure integrity of modification projects, counties or tribal human service agencies may authorize vehicle modifications in separate payment amounts, for example:

- Line 1: Materials and permits
- Line 2: Down payment
- Line 3: Completion and inspection, or final payment

If, for any unforeseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), the county or tribal human service agency may bill for environmental accessibility adaptation - vehicle modifications as a Medicaid administrative cost.

If the individual unexpectedly exits the waiver prematurely (due to death, or due to a move to a nursing facility or institution) after the completion of an environmental accessibility vehicle modification, the provider shall be paid for the full cost of work completed, up to the amounts prior authorized by the county or tribal human service agency.

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

Provider Specifications

Provider Category	Provider Type
1. Individual	Environmental Accessibility Adaptations/Vehicle Modification Installations
2. Agency	Environmental Accessibility Adaptations/Vehicle Modification Assessments
3. Individual	Environmental Accessibility Adaptations/Vehicle Modification Assessments
4. Agency	Environmental Accessibility Adaptations/Vehicle Modification Installations

1. **Provider Category:** Individual
   Provider Type(s): Environmental Accessibility Adaptations/Vehicle Modification Installations
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Individuals that provide vehicle installation service must:
   - Install equipment according to the manufacturer's requirements and instructions
   - Meet state and federal Americans with Disabilities Act (ADA) requirements
   - Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 CFR Part 595.7)
   - Follow the Society of Automotive Engineers' recommended practices
   - Register as a "vehicle modifier" with the National Highway Traffic Safety Administration

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled Providers: Minnesota Department of Human Services Provider Eligibility and Compliance

   Non enrolled providers: County or tribal human service agency

   Frequency of Verification:
   Enrolled providers: Every five years

Non Enrolled providers: Every five years

2. **Provider Category:** Agency
   Provider Type(s): Environmental Accessibility Adaptations/Vehicle Modification Assessments
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Agencies that provide vehicle modification assessment must meet one of the following:
   1) Certified driver rehabilitation specialist
   2) Occupational therapist with a specialty certification in driving and community mobility
   3) Five years of full time experience in the field of driver rehabilitation
   4) Four year undergraduate degree in a health related field and each of the following:
      a. One year of full time experience in the degree area of study; and
      b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
      c. Supervision by one of the following:
         i. certified driver rehabilitation specialist; or
         ii. An occupational therapist with a specialty certification in driving and community mobility; or
         iii. A person with 2 years of full time experience in the field of driver rehabilitation

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services Provider Eligibility and Compliance

   Frequency of Verification:
   Enrolled providers: Every five years

3. **Provider Category:** Individual
   Provider Type(s): Environmental Accessibility Adaptations/Vehicle Modification Assessments
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Individuals that provide vehicle modification assessment must meet one of the following:
   1) Certified driver rehabilitation specialist
   2) Occupational therapist with a specialty certification in driving and community mobility
   3) Five years of full time experience in the field of driver rehabilitation
   4) Four year undergraduate degree in a health related field and each of the following:
      a. One year of full time experience in the degree area of study; and

b. Continued education in the area of driving mobility and rehabilitation through the Association for Driver Rehabilitation Specialists, Rehabilitation Engineering and Assistive Technology Society or the American Occupational Therapy Association or any programs that have been approved by these entities; and
c. Supervision by one of the following:
    i. A certified driver rehabilitation specialist; or
    ii. An occupational therapist with a specialty certification in driving and community mobility; or
    iii. A person with 2 years of full time experience in the field of driver rehabilitation

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:
Enrolled providers: Every five years

4. **Provider Category:** Agency
Provider Type(s): Environmental Accessibility Adaptations/Vehicle Modification Installations
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Agencies that provide vehicle installation service must:
- Install equipment according to the manufacturer's requirements and instructions
- Meet state and federal Americans with Disabilities Act (ADA) requirements
- Meet Title 49 of the Code of Federal Regulations Parts 500-599 (requirements specific to vehicle modifications are in 49 CFR Part 595.7)
- Follow the Society of Automotive Engineers' recommended practices
- Register as a "vehicle modifier" with the National Highway Traffic Safety Administration

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled Providers: Minnesota Department of Human Services Provider Eligibility and Compliance

Non enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non Enrolled providers: Every five years

Service Title: Family Caregiver Services

Service Definition (*scope*):
Family caregiver services encompasses both “Training and Education” and “Caregiver Counseling”.

Services may be delivered to participants or their caregivers. For purposes of this service, "caregiver" is defined as people who routinely provide care to the participant, and may include a parent, spouse, adult children, relatives, or in-laws, friends and neighbors. Caregivers who are employed to care for the participant cannot be reimbursed for training/education and counseling activities that are the responsibility of their employer.

Training and Education:
Training and Education is a service that provides caregivers with instruction to improve knowledge and performance of specific skills relating to their caregiving roles and responsibilities and builds caregiver capacity to provide, manage and cope with the caregiving role.

It covers training and education on topics, including:
- activities related to health, nutrition, and financial management
- providing personal care
- disease management
- managing risk factors
- mental health
- navigating long-term care systems
- communicating with health care providers and other family members
- family dynamics
- self-care skills
- dealing with difficult behaviors, and other areas as specified in the support plan
- the use of equipment and technology to maintain the health and safety of the participant

Evaluation of the need for equipment and/or devices is covered under Specialized Equipment and Supplies.

Training and Education service pays for the costs of training or conference registration fees for family informal caregivers Areas of training and intended outcomes (i.e., a course syllabus, training objectives, workshop description, etc.) must be submitted to the county or tribal human service agency for approval by provider or by the individual requesting the training and documented in the participant’s support plan. Training may be provided by professionals listed as provider types both inside or outside of the home or by individuals, agencies, or educational facilities offering classes, courses or conferences.

Caregiver Counseling
Caregiver Counseling is an individualized person-centered service designed to support caregivers by assisting them in in their decision-making and problem solving. Caregiver Counseling is provided by enrolled Caregiver Consultant providers who will conduct an assessment of the caregiver’s needs and strengths. Providers will develop a support plan based on the caregiver’s identified needs and provide ongoing support to reach established goals. Ongoing support may include, but is not limited to:
- facilitation of a person-centered learning and discovery process
- development of a service description and plan to reach established goals
- family counseling, family meetings
- implementing tools and strategies for coping with changes in personality and behavior,

- problem solving and conflict resolution,
- finding resources.

For all Family Caregiver Services, providers will submit a service description and plan to the county or tribal human service agency for approval.

Based on the information provided and the participant's needs, the case manager/care coordinator determines whether the service will be authorized. If the service is authorized, the submitted documentation is maintained in the participant's file by the county or tribal human service agency.

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

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Costs related to transportation, travel, meals, and lodging to receive Training and Education are not covered. If any such costs are included in the registration fee, they must be deducted. Caregiver Counseling is limited to enrolled Caregiver Consultant providers and pays for staff time spent with participants. Provider costs such as preparation time, travel, and materials are not covered.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations - Home Modifications; or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Caregiver Counseling and/or Training and Education: Caregiver Consultants
2. Agency	Training and Education: Medical Equipment Suppliers
3. Agency	Training and Education: Centers for Independent Living
4. Agency	Training and Education: Technical Colleges and Schools
5. Agency	Training and Education: Home Health Agencies
6. Agency	Training and Education: Care or Support Related Organizations
7. Individual	Training and Education: Health Care Professionals

1. **Provider Category:** Individual
   Provider Type(s): Caregiver Counseling and/or Training and Education: Caregiver Consultants
   Provider Qualifications

   License *(specify)*:
   Providers who are required to be licensed, certified or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

   Certificate *(specify)*:
   1. Complete all trainings required by the Minnesota Board on Aging (MBA) to be considered a fully-trained Caregiver Consultant.
   2. Participates in continuing education offered by the Minnesota Board on Aging (MBA) and area agencies on aging, including cultural diversity topics

   Other standard (*specify*):
   Caregiver Consultants must:
   1. Have a bachelor's degree from an accredited program in social work, nursing, counseling, gerontology, health education, rehabilitation therapy, health and human services, or a related degree; and
      - Have at least one year of experience providing either:

i. Home care or long-term care services to older adults, or
ii. Training, education or counseling to caregivers of older adults;

Or,

2. An alternative to a bachelor's degree is 5 years of experience supporting older adults/families in social services, health care or other relevant settings, or a combination of work and college credits.

Caregiver Consultants must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Enrolled providers: Every five years.

2. **Provider Category:** Agency
Provider Type(s): Training and Education: Medical Equipment Suppliers
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):

Must be authorized by the case manager to provide training in use of equipment and must be a provider under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:

Enrolled providers: Every five years

Non-enrolled providers: Every five years

3. **Provider Category:** Agency
Provider Type(s): Training and Education: Centers for Independent Living
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Centers for Independent Living must have the ability to train the caregiver on home modifications or the use of specialized equipment that relates to the needs of the participant. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: every five years

Non-enrolled providers: every five years

4. **Provider Category:** Agency
Provider Type(s): Training and Education: Technical Colleges and Schools
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Training and education of caregivers may also be provided by health educators or vocational and technical schools offering courses such as home health aide and certified nursing assistant training when it is determined by the county or tribal human service agency that the content of the training or conference directly applies to the care and well-being of the participant.

Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non-enrolled providers: Every five years

5. **Provider Category:** Agency
Provider Type(s): Training and Education: Home Health Agencies

Provider Qualifications

License *(specify)*:
Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484

Certificate *(specify)*:
Medicare Certification

Other standard (*specify*):
Must be Medicare certified and meet the standards as specified under the state plan and Minnesota Rules, part 9505.0290.

Individual practitioners employed by a home health agency must meet the standards in Minnesota Rules, part 9505.0290.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled Providers: Every five years

Non-enrolled providers: Every 5 years

6. **Provider Category:** Agency
Provider Type(s): Training and Education: Care or Support Related Organizations
Provider Qualifications

License *(specify)*:
Providers who are required to be licensed, certified or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

Certificate *(specify)*:

Other standard (*specify*):
Training and Education may be provided by caregiver support professionals of:

- social service agencies,
- healthcare organizations,
- community or faith-based agencies,
- counties,
- area agencies on aging,
- state and local chapters of chronic disease organizations such as the Alzheimer's Association.

Providers must have:

1. demonstrated expertise in the topic that relates to the needs of the participant or the ability of the caregiver to provide care and support to the participant,
2. at least one year of experience in providing home care or long term care services to the elderly, or at least one year of experience providing training and education to caregivers of elderly persons,
3. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:

Enrolled providers: Every five years.

7. **Provider Category:** Individual

Provider Type(s): Training and Education: Health Care Professionals

Provider Qualifications

License *(specify)*:

Providers who are required to be licensed, certified, or otherwise credentialed must meet the requirements specific to their profession or practice and must provide services within the scope of their respective practice.

Certificate *(specify)*:

Other standard (*specify*):

Providers may include:

- advanced practice registered nurse
- dieticians
- Gerontologists
- Health educators
- licensed practical nurses
- Nutritionists
- Pharmacists
- Physicians
- physician assistants
- Public health nurses
- Registered nurses
- Rehabilitation therapists
- Social workers

Providers must have:

1. at least one year of experience in providing home care or long term care services to the elderly or at least one year of experience providing training, education or counseling to caregivers of elderly persons.
2. Physical cares requiring a specific technique for the safety of both the caregiver and participant must be taught by a professional specializing in such techniques, such as public health nurses, registered nurses and licensed practical nurses.
3. Must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:

Enrolled providers: every five years

Additionally, the following licensing requirements apply:

- Nurses must renew their licenses every two years.
- Nutritional therapists and nutritionists must renew their licenses annually.
- Medical licenses must be renewed annually.

Non-enrolled providers: Every five years

Service Title: Home Delivered Meals

Service Definition (*scope*):

A home delivered meal is an appropriate, nutritionally balanced meal that is delivered to the participant's home or in a common dining space where they can eat their meal that must be located in the building where the participant resides. Meals must contain at least one-third of the current Dietary Reference Intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, and must be modified, as needed, to meet the participant's dietary requirements. Menu plans must be reviewed and approved by a licensed dietician, or licensed nutritionist.

A unit of service equals one meal.

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

No more than one meal per day will be covered by the waiver.

Provider Specifications

Provider Category	Provider Type
1. Individual	Individuals that meet the provider standards

2. Agency	Hospitals, Schools, Restaurants. and Any Entity Providing Home Delivered Meals that meet the provider standards

1. **Provider Category:** Individual
   Provider Type(s): Individuals that meet the provider standards
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must comply with all state and local health regulations and ordinances concerning food preparation, handling and serving of food as defined under Minnesota Rules, Chapter 4626. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietician or nutritionist must meet requirements as specified in Minnesota Statutes, section 148.621 and Minnesota Rules, chapter 3250.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services, Provider Eligibility and Compliance

   Frequency of Verification:
   Every five years

2. **Provider Category:** Agency
   Provider Type(s): Hospitals, Schools, Restaurants. and Any Entity Providing Home Delivered Meals that meet the provider standards
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must comply with all state and local health regulations and ordinances concerning food preparation, handling and serving of food as defined under Minnesota Rules, Chapter 4626. Insulated hot and cold containers must be used to assure that food is delivered at appropriate temperatures. Licensed dietician or nutritionist must meet requirements as specified in Minnesota Statutes, section 148.621 and Minnesota Rules, chapter 3250.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services, Provider Eligibility and Compliance

   Frequency of Verification:
   Every five years

Service Title: Home Care Services

Service Definition (*scope*):
Services a home care agency provides to a person with medical needs due to illnesses, disabilities or physical conditions, based on an assessment of the person's medical and health care needs. These services are delivered in the person's place of residence or in the community. They cannot be delivered in a hospital, nursing facility or intermediate care facility for persons with developmental disabilities (ICF/DD).

The following are covered under home care services:
- Home care nursing
- Home health aide
- Skilled nursing visit

Home care nursing (HCN)
HCN has two levels of care: regular and complex.

Regular HCN covers the following activities:
- Assessments and interventions needed by a person who is considered stable but has episodes of instability that are not immediately life-threatening
- Nursing observation, monitoring, assessment and evaluation to determine appropriate interventions that will maintain or improve the person's health status.

Complex HCN covers all of the regular HCN activities listed above, in addition to life-sustaining interventions that reduce the risk of long-term injury or death for people who meet at least one of the following requirements:
- The person requires life-sustaining interventions to reduce the risk of long-term injury or death
- The person is dependent on a ventilator for life support for at least six hours a day and is expected to be or has been dependent for at least 30 consecutive days.

All HCN services must be:
- Based on an assessed need
- Delivered as described and documented in the person's care or service plan
- Made in accordance with the Minnesota Nurse Practice Act
- Medically necessary
- Ordered by a physician, physician's assistance, or an advanced practice registered nurse.

Home health aide (HHA)
Home health aides may:
- Provide hands-on personal care
- Help with ambulating or doing exercises
- Help with instrumental activities of daily living
- Help with medication administration
- Perform simple procedures as an extension of therapy or nursing services.

All HHA services must be:

- Based on an assessed need
- Delivered as described and documented in the person's care or service plan
- Medically necessary
- Ordered by a physician, physician's assistant, or advanced practice registered nurse
- Supervised by a registered nurse.

Skilled nursing visit (SNV)
SNVs include any of the following tasks:
- Completion of a procedure requiring substantial and specialized nursing skill (e.g., administering intravenous therapy, intra-muscular injections and sterile procedures)
- Consumer teaching and education/training that requires a nurse's skills
- Observation, assessment and evaluation of a person's physical and/or mental status.

All SNVs must be:
- Based on an assessed need
- Delivered as described and documented in the person's care or service plan
- Made in accordance with the Minnesota Nurse Practice Act
- Medically necessary
- Ordered by a physician, physician's assistance, or an advanced practice registered nurse.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home care services are not covered if:
- The person is a resident of a hospital, nursing facility or intermediate care facility for persons with developmental disabilities (ICF/DD)
- The service is provided without the required documentation of the face-to-face visit
- The sole purpose is to provide:
  - Companionship or socialization
  - Education
  - Household tasks
  - Transportation.

HCN does not cover the following activities:
- HCN services if the nurse is the person's legal guardian or spouse, unless these services are provided through an HCN Hardship Waiver
- HCN services to more than two people who receive shared HCN services from a nurse in a single setting at the same time
- Regular HCN services to a person who meets the requirements for complex HCN.

SNVs are not covered:
- To directly observe medication administration for communicable tuberculosis
- To perform a public health nursing (PHN) clinic visit
- For residents of a hospital, nursing facility or intermediate care facility for persons with developmental disabilities (ICF/DD)
- Without the required documentation of the face-to-face visit
- For the sole purpose to:
  - Monitor medication compliance with an established medication program
  - Perform a required Medicare evaluation or administrative nursing visit

- Set up or administer medications or prefill medications/syringes for injections (unless the person, pharmacy or family member is unable to fulfill the need)
- Supervise a home health aide
- Train other home health agency workers.

Provider Specifications

Provider Category	Provider Type
1. Agency	Home Care Agencies
2. Individual	Home Care Nurses

1. **Provider Category:** Agency
   Provider Type(s): Home Care Agencies
   Provider Qualifications

   License *(specify)*:
   Comprehensive home care license in accordance with Minnesota Statutes, sections 144A.43 through 144A.484.

   Certificate *(specify)*:
   Medicare certification

   Other standard (*specify*):
   Must meet the standards as specified under the Medicaid state plan and Minnesota Rules, part 9505.0290.

   Employees of the home care agency must meet the standards in Minnesota Rules, part 9505.0290 and must comply with or meet any other professional requirements that may apply to their specialty or scope of practice.

   Verification of Provider Qualifications

   Entity Responsible for Verification:
   Minnesota Department of Health.

   Frequency of Verification:
   Every one to three years.

2. **Provider Category:** Individual
   Provider Type(s): Home Care Nurses
   Provider Qualifications

   License *(specify)*:
   Must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

   Certificate *(specify)*:

   Other standard (*specify*):
   Must meet the standards as specified under the Medicaid state plan and Minnesota Rules, part 9505.0290.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Health.

Frequency of Verification:
Every one to three years.

Service Title: Homemaker

Service Definition (*scope*):
Homemaker services are delivered when the participant is unable to manage the general cleaning and household activities or when the individual regularly responsible for these activities is unable to manage the household activities or is temporarily absent. All homemakers may assist in monitoring of the client's well-being and safety while in the home.

Homemaker service tasks are divided into three different components. The three homemaker components that may be authorized to meet the needs defined in the participants support plan include:

Homemaker/home management providers deliver home cleaning services and provide assistance with home management activities. Homemaker/home management is a service that includes light housekeeping and assistance with laundry, meal preparation, shopping for food, clothing and supplies, simple household repairs and arranging for transportation.

Homemaker/assistance with activities of daily living providers deliver cleaning services and while on-site, provide assistance as needed with activities of daily living. This service includes: cleaning and providing assistance as needed with activities of daily living., such as bathing, toileting, grooming, eating and ambulating.

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

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;

- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Homemaker Service remote support is only available when homemaker/home management services are being provided.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions; CDCS – environmental modifications-home modifications; CDCS individual directed goods and services; Environmental Accessibility Adaptations - home modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Homemaker/Home management
2. Agency	Homemaker/Home management
3. Individual	Homemaker/Cleaning
4. Agency	Homemaker/Assistance with activities of daily living
5. Individual	Homemaker/Assistance with activities of daily living
6. Agency	Homemaker/Cleaning

1. Provider Category: Individual

Provider Type(s): Homemaker/Home management

Provider Qualifications

License *(specify)*:

Individuals that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (1) and (2) must be:

- licensed under Minnesota Statutes, Chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):

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

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd 2 (a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). Subds 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.

For individuals who are excluded under Minnesota Statutes, section 245A.03,subd. 2 (a) (1) and (2) the county or tribal human service agency monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

County or tribal human service agency: Every five years

2. **Provider Category:** Agency

   Provider Type(s): Homemaker/Home management

   Provider Qualifications

License *(specify)*:
Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2(a)(1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):
Agencies licensed under Minnesota Statutes, Chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd 2 (a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). subds 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Minnesota Department of Human Services monitors providers holding a license under Minnesota Statutes, Chapter 245D. The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.

For providers who are excluded under Minnesota Statutes, section 245A.03 sub 2 (a) (1) and (2), the county or tribal human service agency monitors the provider.

Frequency of Verification:
Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

County or tribal human service agency: Every five years

3. **Provider Category:** Individual
   Provider Type(s): Homemaker/Cleaning
   Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Enrolled individuals: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-Enrolled individuals: County or tribal human service agency

Frequency of Verification:

Minnesota Department of Human Services, Provider Eligibility and Compliance: Every five years

County or tribal human service agency: Every five years

4. **Provider Category:** Agency

Provider Type(s): Homemaker/Assistance with activities of daily living

Provider Qualifications

License *(specify)*:

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):

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

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

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd 2 (a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). Subds 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

For providers who are excluded under Minnesota Statutes, section 245A.03 sub 2 (a) (1) and (2), the county or tribal human service agency monitors the provider.

Frequency of Verification:
Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

County or tribal human service agency: Every five years

5. **Provider Category:** Individual
   Provider Type(s): Homemaker/Assistance with activities of daily living
   Provider Qualifications
   License *(specify)*:
   Individuals that are not excluded from licensure under Minnesota Statutes, section 245A.03 subd. 2 (a) (1) and (2) must be:
   - licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
   - licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

   Certificate *(specify)*:

   Other standard (*specify*):
   Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd 2(a) (1) and (2) must meet the requirements of Minnesota statutes sections 245D.04, subd 1(4). subds. 2(1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraints; and section 245D.09, subds. 1,2,3,4a,5a,6 and 7 regarding staffing standards.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   The Minnesota Department of Human Services monitors individuals holding a license under Minnesota Statutes, chapter 245D. The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A. For individuals who are excluded under Minnesota Statutes, section 245A.03,subd 2 (a) (1) and (2) the county or tribal human service agency monitors the provider.

   Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

County or tribal human service agency: Every five years

6. **Provider Category:** Agency
   Provider Type(s): Homemaker/Cleaning
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers of homemaker/cleaning services must comply with the standards outlined in Minnesota Statutes, chapter 245C concerning criminal background studies must be applied. Homemaker/cleaning providers must be able to perform the cleaning duties expected and provide a cost-effective means of meeting the participant's home cleaning needs.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

   Non-Enrolled providers: Counties or tribal human service agencies

   Frequency of Verification:
   Minnesota Department of Human Services, Provider Eligibility and Compliance: Every five years

   County or tribal human service agency: Every five years

Service Title: Individual Community Living Supports

Service Definition (*scope*):
Individual Community Living Supports (ICLS) includes six service categories. ICLS services offer assistance and support for older adults who need reminders, cues, intermittent/moderate supervision or physical assistance to remain in their own homes.

ICLS includes the following service categories:
- Active cognitive support
- Adaptive support service
- Activities of daily living (ADLs) support
- Household management assistance

- Health, safety and wellness
- Community living engagement.

ICLS workers must deliver support in a minimum of two service categories to a participant. In-person support must be scheduled at least weekly.

The service is flexible and scalable in order to meet a broad range of needs over time in a coordinated, cost-effective manner with all workers able to provide supports needed by the participant.

ICLS will complement and extend the use of informal caregiving and community supports and provide specialized support based on the participant's identified risk factors.

ICLS must be delivered in a single-family home or apartment owned or rented by the participant as demonstrated by a lease agreement or is leased or owned by a friend or family member who has no financial interest in the service.

An ICLS provider cannot:
- Be the person's spouse;
- Be a licensed Assisted Living provider where the person resides;
- Be a home care provider in an affordable housing setting as defined under Minnesota Statutes, section 256S.20 Subd. 1 where the person resides;
- Be the person's professional legal guardian or conservator;
- Be the person's landlord; or
- Have any financial interest in the person's housing.

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

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

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

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

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

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

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

- Participants receiving ICLS services cannot be authorized to receive customized living, foster care or comprehensive community support offered through Moving Home Minnesota.
- To receive ICLS participants must be authorized to receive two or more categories of the service
- Case managers must assure there is no duplication of service when participants are authorized for State Plan home care or other AC services.
- Equipment is not covered by ICLS, but may be selected by the participant and authorized separately by the case manager/care coordinator as the service of specialized equipment and supplies or as an environmental accessibility adaptation service.
- Transportation is not covered by ICLS but may be selected by the participant and authorized separately by the case manager/care coordinator as the service of transportation.
- The person can receive up to 12 hours per day of service.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Providers who meet the Individual Community Living Support (ICLS) service standards
2. Agency	Providers who meet the Individual Community Living Support (ICLS) service standards

1. Provider Category: Individual

Provider Type(s): Providers who meet the Individual Community Living Support (ICLS) service standards

Provider Qualifications

License *(specify)*:

Providers must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for Comprehensive Home Care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):

Providers must be able to provide support in all categories of ICLS in compliance with basic support service requirements in Minnesota Statutes, chapter 245D.

ICLS workers are trained and competent to provide all services in the individual's ICLS plan and work under the supervision of the provider coordinator and manager as specified in Minnesota Statutes, chapter 245D.

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a)(1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers licensed under Minnesota Statutes, chapter 245D.

The Minnesota Department of Health monitors providers holding a home care license under Minnesota Statutes, chapter 144A.

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

Enrolled providers: Every five years

2. **Provider Category:** Agency

Provider Type(s): Providers who meet the Individual Community Living Support (ICLS) service standards

Provider Qualifications

License *(specify)*:

Providers must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for Comprehensive Home Care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community-Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):

Providers must be able to provide support in all categories of ICLS in compliance with basic support service requirements in Minnesota Statutes, chapter 245D.

ICLS workers are trained and competent to provide all services in the individual's ICLS plan and work under the supervision of the provider coordinator and manager as specified in Minnesota Statutes, chapter 245D.

Providers excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2), (3), (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services monitors providers licensed under Minnesota Statutes, chapter 245D.

The Minnesota Department of Health monitors providers holding a home care license under Minnesota Statutes, chapter 144A.

Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

Enrolled providers: Every five years

Service Title: Nutrition Services

Service Definition (*scope*):
Nutrition services include nutrition education and nutrition counseling. The goal of this service is to improve or maintain a participant's nutritional status, and to improve management of the participant's chronic diseases or conditions.

Nutrition education is one or more individual or group sessions which provide formal and informal opportunities for participants to acquire knowledge and skills in managing their diet and nutritional needs. Examples of topics include:

- Shopping
- Selecting foods
- Preparing meals
- Planning healthy menus
- Preparing therapeutic diets
- Cooking for one or two
- Providing tips for eating well on a limited budget.

Nutrition counseling is one or more individual sessions to advise and assist participants on appropriate nutritional intake. Nutrition counseling includes assessment of a participant's nutritional needs that results in an individualized plan with goals and follow-up on established goals. Nutrition counseling can assist participants with:

- Managing therapeutic diets (e.g., diabetic, low sodium, low cholesterol, renal, or gluten free).
- Providing weight management strategies for chronically underweight or overweight conditions.
- Addressing severe weight loss or gain.
- Addressing difficulties chewing or swallowing.
- Other nutritional care issues.

Nutrition services are tied to a specific goal and are authorized in the participant's support plan. All services are consistent with the participant's cultural background.

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

Provider Specifications

Provider Category	Provider Type
1. Agency	Licensed dietitians and licensed nutritionists
2. Individual	Licensed dietitians and licensed nutritionists
3. Agency	Registered dietitians
4. Individual	Registered dietitians
5. Agency	Other professionals who are exempt from licensure
6. Individual	Other professionals who are exempt from licensure

1. **Provider Category:** Agency
   Provider Type(s): Licensed dietitians and licensed nutritionists

Provider Qualifications

License *(specify)*:
Must be licensed under Minnesota Statutes, Section 148.621 and Minnesota Rules, Chapter 3250.

Certificate *(specify)*:

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:
Every five years

2. **Provider Category:** Individual
Provider Type(s): Licensed dietitians and licensed nutritionists
Provider Qualifications

License *(specify)*:
Must be licensed under Minnesota Statutes, Section 148.621 and Minnesota Rules, Chapter 3250.

Certificate *(specify)*:

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:
Every five years

3. **Provider Category:** Agency
Provider Type(s): Registered dietitians
Provider Qualifications

License *(specify)*:
Must meet the education and practice requirements specified for licensed dieticians and nutritionists Minnesota Statutes, Section 148.621 and Minnesota Rules, Chapter 3250.

Certificate *(specify)*:

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:
Every five years

4. **Provider Category:** Individual
   Provider Type(s): Registered dietitians
   Provider Qualifications
   License *(specify)*:
   Must meet the education and practice requirements specified for licensed dieticians and nutritionists Minnesota Statutes, Section 148.621 and Minnesota Rules, Chapter 3250.

   Certificate *(specify)*:

   Other standard (*specify*):

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services, Provider Enrollment Unit

   Frequency of Verification:
   Every five years

5. **Provider Category:** Agency
   Provider Type(s): Other professionals who are exempt from licensure
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers are exempt from licensure according to Minnesota Statutes, Section 148.632, and perform service incidental to their practice (e.g., diabetic nurse practitioners when nutrition practice is related to their practice, registered nurses)

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services, Provider Enrollment Unit

   Frequency of Verification:
   Every five years

6. **Provider Category:** Individual
   Provider Type(s): Other professionals who are exempt from licensure
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

Other standard (*specify*):
Providers are exempt from licensure according to Minnesota Statutes, Section 148.632, and perform service incidental to their practice (e.g., diabetic nurse practitioners when nutrition practice is related to their practice, registered nurses)

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:
Every five years

Service Title: Personal Care Services

Service Definition (*scope*):
Personal care services help participants remain independent in the community. Personal care workers provide covered services in a participant's home or in the community.

A participant may receive personal care if all of the following criteria are met:
- The county or tribal human service agency performs an assessment that determines the participant is eligible for personal care services.
- The personal care delivery plan describes the participant's needed assistance.
- The participant has prior authorization for personal care services.

Personal care covers assistance with:
- Activities of daily living.
- Instrumental activities of daily living.
- Observations and redirection of behaviors.
- Health-related procedures and tasks.

Activities of daily living (ADLs)
A personal care worker may assist the participant with the following ADLs:
- Dressing (e.g., putting on clothing and special appliances or wraps).
- Grooming (e.g., basic hair care, oral care, shaving, basic nail care, applying cosmetics and deodorant, eyeglasses and hearing aids care).
- Bathing (e.g., basic personal hygiene and skin care).
- Eating (e.g., completing the process of eating, including hand washing and applying orthotics required for eating, transfers and feeding).
- Transfers (e.g., helping transfer the participant from one seating or reclining area to another).
- Mobility (e.g., helping with ambulation and use of a wheelchair).
- Positioning (e.g., helping position or turn a participant for necessary care and comfort).
- Toileting (e.g., helping with bowel or bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area, inspecting the skin and adjusting clothing).

Instrumental activities of daily living (IADLs)
A personal care worker may assist a participant with the following IADLs related to living independently in the community:

- Go to medical appointments.
- Participate in the community.
- Pay bills.
- Communicate by telephone and other media.
- Complete household tasks necessary to support the participant with an assessed need (e.g., planning and preparing meals or shopping for food, clothing and other essential items).
- Drive the participant into the community, including to medical appointments.

Observation and redirection of behaviors
A personal care worker may observe and provide redirection to the participant for episodes of behavior that need redirection, as identified in the participant's support plan.

Health-related procedures and tasks
Personal care health-related procedures and tasks may include:

- Assistance with self-administered medications
- Interventions for seizure disorders, including monitoring and observation.
- Range-of-motion and passive exercises to maintain the participant's strength and muscle functioning.
- Tracheostomy suctioning (clean technique) and services if the participant uses ventilator support.
- Other activities within the scope of personal care services that meet the definition of health-related procedures and tasks.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal care does not cover services that are not listed in the service definition. This includes, but is not limited to:

- Services provided without or before authorization.
- Services not related to the participant's assessed need.
- Services not included in the approved support plan.
- Administration of sterile procedures.
- Application of restraints.
- Attempts to control or discipline the participant by limiting their access to something they need or want.
- Purchase of goods and services.
- Home maintenance or chore services (e.g., lawn care, snow removal, packing belongings).
- Homemaking services that are not an integral part of the participant's assessed need for personal care services.
- Services covered by Medicare or any other insurance.
- Injections of fluid and medications into veins, muscles, or skin.
- Services that duplicate or replace services provided through other funding sources.
- Services provided by a non-relative who owns or otherwise controls the living arrangement.
- Services provided by a provider not enrolled in Minnesota Health Care Programs (MHCP).

As participants are assessed or reassessed, the following additional options are available that expand consumer-direction of personal care. Participants may choose to have:

- A budget for personal care that includes budget and employer authority.
- Personal care services may be provided by spouses and legally responsible individuals when the care is determined to be extraordinary and their provision of the service is in the best interest of the participant. These determinations are made by county and tribal human service agency case managers during the individualized support planning process using assessment tool(s) provided by the state.
- Personal care workers attend community education for training (when not affiliated with an agency that provides training).
- Services be provided by people who are recipients of personal care services (all provider requirements apply).
- More flexibility in age limits of workers; provided compliance with labor laws.

Additionally, consultation services to assist the participant in understanding their self-directed options is provided, and Financial Management Services are available to participants that elect a budget model. The budget model includes employer and budget authority. The fiscal management service agency files federal and state payroll taxes on behalf of the participant.

By April 1, 2026, all participants will have been assessed or reassessed and offered the budget option.

All individual personal care workers must be affiliated with a provider agency or financial management service agency. Additionally, personal care workers must:

- Pass a state developed standardized certification test.
- Meet state background study requirements to provide direct care services.
- Be determined not to be on a state or federal Medicaid exclusion list.
- Complete training and orientation concerning the needs of the participant(s) for whom they are proving services.
- Communicate effectively with the participant (e.g., a participant may have specific language or communication needs).

Provider Specifications

Provider Category	Provider Type
1. Agency	Medicare-certified home health agencies
2. Agency	Personal care provider agencies
3. Agency	Financial Management Services
4. Agency	Consultation Services

1. **Provider Category:** Agency
   Provider Type(s): Medicare-certified home health agencies
   Provider Qualifications
   License *(specify)*:
   Must meet the standards and requirements under Minnesota Statutes, section 256B.0659, subds. 21, and 23, or Minnesota Statutes, section 256B.85.

   Certificate *(specify)*:
   Medicare Certification.

Other standard (*specify*):
Must meet the standards and requirements for personal care services as specified in the state plan and under Minnesota Statutes, section 256B.0659 or Minnesota Statutes, section 256B.85.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Health and Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:
Every three years.

2. **Provider Category:** Agency
Provider Type(s): Personal care provider agencies
Provider Qualifications

License *(specify)*:
Must meet the standards and requirements under Minnesota Statutes, section 256B.0659, subds. 21, and 23, or Minnesota Statutes, section 256B.85.

Certificate *(specify)*:

Other standard (*specify*):
Must meet the standards and requirements for personal care services as specified in the state plan and under Minnesota Statutes, section 256B.0659 or Minnesota Statutes, section 256B.85.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
Every three years.

3. **Provider Category:** Agency
Provider Type(s): Financial Management Services
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Must meet the standards and requirements for personal care services as specified in the state plan and under Minnesota Statutes, section 256B.85, subd. 13a.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
Every three years.

4. **Provider Category:** Agency
   Provider Type(s): Consultation Services
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Must meet the standards and requirements for personal care services as specified in the state plan and under Minnesota Statutes, section 256B.85.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Minnesota Department of Human Services, Provider Eligibility and Compliance

   Frequency of Verification:
   Every three years.

Service Title: Respite

Service Definition (*scope*):
Respite care may be provided to participants who are unable to care for themselves. The service is furnished on a short-term basis because of the absence or need for relief of the person who normally provides the care and who is not paid or is only paid for a portion of the total time of care or supervision provided. The unpaid caregiver does not need to reside in the same home as the participant.

Respite care may be provided in:
- the participant's home or place of residence;
- community settings used by the general public;
- a home licensed to provide foster care;
- a community residential setting (CRS);
- a Medicare certified hospital or nursing facility;
- a licensed assisted living facility;
- certified camps;
- unlicensed settings where agencies or individual providers must be licensed under Minnesota Statutes, chapter 245D or meet the exclusion requirements
- or another private home that is identified by the participant.

Respite care may be provided in a private (unlicensed) home identified by the participant when it is determined by the case manager that the service and setting can safely meet the participant's needs. The case manager must take into account the accessibility and condition of the physical setting, ability and skill level of the respite caregiver, and the participant's needs and preferences. The unlicensed

home and caregiver identified by the participant cannot otherwise be in the business or routine practice of providing respite services.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person's support plan. The person's support plan must document:

- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;
- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

Coverage for respite care provided in licensed facilities will include both services and room and board, as appropriate. Room and board will not be covered for respite care provided in the participant's home, participant's family home, or in an unlicensed, private home.

In the event of a community emergency or disaster that required an emergency need to relocate a participant, out of-home respite services may be provided whether or not the primary caregiver resides at the same address as the participant, and whether the primary caregiver is paid or unpaid, provided the commissioner approves the request as a necessary expenditure related to the emergency or disaster. This does not allow the primary caregiver to provide respite services. Other limitations on this service may be waived by the commissioner, as necessary; in order to ensure that necessary expenditures related to protecting the health and safety of participants are reimbursed. In the event of an emergency involving the relocation of waiver participants, the Commissioner may approve the provision of respite services by unlicensed providers on a short-term, temporary basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite care is limited to 30 consecutive days per respite stay in accordance with the support plan. Participants who live in settings that are responsible to provide customized living, 24-hour care, supervision, residential care or shift staff foster care or supports are not eligible for this service with the exception of community emergencies or disasters requiring relocation of waiver participants.

Respite care provided in unlicensed settings is limited to serving a maximum of six people.

The person or people who provide the care or supervision and for whom the respite service is to provide relief shall not be paid to provide the respite service.

Respite Service remote support is only available when in home respite is being provided.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS –Environmental Modification – home modifications; CDCS-individual–directed goods and services, Environmental Accessibility Adaptations-home modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Agency	Long Term Care Facilities
2. Agency	Assisted living facilities
3. Agency	Hospitals as defined in Minnesota Statutes, section 144.696, subd 3
4. Individual	Individuals who meet the respite service standards
5. Agency	Camps
6. Agency	Agencies that meet the respite service standards
7. Agency	Adult Foster Care Providers

1. **Provider Category:** Agency
   Provider Type(s): Long Term Care Facilities
   Provider Qualifications
   License *(specify)*:
   Facilities providing respite care outside of the participant's home must be:
   - licensed in accordance with Minnesota Statutes, chapter 144A; and must meet the definition of a long-term care facility under Minnesota Rules part 9505.0175 subpart 23.

Certificate *(specify)*:
Medicare certification

Other standard (*specify*):
Providers must apply the standards in Minnesota Statutes, chapter 245C concerning criminal background studies.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Health.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:
Long term care facilities are reviewed every 2 years by the state and receive federal certification annually.

Enrolled providers: Every five years

2. **Provider Category:** Agency
Provider Type(s): Assisted living facilities
Provider Qualifications

License *(specify)*:
Assisted living facilities licensed in accordance with Minnesota Statutes, Chapter 144G.

Certificate *(specify)*:

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
The Minnesota Department of Health monitors agencies holding an assisted living facility license under Minnesota Statutes, Chapter 144G.

Minnesota Department of Human Services, Eligibility and Compliance.

Frequency of Verification:
Providers licensed under Minnesota Statutes, Chapter 144G. Minnesota Department of Health shall conduct a survey of each assisted living facility on a frequency of at least once every two years. Surveys may be conducted more frequently than every two years based on the license category, the facility's compliance history, the number of residents served, or other factors as determined by the commissioner deemed necessary to ensure the health, safety, and welfare of residents and compliance with the law.

Enrolled providers: Every five years

3. **Provider Category:** Agency

Provider Type(s): Hospitals as defined in Minnesota Statutes, section 144.696, subd 3

Provider Qualifications

License *(specify)*:
Hospitals must be licensed under Minnesota Statutes, sections 144.50 to 144.591.

Certificate *(specify)*:
Medicare certification

Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Health.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

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

Enrolled providers: every 5 years.

4. **Provider Category:** Individual

Provider Type(s): Individuals who meet the respite service standards

Provider Qualifications

License *(specify)*:
Providers must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services; or
- licensed for home care under Minnesota Statutes, sections 144A.43 through 144A.483 with a Home and Community Based Services designation under Minnesota Statutes, section 144A.484.

Certificate *(specify)*:

Other standard (*specify*):
Individuals licensed under Minnesota Statutes, chapter 144A as a home care provider must meet the provider standards in Minnesota Statutes, chapter 245D

Individuals providing in-home respite services must demonstrate to the case manager that they are able to provide, on a temporary, short term basis, the care and services needed by the participant. Documentation will be in the person's community support plan. In addition, in-home respite providers who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the participant: 1) the provider is physically able to care for the participant; 2) the provider has completed training identified as necessary in the care plan; and 3) the provider complies with monitoring procedures as described in the care plan. The case manager must evaluate and document whether the provider meets the standards to provide respite services.

Individuals excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2(a) (1) and (2) must meet the requirements of: sections 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards if applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation of such an assessment will be included in the person's community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

The Minnesota Department of Health monitors individuals holding a home care license under Minnesota Statutes, chapter 144A.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

For individuals who are excluded under Minnesota Statutes, section 245A.03, sub 2(a) (1) and (2) the county or tribal human service agency monitors the provider.

Frequency of Verification:

Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

Enrolled providers: Every five years

County or tribal human service agency: Every five years

5. **Provider Category:** Agency
   Provider Type(s): Camps
   Provider Qualifications

   License *(specify)*:
   Licensed under Minnesota Statutes, chapter 245D.

   Certificate *(specify)*:
   Certified by the American Camp Association.

   Other standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

The Minnesota Department of Human Services Provider Eligibility and Compliance agencies.

Enrolled providers: Minnesota Department of Human Services, Provider Enrollment Unit

Frequency of Verification:

Enrolled Providers: Every five years

6. **Provider Category:** Agency

Provider Type(s): Agencies that meet the respite service standards

Provider Qualifications

License *(specify)*:

Providers that are not excluded from licensure under Minnesota Statutes, section 245A.03 sub 2(a) (1) and (2) must be:

- licensed under Minnesota Statutes, chapter 245D as a provider of basic support services or
- licensed for home care under Minnesota Statutes, section 144A.43 through 144A.483 with a Home and Community Based Services Designation under Minnesota Statutes, section 144A.484

Certificate *(specify)*:

Other standard (*specify*):

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

Agencies excluded from licensure under Minnesota Statutes, section 245A.03, subd. 2 (1) and (2) must meet the requirements of: section 245D.04, subd. 1(4), subds. 2 (1), (2) (3) (6) and subdivision 3 regarding the rights of participants; sections 245D.05 and 245D.051 regarding health services and medication monitoring; section 245D.06 regarding incident reporting and prohibited and restricted procedures; section 245D.061 regarding the emergency use of manual restraint; and section 245D.09 subds. 1, 2, 3, 4a, 5a, 6 and 7 regarding staffing standards if applicable.

If the service is furnished in an unlicensed setting, the case manager must assess whether the setting is appropriate to meet the needs of the participant. Documentation of such assessment will be included in the person's community support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.

Enrolled providers: Minnesota Department of Human Services Provider Eligibility and Compliance

For agencies who are excluded under Minnesota Statutes, section 245A.03,subd.2(a) (1) and (2), the county or tribal human service agency monitors the provider.

Frequency of Verification:
Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

Enrolled providers: Every five years

County or tribal human service agency: Every five years

7. **Provider Category:** Agency
   Provider Type(s): Adult Foster Care Providers
   Provider Qualifications
   License *(specify)*:
   Out-of-home providers furnishing respite care outside of the participant's home must be licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A.

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

   Certificate *(specify)*:

   Other standard (*specify*):
   Providers must meet the requirements of Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, section 256B.0919 subds. 1 and 2.

   Adult foster care providers must deliver the services in one of the following licensed facilities:
   - adult foster care providers licensed under Minnesota Statutes, chapter 245A must deliver the services in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265;
   - providers that are licensed under Minnesota Statutes, chapter 245D, in addition to chapter 245A, are required to meet the 245D licensing standards;
   - adult foster care providers licensed under Minnesota Statutes, chapter 245D must deliver services in a facility licensed under Minnesota Rules, parts 9555.5050 to 9555.6265; or licensed community residential setting (CRS) facility as defined under Minnesota Statutes, chapter 245D.

   Verification of Provider Qualifications
   Entity Responsible for Verification:

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

The Minnesota Department of Health monitors agencies holding a home care license under Minnesota Statutes, chapter 144A.

Counties, under department supervision, are responsible to complete 245A licensing verification and review the 245D CRS facility license.

Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

For providers who are excluded under Minnesota Statutes, section 245A.03, subd 2(1) and (2) the county or tribal human service agency monitors the provider.

Frequency of Verification:
Providers licensed under Minnesota Statutes, chapter 245D: Reviews occur in the first year for newly licensed providers, and at least every four years thereafter. More frequent monitoring occurs when DHS has concerns about the nature, severity, and chronicity of the violations of law or rule.

Providers licensed under Minnesota Statutes, chapter 144A: Every one to three years

CRS licensed facilities and providers licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, chapter 245A are reviewed every one to two years. For newly licensed providers, reviews are conducted within the first year. Counties must be certified by the department to conduct licensing reviews. The department reviews the licensing activities of county agencies at least once every four years to determine whether they continue to meet the certification standards.

Provider Eligibility and Compliance: Every five years

County or tribal human service agency: Every five years

Service Title: Specialized Equipment and Supplies

Service Definition (*scope*):
Specialized equipment and supplies include devices, controls, or appliances, mobility aids, and assistive technology devices including augmentative communication devices and personal emergency response systems, sensing equipment, controls or medical appliances as specified in the support plan that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, interact or communicate with their environment.

This service may cover evaluation of the need for equipment and/or device and, if appropriate, subsequent selection and acquisition. This service also includes equipment rental during a trial period, customization, training and technical assistance to participants, maintenance, repair of devices, and

rental of equipment during periods of repair, unless covered by warranty. Training is not covered separately. Shipping and handling costs are covered under this service if the shipping cost is included in the price of the item and the waiver is purchasing the item. Installation can be covered regardless of who purchased the item, it if the item meets HCBS authorization criteria.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment that are not covered under the state plan. Specialized Equipment and Supplies does not cover utilities that may be required to operate the supplies and/or equipment purchased for a participant.

All items must meet applicable standards of manufacture, design, and installation. Items, equipment, and supplies that exceed the scope or limits in the state plan may be covered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items that are not of direct medical or remedial benefit to the participant. Items that are covered by the state plan as durable medical equipment are not covered, including related assessments, repairs, and service. The following items are not covered:

- experimental treatments;
- items that restrict a participant's rights;
- items that restrain a participant; and;
- items that are not adaptive aids or equipment, orthotic devices or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition
- utilities that operate the equipment or supply.

For participants who reside in settings that are responsible to provide 24 hour supervision, emergency response systems are not covered as a separate item or service nor may they be used in lieu of staff supervision in accordance with the service description. This does not preclude covering emergency response technology (e.g., pendant call systems) that may be appropriate for participants to use outside of the residential setting.

All prescription and over-the counter medications, compounds and solutions, and related fees including premiums and co-payments are not covered.

Provider Specifications

Provider Category	Provider Type
1. Agency	Pharmacies
2. Agency	Agencies who provide supplies and equipment
3. Individual	Individuals who provide supplies and equipment
4. Agency	Home Health Agencies and Medical Equipment Providers and Supplies

1. **Provider Category:** Agency
   Provider Type(s): Pharmacies
   Provider Qualifications
   License *(specify)*:
   Pharmacies are licensed by the Minnesota Board of Pharmacy in accordance with Minnesota Rules, parts, 6800.0100 to 6800.9954.

Certificate *(specify)*:

Other standard (*specify*):
State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310. Providers must also meet the definition under Minnesota Rules, part 9505.0195.

Verification of Provider Qualifications

Entity Responsible for Verification:
Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
Enrolled providers: Every five years.

2. **Provider Category:** Agency
Provider Type(s): Agencies who provide supplies and equipment
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Services must provide a cost effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non-enrolled providers: Upon purchase of goods/supports and every five years

3. **Provider Category:** Individual
Provider Type(s): Individuals who provide supplies and equipment
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Services must provide a cost effective, appropriate means of meeting the needs identified in the participant's support plan.

Verification of Provider Qualifications

Entity Responsible for Verification:
Enrolled providers: Minnesota Department of Human Services, Provider Eligibility and Compliance

Non-enrolled providers: County or tribal human service agency

Frequency of Verification:
Enrolled providers: Every five years

Non-enrolled providers: Upon purchase of goods/supports and every five years

4. **Provider Category:** Agency
   Provider Type(s): Home Health Agencies and Medical Equipment Providers and Supplies
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310. Providers must also meet the definition under Minnesota Rules, part 9505.0195.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   Home Health Agencies: Minnesota Department of Health

   Medical Equipment Providers and Suppliers: Minnesota Department of Human Services

   Frequency of Verification:
   Every one to three years

   Enrolled providers: Every five years

Service Title: Transitional Services

Service Definition (*scope*):
Transitional services include expenses related to establishing community-based housing for persons transitioning to an independent or semi-independent community residence from the following licensed settings:

- hospitals licensed under Minnesota Statutes, sections 144.50 to 144.591;
- adult foster care homes licensed under Minnesota Rules, parts 9555.5105 to 9555.6265 and Minnesota Statutes, Chapter 245A or under Minnesota Statutes, Chapter 245D; and
- nursing facilities and intermediate care facilities as defined under Minnesota Rules, part 9505.0175, subpart 23 and licensed under Minnesota Statutes, Chapter 144.

Transitional Services are solely for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement where the person is directly responsible for their own living expenses.

Items and expenses that may be covered include lease and rental deposits, essential furniture, utility set up fees and deposits, basic household items, window coverings, personal items, and one time pest and allergen treatment of the setting. Used items may be purchased if they are safe by reasonable standards.

Supports that can be covered include assistance in locating and transitioning to the community based housing, move personal items from the licensed facility to the home, arrange for utilities to be connected and help with purchasing the household items and essential furniture.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses.

The case manager determines whether the items, expenses, and supports are necessary and reasonable for the participant to establish an independent or semi-independent community living arrangement.

To be eligible an individual must:
1) not have another source to fund or attain the items or support; and,
2) be moving from a living arrangement were these items were provided; and,
3) be moving to a residence where these items are not normally furnished (e.g., items cannot be provided in a setting where the setting is otherwise responsible to provide them);
4) if the individual is not presently enrolled in the waiver, the local county or tribal human service agency must evaluate and reasonably expect that the person will be eligible for and will open to the waiver within 180 days; and,
5) incur the expense within 90 days of the waiver opening date.

Transitional services must be identified on the participant's support plan. There are no limitations on frequency of use for this service.

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

Remote support can be initiated by the person or the caregiver on either a scheduled or intermittent/as needed basis depending on the individual support needs of the person and as documented in the person’s support plan. The person’s support plan must document:
- the assessed needs and identified goals of the person that can be met using remote supports;
- how remote support will support the person to live and work in the most integrated community settings;
- the needs that must be met with in-person support;
- how remote support does not replace in-person support provided as a core service function;

- the plan for providing in-person and remote supports based on the person's needs to ensure their health and safety; and
- whether the person, or their guardian (if applicable), agree to the use of cameras for the delivery of the service.

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

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

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

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

The service will be considered provided and may be billed after the waiver is open. In these situations, the county or tribal human service agency is responsible to make the determination that the individual meets all of the applicable eligibility criteria and is expected to move to the community within 180 days.

If for an unforeseen reason the person does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transitional service(s) that was(were) provided may be covered through Medicaid administrative funds.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Transitional services do not include items, expenses, or supports that are otherwise covered under the waiver (e.g., chore, homemaker services, home modifications and adaptations, environmental accessibility adaptations, supplies and equipment, etc.).

Items and Expenses that cannot be covered:
Expenses related to on-going rent, or housing costs, food or clothing, recreational or diversional items. Recreational and diversionary items include but are not limited to computers, VCR's, DVD players, televisions, cable access, etc.

Remote support does not fund the enabling technology. Technology may be covered through Assistive Technology, CDCS-Environmental Modifications and Provisions, CDCS-Environmental Modifications – Home Modifications; CDCS-individual directed goods and services, Environmental Accessibility Adaptations–Home Modifications or Specialized Equipment and Supplies. Remote support does not include the use of cameras in bathrooms.

Provider Specifications

Provider Category	Provider Type
1. Individual	Providers of Items and Expenses (receipt services)
2. Individual	Providers of Support (market services)
3. Agency	Providers of Support (market services)
4. Agency	Providers of Items and Expenses (receipt services)

1. **Provider Category:** Individual
   Provider Type(s): Providers of Items and Expenses (receipt services)
   Provider Qualifications
   License *(specify)*:
   Must maintain all applicable licenses, permits, registrations as required for their business.

   Certificate *(specify)*:

   Other standard (*specify*):
   All receipts or other documentation related to the item or expense covered must be maintained in the participant's file at the county or tribal human service agency.

   Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

   Verification of Provider Qualifications
   Entity Responsible for Verification:
   County or tribal human service agency or Minnesota Department of Human Services Provider Eligibility and Compliance

   Frequency of Verification:
   County or tribal human service agency: Upon purchase of goods/supports

   Enrolled provider DHS review every 5 years

2. **Provider Category:** Individual
   Provider Type(s): Providers of Support (market services)
   Provider Qualifications
   License *(specify)*:

   Certificate *(specify)*:

   Other standard (*specify*):
   Support providers as determined by the county or tribal human service agency to have all of the following:
   - General knowledge of disabilities and chronic illnesses and their effect on an individual's ability to live independently in the community; and
   - Ability to assess the individual's community based housing needs; and
   - Functional knowledge of community based housing options; and

- Sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the individual regarding these matters; and
- Ability to assist the individual in attaining the items that are covered by transitional services; and
- Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:
County or tribal human service agency or Minnesota Department of Human Services Provider Eligibility and Compliance

Frequency of Verification:
County or tribal human service agency: Upon purchase of goods and supports

Enrolled provider: DHS review every five years

3. **Provider Category:** Agency
Provider Type(s): Providers of Support (market services)
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other standard (*specify*):
Support providers as determined by the county agency must meet all of the following:
- General knowledge of disabilities and chronic illnesses and their effect on an individual's ability to live independently in the community; and
- the ability to assess the individual's community based housing needs; and
- functional knowledge of community based housing options; and
- a sufficient understanding of housing procurement procedures and funding mechanisms to adequately advise the individual regarding these matters; and
- the ability to assist the individual in attaining the items that are covered by transitional services; and
- Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan

Verification of Provider Qualifications

Entity Responsible for Verification:
County or tribal human service agency: Upon purchase of goods/supports

Enrolled provider: Minnesota Department of Human Services, Provider Eligibility and Compliance

Frequency of Verification:
County or tribal human service agency

Enrolled Provider: DHS review every 5 years

4. **Provider Category:** Agency
   Provider Type(s): Providers of Items and Expenses (receipt services)
   Provider Qualifications
      License *(specify)*:
      Must maintain all applicable licenses, permits, registrations as required for their business.

      Certificate *(specify)*:

      Other standard (*specify*):
      All receipts or other documentation related to the item or expense covered must be maintained in the participant's file at the county or tribal human service agency.

      Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

   Verification of Provider Qualifications
      Entity Responsible for Verification:
      County or tribal human service agency or Minnesota Department of Human Services Provider Eligibility and Compliance

      Frequency of Verification:
      County or tribal human service agency: Upon purchase of goods/supports

      Enrolled provider: DHS review every 5 years

Service Title: Transportation Services

Service Definition (*scope*):
Transportation services may be covered to enable participant to gain access to waiver and other community services, resources, employment, and activities related to goals specified in the participant's support plan. When possible, family, neighbors, friends, or community agencies that are able to provide the service without charge will be utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service does not replace or supplant transportation that is available at no charge. This service does not cover transportation provided by providers for which the cost of transportation is included in their rates.

Provider Specifications

Provider Category	Provider Type
1. Agency	Non-Profit Groups that Provide Transportation (receipt service)
2. Agency	Taxi and Commercial Companies including buses and county-owned or leased vehicles (receipt service)
3. Individual	Individuals who are not common carriers (receipt services)

4. Agency	Special Transportation Vendors to transport a participant because of physical or mental impairment is unable to use a common carrier and does not require ambulance transportation

1. **Provider Category:** Agency
   Provider Type(s): Non-Profit Groups that Provide Transportation (receipt service)
   Provider Qualifications

   License *(specify)*:
   Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statues, chapter 65B.

   Certificate *(specify)*:

   Other standard (*specify*):
   Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

   Verification of Provider Qualifications

   Entity Responsible for Verification:
   Minnesota Department of Human Services Provider Eligibility and Compliance

   Frequency of Verification:
   Every 5 years

2. **Provider Category:** Agency
   Provider Type(s): Taxi and Commercial Companies including buses and county-owned or leased vehicles (receipt service)
   Provider Qualifications

   License *(specify)*:
   Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statues, chapter 65B.

   Certificate *(specify)*:

   Other standard (*specify*):
   Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

   Verification of Provider Qualifications

   Entity Responsible for Verification:
   County or tribal human service agency or Minnesota Department of Human Services Provider Eligibility and Compliance

   Frequency of Verification:
   County or tribal human service agency review: Upon purchase of goods and supports

Enrolled provider: DHS review every 5 years

3. **Provider Category:** Individuals
   Provider Type(s): Individuals who are not common carriers (receipt services)
   Provider Qualifications

   License *(specify)*:
   Drivers must have a valid driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, chapter 65B.

   Certificate *(specify)*:

   Other standard (*specify*):
   Services must provide a cost effective, appropriate means of meeting the needs defined in the participant's support plan.

   Verification of Provider Qualifications

   Entity Responsible for Verification:
   County or tribal human service agency, or Department of Human Services Provider Eligibility and Compliance

   Frequency of Verification:
   County or tribal human service agency review: Upon purchase of goods/supports

   Enrolled provider: DHS review every 5 years

4. **Provider Category:** Agency
   Provider Type(s): Special Transportation Vendors to transport a participant because of physical or mental impairment is unable to use a common carrier and does not require ambulance transportation
   Provider Qualifications

   License *(specify)*:
   Drivers or carriers must have a valid Minnesota driver's license appropriate to the type of transportation being provided and adequate insurance coverage, including auto insurance as required under Minnesota Statutes, Chapter 65B.

   Certificate *(specify)*:
   Providers of special transportation, not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, sections 174.29 to 174.315.

   Other standard (*specify*):
   Additional qualifications that are necessary to meet a participant's unique needs and preferences will be documented in the support plan.

   Verification of Provider Qualifications

   Entity Responsible for Verification:

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

Frequency of Verification:
Enrolled provider: DHS review every 5 years

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00286/5

TITLE: Minnesota 2020 System Reform Demonstration

AWARDEE: Minnesota Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Minnesota for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not identified as not applicable in this document, shall apply to this demonstration extension beginning with the date of the approval letter through January 31, 2025 (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act).

The following expenditure authorities enable Minnesota to operate its demonstration effective as of the date of the associated CMS approval letter through January 31, 2025:

1. **Alternative Care Program (AC).** Expenditures to provide a targeted set of home and community-based services (HCBS) as described in the accompanying Special Terms and Conditions (STCs) to people ages 65 and older who are: 1) in need of a nursing facility level of care; 2) not eligible for Medicaid coverage because their income and assets exceed eligibility limits; and 3) their income and/or assets are insufficient to pay for 135 days of nursing facility care. These authorized expenditures are provided under the Alternative Care program component of the demonstration as set forth in the accompanying STCs.

2. **Children Under 21 with Activities of Daily Living (ADL) Needs.** Expenditures to provide Medicaid State Plan benefits to children under 21 who met the state's March 2010 Medicaid State Plan institutional level of care but do not meet the state's current Medicaid State Plan institutional level of care made effective January 1, 2015 and therefore would otherwise lose Medicaid eligibility and were enrolled on February 1st. These authorized expenditures are provided under the Children with Activities of Daily Living (ADL) Needs program component of the demonstration as set forth in the accompanying STCs. This authority is applicable to eligible expenditures until October 31, 2020.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00286/5

TITLE: Minnesota 2020 System Reform Demonstration

AWARDEE: Minnesota Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the approval date, through January 31, 2025, unless otherwise specified.

Under the authority of section 1115(a) (1) of the Social Security Act (the Act), the following waivers shall enable Minnesota to implement the Minnesota 2020 System Reform Demonstration.

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to mandatorily enroll the AC demonstration population into a delivery system that restricts the free choice of provider.

2. Cost Sharing Requirements **Section 1902(a)(14) so far as it it incorporates Section 1916**

To permit the state to impose premiums, deductions, cost sharing, and similar charges that exceed the statutory limitations for individuals in the AC population.

3. Assurance of Transportation **Sections 1902(a)(4) and 1902(a)(19)**

To permit the state not to provide non-emergency transportation benefits to the AC population in this demonstration.

4. Comparability **Section 19029(a)(10)(B) and 1902(a)(17)**

To the extent necessary to permit the state to offer benefits to the AC demonstration population that differ from the benefits offered under the Medicaid state plan.

5. Retroactive Eligibility **Section 1902(a)(34)**

To the extent necessary to enable the state to not provide Medicaid services to the AC demonstration population prior to the date of application for the demonstration benefits**.**

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00286/5

TITLE: Minnesota 2020 System Reform Demonstration

AWARDEE: Minnesota Department of Human Services

I. PREFACE

The following are the special terms and conditions (STC) for the "Minnesota 2020 Reform" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Minnesota Department of Human Services (hereinafter "state"), to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

These STCs are effective from February 1, 2020 through January 31, 2025, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility, Benefits, and Enrollment
V. Cost Sharing
VI. Delivery Systems
VII. General Reporting Requirements
VIII. Monitoring Requirements
IX. Financial Reporting Requirements
X. Monitoring Budget Neutrality
XI. Evaluation of the Demonstration
XII. Schedule of Deliverables for the Demonstration Extension Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Evaluation Design

- Attachment K: Emergency Preparedness and Response

II. PROGRAM DESCRIPTION AND OBJECTIVES

Historical Context and Objectives

The demonstration was originally approved on October 18, 2013 for a five year period. As originally approved the demonstration provided federal authority to implement the below three key components of Minnesota's reform initiative to promote independence, increase community integration and reduce reliance on institutional care for older adults and people with disabilities:

1. Medicaid 1115 expenditure authority for the Alternative Care (AC) program, which provides community-supports to elders not financially eligible for Medicaid;
2. Medicaid funding to expand self-directed options under the Community First Services and Supports (CFSS) program for people who would otherwise be ineligible under the 1915(i) and 1915(k) Medicaid State Plan options; and,
3. Medicaid funding for covering children under the age of 21 in the ADL program who met the state's March 23, 2010 institutional level of care but do not meet the state's current required institutional level of care made effective January 1, 2015 and therefore would lose Medicaid eligibility without the demonstration.

The Reform 2020 demonstration goals and objectives were to:

- Achieve better health outcomes;
- Increase and support independence and recovery;
- Increase community integration;
- Reduce reliance on institutional care;
- Simplify the administration of the program and access to the program; and,
- Create a program that is more fiscally sustainable.

On July 21, 2017, the state submitted a request to extend the demonstration with no program changes for a five-year period beyond its scheduled expiration date of June 30, 2018. On February 5, 2018, the state withdrew its 1915 (i) and 1915 (k) Medicaid State plan amendments due to not being able to come into compliance with CMS' section 1915(i) and 1915(k) requirements because of conflicting state legislation. As a result, on March 12, 2018, the state submitted a letter requesting to revise its original extension request to continue the demonstration program without the Community First Services and Supports (CFSS) program component. In accordance, as requested by the state, these STCs remove the authority for the CFSS program as of the effective date of these STCs.

The demonstration extends Medicaid eligibility to: 1) participants in the AC program, and 2) children under the age of 21 within the ADL Needs program who were enrolled as of February 1, 2020. The expenditure authority for the ADL children will remain effective until October 31, 2020.

The initial five-year demonstration period expired on June 30, 2018, and several temporary extensions have been granted since to allot time for CMS and the state to develop an acceptable budget neutrality (BN) model. After careful consideration and analysis, CMS has determined that the state has presented a BN model that is in compliance with our current BN policy.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state

plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
    b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
    c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
    d. An up-to-date CHIP allotment worksheet, if necessary;
    e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve (12) months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets

federal requirements at CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of dis-enrolling beneficiaries.

10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of dis-enrolling beneficiaries.

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. Common Rule Exemption. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

Standards for eligibility remain as set forth under the approved Medicaid State Plan and as described elsewhere in these special terms and conditions.

16. Eligibility for the Demonstration. The following two populations of individuals, who meet the identified criteria, are Medicaid eligible for the services defined in the demonstration.

a. **Children under 21 with Activities of Daily Living (ADL) Needs** – Children under 21 who met the state's March 2010 Medicaid State Plan institutional level of care but do not meet the state's current Medicaid State Plan institutional level of care made effective January 1, 2015 and therefore would otherwise lose Medicaid eligibility.

b. **Alternative Care Program (AC)** – Alternative Care provides a targeted set of home and community based services to people ages 65 and older who are: 1) in need of a nursing facility level of care; 2) not eligible for Medicaid coverage because their income and assets exceed eligibility limits; and 3) their income and/or assets are insufficient to pay for 135 days of nursing facility care.

The AC program is a payor of last resort and other insurance is primary. If long-term care (LTC) insurance has paid for all the individual's assessed needs, the person would not be eligible for the Alternative Care program. If other insurance benefits and /or payments are sufficient to meet all the beneficiary's assessed needs, the beneficiary would not be eligible for Alternative Care program. If the LTC insurance only paid for a portion of the

beneficiary's assessed needs, the Alternative Care program would pay for other assessed unmet needs.

17. **Minimum Essential Coverage (MEC).** This demonstration is limited to the provision of services, for the AC population, as described in STC 20 and, consequently, is not recognized as Minimum Essential Coverage (MEC) as outlined in section 5000A(f)(1)(A)(ii) of the Internal Revenue Code of 1986. The state shall adhere to all applicable Internal Revenue Service reporting requirements with respect to MEC for demonstration enrollees in the AC program.

18. **Alternative Care Eligibility Process.** Applicants must submit applications to lead agencies as identified by the state. Lead agencies must annually re-determine financial and service eligibility. Applicants may be required to provide all information necessary to determine eligibility for Alternative Care and potential eligibility under the Medicaid State Plan. Applicants for Alternative Care who appear to be categorically eligible under the Medicaid State Plan shall receive Alternative Care for up to 60 days while State Plan eligibility is determined.

19. **Benefits under the Children under 21 with Activities of Daily Living (ADL) Needs.** Benefits provided to these children are the same as provided under the Medicaid State Plan.

20. **Benefits under the Alternative Care Program.** The Alternative Care program provides an array of home and community-based services similar to the home and community-based services provided under the federally approved 1915(c) Elderly Waiver program (CMS control number 0025.91.R07.00), except that the following services are not covered: transitional support services, assisted living services, adult foster care services, , and benefits that meet primary and acute health care needs. Alternative Care does additionally cover nutrition services and discretionary benefits that address special or unmet needs of a client or family caregiver that are not otherwise defined in the Alternative Care program service menu. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program. The service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved 1915(c) Elderly Waiver. In summary, Alternative Care program benefits include but are not limited to:
    a. Adult day service/adult day service bath;
    b. Family caregiver training and education;
    c. Case management and conversion case management;
    d. Chore services;
    e. Companion services;
    f. Consumer-directed community supports;
    g. Home health services;
    h. Home-delivered meals;
    i. Homemaker services;
    j. Environmental accessibility adaptations;
    k. Nutrition services;

l. Personal care;
m. Respite care;
n. Skilled nursing and home care nursing;
o. Specialized equipment and supplies including Personal Emergency Response System (PERS);
p. Non-medical Transportation;
q. Tele-home care; and,
r. Individual Community Living Supports (ICLS).

21. Alternative Care Enrollment. Enrollment procedures for the Alternative Care program are very similar to Medicaid home and community-based services waiver enrollment, except that Alternative Care enrollees do not need to select a health plan. Lead agencies (which may be a county or tribal health agency) administer both the Alternative Care program and the 1915(c) Elderly Waiver. Lead agencies determine financial and program eligibility.

a. Comprehensive Assessment. Each individual will receive a comprehensive assessment under the Long Term Care Consultation process. The certified assessor/case manager also evaluates financial eligibility. Applicants who would be eligible for medical assistance under Medicaid State Plan categorical eligibility standards are referred for medical assistance. The certified assessor/case manager also discusses with applicants the option of qualifying medical assistance under a medically needy basis.
b. Service Plan. If the AC program is selected, the assessor/case manager develops a person-centered service plan that identifies the amount, frequency and duration of services needed by the beneficiary and, where appropriate, caregiver supports. Approved services are prior authorized in the Medicaid Management Information System (MMIS) system. Reassessments are done at least annually or sooner if individual needs change.

22. Application and Eligibility Determination Process.

The state assures that the eligibility process for the AC program is integrated with other programs that receive federal Medicaid matching funds so that people applying for AC or long term care services are appropriately screened for the most appropriate program and category of eligibility, and that people who apply through the on-line, streamlined application process are directed to the appropriate program for long term care services. The state will integrate eligibility and application processes for the AC program when other long term care programs are integrated into the eligibility system operated by the state for Medicaid State Plan coverage in accordance with section 1943 of the Act.

Within 60 days of CMS approval of this extension, the state will submit for CMS review and approval, its timeline to ensure the state does not make a final determination of ineligibility based on lack of documentation of citizenship/qualified immigration status provided by the applicant until the state first utilizes an alternative process (pre-or post-enrollment) to verify this information through the electronic data sources used for Medicaid state plan eligibility. That timeline will include full implementation within 12 months from the date of submission.

23. Person-Centered Planning. The state assures there is a person-centered service plan for each individual determined to be eligible for services under this demonstration. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

24. Conflict of Interest: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

25. Community Participation. The state, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

26. HCBS Settings. The state assures compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.

V. COST-SHARING

27. Children under 21 with Activities of Daily Living (ADL) Needs Cost-Sharing. This population is only subject to cost-sharing to the extent allowable under Medicaid State Plan.

28. Alternative Care Program Cost-Sharing. Individuals in the Alternative Care program pay cost-sharing fees up to 30 percent of the average monthly cost of the individual's Alternative Care services.

Determining Fees. Minnesota uses adjusted income and gross assets and the average monthly amount of services authorized for the beneficiary. Adjusted income for a married applicant who has a community spouse is calculated by subtracting the following amounts from gross income: the monthly spousal income allowance to the community spouse (which is calculated using the spousal impoverishment rules applicable under the 1915(c) Elderly Waiver); recurring and predictable medical expenses; and the federally indexed clothing and personal needs allowance. Adjusted income for all other applicants is calculated by subtracting the following amounts from gross income: recurring and predictable medical expenses and the federally indexed clothing and personal needs allowance.

Alternative Care Adjusted Income	Gross Assets	Monthly Fee Charge (percentage of average monthly cost of services)
Less than 100% of the FPL	Less than $10,000	No monthly fee
Between 100% and 149% of the FPL	Less than $10,000	5 percent
Between 150% and 199% of the FPL	Less than $10,000	15 percent
At or greater than 200% of the FPL	At or greater than $10,000	30 percent

a. Billing and Non-payment of Fees. Enrollee fees are billed the month after services begin. If enrollee fees are not paid within 60 days, the lead agency works with the enrollee to arrange a payment plan. The lead agency can extend the enrollee's eligibility as necessary while making arrangements to rectify nonpayment of past due amounts and facilitate future payments. If no arrangements can be made, a notice is issued 10 days prior to termination stating that the enrollee will be dis-enrolled from the program. The enrollee may appeal the disenrollment under the standard State Fair Hearing process. Following disenrollment due to nonpayment of a monthly fee, eligibility may not be reinstated for 30 days.

VI. DELIVERY SYSTEM

29. AC Program Delivery System. These program services are provided on a fee-for-service basis and are administered by counties and tribal human service programs. The service definitions and standards for Alternative Care services are the same as the service definitions and standards specified in the federally approved 1915(c) Elderly Waiver plan. Approved services are prior authorized in the MMIS system. Services are provided by qualified providers who are enrolled Medicaid providers**.**

30. Children under 21 with Activities of Daily Living (ADL) Needs. These program services are provided on a fee-for-service basis in the same manner as authorized under the Medicaid State Plan.

VII. GENERAL REPORTING REQUIREMENTS

31. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely

to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).
b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

32. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

33. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

34. HCBS Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

35. For 1915(c) HCBS services, the state must have an approved Quality Improvement Strategy and is required to work with CMS to develop approvable performance measures within 90 days following approval of the 1115 for the following waiver assurances (a through f below):

a. **Administrative Authority**: A performance measure should be developed and tracked any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.
b. **Level of Care**: Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.
c. **Qualified Providers**: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.
d. **Service Plan**: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
e. **Health and Welfare**: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
f. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered,

and that it provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

36. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. NOTE: This information could be included in the annual reports submitted for 1115 waivers detailed in STC 38.

37. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers. NOTE: This information could be captured in the Summative Evaluation Report detailed in STC 73.

VIII. MONITORING REQUIREMENTS

38. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The

required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

39. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

40. Close Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 31.

41. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

42. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the

demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time, and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

IX. FINANCIAL REPORTING REQUIREMENTS

43. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

44. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

45. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section IX**:**

a. Administrative costs, including those associated with the administration of the demonstration;
b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

46. Sources of Non-Federal Share. The state certifies that its match for the non-federal share of funds for this section 1115 demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. The state acknowledges that any amendments that impact the financial status of this section 1115 demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

47. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that

payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

48. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

49. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The following table provides a master list of MEGs defined for this demonstration.

Table 2: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
AC population	Main	N/A	X	X	See Expenditure Authority #1
ADL children	Hypo	N/A	X	X	See Expenditure Authority #2

50. Reporting Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00286/5). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
b. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
c. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.
d. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the table below, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in STC 38, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita, and as also indicated in the table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
f. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality

Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 3: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
AC population	Individuals ages 65 and older who are: 1) in need of a nursing facility level of care; 2) not eligible for Medicaid coverage because their income and assets exceed eligibility limits; and 3) their income and/or assets are insufficient to pay for 135 days of nursing facility care.	*N/A*	Report on customary lines by category of service	Date of service	MAP	Y	2/01/2020	1/31/2025
ADL children	Expenditures to provide Medicaid State Plan benefits to children under 21 who met the state's March 2010 Medicaid State Plan institutional level of care but do not meet the state's current Medicaid State Plan institutional level of care made effective January 1, 2015.	*N/A*	Report on customary lines by category of service	Date of service	MAP	Y	2/1/2020	10/31/2020

51. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 4: Demonstration Years		
Demonstration Year 7	February 1, 2020 to June 30, 2020	5 months
Demonstration Year 8	July 1, 2020 to June 30, 2021	12 months
Demonstration Year 9	July 1, 2021 to June 30, 2022	12 months

Demonstration Year 10	July 1, 2022 to June 30, 2023	12 months
Demonstration Year 11	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 12	July 1, 2024 to January 31, 2025	7 months

52. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in section X. CMS will provide technical assistance, upon request.[1]

53. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

54. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply

[1] 42 CFR 431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation. The changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. If, after review and/or audit, the data supplied by the state to set the budget neutrality expenditure limit are if found to be inaccurate. The state certifies that the data it provided are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief.

X. MONITORING BUDGET NEUTRALITY

55. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

56. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

57. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality spending limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which projected fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share of the AC program limit will be calculated by subtracting the EW actual expenditures from the EW expenditure amount as listed on the WOW table below then multiplying it by the Composite Federal Share.

58. Main Budget Neutrality Test. The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The Main Budget Neutrality Test will incorporate net savings from the immediately prior demonstration period of July 1, 2015 through June 30, 2019 (but not from any earlier approval period) in the amount of $16,971.003.70. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit in addition to carry forward savings from the prior demonstration period. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 5: Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	TREND	DY 7	DY 8	DY 9	DY 10	DY 11	DY 12
EW	Agg	Both	N/A	$214,116,141	$557,878,712	$605,645,153	$657,503,575	$713,800,880	$452,036,201
AC	WW Only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

***PC = Per Capita, Agg = Aggregate**

59. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats

these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

60. Hypothetical Budget Neutrality Test 1: The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6: Hypothetical Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or Both	Trend rate	DY 7	DY 8
ADL	PC	Both	3.7%	$10,784.71	$11,183.74

61. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

62. Transitional Phase-Down of Newly Accrued Savings. Beginning with DY 1, the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medical population based MEGs. The reduced variance, calculated as an applicable percentage times the total variance, will be used in place of the total variance to determine

overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The applicable percentages have been determined in accordance with the policy for Transitional Phase-Down of Newly Accrued Savings described in State Medicaid Director Letter # 18-009. This provision only applies to the Main Budget Neutrality Test, and to the MEGs that are designated "Both" without-waiver and with-waiver. The MEGs affected by this provision and the applicable percentages are shown in the table below. If the total variance for an MEG in a DY is negative, the applicable percentage is 100 percent.

Table 7: Savings Phase-Down						
Base	**DY 7**	**DY 8**	**DY 9**	**DY 10**	**DY 11**	**DY 12**
EW Diversion Savings	80%	70%	60%	50%	40%	30%

63. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from February 1, 2020 to January 31, 2025. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds received for the AC program or the ADL needs program in excess of the federal share of the limits will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

64. Expenditure Reconciliation and Limitations. At the time of the approval of this demonstration extension, the state does not have full expenditure data available in its CMS 64 report for first 2 quarters of DY 7 to allow CMS to calculate its accrued savings to carry forward into the new demonstration period. The state must complete reporting of expenditures subject to the budget neutrality limit for DY 7 by December 31, 2020, to adjust the savings carry forward amount in STC 62 to be adjusted to consider this partial year. Failure to complete the reconciliation process will result in forfeiture by the state of all budget neutrality savings from the first 2 quarters of DY 7. The inclusion of savings from DY 7 will affect the use of savings for DY 2. As per the SMDL 18-009, only five years of savings can "roll over" into an extension.

65. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 9: Main Budget Neutrality Test Mid-Course Correction Calculations		
EW population	**Cumulative Target Definition**	**Percentage**
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 8 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 9 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 10 through DY 11	Cumulative budget neutrality limit	0.0 percent
DY 11 through DY 12	Cumulative budget neutrality limit	0.0 percent

Table 10: Hypothetical Budget Neutrality Test Mid-Course Correction Calculations		
	Cumulative Target Definition	**Percentage**
DY 7	Cumulative budget neutrality limit plus:	2.0 percent
DY 7 through DY 8	Cumulative budget neutrality limit plus:	1.5 percent
DY 8 through DY 9	Cumulative budget neutrality limit plus:	1.0 percent
DY 9 through DY 10	Cumulative budget neutrality limit plus:	0.5 percent
DY 10 through DY 11	Cumulative budget neutrality limit plus:	0.0 percent
DY 11 through DY 12	Cumulative budget neutrality limit plus:	0.0 percent

XI. EVALUATION OF THE DEMONSTRATION

66. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce, or maintain data and files for the demonstration, a requirement that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim

administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 31.

67. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

68. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable evaluation design guidance, including guidance about premiums, non-eligibility periods as a consequence of noncompliance with other demonstration policies, and waivers of retroactive eligibility.
b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing CE Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

69. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment C to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval.

70. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS's measure sets for eligibility and coverage (including community engagement), Consumer Assessment of Health Care Providers and Systems (CAHPS), the

Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, and/or measures endorsed by National Quality Forum (NQF).

71. **Evaluation Budget.** A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

72. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
    a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted, should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
    d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
    e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

73. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.
    a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

74. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's Interim Evaluation Report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10.

75. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

76. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

77. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles, or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XII. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

Deliverable	Timeline	STC Reference
State acceptance of demonstration extension STCs and expenditure authorities	30 days after demonstration extension approval date	Approval letter
Quarterly Monitoring Report	Within 60 days following the end of each demonstration quarter	STC 38
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 38
Draft Evaluation Design Plan	Within 180 days after the approval of the demonstration extension	STC 68
Final Evaluation	Within 60 days following receipt of CMS	STC 69

Plan	comments on Draft Evaluation Design	
Draft Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 73
Final Summative Report	Within 60 days of receipt of CMS comments	STC 73
Draft Final Close Out Demonstration Report	Within 120 days following the expiration of the demonstration (If Applicable)	STC 40
Final Close Out Demonstration Report	Within 30 days of receipt of CMS comments (If Applicable)	STC 40

ATTACHMENT A
Developing the Evaluation Design

Introduction

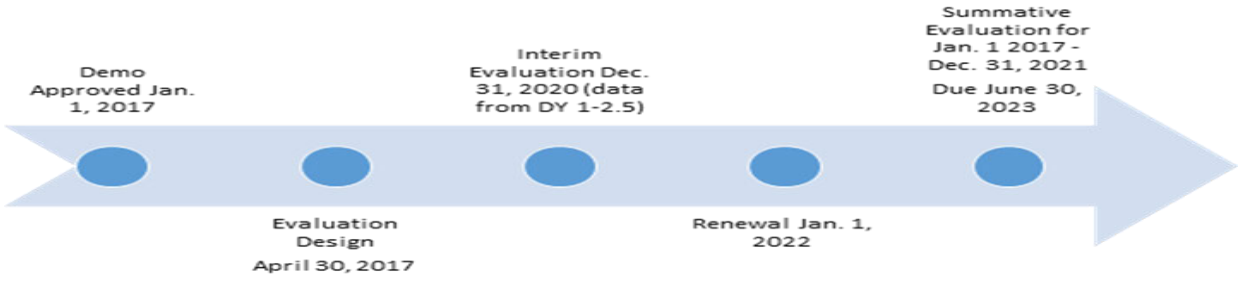
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
5. Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to

improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3. Identify the state's hypotheses about the outcomes of the demonstration:

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
3) *Evaluation Period* – Describe the time periods for which data will be included.
4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.

c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to	Sample or population subgroups to be compared	Data Sources	Analytic Methods

	address the research question			
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent

Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

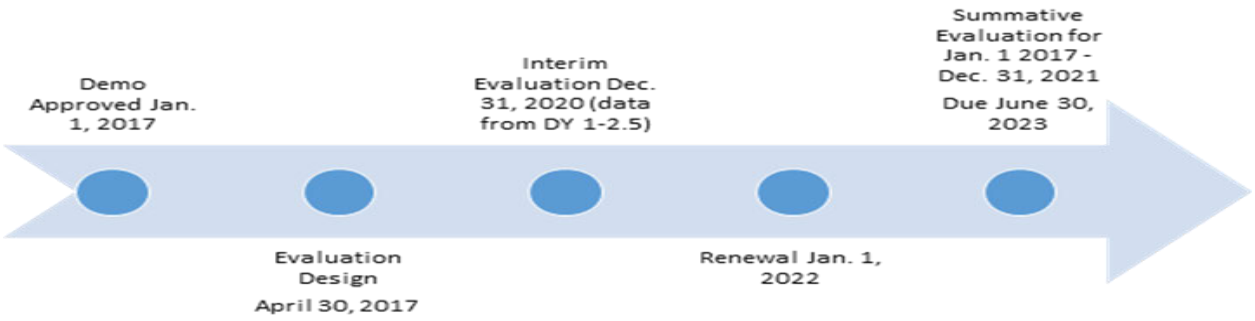
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the

implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions – The state may provide any other information pertinent to the evaluation of the demonstration.

A) Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

B) Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C) Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Evaluation Design

Evaluation Plan for Reform 2020 Section 1115 Demonstration Waiver

This is a proposed evaluation plan for the Alternative Care program under Minnesota's demonstration waiver entitled Reform 2020: Pathways to Independence. The waiver was originally approved in October 2013 and was extended in February 2020.

Minnesota's Medicaid program, known as Medical Assistance (MA), offers an array of home and community–based services for low-income seniors and people with disabilities.

Minnesota has been reducing use of institutions through development of home and community-based long-term supports and services for over thirty years. Minnesota has rebalanced its system so that a large majority of the older adults (74% in 2018) and people with disabilities (95% in 2018) who are enrolled in MA and need long term care services are living in the community rather than in institutional settings.

Minnesota has five home and community-based services waivers: Developmental Disability (DD)[1], Community Alternatives for Disabled Individuals (CADI)[2], Community Alternative Care (CAC)[3], Brain Injury (BI)[4] and Elderly Waiver (EW)[5]. Similar services to support individuals living in the community are offered under each waiver, but since each was developed over time and under different constraints, opportunities, and different populations, HCBS waivers differ from one another in areas such as eligibility criteria and annual spending.

In addition, Minnesota provides the following long-term services and supports through the state plan: home health agency services, private duty nursing services, rehabilitative services (several individualized community mental health services that support recovery) and personal care assistant (PCA) services.

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[1] DD: 2019 unduplicated enrollment was 21,120

[2] CADI: 2019 unduplicated enrollment was 31,715

[3] CAC: 2019 unduplicated enrollment was 649

[4] BI: 2019 unduplicated enrollment was 1,242

[5] EW: 2019 unduplicated enrollment was 36,680 (managed care and fee-for-service)

There are other Medicaid and state programs that support community living such as day treatment and habilitation, semi-independent living services, the Family Support Grant Program, mental health services, AIDS assistance programs, group residential housing, independent living services, vocational rehabilitation services, extended employment, special education and early intervention.

Minnesota's Reform 2020 demonstration enables the state to continue its history of on-going improvement to enhance its home and community-based service system by enabling the state to provide preventive services to seniors who are likely to become eligible for Medicaid and who need an institutional level of care. The demonstration goals align with those of Medicaid and assist the state in promoting title XIX program objectives in the following ways:

- Achieving better health outcomes;
- Ensuring that the demonstration increases the participants' level of support for independence and recovery;
- Increasing community integration;
- Reducing the reliance on institutional care;
- Simplifying the administration of the program; and
- Ensuring access to the program's offered services.

Table of Contents

Background on the Reform 2020 Section 1115 Waiver for Alternative Care

The Alternative Care or AC program was implemented under Reform 2020 beginning November 1, 2013. Formerly a state-funded program, the Reform 2020 waiver allows Minnesota to receive federal financial participation to provide Alternative Care services to people over age 65 whose functional needs indicate eligibility for nursing facility care but have combined adjusted income and assets exceeding state plan Medicaid standards for aged, blind and disabled categorical eligibility.

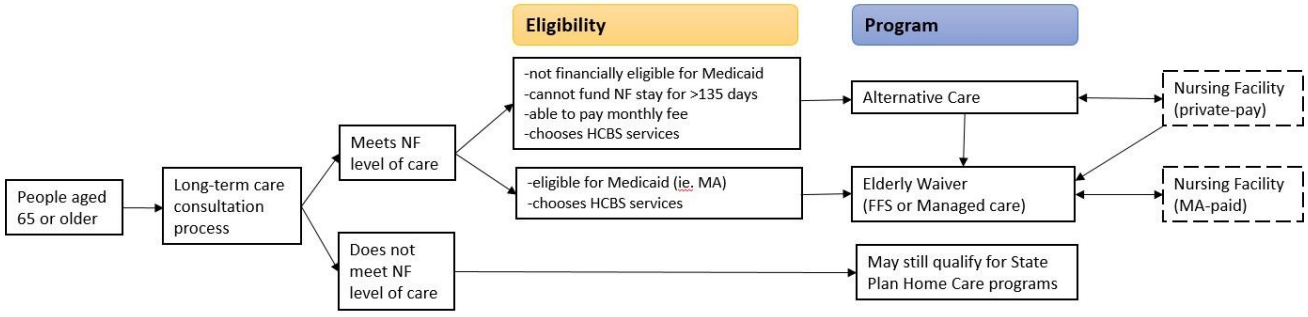
Acute and primary care services are not covered under the program. However, connecting seniors with community services earlier may divert them from nursing facilities and encourage more efficient use of services when full Medicaid eligibility is established. Minnesota has a home and community-based waiver for people over age 65 that need nursing facility care called the Elderly Waiver. Although Alternative Care covers fewer services, service definitions and provider standards for the Alternative Care program are the same as the service definitions and provider standards specified in Minnesota's federally approved Elderly Waiver. Services are provided by qualified enrolled Medicaid providers.

Alternative Care is available to eligible individuals who meet all of the following *financial requirements*:

- Those with combined income and assets insufficient to pay for 135 days of nursing facility care, based on the statewide average nursing facility rate
- Those not within an uncompensated transfer penalty period
- Those with home equity within the home equity limit applicable under the state plan

Functional eligibility for nursing home care and identification of needed services for Alternative Care is performed using the Long-term Care Consultation process, which is the same assessment tool and process that is used for the Elderly Waiver. Applicants for Alternative Care also discuss the option of qualifying for Medical Assistance under a medically needy basis (see Figure 1).

Figure 1. Minnesota Health Care Program Options for the Elderly



AC, alternative care program; FFS, fee-for-service; HCBS, home and community-based services; MA, Medical Assistance (Minnesota's Medicaid program); NF, nursing facility; SNF, skilled nursing facility

If an Alternative Care participant is admitted to a nursing facility, their stay is either paid by Medicare (if eligible), other long-term care insurance, or out-of-pocket. Continued facility stays can result in spenddown to MA. A person may also spend-down and become eligible for Medicaid while enrolled I Alternative Care. In

that case, he/she can also transition to the Elderly Waiver. For details on how a person transitions from Alternative Care to Elderly Waiver program, refer to the "AC Operational Protocol".

The Alternative Care program provides an array of home and community-based services based on assessed need and as authorized in the community support plan or care plan developed for each participant. The monthly cost of the Alternative Care services must not exceed 75 percent of the monthly budget amount available for an individual with similar assessed needs participating in the Elderly Waiver program.

The services available under Alternative Care are the same as the services covered under the federally approved Elderly Waiver, *except:*

- Alternative Care **does not cover** transitional support services, assisted living (customized living) services, adult foster care services, or services that meet primary and acute health care needs
- Alternative Care **additionally covers** nutrition services and discretionary services

The comprehensive list of Alternative Care services is below.

- Adult day service/adult day service bath;
- Family caregiver training and education and family caregiver coaching and counseling/assessment;
- Case management and conversion case management
- Chore services;
- Companion services;
- Consumer-directed community supports;
- Home health agency services;
- Home-delivered meals;
- Homemaker services;
- Environmental accessibility adaptations;
- Nutrition services;
- Personal care;
- Respite care;
- Skilled nursing and private duty nursing;
- Specialized equipment and supplies including Personal Emergency Response System (PERS);
- Non-medical transportation;
- Tele-home care;
- Discretionary services

An overview of the Alternative Care program, services, and outcomes are provided in Figure 2.

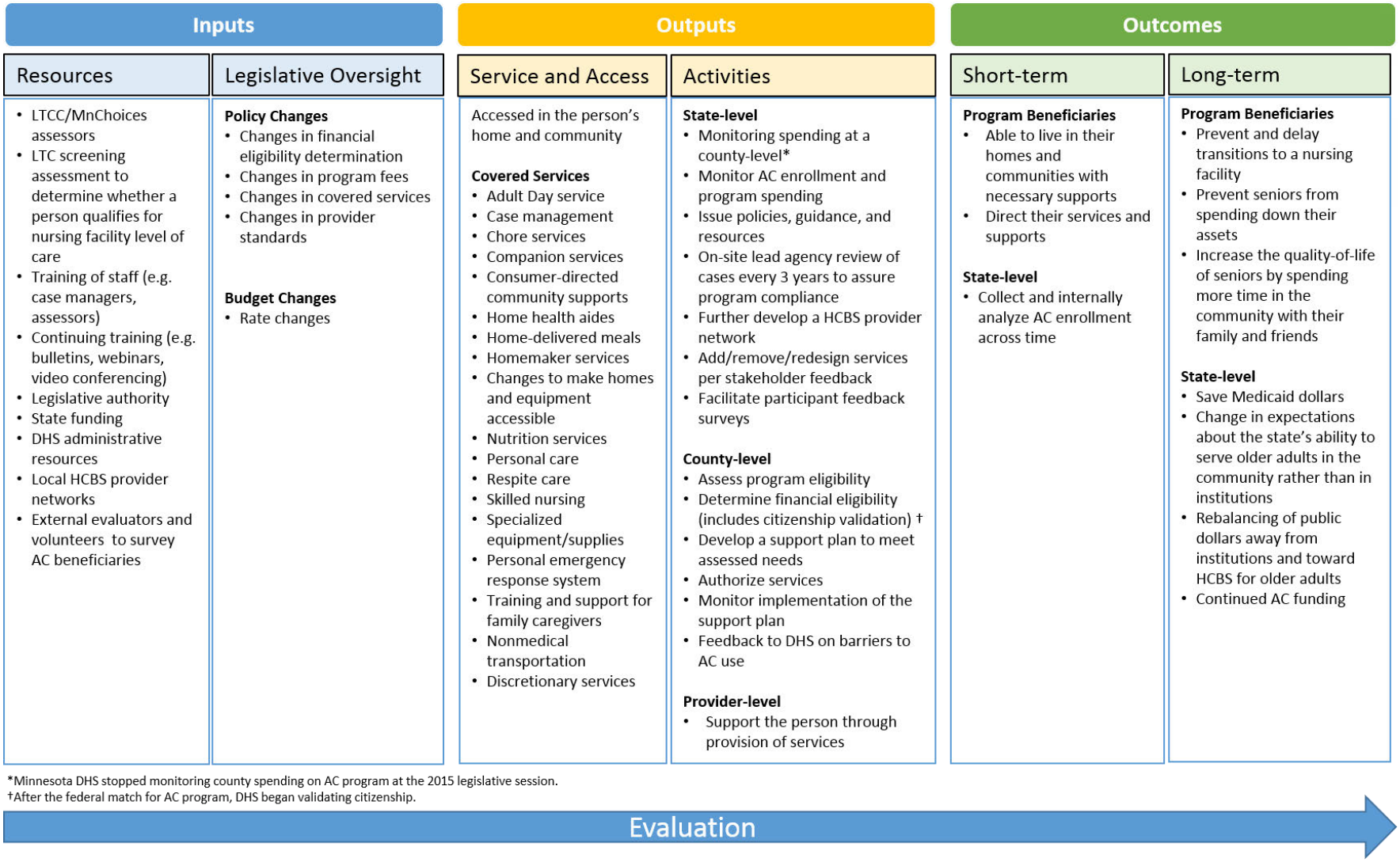
Program Goals

The goals of the Alternative Care program are to:

- Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.

- Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care.
- Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time.

Figure 2: Alternative Care Program Logic Model



Evaluation Questions and Hypotheses

The Reform 2020 demonstration waiver extension is approved for the period February 1, 2020 through January 31, 2025. Since the federal waiver authorization has not resulted in any substantial changes to the Alternative Care program structure, we expect that key evaluation metrics will not change over the extension period (2020–2025) as a result of the continuation of the AC waiver. We will be testing the null hypotheses of no change attributable to the AC waiver extension. We will test these null hypotheses by tracking trends in service use and outcomes and drawing comparisons with a matched sample of EW participants who presumably will be subject to the same external events, such as COVID-19, as AC participants.

We plan to assess the following hypotheses.

As a consequence of the AC Waiver extension from 2020-2025:

- The demographic characteristics and service needs of AC participants will not change.
- AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service.
- AC participants will experience equal or better access to consumer-directed service options;
- AC participants will not experience an increase in nursing facility use;
- AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits; and

The rate of Medicaid conversion for AC participants though transitions between AC and EW and other waiver programs or nursing home use will not increase.

We must consider the possibility of changes occurring in these metrics due to external events outside of the AC waiver itself. These events could influence access to or use of HCBS or other services or change health status over the extension period. For example, the COVID-19 pandemic is an external event that has likely influenced service use patterns and outcomes in 2020-2021 and it may continue to do so in the future. The evaluation design, therefore, should attempt to separate out changes over time due to the AC Waiver from those attributable to COVID-19 or other external events.[6]

To strengthen the evaluation design, we propose to examine trends over a five year period prior to the waiver (2015-2019) as a backdrop to the trends during the extension period. In addition, we will compare the AC participants with a balanced sample of Elderly Waiver participants. By examining past trends, we can estimate the impact of COVID-19 or other identifiable external events, such as HCBS policy changes. We anticipate some disruption of HCBS, acute care, and other service use. In the period 2021-2025, some changes associated with the COVID-19 pandemic may continue. By selecting an EW comparison group that is similar to AC participants in demographics, need, and access to services, we can check for parallel trends and perform difference in difference calculations in an attempt to isolate waiver-related changes from COVID-19

[6] Available at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-covid19-implications.pdf

or other external events. If AC and EW participants follow the same patterns of HCBS or other service use disruption during or after the COVID-19 pandemic, we have a stronger basis for inferring that it was COVID-19 rather than the AC waiver that contributed to these changes. Given data limitations and the complexity of events during and after COVID-19, we must be cautious in our interpretations of patterns in the data.

Methodology

To test these hypotheses, we will employ multiple strategies: (1) examine trends in repeated 12-month cross sectional measures of demographics, service use and other patterns for AC participants beginning with the baseline period (2015-2019) and continuing through the extension period (i.e., 2020-2025); (2) conduct a parallel cross-sectional analysis for a comparison groups of EW participants selected through balanced sampling; (3) track patterns in key metrics for longitudinal cohorts of AC participants and EW participants beginning in 2019, 2020, and 2021 and then followed through 2025. In conducting the trend and cohort analyses, we will look for changes in service use and other metrics, particularly any unintended consequences for program participants that could be attributable to the AC waiver compared to external events such as COVID-19.

Comparison of AC Participants and EW Sample

The populations included in the evaluation consist of Alternative Care (AC) program participants and Elderly Waiver (EW) participants. Elderly Waiver participants are similar to Alternative Care program participants. Both groups: 1) are aged 65 and above, 2) must have an assessed need for an institutional level of care, and 3) are using home and community-based services to meet their needs and remain living in the community instead of in a nursing facility.

Some EW participants will use residential services (i.e., customized living, adult foster care). We will identify EW participants in non-residential settings by excluding participants with any claims for residential services. Internal program monitoring and evaluation show that the number of unique participants in AC remained relatively constant from 3,679 in 2015 to 3,652 in 2018; whereas the number of EW participants in non-residential settings increased somewhat from 19,934 in 2015 to 22,042 in 2018.[7]

We will select a comparison group of EW participants according to balance sampling techniques in order to ensure that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning.

[7] Evaluation of Minnesota's Reform 2020 Section 1115 Demonstration Waiver

Alternative Care Program. Minnesota Department of Human Services, June 2021.

Metrics Aligned with Hypotheses

Hypothesis 1. The demographic characteristics and service needs of AC participants will not change.

- Gender, race/ethnicity, age composition, living arrangement, and residential location
- Case mix status (low-need vs. high-need)[8]
- Professional recommendations for service need and supports
- ADL dependencies
- Health status – major diagnoses

Hypothesis 2. AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service.

- Prevalence of HCBS waiver services
- Prevalence of state-plan LTSS services, e.g., PCA
- Hours/units of HCBS waiver services
- Hours/units of state-plan services, e.g., PCA

Hypothesis 3. AC participants will experience equal or better access to consumer-directed service options.

- Prevalence of authorized consumer-directed community supports
- Number of units/hours of consumer-directed community supports

Hypothesis 4. AC participants will not experience an increase in nursing facility use.

- Proportion of participant days spent in nursing facilities
- Frequency of nursing facility admission, by length of stay
- Case mix adjusted nursing facility admission
- Number of nursing facility days
- Return or new use of AC or Elderly Waiver programs after discharge from nursing facility

Hypothesis 5. AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits.

- Rate of acute inpatient admissions
- Rate of ED visits
- Mortality rate

Hypothesis 6. The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase.

- AC participants converting to Medicaid

[8] See section 2.42 for details on case mix is determined and level of need is defined.

- Transition from AC to EW or other HCBS waiver program
- AC participant transition to Essential Community Supports[9]
- Days alive in the community and not on Medicaid

Data Sources and Variable Construction

Data Sources

MMIS

Medicaid Management Information Systems (MMIS) is the largest health care payment system in Minnesota. Health care providers, county staff, and DHS administration uses the MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in Minnesota Health Care Programs. The MMIS contains both fee-for-service claims and data on use of services by individuals enrolled in managed care plans. The following types of data will be used for the current evaluation:

- Program begin and end date
- Claims for HCBS and other services
- Death date
- Demographics
- In residential or non-residential setting

LTC Screening Document

This form is used to document pre-admission screening and long-term care consultation (LTC)

activities. It is used to record public programs eligibility determination as well as to collect information about people screened, assessed, or receiving services under home and community-based services programs. These assessments contain the following variables that will be used for the current evaluation:

- Program type (i.e., indicates waivered program, change to another waivered program)
- Entry and exit from waivered programs (including death) and exit reasons
- Continued use of waivered program at reassessment
- Case mix
- Health functions (e.g. activities of daily living (ADLs))
- Level of care
- Housing type (e.g. nursing facility, assisted living, foster care)

[9] The Essential Community Supports Program (ECS) program was established by the Minnesota Legislature and became effective January 1, 2015. Initially designed to provide support for individuals who might lose their HCBS program eligibility as a result of changes to the nursing facility level of care criteria that also became effective January 1, 2015, it was also adopted as an ongoing program for individuals aged 65 and older with emerging needs for HCBS but who do not yet meet level of care criteria and who are not MA eligible but meet the AC financial eligibility criteria. This program has a relatively small basket of services and monthly budget.

- Authorization of CDCS services

Minimum Data Set (MDS)

This is a federally mandated assessment. Nursing facilities conduct the MDS assessment on each resident and transmit that data to the Minnesota Department of Health (MDH). Case mix related functions are conducted by the MDH on behalf of the Medicaid program under contract to the DHS (the Medicaid Agency). The MDH determines the resident's case mix classification based on the MDS data and also conducts regular audits of the MDS data submitted by NFs to ensure the data is accurate. These assessments contain the following variables that will be used for the current evaluation:

- Admission and discharge date
- Admission source (e.g., acute and primary care or community) and discharge destination (e.g. acute and primary care transfer, community, or mortality)
- Post-acute Medicare stay, either alone or in combination with a subsequent long stay.
- Health and functional status at admission and the latest assessment before discharge back to the community, if applicable.

Medicare Data

Medicare claims will provide utilization for non-Medicaid-covered services (particularly for AC participants or for periods when a participant is not covered by Medicaid), but otherwise will largely duplicate what we can learn from MMIS. Medicare files will be requested for persons age 65+ who were enrolled in Medicaid or AC (from existing MMIS) and anyone using skilled nursing facilities (from MDS). The MBSF and MedPAR files will provide sufficient information for the outcome variables.

- Dates of acute hospital stays and emergency department visits
- Utilization outside of periods of Medicaid eligibility or for services not covered by Medicaid
- Associated diagnoses and procedure codes
- Date of death
- Special Variable Construction
- Case mix

Case mix is a classification tool that is used in both AC and EW programs to establish monthly budget limits for HCBS services. A copy of the Case Mix Classification Worksheet describing the factors used to determine a case mix classification for all AC and EW participants is at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3428B-ENG. The classification is based on assessed need in:

- Eight activities of daily living (ADLs): bathing, dressing, grooming, walking, toileting, positioning, transferring, and eating
- The need for clinical monitoring in combination with a physician-ordered treatment, and
- The need for staff intervention due to behavioral or cognitive needs.

After assessment, the individual is assigned a case mix classification of A-L based on their combination of ADLs, clinical monitoring and behavioral/cognitive needs.[10]

Level of Need

For purposes of this evaluation, the case mix classifications have been grouped as follows:

- Low Need (A, L): This group includes individuals with 0-3 ADL dependencies
- Moderate Need (B, D, E): This group includes individuals with 4-6 ADL dependencies and/or behavioral/cognitive needs.
- High Need (G, H, I, J): This group includes individuals with dependencies in 7 or 8 ADLs (G), and those with specific other needs in combination with 7-8 ADL dependencies.
- High Need Clinical (C, F, K, V): This group includes individuals with varying number of dependencies but who have an assessed need for clinical monitoring at least once every 8 hours.

Analytic Methods

We propose the following methods to address the hypotheses for the evaluation. The sections below provide information about each approach, including the comparison group(s), metrics, and statistical methods.

Data Set Development

The cross-sectional data sets will be developed by assembling data each calendar year from 2015-2025 for AC and EW participants, constructing all relevant variables, and sample balancing matching to select the EW participant sample.

For each calendar year, we will identify AC and Elderly Waiver participants using LTC screening assessment data (also available in MMIS). We will further identify Elderly Waiver participants in non-residential settings by excluding participants with any claims for procedure codes denoting residential services (i.e., customized living, adult foster care, and residential care services). While living in the community, if an AC participant uses CDCS, this information will be recorded in the MMIS claims data, as well as the total dollars paid for CDCS in a fiscal year. We will categorize acuity into two categories: low-need and high-need and calculate differences in case mix for each year between AC and Elderly Waiver participants by acuity type.

The cohort data sets will consist of participants selected from the cross-sectional data sets in 2019-2021. Longitudinal data will be assembled for three participant cohorts from the beginning cohort year (2019, 2020, or 2021) through 2025. Although the cross-sectional and cohort samples will be separated analytically, the data sets will have overlapping participants who were receiving waivered services in more than one year.

[10] EW also has a case mix V for people who are vent dependent

Comparison Sample Selection

We will employ a sample balancing methodology to select samples of EW participants that match as close as possible on key characteristics of the AC participants..[11] Predictor variables include gender, race/ethnicity, age composition, living arrangement, and residential location, case mix status (low-need vs. high-need), professional recommendations for service need and supports, ADL dependencies, and health status and major diagnoses.

The matching sample with the minimum total difference (Mahalonobis distance) will used for the analysis. [12] Individual characteristics will be compared between the pseudo control and assisted groups and tested for significant differences ($P < 0.05$) with t-tests and Fisher's exact test.

Repeated Cross-Sectional Analysis

In the first step in the analysis, will compare annual cross-sections of AC participants to the matched samples of EW participants. We will calculate the proportions and intensity (hours or units) of HCBS other Medicaid services. We will also count the number of acute care episodes and nursing home admissions. We will calculate the proportion of individuals that remain enrolled in AC, those that switched to Elderly Waiver, and the days alive in the community and not on Medicaid (i.e., not using residential services). We will also account for death and loss of AC eligibility.

For all measures, we will report the denominator, number and percent of participants, and person months in each service category, program category, and care setting. We will test the difference in proportions and means between AC and EW participants in each year, as well as differences between years. We will apply t-tests or Z-tests to test for differences in means and proportions. We will also test for differences in trends in service use over time with generalized estimating equations (GEE). [13]

Cohort Analysis

Patterns in outcomes (e.g., transitions between program statuses or care settings) for AC and EW participants in the three cohorts (2019, 2020, 2021) will be visualized with time plots. Separate Cox-proportional hazard models were used to test for differences in the time to event. Variables causing a violation of the proportional hazards assumption will be removed. Multilevel or mixed effect growth models will be used to evaluate HCBS and other service utilization. The models will be calendar quarter time periods from 2019 – 2021. Service use will the outcome. Calendar quarter, AC participation, and interaction between quarter and AC participation will be fixed effects.

---

[11] Deville, J. C., & Tillé, Y. (2004). Efficient balanced sampling: the cube method. *Biometrika*, *91*(4), 893-912.

[12] Rosenbaum, P. R. (1989). Optimal Matching for Observational Studies. *Journal of the American Statistical Association*, *84*(408), 1024-1032.

[13] Hardin JW, Hilbe JM (2003) Generalized estimating equations. Boca Raton: CRC Press.

Table 1. Design Table for the Evaluation of the Demonstration

Research Question	Outcome measure used to address the research question	Data Sources	Sample or population	Analytic Methods
Hypothesis 1. The demographic characteristics and service needs of AC participants will not change				
1a. What are demographic characteristics of people who use the AC waiver?	- Gender, race/ethnicity, age composition, living arrangement, and residential location	- MMIS - LTC assessment	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW)	- Multiple cross-section comparisons - Descriptive statistics - Chi-square test/Fishers exact test
1b. What are the service needs of people who use the AC waiver?	- Case mix status (low-need vs. high-need)[14] - Professional recommendations for service need and supports - ADL dependencies - Health status – major diagnoses	- LTC Screening Document - MMIS	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics	- Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square test/Fishers exact test - Regression models with service need as an outcome, controlling for demographics

[14] See section 2.42 for details on case mix is determined and level of need is defined.

Research Question	Outcome measure used to address the research question	Data Sources	Sample or population	Analytic Methods
Hypothesis 2. AC participants will not experience a change in the types of HCBS services or a decrease in the intensity of services, i.e., number of hours or units of service.				
2a. What are the types of services used by AC participants?	- Prevalence of HCBS waiver services - Prevalence of state-plan LTSS services, e.g., PCA	- MMIS	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need	- Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square test/Fishers exact test - Regression models with service use as an outcome, controlling for demographics and service need
2b. What is the intensity of services used by AC participants?	- Hours/units of HCBS waiver services - Hours/units of state-plan services, e.g., PCA	- MMIS	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need	- Multiple cross-section comparisons for successive years - Descriptive statistics - t-tests - Regression models with service intensity as an outcome controlling for demographics and service need

Research Question	Outcome measure used to address the research question	Data Sources	Sample or population	Analytic Methods
Hypothesis 3. AC participants will experience equal or better access to consumer-directed service options.				
3a. What is the utilization of consumer-directed support (CDCS) options for AC waiver participants?	Prevalence of authorized consumer-directed community supports Number of units/hours of consumer-directed community supports	- MMIS	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need	- Multiple cross-section comparisons for successive years - Descriptive statistics - t-tests - Regression models with CDCS use as an outcome controlling for demographics and service need
Hypothesis 4. AC participants will not experience an increase in nursing facility use.				
4a. What are the utilization trends in nursing facility use?	- Time to nursing home use - Proportion of participant days spent in nursing facilities - Frequency of nursing facility admission, by length of stay - Case mix adjusted nursing facility admission - Number of nursing facility days - Return or new use of AC or Elderly Waiver programs after discharge from nursing facility	MDS, MMIS	Recipients who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need AC and EW longitudinal cohorts consisting of current and new participants in 2019, 2020, and 2021 through 2025.	- Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square/Fishers exact test, t-tests - Regression models with NH use as an outcome controlling for demographics and service need - Time-to-event models (e.g., Cox proportional hazard)

Research Question	Outcome measure used to address the research question	Data Sources	Sample or population	Analytic Methods
Hypothesis 5. AC participants will not experience an increase in acute events, as indicated by an increase in acute hospitalizations or emergency department visits.				
5a. What is the rate of acute events of people participating in AC waiver?	- Rate of acute inpatient admissions - Rate of ED visits - Mortality rate	- MMIS - Medicare data	Multiple cross-sections of people who are eligible for either Alternative Care (AC) or Elderly Waiver (EW) AC compared to all EW participants and to EW sample matched to AC on demographics and service need AC and EW longitudinal cohorts consisting of current and new participants in 2019, 2020, and 2021 through 2025.	- Multiple cross-section comparisons for successive years - Descriptive statistics - Chi-square/Fishers exact test, t-tests - Cross-sectional regression and growth models controlling for demographics and service need - Time-to-event models (e.g., Cox proportional hazard)
Hypothesis 6. The rate of Medicaid conversion for AC participants through transitions between AC and EW and other waiver programs or nursing home use will not increase.				
6a. What are the trends of Medicaid conversion for AC participants through transitions to EW, other waiver use, or nursing home use?	- Time to conversion - AC participants converting to Medicaid - Transition from AC to EW or other HCBS waiver program - AC participant transition to Essential Community Supports - Days alive in the community and not on Medicaid	- MMIS - Medicare data	Multiple cross-sections of people who are eligible for Alternative Care (AC) AC longitudinal cohorts consisting of current and new AC participants in 2019, 2020, and 2021 - 2025.	- Multiple cross-section comparisons for successive years - Descriptive statistics - Cross-sectional regression models - Time-to-event models (e.g., Cox proportional hazard)

Methodological Limitations

Establishing a Baseline

Prior Alternative Care Evaluation reports have chosen the period prior to the introduction of the waiver (2010-2013) as the pre-waiver baseline, while 2014-2017 served as the implementation period after the waiver. The AC program underwent significant changes, as did the Elderly Waiver program over these years. However, we found no evidence that these changes occurred because of the waiver. There were other external events, such as policy, programmatic, and demographic changes) that affected the program. The evaluation of the waiver extension will involve a baseline period of 2015-2019 and an evaluation period from 2020-2025. We selected this baseline for the extension period in order to estimate trends prior to the extension period, while avoiding a baseline that is too lengthy and where major policy changes had occurred, such as the change in the nursing facility level of care criteria at the end of 2014.

Selecting a Comparison Population

The Elderly Waiver population serves as a comparator for Alternative Care in most of the analysis. EW participants differ significantly from AC participants in some respects. Controlling statistically for these differences would strengthen the evaluation design. A sample balancing methodology will be used in order that the EW comparison group is as similar as possible to the AC participants in demographics, health, and functioning. Consideration will be given to characteristics and matching techniques for this population throughout the baseline and extension periods.

External Events – COVID-19

The COVID-19 public health emergency is likely to have had an impact on service needs and use of care for the AC population at the beginning of the extension period and perhaps continuing throughout the period. We will address this and other potential confounders by conducting a trend analysis for a period prior to COVID-19 and extending beyond the pandemic, assuming hopefully that it is nearing an end in mid-2021. Additionally, the EW participant comparison group will be employed as an indicator of the COVID-19 effect.=

Cautious Generalization

We must exercise caution in the interpretation of our findings because of the strong possibility of unmeasured events or policy changes and the difficulty of inferring causality from our observational, quasi-experimental design.

Attachments

Please see the following attachments for additional information:

1. Independent Evaluator
2. Evaluation Budget
3. Timeline and Major Milestones

Attachment 1. Independent Evaluator

Since May 2016, the Minnesota Department of Human Services has had a Professional/Technical Contract with the University of Minnesota to conduct the evaluation of the Alternative Care demonstration waiver. According to Minn. Stat. 16C.06 Subd. 3b(b), the combined length of a contract and amendments cannot exceed five years, unless approved by the Commissioners of the Department of Administration and Minnesota Management and Budget. DHS has approval to continue this contract with the University of Minnesota beginning July 1, 2021.

The contract between DHS and the University details the services to be performed during the contract period, a description of deliverables, such as reports, their due date, and amount to be paid for each deliverable. It also specifies the total payment obligation for all compensation and reimbursements to the University under this contract.

In addition, this contract details information privacy and security obligations in a Data Sharing Agreement and Business Associate Agreement Terms and Conditions. This covers all Protected Health Information and non-public information under the Minnesota Government Data Practices Act that is shared between the state and University. This outlines the protected data to be shared and responsibilities in the case of a breach.

Independent Capacity: This contract is between the State of Minnesota and the Regents of the University of Minnesota, an independent contractor, not an employee of the State of Minnesota. The contract certification form specifies that a contract shall not establish an employment relationship between the state or the agency performing work under the contract. The contractor and agency must not be employees of the state. Minnesota Professional Technical contracts also certify that the contractors' employees and agents will not be considered employees of the state. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these employees or agents are in no way the state's obligation or responsibility. By the terms of the contract the University certifies that it has liability insurance. Each party shall be responsible for claims, losses, damages and expenses which are proximately caused by wrongful or negligent acts or omissions of that party or its agents, employees or representatives acting within the scope of their duties. The liability of each party is as set out in chapter 3.736 of the Minnesota Statutes and subject to the limitations therein.

Attachment 2. Evaluation Budget

Below are the proposed tasks, staffing, and costs for the evaluation budget. The budget is based on estimated costs incurred by the State of Minnesota in the form of staff time and a contract with an external evaluator who will conduct the analysis.

Evaluation Budget Tasks

Project Management and Consultation: The external evaluator and State of Minnesota will participate in bi-monthly meetings, and additional consultation via email, phone calls, and other methods as needed to support the research and evaluation activities. This includes support to administer the contract and provide subject matter expertise on policies, processes, and data needed to develop, implement, and interpret analytic models. In addition, presentations and summaries are expected to be used for ongoing monitoring of the evaluation. The State of Minnesota expects to dedicate 0.2 FTE of a program evaluation specialist, 0.1 FTE of a research and analysis supervisor, and 0.05 FTE of a research and analysis manager to this work each year.

Contract Deliverables: The external evaluation contract is expected to include annual deliverables, such as implementing an updated evaluation plan, annual analyses, and the interim and summative evaluation reports due Feb. 2024 and July 2026. It also includes the cost of Medicare data as made available to the University by CMS. Projections are estimated based on deliverable costs for the previous five year waiver reporting period.

Annual Costs

The table below reflects annual costs during the waiver reporting period. These include a 3% annual adjustment to account for inflationary cost increases.

	2020	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Project Management & Consultation	$44,079	$ 45,401	$ 46,763	$48,166	$49,611	$51,100	$52,633
Contract Deliverables		$ 45,085	$ 54,546	$61,800	$57,819	$59,553	$67,474
Total	**$44,079**	**$ 90,486**	**$ 101,309**	**$ 109,967**	**$ 107,430**	**$ 110,653**	**$120,106**

Attachment 3. Timeline and Major Milestones

This demonstration approved period is from February 1, 2020 through January 31, 2025. The table below displays the timeline for the deliverables for the demonstration period including who is responsible.

Deliverable	**Responsible Party (from to)**	**Date**
Draft Evaluation Design Plan	State to CMS	Within 120 days after the approval of the demonstration extension (July 30, 2020)
Final Evaluation Plan	State to CMS	Within 60 days following receipt of CMS comments on Draft Evaluation Design Plan
Annual internal report to DHS from independent evaluator	Independent Evaluator to DHS	June of each year during demonstration
Interim Evaluation Report	Independent Evaluator to DHS	June 2023
Final evaluation report	Independent Evaluator to DHS	Within 12 months following the end of the demonstration extension period
Draft Summative Evaluation Report	State to CMS	Within 18 months following the end of the demonstration extension period
Final Summative Report	State to CMS	Within 60 days of receipt of CMS comments

ATTACHMENT K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Attachment K-1: General Information

General Information:

A. State:_____ _____**Minnesota**__

B. Waiver Title: Minnesota 2020 System Reform Demonstration

C. Control Number:

Project Number 11-W-00286/5

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply to all individuals in the Alternative Care Program and impacted by the virus or the response to the virus. The purpose of this amendment is to:

- Temporarily permit certain relatives of participants to provide personal care assistance services.

This change is additive to the Attachment K(s) already approved for the COVID-19 pandemic.

F. Proposed Effective Date: Start Date: March 13, 2020 **Anticipated End Date:** November 11, 2023 (i.e. 6 months after the end of the Public Health Emergency)

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

This action will apply across the Alternative Care Program to all individuals impacted by the COVID-19 virus.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

N/A

Attachment K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c._X_ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

The following individuals may provide personal care assistance:
• parents, stepparents, and legal guardians of minor participants; and
• spouses of participants.

The above individuals must meet the same qualifications that apply to all providers of personal care assistance, including the following:

- passing the required individual training and test;
- passing the NetStudy 2.0 DHS Background Study; and

- adhering the current provider enrollment process described in the MHCP Provider Manual – PCA Services.

Documentation requirements to ensure individuals receive services are set forth in 256B.0659, subd 12. Services are required to be documented daily for each worker, on a time sheet approved by the commissioner, and retained in the individual's health record. The required components of the time sheet are listed in statute as well and include the following –

The time and activity documentation contains a required statement that states that it is a crime to provide false information on PCA billings for Medical Assistance payment.

The individual receiving services and the worker are required to sign the time and activity document, which indicates they verify the services entered are accurate, were performed by the worker who signed the document, as specified in the PCA care plan.

The Department's Surveillance and Integrity Review Section (SIRS) is responsible for post-payment review of provider claims paid through MMIS. Providers and claims are selected for review based on data analysis, complaints, and referrals. This includes identifying and investigating possible Medicaid fraud.

Case managers continue to be responsible for ongoing monitoring of the provision of services included in the participant's coordinated services and supports plan and ensure providers deliver services as written in the person's plan. Through the support planning process, case managers are responsible for identifying issues that may affect the participant's health and safety and addressing these through the support plan. Case managers are also responsible for developing emergency back-up plans to ensure the participant's health and safety.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

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

First Name:	Patrick
Last Name	Hultman
Title:	Deputy Medicaid Director
Agency:	Minnesota Department of Human Services
Address 1:	540 Cedar Street
Address 2:	PO Box 64983
City	St. Paul
State	MN
Zip Code	55164-0983

Telephone:	651-431-4311
E-mail	patrick.hultman@state.mn.us
Fax Number	Click or tap here to enter text.

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

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature:

[redacted]

Date:

5/10/2023

State Medicaid Director or Designee

First Name:	Julie
Last Name	Marquardt
Title:	Interim Assistant Commissioner, Health Care Administration, State Medicaid Director
Agency:	Minnesota Department of Human Services
Address 1:	540 Cedar Street
Address 2:	PO Box 64983
City	St. Paul
State	MN
Zip Code	55164-0983
Telephone:	651-431-2669
E-mail	julie.a.margqardt@state.mn.us
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.