Reform 2020: Pathways to Independence

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

Demonstration Year X
July 1, 2022 through June 30, 2023
Quarter 4 and Annual Report

Submitted to:

U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services

Submitted by:

Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55164-0983

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Attachments

1. Introduction

Minnesota's Reform 2020 demonstration waiver authorized under section 1115 of the Social Security Act provides federal waiver authority to implement key components of Minnesota's broader reform initiatives to promote independence, increase community integration and reduce reliance on institutional care for Minnesota's older adults and people with disabilities. Federal waiver authority for the five-year demonstration was scheduled to expire on June 30, 2018. On July 19, 2017 the State submitted a request to renew the Reform 2020 waiver through June 30, 2021. The Reform 2020 waiver operated under a temporary extension through January 31, 2020. CMS approved the extension of the waiver on January 31, 2020 for the period February 1, 2020 through January 31, 2025.

1.1 Alternative Care Program

The Alternative Care program provides a home and community services benefit to people age 65 and older who need nursing facility level of care and have income or assets above the Medical Assistance (MA) standards. The Alternative Care program was established as an alternative to provide community services to seniors with modest income and assets who are not yet eligible for MA. This allows people to get the care they need without moving to a nursing home. The Reform 2020 demonstration waiver provides federal matching funds for the Alternative Care program.

1.2 Goals of Demonstration

The Reform 2020 waiver provides federal support for the State's Alternative Care program. The Alternative Care program is designed to assist the State in its goals to:

- Increase and support independence;
- Increase community integration; and
- Reduce reliance on institutional care.

2. Enrollment Information

The following tables provide the fourth quarter and annual enrollment data.

Quarter 1 (Jul. 1, 2022 – Sept. 30, 2022)

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (9/30/2022)	Current Enrollees (as of data pull 10/3/2022)	Disenrolled in Current Quarter (7/1/2022 to 9/30/2022)
Population 1: Alternative Care	2,763	2,734	7

Quarter 2 (Oct. 1, 2022 – Dec. 31, 2022)

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (12/31/2022)	Current Enrollees (as of data pull 1/4/2023)	Disenrolled in Current Quarter (10/1/2022 to 12/31/2022)
Population 1: Alternative Care	2,789	2,768	7

Quarter 3 (Jan. 1, 2023 – Mar. 31, 2023)

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (3/31/2023)	Current Enrollees (as of data pull 4/10/2023)	Disenrolled in Current Quarter (1/1/2023 to 3/32/2023)
Population 1: Alternative Care	2,746	2,728	6

Quarter 4 (Apr. 1, 2023 – June 30, 2023)

Demonstration Population (as hard coded in the CMS 64)	Enrollees at close of quarter (6/30/2023)	Current Enrollees (as of data pull 7/10/2023)	Disenrolled in Current Quarter (4/1/2023 to 6/30/2023)
Population 1: Alternative Care	2,715	2,686	5

2.1 Alternative Care Program Wait List Reporting

There is no waiting list maintained for the Alternative Care program and there are no plans to implement such a list.

3. Outreach and Innovative Activities

3.1 Minnesota Department of Human Services Public Web Site

Information on the Alternative Care program is available to the public on the Department of Human Services (DHS) website. The Alternative Care web page provides descriptive information about program eligibility, covered services, and the program application process. The web page also refers users to the Senior LinkAge Line® (described in the following section) where they can speak to a human services professional about the Alternative Care program and other programs and services for seniors.

3.2 Senior Linkage Line®

The Senior Linkage Line® is a free information service available to assist older adults and their families find community services. Information is available on the website or people can call to receive information about services near them or get help evaluating their situation to determine what kind of service might be helpful. Information and Assistance Specialists direct callers to the organizations in their area that provide services. Specialists can conduct three-way calls to link callers with resources and offer follow-up as needed. Specialists are trained health and human service professionals. They offer objective, neutral information about senior services and housing options.

3.3 Statewide Training

DHS supports county social service and tribal health care agencies by providing technical assistance through webinars and response to issues and questions via email and phone contacts. Ongoing training related to the Medicaid Management Information System (MMIS) tools and processes, long term care consultation and level of care determinations, case management, vulnerable adult and maltreatment reporting and prevention is also provided. DHS staff regularly attend regional meetings convened by county social service and tribal health care agencies.

DHS also publishes and maintains the following policy manuals to provide direction and support the work of county social service and tribal health care agencies. The primary manuals are:

- Community-Based Services Manual (CBSM) for counties and tribal health care agencies who administer home and community-based services that support people receiving services;
- Minnesota Health Care Programs (MHCP) Provider Manual for providers enrolled to provide services; and
- MMIS User Manual for payment of claims for services.

4. Updates on Post-Award Public Forums

In accordance with paragraph 42 of the Reform 2020 special terms and conditions, DHS held a public forum on July 27, 2023 to provide the public with an opportunity to comment on the progress of the Reform 2020 demonstration. This forum covered DY10 (July 1, 2022 – June 30, 2023). A notice was published on the DHS Public Participation website on June 27, 2023 informing the public of the date and time of the forum and instructions on how to join the forum. There were no members of the public in attendance at the forum. The next public forum is planned for February 2024.

5. Policy and Operational Developments

There are two policy and operational updates:

- Implementation status of the Electronic Visit Verification requirements; and
- The amendment status of Community First Services and Supports.

5.1 Electronic Visit Verification

Paragraph 34 of the Reform 2020 special terms and conditions requires that the State demonstrate compliance with the Electronic Visit Verification (EVV) system requirements. EVV for personal care services and home health services was phased in beginning in June 2022 with and completed in October 2023. For services subject to the requirements, EVV implementation is expected to reduce inappropriate service payments by 1% through the identification of recordkeeping inaccuracies, administrative errors, and fraud during post-payment review.

The Alternative Care services subject to EVV as personal care services are:

- Consumer Directed Community Supports (CDCS) direct support workers within the personal assistance category
- Personal care assistance
- Homemaker (assistance with activities of daily living)
- Individual Community Living Supports (in person)
- Respite (in-home)

The services subject to EVV as home health services are:

- Home health aide
- Nursing services

- Skilled nursing visit
- Tele-homecare

5.2 Community First Services and Supports

Minnesota is redesigning its state plan personal care assistance services to expand self-directed options under a new service called Community First Services and Supports (CFSS). This service, designed to maintain and increase participants' independence, is modeled after the Community First Choice Option. When the revisions to CFSS are finalized, DHS will resubmit the revisions to include CFSS coverage under the Reform 2020 waiver.

6. Financial and Budget Neutrality Development Issues

Demonstration expenditures are reported quarterly using Form CMS-64, 64.9 and 64.10. DHS also provides CMS with quarterly budget neutrality status updates using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system.

7. Member Month Reporting

Eligibility Group	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023
Population 1: Alternative Care	2,791	2,805	2,806	2,796	2,825	2,824	2,827	2,820	2,813	2,778	2,775	2,762

8. Consumer Issues

8.1 Alternative Care Program Beneficiary Grievances and Appeals

A description of the State's grievance system and the dispute resolution process is outlined in Minnesota's home and community-based services waiver application and the CMS-372 report for the Elderly Waiver, authorized under section 1915(c) of the Social Security Act. These processes apply to the Alternative Care program. Grievances and appeals filed by Alternative Care program participants are reviewed by DHS on a quarterly basis. Alternative Care program staff assist in resolving individual issues and identifying significant trends or patterns in grievances and appeals filed. The following is a summary of Alternative Care program grievance and appeal activity during the period July 1, 2022 through June 30, 2023, which includes the fourth quarter and annual data.

Alternative Care Program Beneficiary Grievance and Appeal Activity
July 1, 2022 through September 30, 2022

	Affirmed	Reversed	Dismissed	Withdrawn
Filed	0	0	0	0
Closed	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
October 1, 2022 through December 31, 2022

	Affirmed	Reversed	Dismissed	Withdrawn
Filed	0	0	0	1
Closed	0	0	0	1

Alternative Care Program Beneficiary Grievance and Appeal Activity
January 1, 2023 through March 31, 2023

	Affirmed	Reversed	Dismissed	Withdrawn
Filed	0	0	0	0
Closed	0	0	0	0

Alternative Care Program Beneficiary Grievance and Appeal Activity
April 1, 2023 through June 30, 2023

	Affirmed	Reversed	Dismissed	Withdrawn
Filed	0	0	0	0
Closed	0	0	0	0

8.2 Alternative Care Program Adverse Incidents

A detailed description of participant safeguards applicable to Alternative Care enrollees, including the infrastructure for vulnerable adult reporting, the management process for critical event or incident reporting, participant training and education, and methods for remediating individual problems is outlined in the section1915(c) HCBS Waiver application and the CMS-372 report for the Elderly Waiver.

Incidents of suspected abuse, neglect, or exploitation are reported to the Minnesota Adult Abuse Reporting Center (MAARC) established by DHS. MAARC forwards all reports to the respective investigative agency. In addition, MAARC staff also screen all reports for immediate risk and make all necessary referrals. Immediate referral is made by MAARC to county social services when there is an identified emergency safety need. Reports containing information regarding an alleged crime are forwarded immediately by MAARC to law enforcement. Reports of suspicious death are forwarded immediately to law enforcement, the medical examiner and the ombudsman for mental health and developmental disabilities.

For reports that do not contain an indication of immediate risk, the MAARC notifies the lead agency responsible for investigation within two working days. The lead investigative agency provides information, upon request of the reporter, within five working days as to the disposition of the report to the reporter. Each lead investigative agency evaluates reports based on prioritization guidelines. DHS requires county lead investigative agencies to use a standardized tool that promotes safety through consistent, accurate and reliable report intake and assessment of safety needs.

Investigation guidelines for all lead investigative agencies are established in state law and include interviews with alleged victims and perpetrators, evaluation of the environment

surrounding the allegation, access to and review of pertinent documentation and consultation with professionals, as applicable.

Supported in part by funding under a CMS Systems Change Grant, DHS developed, implemented and manages a centralized reporting data collection system housed within the Social Services Information System (SSIS). This system stores adult maltreatment reports for MAARC. SSIS also supports county functions related to vulnerable adult report intake, investigation, adult protective services and maintenance of county investigative results. Once maltreatment investigations are completed, the county investigative findings are documented within SSIS.

Due to an IT issue, DHS is unable to obtain the data needed to report adverse incidents. There is no impact on the ability for data to be entered in the system. The data is being collected but the IT process required to synthesize the data is not functional. IT work to improve and expand the system's data reporting capacity caused significant programming problems. State IT services expects that it will take some time to rebuild the program and the State does not have a target date at this time.

State staff are evaluating whether there are other data sources that could be used to meet the adverse incident reporting requirement. Once the IT programming is corrected, DHS will have the data to summit the outstanding quarterly and annual reports impacted by this problem.

9. Quality Assurance and Monitoring Activity

9.1 Alternative Care Program and HCBS Quality Strategy

As described in the section 1915(c) Elderly Waiver, the DHS Quality Essentials Team (QET) within the Aging and Disability Services Administration will meet twice a year to review and analyze collected performance measure and remediation data. The QET is a team made up of program and policy staff from the Alternative Care and HCBS waiver programs. The QET is responsible for integrating performance measurement and remediation associated with monitoring data and recommending system improvement strategies, when such strategies are indicated for a specific program, and when DHS can benefit from strategies that impact individuals served under the Alternative Care and HCBS programs.

Problems or concerns requiring intervention beyond existing remediation processes, such as systems improvements, are directed to the Policy Review Team for more advanced analysis and improved policy and procedure development, testing, and implementation. The QET has identified and implemented a quality monitoring and improvement process for determining the level of remediation and any systems improvements required as indicated by performance monitoring.

Paragraph 35 of the Reform 2020 special terms and conditions requires that the State have an approved Quality Improvement Strategy and that the State work with CMS to develop approvable performance measures within 90 days following the approval of the waiver. On July 17, 2020, DHS submitted its quality improvement strategy (QIS) to CMS as final. See

Attachment A, Quality Management Model for the Alternative Care Program. The QIS includes assurances and performance measures for the Alternative Care program and parallels the State's section 1915(c) waiver QIS process. Specifically, the State collects three full years of data and submits the data 18 months prior to submitting the extension request. DHS plans to parallel this process and submit the QIS data for Alternative Care for DY8, DY9 and DY10 18-months prior to the extension.

Paragraph 36 of the Reform 2020 special terms and conditions requires the State to report annually the deficiencies found during the monitoring and evaluation of the quality 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 is also required to 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. The Alternative Care program report is modeled after the Elderly Waiver annual CMS-372 report and includes information on deficiencies, data related to cases of maltreatment and neglect, and corrective action/remedial steps taken. See Attachment B, Annual Report on Home and Community Based Services Waiver Alternative Care 1115 Waiver.

10. Demonstration Evaluation

DHS contracted with the University of Minnesota and Purdue University for development of an evaluation design and analysis plan that covers all elements outlined in paragraph 68 of the Reform 2020 waiver special terms and conditions. A draft evaluation plan for the waiver extension period effective February 1, 2020 through January 30, 2025 was submitted to CMS on July 20, 2020. Initial feedback from CMS was received on April 12, 2021. Additional CMS feedback was received on July 6, 2021. The State incorporated CMS' feedback, and final approval from CMS on the evaluation plan was received on September 27, 2021.

The draft Summative Evaluation Report for the previous demonstration period of July 1, 2013 through January 31, 2020 was submitted to CMS on August 12, 2021. CMS' comments on the draft report were received on January 11, 2022. The State revised the report in response to CMS' feedback and resubmitted the report on March 4, 2022. The State has not received feedback on this report to date.

11. State Contact

Christina Samion
Federal Relations
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

(651) 431-5885
christina.samion@state.mn.us

Quality Management Model for the Alternative Care Program

Program Organizational Structure

The Alternative Care (AC) program is managed and administered by the Minnesota Department of Human Services (department), the State's Medicaid agency. The department delegates certain AC operations to county agencies, and federally recognized American Indian tribes under contract with the department. Counties and tribes that carry out delegated AC operations are referred to as lead agencies. Unless otherwise noted, references to lead agencies in this document include these entities.

Activities delegated to lead agencies include:

- Evaluation of an applicant's financial eligibility for AC
- Completion of needs assessment and level of care determination
- Development of a person-centered community support plan
- Prior authorization of services in the State's Medicaid Management Information System (MMIS) and
- Monitoring the adequacy of the support plan and services provided to the person.

Program Management Structure

The department has an established infrastructure within which AC is managed. This includes use of MMIS to collect data on the individuals who are assessed, validate eligibility for AC services, prior authorize AC services, and pay AC provider claims that meet certain criteria. The MMIS includes a comprehensive network of edits that support AC policies and minimize data entry errors.

The department also has:

- A robust and comprehensive assessment and care planning process to determine eligibility for services (referred to as long term care consultation or LTCC) and identify service needs, including health and safety needs
- Maltreatment reporting, investigation and remediation processes
- Systems to address participant concerns through conciliation and formal fair hearing processes
- Methods to monitor that providers meet standards
- Multiple automated assurances to pay only those claims that meet certain criteria (e.g., being authorized and corresponding with an appropriate eligibility period, provided by a qualified and enrolled provider, etc.)

Technical Assistance, Training, and Consultation: The department provides ongoing training related to MMIS tools and processes, LTCC and level of care determinations, case management, vulnerable adult and maltreatment reporting and prevention, etc.

Administrative Oversight - Lead Agency Review

The department is the single state Medicaid agency and is responsible for assessing the performance of lead agencies in conducting AC operational and administrative functions. Lead agencies carry out certain AC activities under parameters established by the department. The department retains administrative authority over AC.

The department monitors and oversees lead agency implementation of delegated activity through a variety of quality assessment mechanisms, including an on-site lead agency review and subsequent corrective action when indicated. This on-site review is carried out for all of Minnesota's home and community-based service (HCBS) programs, including AC.

The on-site lead agency review includes a case file/care plan review of a random sample of cases for each HCBS program, including AC. The case file review provides monitoring and feedback related to timely and comprehensive assessments, person-centered planning that addresses identified needs and supports choice, and risk management elements within the plan.

For more detailed information about, and complete description of the review protocols used during the lead agency review, including the case file review, please go to https://mn.gov/dhs/hcbs-lead-agency-review/ The website also includes information about the reviews scheduled beginning September 2019 and later.

Remediation - Lead Agency Reviews
Corrective actions are issued when patterns of non-compliance are found during the on-site review. Individual or case-specific problems are addressed with the lead agency before the conclusion of the review, and correction is required. If the department finds the county or tribe deficient in a required AC activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan to correct 100% of identified deficiencies. The corrective action plans are posted on the department website. 100% of cases that are found out of compliance with AC requirements during the site visit are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

Level of Care Determination
The State verifies that all AC participants have been assessed as meeting the State's NF LOC criteria. This verification occurs in the State's MMIS at initial assessment and opening to the program, as well as at least annually at required reassessment. Eligibility must be established and verified in the MMIS before any AC services can be prior authorized.

Financial Eligibility
Lead agencies complete calculating worksheets developed and published by the department to verify the applicant/participant meets or continues to meet financial eligibility thresholds for AC, and includes worksheets for married couples that account for allowable asset and/or income allocation[1]. This information is also entered into the State's MMIS for editing and validation.

AC Coordinated Services and Support Plan
Nineteen services are covered through the AC program, including a self-directed option – consumer-directed community supports or CDCS. The person's needs are assessed by lead agency assessors, and an individualized coordinated services and support plan (CSSP) is developed, using a format developed by the department that incorporates person-centered planning elements. Person-centered processes are required for all assessment activities and support plan development.

The person-centered CSSP describes:

- Identified needs and preferences, including risks and risk mitigation
- The AC services that will be furnished to the participant, their projected frequency, and provider that will furnishes each service (the AC service plan)
- Other services and/or supports, regardless of funding source, including informal supports that complement AC services in meeting the needs of the participant
- Emergency and back up plans
- Goals selected by the person related to community life, health, etc.

The AC service plan is subject to the approval of the Medicaid agency through prior authorization of services and eligibility verification in the State's MMIS. Federal financial participation (FFP) is not claimed for AC services furnished

[1] Applications for married couples are subject to asset and income verification and calculation of any long-term care penalty period following the rules and requirements of MA.

prior to the development of the service plan or for services that are not included in the service plan for eligible AC individuals.

Choice
An AC participant may select from all available services which may address assessed needs, and may choose any willing and qualified provider to furnish AC services included in the service plan. The person may choose consumer-directed community supports, the self-directed service option under AC.

Qualified Providers
All providers of AC services are subject to the department's provider enrollment requirements, including verification of all provider qualifications. These qualifications are the same as those for providers under the Elderly Waiver program for the same services, with the exception of discretionary service[2].

Conflict of Interest
A lead agency assessor or AC case manager cannot have any financial interest in any AC service provided to an individual. Unless otherwise noted, spouses and professional guardians or conservators of a participant may not be paid to provide AC services for that participant. A professional guardian or conservator is an individual, agency, organization or business entity that provides guardianship or conservatorship services for a fee.

Legal representatives who are not otherwise legally responsible to provide a support service may be paid to provide AC services when it is part of the participant's approved support plan.

Fair Hearing
The State provides all HCBS participants, including AC participants, the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals:

(a) who are not given the choice of home and community-based AC services as an alternative to nursing facility institutional level of care; or
(b) who are denied the service(s) of their choice or the provider(s) of their choice; or
(c) whose services are denied, suspended, reduced or terminated.

The State's procedures to provide individuals the opportunity to request a Fair Hearing for AC, including providing advance notice of action, is the same as that required in 42 CFR §431.210 for MA waiver programs.

Quality Assurance and Improvement. The State operates a formal, comprehensive system to ensure that implementation, management and administration of the AC program meets the assurances and other requirements outlined in Minnesota Statutes, sections 256B.0911 governing Long Term Care Consultation, and 256B.0915 governing the Alternative Care Program.

Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the AC.

The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the AC is in effect, the State will implement the Quality Assurance and Improvement Strategy specified below.

The department employs several methods to monitor AC functions delegated to lead agencies, including:

1. Lead agency on-site reviews (counties and tribes)
2. Care plan/case file audits during the review

[2] Discretionary services

3. Quality assurance plans
4. MMIS controls
5. Data Analysis
6. Fair Hearing requests
7. Consumer surveys

1. *Lead agency site reviews*. The department conducts on-site lead agency reviews on an ongoing basis. Counties and tribes are randomly selected for review each year. The purpose of the review is to monitor lead agency compliance with program requirements, performance of delegated administrative functions, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Lead agency reviews are continuous and ongoing; all agencies are reviewed at least once every three years.

2. *Case file review/care plan audit*. The lead agency review protocol includes a review of a randomly selected representative sample of cases for each MA waiver program, AC, and the state-funded Essential Community Supports program. If the department finds the county or tribe deficient in any required lead agency activity, the deficiency is identified in a report and the county or tribe must submit a corrective action plan to correct 100% of identified deficiencies. The corrective action plan is posted on the department's Lead Agency Review website. All cases that are found out of compliance with AC requirements during the site visit are required to be corrected. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made. The department also reviews and approves corrective action plans related to care plan audit findings annually.

3. *Quality assurance plans (QA Plan)*. Counties and tribes submit a Quality Assurance Plan for Home and Community-Based Services to the department as part of the preparation for on-site review. The QA Plan is a self-assessment and self-monitoring tool for lead agencies. Many of the questions in the self-assessment correlate to activities that are assessed during the on-site reviews.

The QA Plan parallels the structure of CMS' quality assurance matrix and includes self-assessment questions concerning AC operational and administrative activities. If the self-assessment is not fully compliant, the lead agency must submit a remediation plan. The department reviews the plan and discusses with the lead agency any areas of concern as part of the technical assistance delivered during the on-site review. The department also uses the information provided in the plans to identify possible trends or HCBS issues apparent across lead agencies.

These plans provide a source of information that complements that collected during the onsite review and care plan audit/case file review.

4. *MMIS controls*. The State's MMIS applies multiple editing functions designed to assure financial and service eligibility, provider qualifications, state-wide rate-setting methodology, and financial accountability in the management and administration of all HCBS programs, including AC. Level of care and financial eligibility information is entered into the MMIS by counties and tribes, where rules-based editing logic is applied before a person is determined and approved eligible for AC. When eligibility is approved in the MMIS, service authorizations are then entered into MMIS, where authorization information is interfaced with MMIS provider enrollment records, categories of service, rates reference tables, and individual case mix budget amounts to approve authorized services and payments to selected AC providers. This authorization must be present and approved in MMIS before AC claims can be paid. Claims editing assures that AC claims paid match AC prior authorizations.

5. *Data analysis*. MMIS data includes information about assessed needs and planned services for all AC participants. The department has designed and generates several types of reports using MMIS data, such as encumbrance and payment reports that may be used to monitor authorization patterns, and which are available to lead agencies as well as department staff overseeing the AC program. MMIS information is used for a variety of quality assessment and program improvement purposes. The department monitors claims and payment information for AC participants. Production reports are generated monthly and ad hoc reports are used to research and analyze issues.

6. *Fair hearing requests*. The department monitors fair hearing requests to identify patterns or trends that may indicate problems in the administration and management of AC. AC policy staff at the department contact the county or tribe if there are concerned about an individual appeal issue that does not appear to be consistent with department policies or procedures. When possible, these contacts are made in advance of the hearing to resolve the issue if possible before the hearing.

7. *Consumer surveys*. Minnesota has implemented a National Core Indicators- Aging and Disability (NCI-AD) survey that includes AC participants. Minnesota was one of the original states that piloted the NCI-AD survey and one of 13 states in 2015-2016 to participate in the first implementation of the finalized survey.

The first NCI survey completed for people age 65 and older receiving long term services and supports included a sample of AC participants. The results of this survey can be found at https://nci-ad.org/resources/reports/.

Results are used to support Minnesota's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life and outcomes of older adults, including AC participants and people with disabilities.

To measure and track results over time, Minnesota implements the NCI-AD survey on a yearly basis for varying populations, with AC sampling occurring every other year. Implementation of this survey will assist Minnesota in ongoing efforts to evaluate the quality of life experienced and the quality of services received by participants in the AC and other HCBS programs.

Assurances and Performance Measures

I. Assurance: Administrative Authority

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

Performance Measure 1: Percent of administrative AC requirement compliance deficiencies resolved, over the most recent three calendar years.

Numerator: Number of AC requirement corrective actions resolved.
Denominator: Number of AC requirement corrective actions issued, per initial lead agency review.
Source of Evidence: Lead Agency Review data base

II. Assurance: Level of Care (LOC) Determination

The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an AC applicant's/participant's level of care consistent with care provided in a nursing facility.

Level of Care Determination – Sub Assurance 1: An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measure 2: Number and percent of completed assessments that include a level of care determination, per calendar year.
Numerator: Number of completed assessments that include a level of care determination, per calendar year.
Denominator: Number of assessments completed, per calendar year.
Source of Evidence: MMIS

Performance Measure 3: Number and percent of people who receive a level of care determination within required timelines, per calendar year.

Numerator: Number of requested assessments completed within required timelines, per calendar year.
Denominator: Number of requested assessments, per calendar year.
Source of Evidence: MMIS

Level of Care Determination – Sub Assurance 2: The level of care of enrolled participants is reevaluated at least annually or as specified in its approved protocol.

While this performance measure is no longer required under MA waivers, the department continues to assure annual reassessment through MMIS editing that controls and limits the span of program eligibility and service authorization in MMIS to no more than 365 days without reassessment, including LOC determination.

Level of Care Determination – Sub Assurance 3: The process and instruments described in the approved protocol are applied appropriately and according to the approved description to determine the applicant and/or participant level of care.

Performance Measure 4: Percent of screening documents entered into MMIS for AC consumers where all required fields are completed.

Numerator: Number of AC screening documents that are complete each year.
Denominator: Number of total AC screening documents entered each year.
Source of Evidence: MMIS

III. Assurance: Qualified Providers

The State demonstrates it has designed and implemented an adequate system for assuring that all AC services are provided by qualified providers.

Qualified Providers – Sub Assurance 1: 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 AC services.

Performance Measure 5: Percent of total AC claims[1] paid to active MHCP providers, per state fiscal year.

Numerator: Number of AC claims paid to active MHCP providers for services provided to AC participants, per state fiscal year.
Denominator: Number of all AC claims paid for services provided to AC participants, per state fiscal year.
Source of Evidence: MMIS

Performance Measure 6: Percent of HCBS provider applications that met all required standards in a calendar year.

Numerator: Number of HCBS provider applications that met all required standards.
Denominator: Number of HCBS provider applications randomly reviewed, in a calendar year.
Source of Evidence: Provider Enrollment data

Qualified Providers – Sub Assurance 2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure 7: Percent of total AC claims paid to active MHCP providers, per state fiscal year.

Numerator: Number of AC claims paid to active MHCP providers for services provided to AC participants, per state fiscal year.
Denominator: Number of all AC claims paid for services provided to AC participants, per state fiscal year.
Source of Evidence: MMIS

Performance Measure 8: Percent of HCBS provider applications that met all required standards in a calendar year.

Numerator: Number of HCBS provider applications that met all required standards.
Denominator: Number of HCBS provider applications randomly reviewed, in a calendar year.
Source of Evidence: Provider Enrollment data

Performance Measure 9: Percent of (non-receipt) services by non-enrolled providers appropriately determined as qualified providers by lead agencies.

Numerator: Number of services provided by non- enrolled providers appropriately determined as qualified by lead agencies.
Denominator: Number of services provided by non-enrolled providers.
Source of Evidence: Lead agency review data base

Qualified Providers – Sub Assurance 3: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved protocol.

Performance Measure 10: Percent of total AC claims paid to active MHCP providers, per state fiscal year.

Numerator: Number of AC claims paid to active MHCP providers for services provided to AC participants, per state fiscal year.
Denominator: Number of all AC claims paid for services provided to AC participants, per state fiscal year.
Source of Evidence: MMIS

IV. Assurance: Service Plans

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for AC participants.

Service Plans – Sub Assurance 1: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of AC services or through other means.

Performance Measure 11: Percent of AC participant case files reviewed during the current lead agency review cycle in which all domains of assessed need are documented in the support plan.

Numerator: Number of AC participant files reviewed during the current review cycle in which all domains of assessed needs are documented in the support plan.
Denominator: Number of AC participant files reviewed during the current review cycle.

Source of Evidence: Lead Agency Review database

Performance Measure 12: Percent of AC participant files reviewed during the current lead agency review cycle where the support plan documents services and supports to address all domains of assessed need.

Numerator: Number of AC files reviewed where the support plan documents services and supports to address all domains of assessed needs.
Denominator: Number of AC participant files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Performance Measure 13: Percent of AC participant files reviewed during the current lead agency review cycle where the support plan documents assessed health and safety issues.

Numerator: Number of AC files reviewed where the support plan documents assessed health and safety issues.
Denominator: Number of AC participant files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Performance Measure 14: Percent of AC participant files reviewed during the current lead agency review cycle where the support plan documents participant goals.

Numerator: Number of AC files reviewed where the support plan documents participant goals.
Denominator: Number of AC participant files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Service Plans – Sub Assurance 2: The State monitors service plan development in accordance with its policies and procedures. NO LONGER REQUIRED FOR PERFORMANCE MEASUREMENT. States must still monitor and assure this.

Service Plans – Sub Assurance 3: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measure 15: Percent of AC participant files reviewed during the current lead agency review cycle that include a support plan that was completed within required timelines following assessment/reassessment.

Numerator: Number of AC case files reviewed during the current lead agency review cycle that include a support plan that was completed within required timelines following assessment/reassessment.
Denominator: Number of AC participant files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Performance Measure 16: Percent of AC participant files reviewed during the current lead agency review cycle where the community support plan was updated within the past 365 days.

Numerator: Number of AC participant files reviewed where the support plan was updated within the past 366 days.
Denominator: Number of AC participant files (with a documented support plan date) reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Service Plans – Sub Assurance 4: Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.

Performance Measure 17: Percent of AC participant files reviewed during the current lead agency review cycle in which the support plan is signed and dated by and disseminated to all relevant parties as required.

Numerator: Number of AC participant files reviewed in which the support plan is signed and dated and disseminated to all relevant parties.
Denominator: Number of AC participant files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

Performance Measure 18: Percent difference between the dollar amounts encumbered for services for AC participants compared to the dollar amounts claimed for services provided to AC participants, per calendar year.

Numerator: Dollar amount claimed for services provided to AC participants, per calendar year.
Denominator: Dollar amount encumbered for services for AC participants, per calendar year.
Source of evidence: MMIS

Service Plans – Sub Assurance 5: Participants are afforded choice between/among waiver services providers.

Performance Measure 19: Percent of AC participant files reviewed during the current lead review cycle in which participant choice between/among waiver services and providers is documented.

Numerator: Number of AC participant files reviewed during the current lead agency review cycle in which participant choice is documented.
Denominator: Number of AC participant case files reviewed during the current review cycle.
Source of Evidence: Lead Agency Review database

V. Assurance: Participant Safeguards

The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

Health and Welfare – Sub Assurance 1: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and unexplained death.

Performance Measure 20: Percent of AC participants per SFY who are not victims of substantiated maltreatment.

Numerator: Number of AC participants per SFY who are not victims of substantiated maltreatment.
Denominator: Number of AC participants per SFY.
Source of Evidence: MAARC data base

Performance Measure 21: Percent of AC case files reviewed over the most recent three SFYs in which a participant's assessed health and safety issues are documented in the support plan.
Numerator: Number of AC case files reviewed over the most recent three SFYs where a participant's assessed health and safety issues are documented in the support plan.
Denominator: Total number of AC case files reviewed over three recent three SFYs.
Source of Evidence: Lead Agency Review database

Performance Measure 22: Percent of AC participant deaths associated with alleged maltreatment referred to the local Medical Examiner for independent investigation, per calendar year.

Numerator: Number of AC deaths associated with alleged maltreatment reported to MAARC that were referred to the ME.
Denominator: Number of EW deaths associated with alleged maltreatment reported to MAARC.
Source of Evidence: MAARC

Health and Welfare - Sub-assurance 2: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Performance Measure 23: Percent of reports of maltreatment of AC participants submitted to MAARC and referred to a lead investigative agency (LIA) in a timely manner, per calendar year.

Numerator: Number of allegations of maltreatment of AC participants reported to MAARC and referred to a LIA within two working days.
Denominator: Number of allegations of maltreatment of AC participants reported to MAARC, per year.
Source of Evidence: MAARC

Performance Measure 24: Percent of AC participants who did not have a determination of substantiated maltreatment within 12 mos. of a substantiated maltreatment determination in the reporting yr.

Numerator: Number of AC participants who did not have a determination of substantiated maltreatment within 12 mos. following a determination in the reporting year.
Denominator: Number of AC participants who had a determination of maltreatment in the reporting year.
Source of Evidence: MAARC

Health and Welfare - Sub-assurance 3: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measure 25: Percent of AC participants per SFY who are not victims of substantiated maltreatment.
Numerator: Number of AC participants per SFY who are not victims of substantiated maltreatment.
Denominator: Number of AC participants per SFY.
Source of Evidence: MAARC

Health and Welfare - Sub-assurance 4: 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.

Performance Measure 26: Percent of AC participants that receive health screening at initial assessment and annual reassessment
Numerator: Number of AC participants that received health screening at assessment and reassessment, per calendar year.
Denominator: Number of AC participants assessed per calendar year.

VI. Assurance: Financial Accountability

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

Financial Accountability – Sub Assurance 1: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measure 27: Percent of AC claims paid for services provided to AC participants for which there is corresponding prior authorization, per SFY.
Numerator: Number of AC claims paid with authorization.
Denominator: Total number of claims paid.
Source of Evidence: MMIS

Financial Accountability - Sub-assurance 2: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measure 28: Percent of AC claims paid for services provided to AC participants for which there is corresponding prior authorization, per SFY.
Numerator: Number of AC claims paid with authorization.
Denominator: Total number of claims paid.
Source of Evidence: MMIS

Annual Report on Home and Community Based Services Waiver
Alternative Care 1115 Waiver
Dec 2023 for the period of 7/1/2022 – 6/30/2023

Documentation:

Provide a Brief description of the process for monitoring the safeguards and standards under the waiver

Minnesota monitors waiver services provider standards through the following:

- Ongoing individual care monitoring by county case managers and tribal case managers.
- Provider Enrollment process through which the department determines whether providers meet the qualifications/standards specified in the waiver. Providers that meet the qualifications are enrolled and assigned a provider number. The number is used in MMIS to identify the provider on service authorizations, verify the services enrolled to provide, and to process claims. If providers do not have, or no longer have, the proper qualifications and/or license/certifications to provide AC services, they will not be enrolled, or will be disenrolled and cannot be paid for providing AC services.
    - A Lead Agency may approve non-enrolled vendors to deliver HCBS waiver services for services classified as Approval Option Services by the department. When doing so, lead agencies must document that the vendor meets standards established by DHS. As part of the DHS HCBS lead agency review activities, a lead agency must provide the required documentation that is used to track the qualified vendors a lead agency has approved. When a lead agency is found to be non-compliant with the program requirements at the case level, they have 60 days to correct it.
- Licensing and certification standards for and reviews of Adult Day Service, Home Health services, respite, adult companion and homemaker. The licensing entity (DHS or MDH) determines whether the provider meets necessary

criteria to obtain and retain licensure through periodic licensing reviews. The licensing entity is also responsible to follow up on reported complaints, concerns and maltreatment reports involving licensed providers. Licensing information is shared with Provider Enrollment. Termination of a license will result in disenrollment of the provider;

Minnesota monitors waiver services planning and delivery through the following:

- Reviews of lead agencies by the Department are conducted both in person and remotely. The lead agency reviews include surveys of case managers and assessors, review of support plans and related policies and procedures, and HCBS attestation documents. These reviews include health and safety components of the support plans. If the department finds the lead agency (county or tribe) overall deficient in a required waiver activity, corrective action at the lead agency level is required. The deficiencies requiring corrective action are identified in a report and the lead agency must submit a corrective action plan which is posted publicly on the department website. All individual cases that are found out of compliance with waiver requirements are required to be remediated. A lead agency has 60 days to correct all compliance issues and certify that the corrections were made.

- Interviews and surveys with waiver enrollees;

- On-going policy consultation, training and technical assistance/instruction provided by Department staff with all lead agencies, including written resource material and help desk technical support;

- Department staff/regional meetings with lead agencies;

- Fair Hearing Process and monitoring fair hearing requests –enrollees receive information concerning their right to a fair hearing and how to request a hearing, including any time their waiver services are changed (e.g., increased, decreased, suspended or terminated).

Department staff who manage the waiver review fair hearing requests assist in resolving individual issues, and identify possible trends or patterns in appeals to identify opportunities for additional training, policy clarification, systems changes, etc.

Minnesota's incident management system to protect individuals from, and respond to reports of maltreatment:

- County social service agencies, Minnesota Department of Health (MDH) Office of Health Facility Complaints or Department of Human Services (DHS) Licensing Division respond to reports of suspected maltreatment, including abuse, neglect or financial exploitation of vulnerable adults. Minnesota designed and implemented a single statewide common entry point (Minnesota Adult Abuse Reporting Center (MAARC), as designated under Minnesota statute by the commissioner of human services to receive and act on reports of maltreatment. Each report received by the common entry point is entered into the Social Service Information System (SSIS) and forwarded to the lead investigative agency responsible for responding to the report. Each report received is subsequently assessed by a lead investigative agency to determine the required action. Actions required under Minnesota statute are taken as follow-up to reports of suspected maltreatment received by the common entry point;

- Investigation dispositions for reports of suspected maltreatment of a vulnerable adult received by the common entry point are reported to DHS via SSIS when the county, Department of Human Services, or the Department of Health is the lead investigative agency (work is underway to capture in SSIS investigative outcome data from the Department of Human Services OIG Licensing and Minnesota Department of Health). Aggregate maltreatment data for waiver recipients is reviewed and analyzed for patterns and trends for use in program management and policy planning;

- Interface with existing Ombudsman programs and data.

Other waiver design elements that contribute to assurances:

- MMIS system edits that ensure, as part of waiver design, that institutional level of care is established and verified, that the person has eligibility for long term care services and that providers of services are enrolled and qualified to provide authorized services;

- Financial Management Services (FMS) which are the Consumer Directed Community Supports (CDCS) Medicaid enrolled provider for all CDCS services must be certified by the department prior to providing services. Recertification reviews are conducted every two years or as determined by the department;

Quality Initiatives:

DHS uses available data sources to complete MMIS reports of various waiver activities and issues. Information from MMIS (i.e., prior authorizations, assessment results, financial eligibility and claims) is downloaded into the DHS data warehouse. The data warehouse includes data from across the department and can be used to research and analyze various waiver issues.

The HCBS lead agency reviews are a multi-year statewide initiative conducted by DHS to collect and analyze data on the local administration and implementation of home and community-based waiver programs. This evaluation process uses a comprehensive, mixed-method approach to review data, much of which is gathered during a multi-day review. These methods are intended to provide a full picture of compliance, context, and practices within each lead agency, and further explain how individuals benefit from the HCBS programs. The length of the review depends on the lead agency's waiver participant population, which determines the sample size of individual cases reviewed. The sampling strategy is: 10% of cases by program; 10 cases; or all cases if there are less than 10 in a program – whichever is largest. For the largest few lead agencies, a sample size that reaches 95% +/- 10% significance is used. Lead agencies are required to correct all cases reviewed that are found to be out of compliance with program requirements. A lead agency has 60 days to correct all compliance issues and submit certification to DHS that the corrections were made. Lead Agencies are required to submit corrective action plans to DHS when a pattern of non-compliance is identified with program requirements. Individual lead agency reports, and corrective action plans are posted publicly on the DHS website.

DHS manages a centralized data base called the Social Services Information System (SSIS) which contains a module for the Common Entry Point (CEP)/ Minnesota Adult Abuse Reporting Center (MAARC) and for county adult protective services. All reports of suspected Vulnerable Adult (VA) Maltreatment made to the commissioner-designated common entry point are put into SSIS and referred to the lead investigative agency responsible for the report. Once resulting investigations are complete, the investigative findings for the counties as the Lead Investigative Agency are documented within SSIS. The VA maltreatment data gathered from SSIS is used for state supervision of the adult protection system to evaluate outcomes and quality in preventative and protective services provided to vulnerable adults, assess trends in

maltreatment, improve and target training issues and better identify opportunities for program and policy improvement. Adult protection information in SSIS is available to the counties to self-monitor performance as well.

Fair Hearings

During the 12 month reporting period, 1 fair hearing request involving an AC enrollee was filed with DHS (3,661 persons were on AC during this reporting cycle). The request was withdrawn before an issue could be determined. Due to only 1 appeal being filed and being withdrawn before an issue could be determined, no significant patterns could be identified.

Adult Protection

Data Importance: Minnesota encourages reporting of allegations of suspected maltreatment of a vulnerable adult. Reports of suspected maltreatment of a vulnerable adult are required to be made by mandated reporters and may be made by any person. Reports are received by the centralized Minnesota Adult Abuse Reporting Center (MAARC), the single state-wide common entry point (CEP) designated by the commissioner. MAARC enters each report into the state's Social Services Information System (SSIS) and makes required evaluation and referrals.

Minnesota's Vulnerable Adult law requires the CEP to immediately screen and refer reports to the appropriate county agency if the vulnerable adult may be in need of emergency adult protective services. Immediate notification is made by MAARC to law enforcement if the report contains suspected criminal activity. Each report is referred to the appropriate lead investigative agency (LIA) as soon as possible, but no longer than two working days from the receipt of the report. The LIAs are: county adult protection agencies, DHS-OIG Licensing and the Minnesota Department of Health.

Each report made to the CEP may contain multiple allegations. Duplicate reports of the same incident may also be made. Each allegation reported is reviewed by the LIA responsible. Lead investigative agencies have 5 days to conduct intake on the reported allegation(s) and determine if an investigative response is appropriate. County agencies use standardized tools provided by the DHS to make decisions on report response. If the LIA determines an investigative response is required, the LIA has 60 days to conduct the investigation and determine, based on a preponderance of the evidence, if the reported allegation was: substantiated, false, inconclusive or unable to be investigated. Investigations may be extended past 60 days with required notifications. LIAs and law enforcement are required to coordinate investigations and may share information for protection of the vulnerable adult.

Data Calculation:

Total allegations:
Numerator: Number of allegations for discrete allegation types reported to the CEP in the time period for vulnerable adults (VAs) identified as an Alternative Care waiver enrollee where a county is the LIA responsible.

Denominator: Total of all allegation types reported for VAs identified in the state system as Alternative Care waiver enrollees in the time period where the county is the LIA responsible.

Allegations investigated:
Numerator: Number of allegations for discrete allegation types reported to the CEP in the time period for VAs identified as Alternative Care waiver enrollees where the allegation was investigated by a county LIA.

Denominator: Total of all allegation types investigated by the county LIA in the time period for VAs identified as Alternative Care waiver enrollees.

Allegations with final disposition:
Numerator: Number of allegations for discrete allegation types substantiated following county investigation where the VA was identified as an Alternative Care waiver enrollees where the investigation was completed 3 months and 10 days following the end of the time period.

Denominator: Total number of all allegation types investigated by the county LIA with a substantiated disposition 3 months and 10 days following the end of the time period.

Data Limitations:

Data from 7/1/2022 reflects reported allegations of suspected maltreatment made to MAARC and entered into the Social Services Information System (SSIS) where the county was the Lead Investigative Agency (LIA) responsible for the report and the vulnerable adult, who was the subject of the report, was able to be identified in the state's data warehouse as an Alternative Care waiver enrollee type identified in this report. Data calculations from 7/1/22 do not reflect MAARC reported allegations where DHS or MDH were the LIA responsible for the report.

Data includes only allegations of suspected maltreatment of a vulnerable adult reported to MAARC that received an investigative response and were determined by a LIA in state fiscal year 23 (SFY23); July 1, 2022 - June 30, 2023. All people who are the subject of reports and all alleged incidents reported do not meet the definitions of vulnerable adult and maltreatment established under Minnesota laws. Not all allegation investigations are completed within the calendar year in which the allegation was reported. Not all investigations are able to be completed by the LIA. Not all allegations investigated are able to be determined.

This calculation does not reflect Alternative Care waiver participants who were not cleared to the state's system to identify the person's status with respect to enrollment in the Alternative Care waiver. For reported allegations from 7/1/2022, clearing to state systems to identify the person is done only for persons who are the subject of reported allegations when the county is the LIA responsible.

This data does not reflect investigation decisions related to maltreatment allegations made to MAARC when the investigation was not completed within 3 months and 10 days following the end of the report time period.

Data is from a working database, thus numbers can change over time due to data cleanup and statutory requirements for data destruction after 3 years.

In Minnesota, vulnerable adult maltreatment reporting moved from a county-based to a single state entry point system on 7/1/2015. The table below shows the total number of allegations reported to MAARC, by allegation type where the alleged victim was on Alternative Care at the time the allegation was reported and a county was the lead investigative agency responsible for the report. Each allegation reported to MAARC is assessed by the lead investigative agency responsible. County lead investigative agencies use a standardized tool provided by the department. Vulnerable adults who are the subject of reports of suspected maltreatment are offered emergency and continuing protective social services for purposes of safeguarding the person and preventing further maltreatment. The table also summarizes the disposition of county investigations of maltreatment involving Alternative Care waiver enrollees including the number of allegations opened for investigation and services by a county. The second table summarizes investigation final determinations by allegation.

CEP- Reported Adult Maltreatment Involving AC Participants (07/01/2022 - 06/30/2023)							
	Allegations Reported to CEP where Alleged Victim is an enrollee*		Allegations Investigated by the County		County Investigations with Final Disposition as of *10/13/2023*	% Substantiated Maltreatment (of Allegations Investigated with Final Disposition)	
	#	% Total Allegations	# Allegations Investigated by the County	% of Total Allegations Investigated by the County	# County Investigations with Final Disposition	# Substantiated	% Substantiated of Total Investigated with Final Disposition
Emotional Abuse							
Physical Abuse							
Sexual Abuse							
Financial Exploitation (Fid. Rel.)							
Financial Exploitation (Non-Fid. Rel.)							
Caregiver Neglect							

Self-Neglect							
Total							
			Total De-duplicated AC participants with substantiated maltreatments				

Source: DHS Data Warehouse 10/13/23 (this should be at least 3 months 10d following end of waiver reporting period.)

Disposition of County Investigations of Maltreatment Allegations Involving AC Participants CEP Reported Allegations: 07/01/2022 and 06/30/2023					
	Allegation Disposition				
	Substantiated Maltreatment	**False Allegation**	**Inconclusive**	**No Determination - Investigation Not Possible***	**Total**
Emotional Abuse					
Physical Abuse					
Sexual Abuse					
Fin. Exploitation (Fid Rel)					
Fin. Exploitation (Non-Fid Rel)					
Caregiver Neglect					
Self -Neglect					
Total					

* Includes No Determination: Not a Vulnerable Adult

Source: DHS Data Warehouse 10/13/23 (this should be at least 3 months 10d following end of waiver reporting period.)

Interventions Offered and Provided by County Adult Protective Services to Remediate Maltreatment of a Vulnerable Adult (VA)

Interventions are recommended, referred or implemented by county adult protective services (APS) as part of safety planning for the VA during the investigation and through case closure.
Intervention may be for the VA or the Primary Support Person (PSP) for the VA. The PSP is the individual who is providing or managing the majority of ongoing care for the vulnerable adult. The primary support person can be different than a caregiver.
Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination. Adults have the right to accept or refuse services.

Intervention Definitions:
Caregiver education or support – Assistance for family or other informal caregivers to improve or sustain capacity for caregiving. Includes counselling, support groups, training or respite.
Case management/Care coordination – Assessment of needs, development and monitoring of a service plan, service referral, coordination and advocacy to ensure the safety and well-being of the VA.
Chemical dependency assessment/treatment – Services and activities to deter, reduce or eliminate substance abuse or chemical dependency.
Commitment – Court process for involuntary treatment of mental illness or chemical dependency under circumstances of danger to self or others.
Criminal conviction of perpetrator – Perpetrator is criminally convicted.
Domestic abuse services – Advocacy, counselling, support, support groups for victims or perpetrators of domestic violence.
Emergency assistance – Food, shelter, clothing, transportation, social services or financial assistance provided on an emergency basis.
Economic assistance – Cash assistance, Supplemental Nutrition Assistance (SNAP), energy or child care assistance.
Family counseling or mediation – To help family members improve communication, resolve conflict or identify and change patterns. Provided by a trained or licensed therapist or mediators.
Financial management assistance – Services or activities to assist in managing finances or planning for future financial needs. Includes meeting with financial institutions, financial planning, estate planning, money management and planning to meet needs associated with impaired capacity.
Guardian/conservator appointment or replacement - Court order resulting in appointment, appointment revocation or modification of a guardian or conservator.
Health and welfare check - Performed by Law enforcement.

Home or community-based services – Supports provided outside of a nursing home or hospital to meet needs for food, shelter, clothing, health care or supervision.
Housing clean-up or repair – Supports to clean up or repair dilapidated or hazardous housing conditions or meet housing codes.
Housing code inspection – Housing or fire code inspection.
Law Enforcement – Criminal report, coordination of the civil and criminal investigation or for adult protective services for the vulnerable adult.
Legal advice, counsel or representation – Legal counsel or representation by an attorney for the VA or support person to address civil or criminal matters such as: housing issues, estate or incapacity planning, asset recovery, bankruptcy or criminal allegations.
Medical evaluation or care – Services to attain or maintain physical health.
Mental health evaluation or services – Services to attain or maintain mental health.
Medical Assistance (MA) application – Applying and meeting verifications for Medical Assistance.
MN Choices Assessment/Long Term Care Consultation – Referral and/or support through the process.
Move or relocation of the VA – Assistance or support.
Move or relocation of the perpetrator –Assistance or support.
Multidisciplinary adult protection team review – Using an MDT for service recommendations, support of safety planning, case review or coordination with MDT members.
No intervention - VA died
Power of Attorney or trust completed or modified - Power of Attorney or trust completed or modified – A power of attorney or trust document was executed, revoked or modified.
Representative Payee appointed or modified – New or modified Social Security, Veterans Administration, or other government retirement income Payee.
Restraining order for removal of the perpetrator – Order for Protection, Harassment Order, Restraining Order for the protection of the VA.
Support System for VA Engaged - Family, responsible party, informal supports identified, located, engaged to support, meet or monitor needs, or provide safety to prevent maltreatment
Transportation – Provide or arrange travel to access services, medical care or employment.
Unique Service – Selected when the intervention type is not listed.
Victim services – Provided to, or on behalf of, victims in the criminal justice system. Includes post sentencing services and supports for crime victims handled by a prosecutor's office.

Interventions Offered/Provided to Remediate Maltreatment for AC Participants (07/01/2022 - 06/30/2023)

Interventions Offered/Provided to Remediate Maltreatment for AC participants and where:
Reports were received by the Common Entry Point, MAARC, between 07/01/2022 and 06/30/2023
Maltreatment determined to be substantiated following investigation and limited to those made between 07/01/2022 and 10/13/2023
Interventions offered/provided to the vulnerable adult (VA) and the primary support person (PSP)
County is the Lead Investigative Agency
Determinations of the following types were included:

Intervention Type	Intervention Code	Intervention Description	# of Intervention Offered/Provided	% of Interventions by Intervention Code
PSP	1	Caregiver education or support		
PSP	10	Unique Service		
VA	2	Case management/Care Coordination		
VA	12	Financial management assistance		
VA	14	Guardian/conservator appointment or replacement		
VA	15	Health and welfare check		
VA	18	Home or community based services		
VA	21	Law enforcement		
VA	23	Medical evaluation or care		
VA	24	Mental health evaluation or services		
VA	28	Move or relocation of the VA		

VA	29	Move or relocation of the perpetrator		
VA	38	Support system for VA engaged (family, responsible party, other)		
VA	46	No intervention - refused services		
Total Interventions Offered/Provided				
Total De-duplicated AC Participants with Substantiated Maltreatment				
Total AC Participants w/included /Remediated Maltreatment				
Percent of included with an intervention listed				
Numerator: Total AC Participants with Remediated Maltreatment				
Denominator: Total De-duplicated AC Participants with Substantiated Maltreatment				
This report shows the number of interventions provided to remediate maltreatment for AC participants where maltreatments were determined to be substantiated following investigation by the Lead Investigative Agency. Remediation is offered/provided to the vulnerable adult (VA) and the primary support person (PSP). The report also shows the percent of offered/provided interventions. County is the Lead Investigative Agency.				

Source: DHS Data Warehouse 10/13/2023 (this should be at least 3 months 10d following end of waiver reporting period.)

Findings of Monitoring:

Deficiencies were detected.
Provide a summary of the significant areas where deficiencies were detected, (Note: Individual reports or assessment forms for waiver individuals and/or providers disclosing deficiencies and which document the summary are not necessary):

During the reporting period, DHS licensing deficiencies included both licensing actions and maltreatment reports. The licensing information does not indicate if the actions were specifically related to AC enrollees.

During the reporting period, DHS received and investigated alleged maltreatment reports related to patient rights, environmental hazards, neglect/self-neglect, and medication administration. The complaint information does not indicate if the complaints were specifically related to AC enrollees.

Licensing: Department of Human Service (DHS). During the reporting period, licensing deficiencies involving providers of services to AC waiver enrollees including both licensing actions and substantiated maltreatment findings are summarized below in the aggregate data. The licensing action information does not indicate if the complaints were specifically related to AC enrollees.

Time Period 7/1/22– 6/30/23

Licensing Sanctions – reflecting sanction issue date

1) Adult Day Centers *(7/1/22 - 6/30/23).* 174 facilities (*01/01/23)*	# Issued
Conditional	8
Denial	2
Fine	12
Revocation	5
Temporary Immediate Suspension	2

2) 245D Programs *(7/1/22 – 6/30/23)*** 6,912* programs *(01/01/23)*	# Issued
Conditional	14
Denial	27
Fine	44
Revocation	13
Suspension	0
Temporary Immediate Suspension	2

Note: The figures above pertain to providers of AC services licensed by DHS and include Adult Day Centers and 245D Programs. Licensing information does not indicate if the actions were specifically related to AC enrollees. The complaint information above does not indicate if the complaints were specifically related to AC enrollees being served by the provider.

*** Licensure under chapter 245D Home and Community Based Services includes services that are offered under AC, EW, and the disability waivers.

Providers Licensed by the Minnesota Department of Human Services (DHS): If it is determined that an enrollee is at risk of imminent harm, the provider's license may be immediately suspended or different services arranged for the enrollee. When a provider fails to comply with regulations but the failure does not pose an imminent threat to enrollee health and safety the department may issue a conditional license for a period of time. During this time, the provider must make changes to correct the issue(s) of noncompliance identified. When the department issues licensing actions, consideration is given to the nature, frequency, and severity of the violation and its real or potential effect on the health, safety, and rights of service recipients.

Maltreatment Allegations/Findings - *no breakdown available for the age of the victim*

1) Adult Day Centers *(7/1/22 – 6/30/23)*	
Reports completed & substantiated	0
Allegations substantiated	0
Responsibility: Facility/Provider Agency	0
Responsibility: Facility/Provider Staff	0
Responsibility: Inconclusive	0

2) 245D Programs *(7/1/22 – 6/30/23)* ***	
Reports completed & substantiated	97
Allegations substantiated	239
Responsibility: Facility/Provider Agency	37
Responsibility: Facility/Provider Staff	192

Responsibility: Inconclusive	10

* Maltreatment findings may be dually represented in programs that have both an AFC license and 245D license.

Deficiencies have been, or are being corrected.
Provide an explanation of how these deficiencies have been, or are being corrected as well as an explanation of what steps have been taken to ensure the deficiencies do not recur:

If it is determined that an enrollee is at risk of imminent harm, the provider's DHS license may be immediately suspended or different services arranged for the enrollee. A license holder may also be subject to suspension or revocation of its license when the provider fails to comply with regulations, knowingly withholds relevant information, or provides false or misleading information related to a license application, staff background study, or maltreatment investigation.

When a provider fails to comply with regulations but the failure does not pose an imminent threat to enrollee health and safety, the department may issue a conditional license for a period of time. During this time, the provider must make changes to correct the issue(s) of non-compliance identified. When the department issues licensing actions, consideration is given to the nature, frequency, and severity of the violation and its real or potential effect on the health, safety, and rights of enrollees.