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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: 24-0045

This file contains the following documents in the order listed:

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

Medicaid and CHIP Operations Group

April 29, 2025

Patrick Hultman, Deputy Medicaid Director
Minnesota Department of Human Services
540 Cedar Street
PO Box 64983
Saint Paul, MN 55164-0983

RE: MN 24-0045 §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit Renewal

Dear Deputy Director Hultman:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number MN 24-0045. The purpose of this amendment is to renew Minnesota's 1915(i) State Plan HCBS benefit. The effective date for this renewal is July 1, 2025. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive this §1915(i) State Plan HCBS benefit, CMS approves this SPA for a five-year period expiring June 30, 2030 in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

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

If you have any questions concerning this information, please contact me at (410) 786-7561. You may also contact Shawn Zimmerman at Shawn.Zimmerman@cms.hhs.gov or (410) 786-8291.

Sincerely,

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

cc: Patrick Hultman, MN DHS
Mark Seigel, MN DHS
Michelle Long, MN DHS
Cynthia Nanes, CMS
Shante Shaw, CMS
Lynell Sanderson, CMS
Deborah Benson, CMS
Wendy Hill Petras, CMS
George Failla, CMS

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0045

2. STATE: MN

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. 441.700-441.750

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 1,868,574
b. FFY 2026 $ 7,224,868

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i., pages 1-55
Supplement 5 to Attachment 4.19-B Pages 1-2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i., pages 1-49
Supplement 5 to Attachment 4.19-B Pages 1-2

9. SUBJECT OF AMENDMENT
Renews housing stabilization services for an additional five years

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

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Patrick Hultman

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
December 23, 2024

15. RETURN TO
Patrick Hultman
Minnesota Department of Human Services
Federal Relations Unit
540 Cedar Street, PO Box 64983
Saint Paul, MN 55164

FOR CMS USE ONLY

16. DATE RECEIVED
December 26, 2024

17. DATE APPROVED
April 29, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING

20. TYPED NAME OF APPROVING OFFICIAL
George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL
Director, Division of HCBS Operations and Oversight

22. REMARKS

Instructions on Back

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

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

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

   Housing Stabilization Services - Transition; Housing Stabilization Services – Sustaining; Housing Consultation Services

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

   Select one:

	Not applicable
X	**Applicable**
v	Check the applicable authority or authorities:

X	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* Special Needs Basic Care contracts & Minnesota Senior Health Options contracts; The MCOs that furnish services under the provisions of §1915(a)(1) are: Blue Plus, HealthPartners, Hennepin Health, Itasca Medical Care, Medica, PrimeWest Health, South Country Health Alliance, UCare Minnesota *(b) the geographic areas served by these plans;* Statewide *(c) the specific 1915(i) State plan HCBS furnished by these plans;* Housing Stabilization Services – Transition; Housing Stabilization Services – Sustaining, and Housing Consultation Services. *(d) how payments are made to the health plans;* The health plans receive capitation payments. *(e) whether the 1915(a) contract has been submitted or previously approved.* The 2024 contracts are submitted but not yet approved.
X	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:* Housing stabilization services are provided to eligible participants under Minnesota's §1915(b) Minnesota Senior Care Plus waiver.
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):

[redacted]				
[redacted]	X	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
X	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
	Family and Children Managed Care Plans. Attachment 3.1-F describes operation of a managed care program under Section 1932 of the Act. The Attachment was originally approved as TN 05-03.			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

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

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

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

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

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

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

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

Managed care organizations under contract with the Department of Human Services ("Department") have a limited role in managing utilization (#5) and establishing a consistent rate methodology (#8) for the services listed in this amendment.

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

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The Department allows certain providers of state plan HCBS to also perform assessments and develop care plans for the same people to whom they are also providing state plan HCBS in the following situations when:

1) such providers are the only willing and qualified providers in certain geographic areas of the state where there is a provider shortage, as described below, or
2) such providers are the only willing and qualified providers with experience and knowledge to provide services to people who share a common language or cultural background.

The Department references the Health Professional Shortage Areas (HPSA) designated by the Minnesota Department of Health to determine provider shortage areas. Health professional shortage areas (HPSAs) are geographic regions, populations and facilities with too few health providers and services. According to the HPSA, the following counties are shortage areas: Roseau, Marshall, Beltrami, Clearwater, Norman, Mahnomen, Koochiching, St. Louis, Wadena, Clay, Wilkins, Otter Tail, Stearns, Kanabec, Renville, Lincoln, Murray, Pipestone, Lyon, Redwood, Jackson, Fairmont, Faribault, Waseca, Hubbard, Marshall, Pennington, Polk, Pope, Becker, Traverse, Lac Qui Parle, Yellow Medicine, Grant, Lake, Pine, Itasca, Cass, Aitkin, Mille Lacs, Morrison, Swift, Chippewa, Kandiyohi, Sibley, Le Suer, Rice, Goodhue, Wabasha, Winona, Fillmore, Nobles, Benton, Todd, and Blue Earth.

To ensure conflict of interest standards are met, the Department employs these safeguards:

A. The same professional within an agency is prohibited from conducting both the assessment and developing the care plan and providing state plan HCBS to the same person.
B. Agencies and clinics that provide both assessment and care plan development, and state plan HCBS must document the use of different professionals.
C. Agencies must receive prior authorization from the Department before providing state plan HCBS to people whom they have assessed or created a care plan. The care plan must indicate that the person was notified of the conflicts and the dispute resolution process, and that the person has exercised their right in free choice of provider after notification of the conflict.
D. People who receive state plan HCBS from the same agency that provided the assessment or care plan development, are protected by the following safeguards: fair

hearing rights, the ability to change providers, and the ability to request different professionals from within the same agency.

E. The Department provides direct oversight and periodic evaluation of the safeguards.

The Department evaluates gaps in capacity and provider shortages and establishes steps to address these barriers to access for people receiving these services. Once a provider shortage no longer exists in an area, the Department prohibits agencies conducting assessments and care plan development from also delivering state plan HCBS. The Department posts information on its website regarding the conflict of interest standards. The Department's goal is to ensure that the outcomes are in the best interests of people receiving these services.

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

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

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

Number Served

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

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2025	6/30/2026	40,937
Year 2	7/1/2026	6/30/2027	47,584
Year 3	7/1/2027	6/30/2028	54,231
Year 4	7/1/2028	6/30/2029	60,878
Year 5	7/1/2029	6/30/2030	67,525

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

Financial Eligibility

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

2. **Medically Needy** (*Select one*):

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

Evaluation/Reevaluation of Eligibility

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

X	Directly by the Medicaid agency
☐	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

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

The independent evaluation and reevaluation is completed by Department staff. The person(s) performing this function must meet the following minimum qualifications:

- Demonstrates an understanding of the behavioral health and community supports systems.
- Demonstrates an understanding of how disability and mental health issues can affect housing.

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

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

Staff from the Department of Human Services (the state Medicaid agency) review assessment outcomes and disability documentation through a secure web-based platform to determine eligibility for these services.

Department staff use the results of the independent assessment to determine whether the person is over 18, has a disability or disabling condition, and meets the needs- based criteria to receive this service. Department staff must be familiar with the eligibility criteria and apply those criteria and the person's assessment information when making a determination.

The "independent assessment" refers to one of the following four tools used to determine eligibility: MnCHOICES, long term care consultation, professional statement of need, or coordinated entry assessment. To ensure a "no wrong door" approach for providing access to services, the Department permits the use of several tools to determine eligibility. All of the tools apply the same criteria to determine eligibility.

Once eligibility is determined, Department staff notify both the provider and person.

This same process is used for both evaluation and reevaluation.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

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

A person is eligible for state plan HCBS if the person is:

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

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

Additionally, the person must be experiencing housing instability, which is evidenced by one of the following risk factors:

- Is homeless. A person or family is considered homeless when they lack a fixed, adequate nighttime residence; or
- Is at risk of homelessness. A person or family is at-risk of homelessness when (a) the person or family is faced with a situation or set of circumstances likely to cause the household to become homeless, including but not limited to: doubled-up living arrangements where the person's name is not on a lease, living in a condemned building without a place to move, having arrears in rent/utility payments, receiving an eviction notice without a place to move and/or living in temporary or transitional housing that carries time limits; or (b) the person, previously homeless, will be discharged from a correctional, medical, mental health or substance use disorder treatment center, and lacks sufficient resources to pay for housing, and does not have a permanent place to live; or
- Is currently transitioning, or has recently transitioned, from an institution or licensed or registered setting (registered housing with services facility, board and lodge, boarding care, adult foster care, hospital, ICF-DD, intensive residential treatment services, the Minnesota Security Hospital, nursing facility, regional treatment center).

6. X **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/DD (& ICF/DD LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
To receive housing stabilization services, the person must be: Assessed to require assistance with at least one need in the following areas resulting from the presence of a disability	A person must meet one of the following categories of need: • Dependency in four or more activities of daily living; • Need the assistance of another person or constant supervision to	A person must meet all of the following: • In need of continuous active treatment and supervision to participate in life activities; • Have a diagnosis of intellectual or	A person must meet all of the following: • Need skilled assessment and intervention multiple times during a 24-hour period to maintain health

and/or a long term or indefinite condition:
 	
• Communication
• Mobility;
• Decision-making; and/or
• Managing challenging behaviors
 	
The person must also be experiencing housing instability, which is evidenced by one of the following risk factors:
 	
• Is homeless. A person or family is considered homeless when they lack a fixed, adequate nighttime residence; or
• Is at-risk of homelessness. A person or family is at-risk of homelessness when (a) the person or family is faced with a situation or set of circumstances likely to cause the household to become homeless, including but not
	begin and complete toileting transferring, *or* positioning, and the assistance cannot be scheduled;
	• Significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;
	• Need clinical monitoring at least once per day; or
	• The person lives alone, or would live alone or be homeless without his or her current housing type, and meets one of the following:
	  • is at risk of maltreatment or neglect by another person, or is at risk of self-neglect;
	  • has had a fall resulting in a fracture within the last 12 months;
	  • has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.
		developmental disability, or a related condition;
		• Require a 24-hour plan of care; and
		• An inability to apply skills learned in one environment to a new environment.
			and prevent deterioration of health status;
			• Have both predictable health needs and the potential for changes in condition that could lead to rapid deterioration or life-threatening episodes;
			• Require a 24- hour plan of care, including a back-up plan, to reasonably assure health and safety in the community; and
			• Be expected to require frequent or continuous care in a hospital without the provision of § 1915(c) waiver services.

limited to: doubled-up living arrangements where the person's name is not on a lease, living in a condemned building without a place to move, having arrears in rent/utility payments, receiving an eviction notice without a place to move and/or living in temporary or transitional housing that carries time limits; or (b) the person, previously homeless, will be discharged from a correctional, medical, mental health or substance use disorder treatment center, and lacks sufficient resources to pay for housing, and does not have a permanent place to live; or • Is currently transitioning, or has recently			

transitioned, from an institution or licensed or registered setting (registered housing with services facility, board and lodge, boarding care, adult foster care, hospital, ICF-DD, intensive residential treatment services, the Minnesota Security Hospital, nursing facility, regional treatment center).			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑**Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

These services are provided to persons who are 18 years and older, and have a documented disability or disabling condition, defined as:

- a person who is aged, blind, or disabled as described under Title II of the Social Security Act;
- a person diagnosed with an injury or illness that is expected to cause extended or long term incapacitation;
- a person who is diagnosed with a developmental disability (or related condition) or mental illness;
- a person diagnosed with a mental health condition, substance use disorder, or physical injury that required a residential level of care, and who is now in the process of transitioning to the community;

- a person who is determined by the county, tribal human services agency or managed care organization, according to rules adopted by the Department, to have a learning disability; or
- a person with a diagnosis of substance use disorder and is enrolled in a treatment program or is on a waiting list for a treatment program.

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

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

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

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

Home and Community-Based Settings

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

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

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

HSS sustaining services are provided only to people who reside in their own home which is leased by the participant or the participant's family member. This includes people who live in their family home and those who may live in housing with rental assistance. The state ensures compliance with the settings requirements under 42 CFR 441.710(a)(1)-(2) because HSS sustaining services can only be provided to people living in their own home. If a person rents a living unit it must meet all requirements under the settings rule, including that services may not be provided in a setting that is owned or controlled by a provider. The state presumes compliance with the settings requirements for people living in their own homes which is consistent with CMS's guidance as set forth in "HCBS Final Regulations 42 CFR Part 441: Questions and Answers Regarding Home and Community Based Settings." The state monitors compliance with the settings requirements by:

1. Assuring appropriate completion of the attestation by housing stabilization providers that they comply with the setting requirement and that people to whom they provide services are in compliant settings.
2. Providing information to participants to inform them of the setting requirements and providing direction to report to the Department if their living arrangement does not comply. In these cases, Department staff will follow-up directly with the participant and take appropriate action. Note: This monitoring will be implemented upon completion of automated IT notices.
3. Surveying participants' experience with HSS, including questions about their living arrangement.

HSS transition and consultation services, by their nature, are individualized, provided in the community, and assist participants to move to their own home.

Person-Centered Planning & Service Delivery

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

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. X Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. X The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.**

There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Applicants can be assessed through one of four processes: a MnCHOICES assessment, a long-term care consultation (LTCC), a Professional Statement of Need, or a Coordinated Entry Assessment. The qualifications for the professionals conducting these assessments are as follows:

MnCHOICES

MnCHOICES is a comprehensive electronic assessment tool that the Department developed and manages. Counties, tribal human services agencies, and managed care organizations administer MnCHOICES assessments using certified assessors or care coordinators who are also certified assessors. Assessors must meet MnCHOICES assessor qualifications, training, and certification requirements as set forth in Minnesota Statutes, section 256B.0911. MnCHOICES certified assessors must:

(1) either have a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field or be a registered nurse; and

(2) have received training and certification specific to assessment and consultation for long-term care services in the state.

Certified assessors must be recertified every three years.

Long Term Care Consultation (LTCC)

Counties, tribal human services agencies, and managed care organizations use certified assessors or Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) care coordinators. Certified assessors and MSHO/MSC+ care coordinators are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field, with at least one year of home and community-based experience; or a registered nurse without public health certification with at least two year of home and community-based experience. Assessors and MSHO/MSC+ care coordinators receive training specific to assessment and support planning for long-term services and supports in the state. The LTCC is a comprehensive assessment process that encompasses more than needs related to institutional level of care.

Professional Statement of Need

The professional statement of need must be completed by a qualified professional. Qualified professionals include the following.

(a) For illness, injury, or incapacity, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), physical therapist, occupational therapist, or licensed chiropractor, according to their scope of practice.

(b) For developmental disability, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse- midwife, or nurse practitioner), licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(c) For learning disability, a "qualified professional" means a licensed physician, physician assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), licensed independent clinical social worker, licensed psychologist, certified school psychologist, or certified psychometrist working under the supervision of a licensed psychologist.

(d) For mental health a "qualified professional" means a licensed physician, physician's assistant, advanced practice registered nurse (clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner), tribally certified mental health professional, or a mental health professional(a registered nurse certified as a clinical specialist in psychiatric nursing or as a nurse practitioner in psychiatric and mental health nursing, licensed independent clinical social worker, licensed professional clinical counselor, licensed psychologist, licensed marriage and family therapist, or licensed psychiatrist).

(e) For substance use disorder, a "qualified professional" means a licensed physician, physician's assistant, tribally certified mental health professional, a mental health professional (a registered nurse certified as a clinical specialist in psychiatric nursing or as a nurse practitioner in psychiatric and mental health nursing, licensed independent clinical social worker, licensed professional clinical counselor, licensed psychologist, licensed marriage and family therapist, or licensed psychiatrist) a substance use disorder treatment director, an alcohol and drug counselor supervisor, a licensed alcohol and drug counselor, or certified alcohol and drug counselor through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., or the Upper Midwest Indian Council on Addictive Disorder (UMICAD).

Coordinated Entry Assessment

The coordinated entry assessor must complete training approved by the Commissioner to administer the coordinated entry tool.

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

For persons receiving Medicaid-funded case management or MSHO/MSC+ care coordination, the person's case manager or MSHO/MSC+ care coordinator is responsible for the development of the person-centered service plan. County providers of targeted case management must be enrolled medical assistance providers who are determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under state law; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services; and child welfare and foster care services; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case records under state and federal requirements.

Private vendors of targeted case management must have a minimum of a bachelor's degree or a license in a health or human services field, comparable training and two years of experience in human services, or who have been credentialed by an American Indian tribe under section 256B.02, subdivision 7, and have been determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements;

(5) the capacity to coordinate with county administrative functions;

(6) have no financial interest in the provision of out-of-home residential services to persons for whom home care targeted case management or relocation service coordination is provided; and

(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom home care targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent; and

(ii) information on a range of other feasible service provider options has been provided.

Case managers providing services to people receiving home and community-based services under the state's approved § 1915(c) waivers must be a social worker, registered nurse, or public health nurse.

An MSHO/MSC+ care coordinator must be one of the following qualified professionals:

- Social worker
- Licensed social worker
- Registered nurse
- Physician's assistant
- Nurse practitioner
- Public health nurse
- Physician

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

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

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

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

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

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

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

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

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

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

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

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

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

A case manager, care coordinator, or provider of housing consultation services works with the person to develop the person-centered plan. The plan is submitted to the Department via a web portal as part of a request for housing stabilization services. All service plans are subject to the review of the Department (the state Medicaid agency). An individual service delivery plan will not be approved by the Department unless the person meets all financial eligibility criteria and needs-based service criteria.

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

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

Services

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

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

Service Title:	Housing Stabilization Service – Transition Services

Service Definition (Scope):

Housing Stabilization - Transition Services are community supports that help people plan for, find, and move to homes of their own in the community including:

- Supporting the person in applying for benefits to afford their housing
- Identifying services and benefits that will support the person with housing instability
- Assisting the person with the housing search and application process
- Assisting the person with tenant screening and housing assessments
- Helping a person understand and develop a budget
- Helping the person understand and negotiate a lease
- Helping the person meet and build a relationship with a prospective landlord
- Providing up to $3000 for certain costs associated with moving, as described below
- Identifying resources to cover moving expenses that are not otherwise covered under this service
- Helping the person arrange deposits
- Ensuring the new living arrangement is safe and ready for move-in
- Providing remote support when required to ensure their housing transition
- Helping a person organize their move

Remote support is real-time, two-way communication between the provider and the participant. The service meets intermittent or unscheduled needs for support for when a participant needs it to live and work in the most integrated setting, supplementing in person service delivery.
Remote support is limited to check-ins (e.g. reminders, verbal cues, prompts) and consultations (e.g. counseling, problem solving) within the scope of housing stabilization services. Remote support may be utilized when it is chosen by the participant as a method of service delivery. To meet the real-time, two-way exchange definition, remote support includes the following methods: telephone, secure video conferencing, and secure written electronic messaging, excluding e-mail and facsimile. All transmitted electronic written messages must be retrievable for review. Providers must document the staff who delivered services, the date of service, the start and end time of service delivery, length of time of service delivery, method of contact, and place of service (i.e. office or community) when remote support service delivery occurs.

Housing Stabilization-Transition Services cannot duplicate other services or assistance available to the person.

Moving Expenses
Moving Expenses are non-reoccurring and are limited to a maximum of $3000 annually for people receiving Housing Stabilization-Transition services and are transitioning out of Medicaid funded institutions or other provider-operated living arrangements to a less restrictive living arrangement in a home where the person is directly responsible for his or her own living expenses.

Moving Expenses include:

- Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
- Services necessary for the person's health and safety such as pest eradication and one-time cleaning prior to occupancy
- Necessary home accessibility adaptations

Moving Expenses are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process. These expenses must be clearly identified in the service plan.

These items are not covered Moving Expenses:

- Rent and mortgage payments
- Food
- Clothing
- Recreational and diversionary items. Recreational items include streaming devices, computers, televisions, cable television access, etc.
- Items, expenses, or supports thatduplicate any other service
- Costs of furnishing living arrangements that are owned or leased by a provider where the provision of these items and services are inherent to the service they are already providing

Providers must maintain all documentation of purchases and spending, including receipts, related to the person's Moving Expenses. Receipts must be uploaded to the Medicaid payer's claim system for review, approval, and to track costs separately from other components of Housing Stabilization - Transition Services.

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

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

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

Moving Expenses may be provided in a setting which does not comport with the settings requirements if the person will be moving into a setting which does comport with the settings requirements at the time of the move. For persons residing in an institutional setting or another provider operated living arrangement, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for Moving Expenses until the ~~t~~ person has transitioned to a community-based setting and is determined eligible for Housing Stabilization – Transition Services.

Housing Stabilization – Transition Services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in.

For persons residing in an institutional setting or another provider operated living arrangement, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the person has transitioned to a community-based setting. In this circumstance, this service is only provided to people transitioning to a less restrictive setting, and for people transitioning from provider-operated settings, the service is only provided to those transitioning to a private residence where the person will be directly responsible for his or her own living expense.

Housing Stabilization -Transition Services are not covered when a person is concurrently receiving Housing Stabilization - Sustaining Services.

Moving Expenses Limitations:

- Moving expense providers and/or their family members cannot sell goods and services to recipients that are reimbursed through moving expense
- Moving expenses cannot be used to purchase goods and services from a recipient's family member

Limitations applicable to remote support service delivery of Housing Stabilization – Transition Services:
Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support any time.

- A person requiring a higher level of remote support annually may be granted an exception through a provider request for prior authorization for up to 75% of the direct service provision.
- Prior authorization for higher remote support is not required during the period of a federal or state public health emergency or disaster declaration affecting the person or the
- person's geographic area.
  A person on Housing Stabilization - Transition Services may use remote support in a flexible manner that meet his/her/their needs within the total yearly authorized units.

In order for providers to provide more than half of the direct service hours annually remotely, Department staff must review the necessary information, and if appropriate, provide prior authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include when the person:

- engages more readily with the provider via remote means due to their disabling condition;
- is transient and difficult to physically locate but remains in contact remotely;
- works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing; or.
- is physically distant from the provider and the person consents to additional remote support Providers need to outline remote support delivery methods agreed upon with the person.

The housing support plan must also document:

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

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

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

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

Providers may not:

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

X	Medically needy *(specify limits):*
	Housing Stabilization-Transition services are limited to 150 hours per transition. Additional hours beyond this threshold may be authorized by the Department. Moving Expenses may be provided in a setting which does not comport with the settings requirements if the person will be moving into a setting which does comport with the settings requirements at the time of the move. For persons residing in an institutional setting or another provider operated living arrangement prior to community transition and 1915(i) enrollment, services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for Moving Expenses until the person has transitioned to a community-based setting and is determined eligible for Housing Stabilization – Transition Services. Housing Stabilization – Transition Services may be provided in a non-compliant setting if the person will be moving into a setting that is HCBS compliant at move in. For persons residing in an institutional setting or another provider operated living arrangement prior to community transition and 1915(i) enrollment services may be furnished no more than 180 consecutive days prior to discharge and providers may not bill for services until the person has transitioned to a community-based setting. Housing Stabilization -Transition Services are not covered when a person is concurrently receiving Housing Stabilization - Sustaining Services. Moving Expenses Limitations: • Moving expense providers and/or their family members cannot sell goods and services to recipients that are reimbursed through moving expense • Moving expenses cannot be used to purchase goods and services from a recipient's family member Limitations applicable to remote support service delivery of Housing Stabilization – Transition Services: • Remote support cannot be used for more than one-half of direct service provided annually. Remote support cannot have the effect of isolating a person or reducing their access to the community. If remote support has such an effect, it is not allowed. A person has a right to refuse, stop, or suspend the use of remote support any time. • A person requiring a higher level of remote support annually may be granted an exception through a provider request for prior authorization for up to 75% of the direct service provision. • Prior authorization for higher remote support is not required during the period of a federal or state public health emergency or disaster declaration affecting the person or the person's geographic area. • A person on Housing Stabilization - Transition Services may use remote support in a flexible manner that meets his/her/their needs within the total yearly authorized units.

In order for providers to provide more than half of the direct service hours annually remotely, Department staff must review the necessary information and, if appropriate, provide prior authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include when the person:

- engages more readily with the provider via remote means due to their disabling condition;
- is transient and difficult to physically locate but remains in contact remotely;
- works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing; or
- is physically distant from the provider and the person consents to additional remote support

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

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

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

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

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

Providers may not:

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

Provider Type *(Specify)*:	License *(Specify)*	Certification *(Specify)*:	Other Standard *(Specify)*:
Agency: agenciesthat meet the housing stabilization service standards Individual: Individuals that meet the housing stabilization service standards			Individuals providing housing stabilization services must have: • Knowledge of local housing resources. • Completed housing stabilization services training approved by the Commissioner. • Completed mandated reporter training which includes training on vulnerable adult law. Additionally, providers of housing stabilizationservices must pass a criminal background study.

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

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

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

☐	Participant-directed	X	Provider managed

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

Service Title:	Housing Stabilization Service - Sustaining

Service Definition (Scope):

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

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

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

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

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

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

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

X Categorically needy *(specify limits):*

Housing Stabilization-Sustaining services are limited to 150 hours annually.

Additional hours beyond this threshold may be authorized by the Department.

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

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

In order for providers to provide more than half of the direct service hours annually remotely, Department staff must review the necessary information and, if appropriate, provide authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include when the person:

- engages more readily with the provider via remote means due to their disabling condition; is transient and difficult to physically locate but remains in contact remotely
- works during regular business hours so remote support enables the person to employed and receive needed supports to find or keep housing.
- is physically distant from the provider and the person consents to additional remote support

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

- why those methods were chosen and detail why remote support better meets the person's needs
- how remote support will support the person to live and work in the most integrated community settings

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

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

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

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

In order for providers to provide more than half of the direct service hours annually remotely, Department staff must review the necessary information and, if appropriate, provide authorization. Providers request authorization through an Additional Remote Support Exception Request form. Reasons an exception may be granted include when the person:

- engages more readily with the provider via remote means due to their disabling condition;
- is transient and difficult to physically locate but remains in contact remotely;
- works during regular business hours so remote support enables the person to remain employed and receive needed supports to find or keep housing; or.
- is physically distant from the provider and the person consents to additional remote support.

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

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

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

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

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

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

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

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

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

(Choose each that applies):

Categorically needy *(specify limits):*

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

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

Remote support- Housing Consultation

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

Medically needy *(specify limits):*

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

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

Remote support- Housing Consultation

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

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

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

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

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

Provider Type *(Specify)*:	Entity Responsiblefor Verification *(Specify)*:	Frequencyof Verification *(Specify)*:
Agency: Agencies that meetthe housing consultation service standards	MinnesotaDepartment of Human Services	Every five years
Individual: Individuals that meetthe housing consultation service standards	MinnesotaDepartment of Human Services	Every five years

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

	Participant-directed	X	Provider managed

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

Participant-Direction of Services

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

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

X	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

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

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

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

4. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the*

authority offered for each. Add lines as required):

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

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

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

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;

- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

8. **Opportunities for Participant-Direction**

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

X	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
	☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

X	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

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

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

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

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

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

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

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

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

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

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

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

	(of Analysis and Aggregation)	

Requirement		***Settings meet the HCBS setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2)***
Discovery		
	Discovery Evidence *(Performance Measure)*	In order to provide housing stabilization-sustaining services, providers must submit documentation attesting that the recipient lives in a HCBS-compliant setting. Percentage of recipients determined eligible in the past 12 months that have a provider attestation that recipient lives in an HCBS-compliant setting. • Numerator: Number of recipient files with the provider attestation noting that recipient lives in a HCBS-compliant setting. • Denominator: Number of recipient files reviewed. Performance Standard: 100%
	Discovery Activity *(Source of Data & sample size)*	Department staff review service plans to verify the recipient lives in a compliant setting. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All recipients.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services
	Frequency	Ongoing

	Discovery Evidence *(Performance Measure)*	Percentage of recipients who had a recertification in the past 12 months that have a provider attestation that meets HCBS settings requirements. • Numerator: Number of recipient files with the provider attestation noting that recipient lives in a HCBS-compliant setting. • Denominator: Number of recipient files reviewed. Performance Standard: 100%
	Discovery Activity *(Source of Data & sample size)*	Department staff review service plans to verify the recipient lives in a compliant setting. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All recipients.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services
	Frequency	Ongoing

Remediation

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	Recipients residing in settings that do not meet the requirements described in this plan may not receive housing stabilization- sustaining services.

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

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

Requirement	***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to active providers during the review period in accordance with the published rate on the date of service. • Numerator: Number of claims paid to active providers at the correct rate during the review period. • Denominator: Number of housing stabilization service claims paid in the sample during the review period. • Performance Review: 90%
Discovery Activity *(Source of Data & sample size)*	Department staff review all paid claims from MMIS/MCO data. Data Source: MMIS Claims data; and MCO data Sample Size: All claims.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department engages in continuous and on-going review and development of MMIS claims edits/MCO claims payments to ensure claims are properly paid.
Frequency *(of Analysis and Aggregation)*	Semi-annual reports of MMIS claims/MCO claims and edit development

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

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

Requirement	***Eligibility Requirements: an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of applicants for 1951(i) services in which the Department completed an eligibility determination. • Numerator: Number of applicants with a completed determination of eligibility. • Denominator: Number of applicants to the Department for 1915(i) services. • Performance Standard: 90%

	Discovery Activity *(Source of Data & sample size)*	Department staff will review data from MMIS and the Housing Stabilization Data System to determine whether all recipients who submitted an application also received a determination of eligibility. Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All 1915(i) applicants.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department is responsible for determinations of eligibility. For those determinations that do not comply, the Department will work to ensure remediation takes place within 30 days.
	Frequency *(of Analysis and Aggregation)*	Annually

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

	Sample Size: All new recipients.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The Department is responsible for determinations of eligibility. The Department reviews the processes and instruments used for determinations annually, and ensure remediation actions for changing these processes and instruments take place within a designated period.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS***
Discovery	
Discovery Evidence *(Performance Measure)*	Percentage of annual reevaluations for 1915(i) service in which the Department completed a determination of eligibility. • Numerator: Number of reevaluations with a completed determination of eligibility in the most recent review cycle. • Denominator: Number of reevaluations submitted to the Department in the most recent review cycle. Performance Standard: 100%
Discovery Activity *(Source of Data & sample size)*	Data Source: Referral and eligibility data manually tracked by Department staff through MMIS and the Housing Stabilization Data System. Sample Size: All cases with an annual re-evaluation.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	Department of Human Services

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

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
The Department regularly surveys recipients, stakeholders, providers and organizations regarding the quality, design, and implementation of the services. A team of program and policy staff from the Department reviews and analyzes collected survey, performance measure, and remediation data. This team will make recommendations for systems and program improvement strategies. Problems or concerns requiring intervention beyond existing remediation processes will be targeted for new/improved policy and/or procedure development, testing, and implementation.			

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
X	Other Services (specify below)

All public, private and tribal (defined as an IHS or 638 facility) providers are reimbursed as described below:

Effective July 1, 2025, housing stabilization services - transition are paid the lower of the submitted charge, or $17.17 per 15-minute unit.

Effective July 1, 2025, housing stabilization services - sustaining are paid the lower of the submitted charge, or $17.17 per 15-minute unit.

Effective July 1, 2025, consultation services are paid the lower of the submitted charge, or $174.22 per session.