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The Honorable Donovan W. Frank
U.S. District Judge, District of Minnesota
United States District Court
724 Federal Building
316 North Robert Street
Saint Paul, MN 55101

April 22, 2014

Dear Judge Frank,

On behalf of the Olmstead Sub-Cabinet I am pleased to present the first Minnesota Olmstead Plan status update. The Sub-Cabinet, and the Olmstead Implementation Office worked across the various state agencies, with the Executive Director of the Governor's Council on Developmental Disabilities, the Ombudsman for Mental Health and Developmental Disabilities, and the Court Monitor as we began the implementation of the Plan. Through this collaborative effort, we are dedicated to full implementation of the Plan and achieving inclusive and integrated communities for individuals with disabilities.

You will find in this report that much work has begun to lay the foundation necessary for full implementation. In particular, the initial stages of implementing a quality of life survey process will allow Minnesota to assess with high reliability and validity progress in achieving improved lives of individuals with disabilities. Additionally, the report shows the first data on tracking individuals with disabilities who are leaving segregated settings and moving into community settings, as well as individuals moving off wait lists. This data over time will allow everyone to track progress in these important areas.

The Sub-Cabinet and the Olmstead Implementation Office is continuing to work with the Court Monitor on the proposed Plan modifications. This includes sharing proposed modifications with the Monitor and the Sub-Cabinet's solicitation of public comments. Throughout the development of the Plan, the Sub-Cabinet made listening a top priority. Through listening to advocates, families and individuals with disabilities, the Plan was shaped in ways that we alone could not have achieved. The Sub-Cabinet is continuing this listening process through written comments to the Olmstead web page and a series of four listening sessions across the state. We are confident the process of listening to those who have the most to gain from this plan, with input from the Court Monitor and with direction from the Court, will make the Plan improvements we are all expecting.

We look forward to hearing your comments on this first report and working with you to strengthen and focus our efforts.

Sincerely

Yvonne Prettner Solon

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, et al.,

Civil No. 09-1775 (DWF/FLN)

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, et al.,

Defendants.

Minnesota Olmstead Sub-Cabinet Report to the Court

STATUS UPDATE AND PLAN MODIFICATION RECOMMENDATIONS
November 1, 2013 – February 28, 2014

Report Number 1

April 22, 2014

Olmstead Sub-Cabinet

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CONTENTS

I. PURPOSE

On January 22, 2014 the Court provided the following direction for updating the status of the Olmstead Plan implementation:

"The State of Minnesota shall file its first update, including any amendment to the Olmstead Plan and a factual progress report that shall not exceed 20 pages, within 90 days of the date of this Order. The Court expects the parties to address the progress toward moving individuals from segregated to integrated settings; the number of people who have moved from waiting lists; and the results of any and all quality of life assessments. The Court needs to be in a better position to evaluate whether the Settlement Agreement is indeed improving the lives of individuals with disabilities, as promised and contemplated by the Settlement Agreement itself.

As the Court ordered on August 28, 2013, updates to the Olmstead Implementation Plan shall include activities undertaken pursuant to the Plan, documentation of such activities, and any requests for modification of the Plan's deadlines or other elements.

The State of Minnesota shall file a revised Olmstead Plan on or before July 15, 2014, after first providing a draft to the Court Monitor on or before July 5, 2014.

This Court respectfully directs that the Olmstead Subcabinet use all of its combined resources and talents to implement the Olmstead Plan. Further, the Court respectfully directs that the Olmstead Subcabinet cooperate, communicate, and work with the Court Monitor. The Court expects the Olmstead Subcabinet to discuss ongoing implementation with the Court Monitor, as well as the Executive Director of the Governor's Council on Developmental Disabilities and the Ombudsman for Mental health and Development Disabilities, on a 60-day report system, with feedback and communication between all parties, so that true progress can be realized in the lives of the individuals with disabilities intended to benefit from the Settlement Agreement and so their lives can truly be significantly improved."

The Olmstead Implementation Office has adopted this schedule to report to the Sub-Cabinet on the status of work being done by state agencies to implement the Plan. This bi-monthly reporting framework will also be used to recommend other actions, such as modifications to the Plan, to the Sub-Cabinet and other parties, including the Court Monitor, the Court, and other stakeholders. Each bi-monthly report will cover actions from the two full months prior to the report date. Additionally, a look forward at the next four months of actions will be included with the intent to inform the Sub-Cabinet, Court, Court Monitor and other stakeholders about progress and potential issues. This first report provides status updates on Olmstead Plan actions and tasks from November 1, 2013 to February 28, 2014; with additional information on action items through June 30, 2014.

II. OLMSTEAD PLAN ACTION ITEMS STATUS UPDATE

The following summaries cover the primary topic areas of the plan and the work completed thus far to implement the plan. For further detail see **Appendix 1-A** which includes a listing of all Olmstead Plan action items in a chronological grid format.

OVERARCHING STRATEGIC ACTIONS

All agencies were asked to submit legislative proposals for the 2014 legislative session by February 25, 2014. Because this particular session is a non-budget session, items requesting funding were limited to funding for the Olmstead Implementation Office, a request from the Department of Employment and Economic Development (DEED), and a request from the Minnesota Department of Health (MDH). See **Exhibit 1-1** for the funding request submitted to the Governor's office. The Olmstead funding requests were submitted to the Minnesota State Legislature through the Governor's supplemental budget request, see **Exhibit 1-1A.** At the time of this report the final status of the legislative action on this request is not known as the legislature is still in session.

QUALITY ASSURANCE AND ACCOUNTABILITY

The Olmstead Implementation Office has created a framework to monitor all actions and tasks within the Plan and analyze implementation plans for progress as well as potential problems. This includes keeping the Sub-Cabinet, Court Monitor and parties apprised of the progress, status and issues in implementing Minnesota's Olmstead Plan.

Each agency represented in the Plan has assigned an "Olmstead Agency Lead" (see **Exhibit 1-2** for current assignments) to coordinate each agency's action items within the Plan. These agency leads meet with the Olmstead Implementation Office on a bi-monthly basis, or as needed, to facilitate cross agency discussions and collaborative work to move the Plan forward. Working relationships are still being formed and this has posed some challenges for those agencies that have collaborative action items. The OIO will continue to work with the Olmstead Agency Leads and the Sub-Cabinet to determine ways to facilitate these relationships across agencies.

The Olmstead Agency Leads are also responsible for submitting bi-monthly status reports on all action items that are in progress but not yet completed, to the Olmstead Implementation Office (OIO). These status reports include a summary of the current status as well as benchmarks and completion dates working toward full implementation of each action item. The OIO evaluates these reports for timeliness, accuracy and inclusion of Olmstead principles set forth in the plan such as how stakeholders were engaged in the process and if their input was incorporated. The OIO, with the assistance of the Olmstead Agency Leads, ensured that all 2013, 2014 and 2015 action items within the Olmstead Plan have been assigned to the appropriate responsible person to complete.

The Olmstead Implementation Office has been established and is functioning with three interim staff. A search committee that included Sub-Cabinet members and members of the disability community has selected an Executive Director for the permanent office, Dr. Darlene Zangara. Dr. Zangara is scheduled

to begin this role on May 5, 2014. Two of the interim staff will remain in place during the transition of the new Executive Director, one at full time status and the other at part time status.

Two existing action items within the topic area of Quality Assurance and Accountability have pending modification requests. They are:

- QA 1A – Identify the quality of life outcome indicators; contract with an independent entity to conduct annual assessment. March 31, 2014 – Requested Modification: Date change.
- QA 1B – Identify the survey instrument that will establish a baseline and allow ongoing evaluation of quality of life outcome indicators. July 1, 2014 – Requested Modification: Date change.

Quality of Life

At the February 20, 2014 Olmstead Sub-Cabinet meeting, approval was given to enter into a contract with the Center for Outcome Analysis to develop a Quality of Life assessment tool specific to the elements identified in the Olmstead Plan. This contract was funded at $5000 by the Minnesota Housing Finance Agency. The tool was delivered to the Olmstead Implementation Office (OIO) on March 31, 2014 and is attached to this report as **Exhibit 1-3**.

The tool, titled the Personal Life Quality Protocol, collects identifying and demographic data, responses to questions about community integration (Time, Money & Integration) and engagement, autonomy over daily life and perceived qualities of life. Instructions for survey administration were included as well as two optional person centered scales. A listing of tool reliability studies was also made available. The developer authorizes the State of Minnesota to employ the Personal Life Quality Protocol through 2018, the last year identified in the Olmstead Plan for gathering this data. The OIO recommends that the Olmstead Sub-Cabinet approve this tool for use in the 2014 pilot study.

The Quality of Life pilot study will be conducted and completed by December 31, 2014. Individuals with disabilities living, learning and working in the most segregated settings will be the primary responders to the survey. The pilot study provides an opportunity to uncover any challenges or barriers to data collection in preparation for the 2015 baseline survey and subsequent annual follow-up sample surveys in years 2016-2018. The OIO contacted Management Analysis and Development (MAD) for the administration of the pilot study. A proposal for the study has been received and will be managed by MAD under their master contract.

A number of Minnesota State agencies have implemented surveys in the past to better understand the perceptions of their service consumers. While providing helpful information, those surveys were usually not designed to provide information across all disabilities, may not have been tested for validity and reliability, and were not responsive to the specific concerns of the Court as identified below. See **Appendix 1-B** for a partial listing of recent surveys and their ability to respond to the required elements listed below:

- applicable across all individuals with disabilities and all ages,
- tested for and demonstrate high levels of validity and reliability,

- comprehensive enough to establish baselines for subsequent sampling,
- identifies the "progress toward moving individuals from segregated to integrated settings" and "the number of people who have moved from waiting lists and the results of any and all quality of life assessments" as called for by the Court.

The pilot study of the Olmstead Personal Life Quality Protocol will help determine if the above standards can be satisfied using this tool and provide an opportunity to standardize quality of life data collection across agencies, disabilities, services and time periods.

EMPLOYMENT

Work is proceeding on forming employment learning communities; while person centered training including enhancements to support competitive employment will be subject to a modification request to extend the completion date to 2015.

The Extended Employment program rule change to cap enrollment for non-integrated employment and subminimum wage programs is in process but funding for the rule making costs is yet to be allocated.

Other goals focus on developing baselines and goals for increasing employment of adults with disabilities and developing effective employment strategies for competitive employment.

Four existing action items within the topic area of Employment have pending modification requests. They are:

- EM 3A –Enhanced person-centered planning training that incorporates Employment First and employment planning strategies. March 1, 2014. – Requested Modification: Date change
- EM 1B – Baselines & goals set for ensuring students with disabilities have at least one paid work experience. June 30, 2014. - Requested Modification: Language change
- EM 1G – Baselines & goals set for increased employment of adults with disabilities. June 30, 2014. – Requested Modification: Language and date change
- EM 1K – Establish a plan to expand Individual Placement and Supports employment for Minnesotans with serious mental illness statewide. June 30, 2015 – Requested Modification: Language change

HOUSING

Data gathering is ongoing to establish a baseline and targets for increasing the number of counties providing individualized housing options.

One existing action item within the topic area of Housing has a pending modification request. It is:

HS 2A – Baseline and targets established for number of new affordable housing opportunities created, the number of people with disabilities accessing affordable housing opportunities in the community, and the number of people with disabilities with their own lease. December 31, 2014– Requested Modification: Language change.

TRANSPORTATION

Efforts over the next several months will focus on gathering transportation access concerns and recommendations from stakeholders, integration of Olmstead Plan transportation goals into Minnesota transit providers' 2015 service plans, and alignment of the Minnesota Council on Transportation Access (MCOTA) work plan with the Olmstead Plan.

One existing action item within the topic area of Transportation has a pending modification request. It is:

TR 1B – Review administrative practices and implement necessary changes to encourage broad cross state agency coordination in transportation. September 30, 2014- Requested Modification: Language change.

SUPPORTS AND SERVICES

In December 2013 the Minnesota Department of Human Services assessed individuals at Minnesota Security Hospital who are recommended for discharge and do not oppose discharge. The results were: Forensic Transition Services = 32, Minnesota Security Hospital = 10, and Forensic Nursing Home = 1, and the Competency Restoration Program = 9.

See **Exhibit 1-4** identifying the number of individuals moving from segregated to integrated settings from November 1, 2013 through February 28, 2014. This grid includes:

- 3 individuals that moved from MSHS-Cambridge,
- 170 individuals under age 65 with stays longer than 90 days from nursing facilities,
- 25 individuals from Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD),
- 51 individuals from the Anoka Metro Regional Treatment Center (AMRTC), and
- 33 individuals from the Minnesota Security Hospital (MSH).

Additionally this exhibit shows that in March 2014 the number of individuals on the waiting list was: 3,563 for the DD waiver and 1,355 for the CADI, CAC, and BI (CCB). Between November 1, 2013 and March 28, 2014, there were 137 individuals who started waiver services under the DD waiver and 709 who started waiver services under the CADI, CAC, and BI (CCB) waivers combined.

The new standards for Minnesota Statute 245D Home and Community-Based Service Standards are in effect and implementation has begun. See **Exhibit 1-5** for verification detail.

An interagency and community team has been identified to develop protocols for successful transitions from MSHS-Cambridge, AMRTC, MSH-St. Peter, ICF-DD facilities, and individuals under age 65 in nursing home facilities to the most integrated setting they choose.

See **Exhibit 1-6** for the timelines established for transition to the most integrated setting for all individuals at the Minnesota Security Hospital who have been recommended for discharge and who do not oppose being discharged. The current status is below:

- Increase the average number of individuals discharged per month. Current = 8
- Percent of individuals in their stage of the discharge process for less than 180 days = 76%
- Percent of individuals in their stage of the discharge process for more than 180 days = 24%
- Number of readmissions within 6 months of discharge = 0

Four existing action items within the topic area of Supports and Services have pending modification requests. They are:

SS 4A – Replace the personal care assistance program with a more flexible personal support service (CFSS), with an emphasis on self-direction. April 1, 2014. – Requested Modification: Date change. See **Exhibit 1-7** for documents submitted to the Center for Medicare & Medicaid Services (CMS) regarding this action item.

SS 2G – Identify a list of other segregated settings; establish baselines, targets, and timelines for moving individuals who can be supported in more integrated settings. September 30, 2014 – Requested Modification: Language change.

SS 1B – Establish characteristics and criteria that define best practices in person-centered planning and the Olmstead requirements, to be used by state agencies to evaluate and revise their assessment and plan content. January 1, 2015. –Requested Modification: Language change.

SS 3K - Crisis services will be made available to any person at risk of civil commitment. July 1, 2015. - Requested Modification: Language change.

SS 2I – Initiate the movement of individuals in other segregated settings to the most integrated setting in accordance with the established timeline. September 30, 2015 – Requested Modification: Language change.

LIFELONG LEARNING AND EDUCATION:

In anticipation of the August 1, 2015 statutory end date for the use of prone restraints, the Minnesota Department of Education (MDE) has reported summary data to the legislature on the use of restraints in the 2012/2013 school year and is working with the Department of Human Services (DHS) to develop a publicized list of training and consultation resources school districts may use to reduce the use of restrictive procedures. A stakeholder group is developing information and guidelines so students with complex disabilities can access crisis services.

Two existing action items within the topic area of Education have pending modification requests. They are:

ED 4A.1- Increase the number of students with disabilities (+50) entering integrated postsecondary education and training programs within one year of exiting secondary education. September 1, 2014. – Requested Modification: Language change.

ED 3C – DEED, DHS and MDE will formalize agreement to develop a return on investment matrix to show how evidence based practices increase integrated competitive employment outcomes for students with disabilities. June 30, 2016 – Requested Modification: Language change.

HEALTHCARE AND HEALTHY LIVING

The Minnesota Department of Health (MDH) is conducting a needs analysis concerning health care messaging to people with disabilities and will use this information to draft an implementation plan by May 31, 2014 (date subject to modification approval).

Eight existing action items within the topic area of Healthcare and Healthy Living have pending modification requests. They are:

HC 2A – Develop plan and set timelines to ensure that health messaging is targeted to people with all types of disabilities. March 31, 2014. – Requested Modification: Date change.

HC 1D – Implement framework for healthcare for adults and children with serious mental illness; some people will have access to care. December 31, 2014. – Requested Modification: Date change.

HC 1E – Develop and align reporting mechanisms for this framework for healthcare for people with serious mental illness. December 31, 2014. – Requested Modification: Date change.

HC 2E – Develop, test and implement module to better assess overall health status of people with disabilities in Minnesota. December 31, 2014. – Requested Modification: Date change.

HC 2G - Establish baseline data for current care; develop an implementation plan to further assess, develop, and respond. December 31, 2014. Requested Modification: Language change.

HC 1A – Establish baselines and targets to increase number of teams that are able to provide integrated, person-centered primary care for persons with disabilities. January 1, 2015. – Requested Modification: Language and date change.

HC 2H – Measure and report on hose health care access and service are changing; establish plans to support quick improvements (biannual report). August 1, 2015. – Requested Modification: Date change.

HC 2F.1 – Complete health status reports regarding health care outcomes and track policy and organizational practice changes at the community and state levels (annual report). December 31, 2015 – Requested Modification: Date change.

COMMUNITY ENGAGEMENT

Community feedback on the Olmstead Plan is continually being received through comments sent to the public website and distributed to all Olmstead Agency Leads and other stakeholders. Listening sessions

concerning proposed modifications to the Olmstead Plan are scheduled this spring for April 21, 2014 in St. Paul, April 29, 2014 in Mankato, May 6, 2014 in Bemidji and May 19, 2014 in Duluth.

All of the various Governor appointed disability councils, committees, advisory boards, etc. were invited to appoint a representative to work with the Olmstead Plan Drafting Team. At this time there are 6 representatives from various groups. Representatives have been invited to participate in the listening sessions, help to organize their various groups to participate in the modification process as well as share with the OIO how they can contribute most effectively to the modification process.

One existing action item within the topic area of Community Engagement has a pending modification request. It is:

CE 1B – Determine the size and scope of peer support and self-advocacy programs; set annual goals for progress. December 31, 2014. – Requested Modification: Language change.

Olmstead Plan Areas Proposed for Modification

The Olmstead Plan modification process was presented to the Sub-Cabinet as part of the February 20, 2014 report and approved. At this point proposed modifications have been compiled by the Olmstead drafting team and shared with stakeholders. The next stage in the process is public comment solicited through four listening sessions referenced above and submission of all proposed modifications to the Court Monitor. A draft will be reviewed by the Sub-Cabinet on June 9, 2014 along with a request for approval; once approved by the Sub-Cabinet it will be submitted to the Court Monitor and parties on July 5, 2014 and delivered to the court on July 15, 2014. The Olmstead Implementation Office anticipates a regularly scheduled twice yearly cycle of plan modifications. In the interim requests for modifications may be reviewed and approved by the Court Monitor. Utilization of the representatives from the various Governor appointed disability groups will continue with each cycle of modifications as well. The modifications provide the opportunity to strengthen the Plan with new information and resources and adjust to barriers encountered along the way.

Changes to the Olmstead Plan include amendments to specific actions, addition of new actions, updates regarding the content of the plan since it was first published, information concerning the modification process, explanatory footnotes, clarifying terminology and definitions. Action modification requests most commonly involve completion date changes, anticipating additional funding needs, establishing new goals (as with the Minnesota Department of Corrections additions), or quantifying outcomes (as with the Minnesota Security Hospital projections for increased discharges).

III. OLMSTEAD PLAN IMPACT ON LIVES OF INDIVIDUALS

The Court has directed that the success of the Olmstead Plan be measured by impact on the quality of life of individuals with disabilities. While Minnesota has several tools currently in use, none of them meet the criteria set forth in the Olmstead Plan for measuring quality of life. The quality of life tool included in the Plan is a quantitative measure that will survey individuals living, working, and learning in

segregated settings and tracking their quality of life perceptions over multiple years. This will provide insight on quality of life changes as individuals move from segregated settings to integrated settings.

Qualitative evaluations encouraging individuals with disabilities to tell their own stories concerning the impact of the Olmstead Plan can also be very effective measurements of change. The Olmstead Plan issued in November of 2013 did not include provisions for such a measure.
The Olmstead Implementation Office recommends to the Sub-Cabinet that the Olmstead Plan be modified to include a qualitative measurement process that requires:

A literature review to determine best practices in qualitative reviews. (This should include validated methodologies for collecting individual stories).

- Determine if other agencies are utilizing such qualitative measures and if those processes could be adopted or modified.
- Design an implementation plan for a qualitative measure process telling people's experiences in their own words.
- The Plan will include assessment of necessary resources, target date for implementation, and a communication plan to ensure the stories are easily available to the public
- Every effort will be made to have people with disabilities in leadership roles in the design, implementation, and monitoring of the process.

IV. ACTIONS NEEDED BY SUB-CABINET:

The Olmstead Implementation Office presented these recommendations on April 21, 2014. They were unanimously adopted by the Sub-Cabinet.

- There are four action items currently assigned to the Sub-Cabinet and the OIO recommends that they be re-assigned to those agencies providing direct care services. The action items are:
    - SS 3C – Create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress;
    - SS 3D – Report outlining recommendations for a statewide plan to increase positive practices and eliminate use of restraint or seclusion;
    - SS 3E – Statewide, develop a common definition of incidents (including emergency use of manual restraint), create common data collecting and incident reporting process;
    - SS 3J – Identify best practices, set service standards, and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions.
- The Quality of Life Assessment tool is recommended for approval by the OIO.
- The OIO recommends approval of a contract with MAD under their master contract to conduct the pilot Quality of Life Assessment using the aforementioned assessment tool.
- The OIO recommends approving the addition of action items incorporating the qualitative measures presented previously in this report to show impact on quality of life for individuals.
- The OIO recommends approving this report to be sent to the Court, Court Monitor and all parties in compliance with the January 22, 2014 order.

V. INDEX OF APPENDICES AND EXHIBITS

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APPENDIX 1-A: CHRONOLOGICAL GRID OF ALL ACTION ITEMS

APPENDIX 1-A: Key to abbreviations:

Topic Area:

OV = Overarching Strategic Actions

QA = Quality Assurance and Accountability

EM = Employment

HS = Housing

TR = Transportation

SS = Supports and Services

ED = Lifelong Learning and Education

HC = Healthcare and Healthy Living

CE = Community Engagement

Responsible Agency:

Sub-Cabinet and/or Olmstead Implementation Office (**OIO**)

DHS = Department of Human Services

DEED = Department of Employment and Economic Development

MHFA = Minnesota Housing Finance Agency

MnDOT = Minnesota Department of Transportation

DOC = Department of Corrections

MDE = Minnesota Department of Education

MDH = Minnesota Department of Health

MDHR = Minnesota Department of Human Rights

Appendix 1-A: Chronological Grid of All Action Items

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of Current Status and Next Steps
QA	3A	November 15, 2013	Ensure that responsible people are assigned to complete actions described in the Olmstead Plan for 2013	Subcabinet	29	**Completed**.
QA	3B	December 1, 2013	Design an oversight and monitoring structure	Subcabinet	29	**Completed**. **Request for Modification** to add action item to report on status of oversight and monitoring.
QA	3C	December 1, 2013	Establish and Olmstead implementation office	Subcabinet	29	Interim staff assigned through interagency agreements including full time Executive Director, full time temporary Deputy Director, and part time Dispute Resolution positions. The search committee has made an offer and it has been accepted. Executive Director, Dr. Darlene Zangara set to start May 5, 2014.
SS	2E	December 31, 2013	Assess individuals at Minnesota Security Hospital determine the number of individuals who have been recommended for discharge and who do not oppose being discharged.	DHS	54	**Completed.**
SS	3A	January 1, 2014	Implement new standards from Minnesota Statutes §245D	DHS	55	**Completed.**
QA	3D	January 15, 2014	Ensure that responsible people are assigned to complete actions described in the Olmstead Plan for 2014	Subcabinet	30	**Completed.**
SS	2A	January 31, 2014	Create interagency and community team to develop protocols for successful transitions from certain facilities to most integrated setting.	DHS	53	**Completed.** **Request for Modification** to add action items that set timelines for implementation and evaluation of the protocols and processes developed in action
SS	2F	January 31, 2014	Establish a timeline for transition to the most integrated setting for all individuals at the Minnesota Security Hospital who have been recommended for discharge and who do not oppose being discharged.	DHS	54	**Completed**. See Exhibit 1-6 **Request for Modification** to add action item to set timelines to increase discharges and report on the timeliness of discharge processes and readmissions within six months
OV	2A	February 25, 2014	Prepare legislative proposals for the 2014 legislative session to reduce barriers to integration.	Subcabinet	26	**Completed.** See Exhibits 1-1 and 1-1A.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
EM	3A	March 1, 2014	Offer enhanced training on person-centered planning to ensure employment first and employment planning strategies are incorporated.	DEED, DHS,MDE, MDHR	36	The Department of Human Services is the lead agency for this action. Person – centered training is already being offered. However, the training needs to be evaluated for enhancements to support competitive employment. **Request for Modification (Date Change)**
QA	1A	March 31, 2014	Identify quality of life outcome indicators; contract with an independent entity to conduct annual assessment	Subcabinet	28	**Completed.** See Exhibit 1-3 for Quality of Life assessment tool. **Request for Modification (Date Change)** to move creation of the assessment tool to March 31, 2014 deadline. See Exhibit 1-3.
EM	2A	March 31. 2014	Form employment community of practice (identify approaches that lead to successful employment outcomes, discuss strategies that adopt employment first principles, informed choice, and support of job seekers who choose to work)	DEED, DHS, MDE	35	The Department of Human Services is the lead agency for this action item. The "Employment Learning Community" had an initial meeting on January 17, 2014. The group expects to finalize membership by February 28, 2014. Additionally they have plans to prioritize further actions by March 31, 2014 and provide recommendation for an interagency employment panel by September 1, 2014.
HS	5A	March 31, 2014	Baseline and targets established to increase the number of counties providing individualized housing options (thereby increasing the number of persons in individualized housing options)	DHS	45	Counties currently participating in the Housing Options plan have been informed of the data requested in the Plan. The data gathering process stated February 13, 2014. Summarized findings are to be available and submitted to DHS by March 17, 2014.
TR	2A	March 31, 2014	Convene community members on transportation; determine strategies to improve access and flexibility	DHS, MnDOT	48	The Department of Human Services has the lead for this action item. They have convened a group of planning partners and have asked the Minnesota State Council on Disabilities to convene a stakeholder group by March 31, 2014. This group will review material gathered previously around transportation, and transit in particular as that is the mode most frequently raised as having issues for persons with disabilities. The group will also review best practices and prioritize future work under the Olmstead plan to provide flexibility in transportation options.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
TR	2B	March 31, 2014	Develop plan to work with transit providers to improve access and flexibility	DHS, MnDOT	48	The Department of Transportation has the lead for this action item. The greater Minnesota transit providers will be informed of the Olmstead Plan and asked to incorporate the goals from the Plan into their 2015 service plans. The Metropolitan Council, which provides transit in the seven county metro areas, is also reviewing transit service to see how they can also incorporate Olmstead Plan goals into the services they provide.
TR	4A	March 31, 2014	Initiate discussions with MCOTA about MCOTA work plan and Olmstead goal	DHS, MnDOT	50	MCOTA will review project to develop consistent approaches to transportation costs and creation of maps showing human service transportation providers by February 25, 2014. MCOTA will be presented with the draft results of the state transportation inventory March 25, 2014.
SS	2B	March 31, 2014	New community based services will be available for people with disabilities as an alternative to MSHS-Cambridge	DHS	54	Two community based homes have been leased in Isanti County. Two additional homes are planned, one in the area of Duluth and one in the Twin Cities. Licenses are expected in February and staff will be assigned and trained March 1, 2014 or sooner. Admissions are projected on or about March 1, 2014.
HC	2A	March 31, 2014	Develop plan and set timelines to ensure that health messaging is targeted to people with all types of disabilities	MDH	65	The Department of Health will be conducting a needs analysis with internal stakeholders beginning March 1, 2014. Ongoing drafting of a project plan includes needs assessment, internal infrastructures, resource constraints and success measures. Draft plan to be presented to MDH by March 15, 2014 with finalized plan submission to OIO by March 31, 2014. **Request for Modification (Date Change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	4A	April 1, 2014	Replace the personal care assistance program with a more flexible personal support service (CFSS), with an emphasis on self-direction	DHS	57	The design phase of the CFSS program is complete and has been submitted to CMS. See Exhibit 1-7. A thirty day public comment period was opened in January. Several stakeholders requested changes in the eligibility criteria which are estimated to increase costs. It is likely that legislative appropriations and direction to change eligibility will be sought. The public development process has required more planning time than originally anticipated. DHS is requesting that the timeline be moved to October 31, 2014. **Request for Modification (Date Change)** and to add action item to evaluate how current services meet the needs of those who use them
EM	3E	June 1, 2014	Establish an Employment Practice Review Panel to discuss issues and successes at the individual level to facilitate action and identify policy changes	DEED, DHS, MDE, with MDHR	37	DHS has contracted with a person to take the lead on Olmstead employment activities. Person started mid-February. Panel members identified by Marc 31, 2014. Set a meeting schedule by April 30, 2014. Prioritize tasks.
QA	2A	June 30, 2014	Establish Olmstead dispute resolution process	Subcabinet	28	Existing processes gathered. Review for overlap and gaps by April 30, 2014. Convene stakeholder group by May 15, 2014, submit proposed process to sub-cabinet June 9, 2014.
EM	1A	June 30, 2014	Baselines & goals set for increased employment of transition-age students	DEED, DHS, MDE	33	Data from the 2013 Minnesota Post School Outcome survey has been reviewed. Stakeholders including Employment First Coalition will host a summit on April 11, 2014. At this summit participants will work to develop an implementation outline to increase integrated competitive employment outcomes in their local community. Agencies working on this action along with Employment First Coalition will add additional members representing the mental health community by April 30, 2014.
EM	1B	June 30, 2014	Develop and maintain lists of training programs and experts to help individualized education program teams reduce the use of restrictive procedures.	DEED, DHS, MDE	33	MDE staff will revise the list of training programs available to help reduce restrictive procedures and have it publicly available by June 30, 2014. Additional list of experts will be developed as a resource for districts. **Request for Modification (Language Change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
EM	1G	June 30, 2014	Baselines & goals set for increased employment of adults with disabilities	DEED, DHS, MDE	34	Work with Employment Learning Community and others to establish priorities by April 15, 2014. Identify existing data resources by April 30, 2014. Use baseline data and feedback from persons with disabilities to establish goals for increased employment by June 30, 2014. **Request for Modification (Language and Date Change)**
EM	1H	June 30, 2014	Establish plan for rule change to cap enrollment for non-integrated and subminimum wage programs	DEED, DHS, MDE	34	Rule change in process. Notification has been drafted and funding requested however as of this report no funding has been allocated. Addition resources are being explored to keep this on track for June 30th completion.
EM	3H	June 30, 2014	Promote the business case for hiring people with disabilities; align supports and services with business needs	DEED, DHS, MDE, with MDHR	37	VRS continuing to work on outreach to businesses. New materials are being developed with community partners and are expected in late April or May.
EM	3I	June 30, 2014	Provide information about effective employment strategies that make competitive employment possible for individuals with complex and significant disabilities.	DEED, DHS, MDE, with MDHR	37	Working with employment learning community and others to identify priorities, by April 15, 2014. Research and compile existing sources of information, April 30, 2014. Develop plan for sharing information May 15, 2014. Gather feedback from people with disabilities and other stakeholders, June 15, 2014. Finalize plan by June 30, 2014.
EM	3K	June 30, 2014	Information on employment in the most integrated setting is available for individuals, families, schools, service providers and businesses	DEED, DHS, MDE, with MDHR	37	Work in progress to develop additional materials including presentations and possible video.
TR	4B	June 30, 2014	Report to subcabinet on MCOTA's work plan alignment with Olmstead plan	DHS, MnDOT	50	Develop 2015 MCOTA work plan incorporating Olmstead – April – July 2014. Approve 2015 plan August 2014.
ED	1A.1	June 30, 2014	School districts will report summary data on their use of restrictive procedures (annual report)	MDE	59	Report regarding school district use of restrictive procedures was submitted to the legislature for the 2012/2013 school year on March 1, 2014. Changes to §125A.0942 have been submitted and are awaiting legislative action. MDE will continue to convene the stakeholder group to review data and discus the use of restrictive procedures in schools.

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ED	1B	June 30, 2014	Develop and maintain lists of training programs and experts to help individualized education program teams reduce the use of restrictive procedures.	MDE, DHS	59	A revised list of training programs to reduce the use of restrictive procedures is being developed by June 30, 2014. An additional list of experts that may be potential resources for districts is being developed for posting on the MDE website by June 30, 2014.
ED	1C	June 30, 2014	Establish a process for school districts so students with complex disabilities can access crisis services	MDE, DHS	60	Establish a stakeholder group including agencies, organizations, crisis service providers, parents, consumers and consumer advocates. Determine what crisis services are available and what can be built on/changed, by February 20, 2014. Establish triage with external resources, with standardized guidelines and protocols for working in schools, March 14, 2014. Develop expectations for consistency. Review service needs, April 16, 2014. Review plan progress, May 22, 2014. Collect data comparing external crisis utilization to seclusion restraint data to guide future practice. Report to Sub-Cabinet June 30, 2014.
ED	5A	June 30, 2014	Review data on students and develop prototype reintegration plans to transition students to more integrated settings	MDE, DOC	61	Review data and evaluate for planning, April 7, 2014. Begin investigation of current integration plan used by districts, states, counties, April 20, 2014. Develop prototype using data and potential examples, May 15, 2014.
HC	2C	June 30, 2014	Develop plan to improve access to dental services for MHCP recipients	DHS	65	Completed dental study submitted to legislature, February 2014. Internal DHS review of findings and identify actions based on study results, May 30, 2014. Circulate plan for approval to be submitted to 2015 legislative session, June 30, 2014.
QA	1B	July 1, 2014	Identify the survey instrument that will establish a baseline and allow ongoing evaluation of quality of life outcome indicators.	Subcabinet	28	**Request for Modification (Date change):** Requested modification was to contract with an independent entity to conduct annual assessment of the quality of life measures listed in the plan. MAD identified a potential entity and work is in progress to develop a contract to conduct the pilot of the quality of life tool that has been developed.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
EM	2B	July 1, 2014	Convene Interagency Employment Panel using Employment First principles to align policy and funding	DEED, DHS, MDE	35	Recommend panel member to commissioners for appointment by March 31, 2014. Finalize group membership by April 15, 2014. Convene first panel meeting April 30, 2015. Conduct monthly meetings thereafter.
EM	3M	July 1, 2014	Establish an outreach plan for families regarding competitive employment and individual benefits	DEED, DHS, MDE, with MDHR	37	Establish outreach priorities by April 15, 2014. Review previously obtained stakeholder feedback. Draft proposal for outreach plan by April 30, 2014. Gather additional feedback from people with disabilities and other stakeholders, May 31, 2014. Incorporate stakeholder feedback, June 15, 2014. Finalize outreach plan, June 30, 2014.
SS	3C	July 1, 2014	Create an inventory and analysis of policies and best practices across state agencies related to positive practices and use of restraint, seclusion or other practices which may cause physical, emotional, or psychological pain or distress	Subcabinet	55	The OIO is recommending to the Sub-Cabinet that this action item be reassigned to those agencies working in the areas of direct care such as DHS, MDE, DEED, etc.
SS	3D	July 1, 2014	Report outlining recommendations for a statewide plan to increase positive practices and eliminate use of restraint or seclusion	Subcabinet	55	The OIO is recommending to the Sub-Cabinet that this action item be reassigned to those agencies working in the areas of direct care such as DHS, MDE, DEED, etc.
SS	3E	August 1, 2014	Statewide, develop a common definition of incidents (including emergency use of manual restraint), create common data collection and incident reporting process.	Subcabinet	55	The OIO is recommending to the Sub-Cabinet that this action item be reassigned to those agencies working in the areas of direct care such as DHS, MDE, DEED, etc.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	3I	August 1, 2014	Develop and implement a coordinated triage and "hand-off" process across mental health services and home and community-based long-term supports and services	DHS	55	Identify participants for the development of plan including consumer advocates, consumers, family members and other interested stakeholders, February 15, 2014. Develop a common language to refer to crisis, emergency and other related events. Clarify the groups that this triage and handoff service will be designed to serve, meeting set for March 6, 2014. Identify similar services that already exist. Explore the use of current services as a mechanism of service delivery rather than creation of new service. April 15, 2014. Logistics of service, May 15, 2014. Write a plan to be submitted to DHS Olmstead Steering Committee, June 1, 2014. Review feedback from steering committee and incorporate into plan, July 15, 2014. Begin implementation and submit final plan to sub-cabinet, August 1, 2014.
TR	3A	August 31, 2014	Complete MnDOT ADA Transition Plan, including Olmstead principles	MnDOT	49	First draft of updated transition plan available May 1, 2014. Public involvement and feedback period June – mid-July 2014. Revisions to the plan incorporating stakeholder feedback, August 2014. Publication of revised plan August 2014.
EM	2C	September 1, 2014	Using priorities identified in Interagency Employment Panel, develop implementation plans to provide access to most integrated settings in order to increase integrated employment outcomes	DEED, DHS, MDE	35	Review priorities set by interagency employment panel by May 31, 2014. Draft implementation plans by June 30, 2014. Gather feedback from people with disabilities and other stakeholders on implementation plans by July 31, 2014. Finalize plans, September 1, 2014.
ED	4A.1	September 1, 2014	Increase in number of students with disabilities (+50) entering integrated postsecondary education and training programs within one year of exiting secondary education.	DEED, DHS, MDE	61	Identify evidence based practices that will lead to an increase in employment and postsecondary outcomes for transition age students, May 31, 2014. Gather existing transition age employment and postsecondary data sources, May 30, 2014. Establish baseline data using existing information, June 15, 2015. Establish goals based on stakeholder feedback from May1, 2014 capacity building institute, July 15, 2014. **Request for Modification (Language change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
QA	4A	September 30, 2014	Adopt an overall Olmstead Quality Improvement Plan	Subcabinet	30	Quality of Life assessment tool contract was finalized in February, 2014 and tool was delivered on March 31, 2014. The Olmstead Implementation Office submitted a resource request to the Olmstead Sub-Cabinet on February 25, 2014 for a legislative analyst. Governor appointed disability councils were invited on March 20, 2014 to participate in the review of plan modifications. By June 15, 2014 develop a cross department committee to establish best practice recommendations for abuse and neglect prevention. By July 15, 2014 convene stakeholders group to seek recommendations describing how people with disabilities and their families can be involved in monitoring and reviewing community supports and have on-going leadership roles. By August 15, 2014 convene a cross department committee to describe the availability of self-advocates and peer support specialists that promote self-determination and greater independence in life choices.
EM	1I.1	September 30, 2014	Implement local placement partnership model for providing professional employment services (metropolitan area).	DEED, DHS, MDE	34	Support the existing ten local placement partnerships statewide. Meet with Monticello VRS &VR Community state by March 31, 2014 to develop framework for implementing Placement Partnership model. Meet with St. Cloud VRS & VR Community Staff by April 15, 2014 to develop framework for implementing Placement Partnership model. Encourage existing placement partnerships to collaborate on events that serve both job seekers with disabilities and employers as customers. Total number of placement partnership will increase from ten to fourteen by September 30, 2014.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
EM	2D	September 30, 2014	State will adopt an Employment First Policy	Subcabinet	35	Meet with DHS employment lead by April 30, 2014 to identify impact of employment first policy on DHS/DEED/MDE's work under Minnesota's Olmstead Plan. By May 30, 2014 meet with Employment First Coalition representatives regarding the Coalition's proposed policy language. By June 30, 2014 convene interagency dialogue group on impact and involvement in adopting state's employment first policy. By August 11, 2014 present summary recommendations to sub-cabinet on adopting employment first policy.
EM	2E.1	September 30, 2014	Establish process and timeline for integrated Memorandum of Agreements (MOA/MOUs) across state agencies to assure the implementation of integrated employment & Employment First principles	DEED, DHS, MDE	35	Identify work group members by April 30, 2014. Research existing MOU's by May 31, 2014. Establish priorities for MOU's by June 30, 2014. Draft MOU's for review by Employment Learning Community and Interagency Employment Panel by July 31, 2014. Review recommendations from ELC and IEP by August 31, 2014. Draft final MOU's by September 30, 2014.
EM	3B	September 30, 2014	Provide training to employment service providers on single point of contact framework, labor market trends, and localized approaches to demand-driven strategies.	DEED, DHS, MDE, with MDHR	36	Host demonstration of the talent acquisition portal through CVAVR, May 1, 2014. Initiate use of talent acquisition portal by May 30, 2014. Develop definition of single point of contact for serving employers by June 30, 2014. Support local placement partnerships by providing training on single point of contact framework by September 30, 2014.
EM	3C	September 30, 2014	Provide training and technical assistance to federal contractors on federal employment goal for people with disabilities	DEED, DHS, MDE, with MDHR	36	Develop business outreach presentation by March 1, 2014. Present business outreach presentation to business leadership network group by March 12, 2014. Develop 503 legislation training for federal contractors by June 30, 2014. Train VRS and VR community staff using new 503 legislation training by July 30, 2014. Provide training and technical assistance to federal contractors by September 30, 2014.
EM	3D	September 30, 2014	Establish plan to provide cross-agency training on motivational interviewing.	DEED, DHS, MDE, with MDHR	36	Initial meeting with all agencies scheduled for April 3, 2014.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
HS	1A	September 30, 2014	Complete data gathering & analysis on demographic data (related to housing) on people with disabilities who use public funding	DHS	41	Define population and specify demographic data points to be analyzed by April 14, 2014. Meet with agency researchers and MHFA to finalize scope of data analysis and develop timelines and work plan for data gathering and analysis by April 28, 2014. Review draft data analysis and identify any further analysis needed by August 26, 2014. Finalize data and summarize findings to submit to DHS for review by September 16, 2014.
HS	4A	September 30, 2014	Consult with persons with disabilities to improve HousingLink	MHFA	44	Complete grant agreement and work plan for consultation and outreach by April 30, 2014. Additional benchmarks will be available In final grant agreement.
HS	4B	September 30, 2014	Develop a plan to inform and educate people with disabilities, case workers, providers and advocates about HousingLink	MHFA	44	Complete grant agreement and work plan for consolation and outreach by April 30, 2014. Additional benchmarks will be available In final grant agreement.
TR	1A	September 30, 2014	Establish a baseline of services and transit spending across public programs	DHS, MnDOT	48	Initial meeting between agencies held February 28, 2014. Review specification for MNCOTA study to determine if study design will encompass needed actin items. If not, designate tasks to affected agencies by March 31, 2014. Interagency meetings by April 30, 2014. Select data sources, finalize queries and obtain data by September 30, 2014.
TR	1B	September 30, 2014	Review administrative practices and implement necessary changes to encourage broad cross state agency coordination in transportation.	DHS, MnDOT	48	Discuss intent, scope and responsibility with MnDOT by February 27, 2014. Upon identification of required changes, hold meetings to determine scope of action item, identify resources, and clarify roles and responsibilities among divisions. Convene interagency meetings to facilitate coordination. Implement agreed upon changes by September 30, 2014. **Request for Modification (Language change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	2G	September 30, 2014	Identify a list of other segregated settings; establish baselines, targets, and timelines for moving individuals who can be supported in more integrated settings.	DHS	54	Develop initial work plan by March 1, 2014. Develop comprehensive list of "other segregated settings" with definitions by March 1, 2014. Identify segregated settings to be targeted by April 1, 2014. Identify baseline numbers for all targeted settings by April 30, 2014. Identify additional data to provide general characteristics for each setting by May 30, 2014. Identify process (es) to identify persons able to transition to more integrated settings and challenges/barriers by June 30, 2014. Establish targets for each setting by July 30, 2014. Establish timelines for each setting by September 30, 2014. **Request for Modification (Language change)**
SS	4B	September 30, 2014	Report and recommendations on how to improve processes related to the home and community-based supports and services waiting list.	DHS	57	Develop implementation plan and assign resources by March 31, 2014. Conduct inventory of current processes related to wait list by March 31, 2014. Report format and content confirmed by June 30, 2014. Draft report complete by August 31, 2014.
HC	2D	September 30, 2014	Identify data needed to measure health outcomes; establish data sharing agreements	MDH, DHS	66	Convene interagency data team and schedule bi-weekly meetings by April 21, 2014. Initiate meetings with stakeholders: TBI Advisory committee, NAMI-MN, MSCD and others identified in the feedback process by May 1, 2014. Complete analysis plan by May 31, 2014. Test, review and revise variable, tests the analysis plan; complete any needed data sharing agreements by July 31, 2014. Submit drafts to stakeholders and disability partners for review and revision by August 15, 2014. Submit drafts to MDH leadership for review and revision by August 31, 2014. Submit results to Sub-Cabinet by September 30, 2014.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
HC	2I	September 30, 2014	Complete a system analysis and develop a plan to address barriers in healthcare transitions from youth to adult	MDH, DHS	67	Consult with the Minnesota Transition communities of Practice to identify barriers to youth transitioning to the adult health care system by September 30, 2014. Develop strategies for the geographical, racial and ethnic disparities impacting youth in transition through the transitions in health care grant by September 30, 2014. Consult with local public health agencies to encourage local partnerships through education on the impact of health on successful transitioning by September 30, 2014. Engage stakeholders to gather their perceptions related to barriers through existing interagency contact where parents and youth are present, i.e. PACER's Youth Advisory Board.
EM	2F.1	October 1, 2014	Baseline established, policy developed to provide all vocational rehabilitation purchased services in most integrated setting	DEED, DHS, MDE	35	Evaluate current contract language with VRS CRP advisory committee by March 28, 2014. Modify contract template to discontinue the use of "in-house". Policy work group will work to develop service standards consistent with Olmstead and submit to VRS leadership and CRP advisory committee by June 27, 2014. New service standards will be implemented by October 1, 2014.
TR	1C & 2C	October 31, 2014	Using established baselines, establish timelines and measures to demonstrate increased access to integrated transportation for people with disabilities	DHS, MnDOT	48	Consider timelines and measures in the course of defining deliverables for item TR 1A and current MNCOTA efforts. Convene interagency meeting to discuss TR 1A findings and next steps by August, 2014. Review and finalize draft timelines and measures by October 31, 2014.
SS	3J	December 1, 2014	Identify best practices, set service standards, and develop and deliver training and technical assistance in order to respond to a request for assistance with least intrusive service/actions	Subcabinet	56	Sub-Cabinet needs to review action item and determine next steps.
OV	1A	December 31, 2014	Define an individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life; establish plan to initiate service	Subcabinet	25	Sub-Cabinet needs to review action item and determine next steps. Possibilities include capstone project or contract with coalition of advocacy groups.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
OV	2B	December 31, 2014	Identify barriers to integration that are linked to federal legislation, regulation, or administrative procedures; identity options to address them	Subcabinet	26	Capstone proposal submitted January 21, 2014. Review project criteria with capstone group either June or September depending which semester is it used. Write MOA with group. Deliverables due on or before December 20, 2014.
OV	3A	December 31, 2014	Leadership opportunities for people with disabilities to be involved in leadership capacities in all government programs that affect them will be identified and implemented	Subcabinet	26	Capstone proposal submitted January 21, 2014. Review project criteria with capstone group either June or September depending which semester is it used. Write MOA with group. Deliverables due on or before December 20, 2014.
QA	1C	December 31, 2014	Conduct a pilot of the quality of life survey	Subcabinet	28	Referral to conduct QOL survey made to MAD on March 12, 2014. MAD determined they did not have the resources to conduct the QOL survey but offered to review with vendors certified in their master contracts. Met with MAD and potential contractor on April 4, 2014. Initiate contract for QOL pilot survey by April 30, 2014.
EM	3J	December 31, 2014	Publicize statistics, research results and personal stories illustrating the contributions of persons with disabilities in the workplace	DEED, DHS, MDE, with MDHR	37	The VRS Community Outreach Team is developing informational materials in addition to existing materials already in use.
HS	2A	December 31, 2014	Baseline and targets established for number of new affordable housing opportunities created, the number of people with disabilities accessing affordable housing opportunities in the community, and the number of people with disabilities with their own lease	MHFA, DHS	42	Specify baseline parameters: define population and identify affordable housing opportunities to be counted by April 21, 2014. Meet with researchers to finalize baseline parameters and develop timelines. Determine mechanism for gathering information by May5, 2014. Review draft baselines and identify any further analysis needed by November 5, 2014. Establish targets for future years by November 26, 2014. Finalize baseline data and targets and summarize findings by December 17, 2014. **Request for Modification (Language change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	2C	December 31, 2014	For individuals in Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) and people under 65 who have been in nursing facilities longer than 90 days: 90 people will have transitioned to community services	DHS	54	Between November, 2013 and February 28, 2014 25 individuals moved from ICF/DD to community settings. 170 individuals under age 65 that had been in a nursing facility for greater than 90 days moved to community settings. Work is ongoing to notify county directors of names of individuals under age 65 who have stays in nursing facilities longer than 90 days or individuals of any age in ICF/DD who have expressed a desire to move to the community. By May 2014, a report will be developed to update lead agencies of monthly status including identification of those with a desire to move. By May 2014 work with individuals desiring to move and lead agencies to develop transitions plans, remove barriers and complete transitions.
SS	2D.1	December 31, 2014	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 30%	DHS	54	Identify parties for data collection and analysis for individuals at AMRTC that are no longer meeting hospital level of care and awaiting discharge by March 31, 2014. Bimonthly reporting of the percent of individuals who do not require hospital level of care beginning April 2014 and bimonthly thereafter. Create a tracking system for identified individuals, including reasons contributing to the delay in discharge by June 30, 2014. Create protocols for data collection and analysis, including responsibilities for all parties by June 30, 2014. Gather, collate, and analyze monthly data on barriers to placement for the period of April 1, 2014 through December 31, 2014. Interagency team will analyze data and take action to decrease the number of persons at AMRTC who do not require hospital level of care by December 30, 2014.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
HC	1C	December 31, 2014	Design framework and develop implementation plan for healthcare for adults and children with serious mental illness	MDH, DHS	64	Planning Phase to include (January 1, 2014 – May 31, 2014) Service Design, Provider standards and infrastructure, Payment methodology, Quality measures, Model evaluation, Learning collaborative, Consumer engagement, Operational planning, Federal relations, Claims, Systems, Provider manual, and Training. Implementation Work (June 1, 2014 – December 31, 2014) Provider enrollment, Provider training, Provider learning collaborative, Identification of eligible individuals, operation work continued, Federal relations, Claims, Systems, Provider manual. Services begin January 1, 2015.
HC	1D	December 31, 2014	Implement framework for healthcare for adults and children with serious mental illness; some people will have access to care	MDH, DHS	64	See status for action item HC 1C **Request for Modification (Date change)** and add action items with timelines to increase the percent of eligible individuals with serious mental illness who access care through the model described above
HC	1E	December 31, 2014	Develop and align reporting mechanisms for this framework for healthcare for people with serious mental illness	MDH, DHS	64	See status for action item HC 1C **Request for Modification (Date change)**
HC	2E	December 31, 2014	Develop, test, and implement module to better assess overall health status of people with disabilities in Minnesota	MDH, DHS	66	Convene meeting with Dr. Nagi Salem in February 2014. Review other modules from CDC and other partners by April 30, 2014. Test, review and revise modules; complete literature reviews by June 30, 2014. Complete finance feasibility assessment by July 31, 2014. Submit results to MDH Executive Office by August 31, 2014. Submit findings and recommendations to Sub-Cabinet via OIO by December 31, 2014. Begin data collection via the BRFSS for first year in January 2015. Complete first year of data analysis by September, 2016. **Modification Requested (Date change)**

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
HC	2G	December 31, 2014	Establish baseline data for current care (medical, dental, chiropractic and mental health) of people with disability; develop an implementation plan to further assess, develop, and respond.	MDH, DHS	66	Hold interagency meetings to identify potential data sources, outline viable approach to complete action item and assign responsibility by Marc 6, 2014. Refine definition of disability, review available research and data sources, identify analytic resources and assign tasks among divisions by May, 2014. Pull utilization data as defined by September, 2014. Assess results, refine data queries if necessary and create report of results by December, 2014. **Request for Modification** to add action items with timelines for developing the assessment, proposing legislation to fund the assessment, establish the baseline and evaluate the results.
HC	2J.1	December 31, 2014	50% of Minnesota's transition age youth with disabilities will receive the services necessary to make transitions to adult health care.	MDH, DHS	67	Monitor data for changes in the number of youth with special health needs who receive the services necessary to make appropriate transitions to all aspects of adult life, including adult health care, work and independence. Explore new data that would indicate that children and youth with special health needs are receiving the necessary services, ongoing. Develop an online transition in health care toolkit for primary care providers and clinic care coordinators across Minnesota so that they discuss and plan with youth and their families for the changing health care needs as the youth transition to adult health care by December 31, 2014. Promote implementation of the transitions in health care online toolkit through the children and youth with special health needs website and through intra and interagency connections by December 31, 2014. Partner with MDE, VRS and DHS to develop and implement a cross agency focus so that youth with special health needs receive the services necessary to make transitions to all adult systems including adult health care by December 31, 2014.

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
CE	1A	December 31, 2014	Develop a plan to increase opportunities for people with disabilities to meaningfully participate in policy development	Subcabinet	70	Capstone proposal submitted January 21, 2014. Review project criteria with capstone group either June or September depending which semester is it used. Write MOA with group. Deliverables due on or before December 20, 2014.
CE	1B	December 31, 2014	Determine the size and scope of peer support and self-advocacy programs; set annual goals for progress.	Subcabinet	70	Sub-Cabinet needs to review action item and determine next steps. Possibilities include capstone project or contract with coalition of advocacy groups. **Request for Modification (Language change)**
CE	2A	December 31, 2014	Evaluate, revise as necessary, and disseminate guidelines and criteria when public dollars are used for ensuring that people with disabilities are incorporated in public planning processes.	Subcabinet	70	Capstone proposal submitted January 21, 2014. Review project criteria with capstone group either June or September depending which semester is it used. Write MOA with group. Deliverables due on or before December 20, 2014.
EM	2G	January 1, 2015	Clarify cross-agency employment service planning and coordination to expand employment in the most integrated setting.	DEED, DHS, MDE	36	
EM	3F	January 1, 2015	Provide technical assistance and support to non-integrated/facility-based employment programs to develop and design new business models that lead to competitive employment in the most integrated setting	DEED, DHS, MDE, with MDHR	37	
EM	3L.1	January 1, 2015	Distribute findings, policy interpretations and recommendations from Interagency Employment Panel (annual)	DEED, DHS, MDE, with MDHR	37	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	1B	January 1, 2015	Establish characteristics and criteria that define best practices in person-centered planning and the *Olmstead* requirements, to be used by state agencies to evaluate and revise their assessment and plan content	Subcabinet	53	**Request for Modification (Language change)**
HC	1A	January 1, 2015	Establish baselines and targets to increase number of teams that are able to provide integrated, person-centered primary care for persons with disabilities	MDH, DHS	63	**Request for Modification (Language and Date change)**
OV	2C	January 6, 2015	Prepare proposals for legislative and fiscal changes for the 2015 session to reduce barriers to integration	Subcabinet	26	
HS	3A	January 6, 2015	Prepare proposals for legislative proposals for the 2015 session, giving priority to ; that promote choice and access to integrated housing settings .	DHS	43	
TR	1D	January 6, 2015	Prepare proposals for legislative proposals for the 2015 session; priority to changes that will increase funding flexibility to support increased access to integrated transportation	DHS, MnDOT	48	
HS	1B	January 30, 2015	Develop timeframe for completing individual assessments and facilitating moves into more integrated housing settings	DHS	41	**Request for Modification** to add related action item for the Department of Corrections to track the number of inmates with disabilities who are having difficulty with their release plan due to lack of community services.
SS	2H	January 31, 2015	Make a legislative request in support of the movement of the individuals in other segregated settings within established timelines	DHS	54	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
OV	1B	March 31, 2015	Initiate new individual planning service to assist people with disabilities in expressing their needs and preferences about quality of life	Subcabinet	25	
EM	3G	June 1, 2015	Develop an improvement strategy for educators and families about the economic benefits of integrated competitive employment	DEED, DHS, MDE, with MDHR	37	
SS	1C	June 1, 2015	Establish funding mechanisms to support person centered planning	Subcabinet	53	
EM	1C.1	June 30, 2015	Increase in number of schools (+20) adopting evidence-based practices for integrated competitive employment (annual) [Duplicate of Education goal]	DEED, DHS, MDE	33	
EM	1D	June 30, 2015	Students on SSI/SSDI (approx. 1000) will receive information and assistance to inform employment planning and benefit choices	DEED, DHS, MDE	34	
EM	1J	June 30, 2015	Expand Individual Placement and Supports employment for Minnesotans with serious mental illness (+17 counties, +200 people)	DEED, DHS, MDE	34	
EM	1K	June 30, 2015	Establish a plan to expand Individual Placement and Supports employment for Minnesotans with serious mental illness statewide	DEED, DHS, MDE	34	**Request for Modification (Language change)**
SS	1A	June 30, 2015	State agency staff, providers, staff from counties, health plans, tribes, and advocacy organizations will receive training on person-centered thinking, planning, and awareness (600 people total)	DHS	52	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
ED	1A.2	June 30, 2015	School districts will report summary data on their use of restrictive procedures (annual report)	MDE	59	
ED	2A.1	June 30, 2015	Increase in number of schools (+40) using Positive Behavioral Interventions and Supports	MDE	60	
ED	5B	June 30, 2015	Implement reintegration plan protocol statewide for students who are placed out of state or who are in juvenile corrections	MDE, DOC	61	
EM	1E	July 1, 2015	Expansion of information and assistance to inform students with disabilities of employment planning and benefit choices (+2500 students)	DEED, DHS, MDE	34	
EM	1L	July 1, 2015	Promulgate rule change to cap enrollment for non-integrated and subminimum wage programs	DEED, DHS, MDE	34	
EM	2E.2	July 1, 2015	Establish all necessary (MOA/MOUs) across state agencies to assure the implementation of integrated employment & Employment First principles	DEED, DHS, MDE	35	
EM	2H	July 1, 2015	Data sharing agreement for DEED, MDE, DHS	DEED, DHS, MDE	36	
SS	3B	July 1, 2015	Promulgate a rule with operational details that replaces Minnesota Rules, parts 9525.2700 to 9525.2810	DHS	55	
SS	3F	July 1, 2015	Statewide reporting of incidents begins	Subcabinet	55	
SS	3H.1	July 1, 2015	Recommendations on how to reduce emergency use of restraints, and increase positive practices. (annual)	Subcabinet	55	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	3K	July 1, 2015	Crisis services, including diversion and early intervention services, will be made available to any person at risk of civil commitment	DHS	56	**Request for Modification (Language Change)** and to add new action item regarding legislative proposal to address the funding for this action item.
SS	3L	July 1, 2015	Establish measurements and baselines to better understand and track crisis episodes across service systems; set targets	DHS	56	
HC	2H	August 1, 2015	Measure and report on how health care access and service are changing; establish plans to support quick improvements (biannual report)	MDH, DHS	66	**Request for Modification (Date change)**
ED	4A.2	September 1, 2015	Increase in number of students with disabilities (+50) entering integrated postsecondary education and training programs within one year of exiting secondary education.	DEED, DHS, MDE	61	
EM	1I.2	September 30, 2015	Implement local placement partnership model for providing professional employment services (one northern area team and one southern area team).	DEED, DHS, MDE	34	
HS	4C	September 30, 2015	Implement the plan to inform and educate people with disabilities, case workers, providers and advocates about HousingLink	MHFA	44	
SS	2I	September 30, 2015	Initiate the movement of individuals in other segregated settings to the most integrated setting in accordance with the established timeline	DHS	54	**Request for Modification (Language change)** and to add action item with timelines for Department of Corrections to develop processes to work with counties on residential options for individuals leaving state correctional facilities

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
EM	2F.2	October 1, 2015	Policy implemented to provide all vocational rehabilitation purchased services in most integrated setting	DEED, DHS, MDE	36	
SS	3G.1	October 1, 2015	Statewide reporting of incidents (quarterly reports)	Subcabinet	55	
QA	1D.1	December 31, 2015	Quality of life survey completed to establish baseline; measurement mechanisms designed and in operation (annually)	Subcabinet	28	
EM	2I	December 31, 2015	Alignment of workforce development policies, funding and data systems across state agencies.	DEED, DHS, MDE	36	
EM	2J	December 31, 2015	Common definitions for employment and employment-related services will be established to be used across the interagency service system	DEED, DHS, MDE	36	
EM	2K	December 31, 2015	Implement strategies to utilize waiver funding to expand employment in the most integrated setting	DEED, DHS, MDE	36	
HS	3B	December 31, 2015	Implement program changes (related to housing) authorized by legislation	DHS	43	
HS	3C	December 31, 2015	Baseline and targets established for how many people use financial incentives and/or income supplements for housing, how many people who move from institutions or congregate living settings to having their own lease, and how many people received housing versus how many were referred	DHS	43	**Request for Modification** to add new action item to evaluate all funding of housing and support services.
SS	2D.2	December 31, 2015	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 25%	DHS	54	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
HC	1F	December 31, 2015	Establish baseline data for quality measures for framework for healthcare for adults and children with serious mental illness	MDH, DHS	64	
HC	1G	December 31, 2015	Establish measures to assess access and use of routine and preventive primary health care and dental care [related to framework for healthcare for adults and children with serious mental illness]	MDH, DHS	64	
HC	2B	December 31, 2015	Analyze the effectiveness of targeted health messaging, report to subcabinet.	MDH	65	
HC	2F.1	December 31, 2015	Complete health status reports regarding health care outcomes and track policy and organizational practice changes at the community and state levels. (annual report)	MDH, DHS	66	**Request for Modification (Date change)**
EM	3L.2	January 1, 2016	Distribute findings, policy interpretations and recommendations from Interagency Employment Panel (annual)	DEED, DHS, MDE, with MDHR	37	
SS	3G.2	January 1, 2016	Statewide reporting of incidents (quarterly reports)	Subcabinet	55	
HC	1B	January 1, 2016	Increase the number of clinics that are certified as *health care homes* to 67% of Minnesota clinics.	MDH, DHS	63	
SS	3G.3	April 1, 2016	Statewide reporting of incidents (quarterly reports)	Subcabinet	55	
EM	1C.2	June 30, 2016	Increase in number of schools (+20) adopting evidence-based practices for integrated competitive employment (annual) [Duplicate of Education goal]	DEED, DHS, MDE	33	
EM	1F.1	June 30, 2016	Increase in number of local education agencies (+5) adopting practices to expand integrated employment for transition age students	DEED, DHS, MDE	34	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
ED	1A.3	June 30, 2016	School districts will report summary data on their use of restrictive procedures (annual report)	MDE	59	
ED	2A.2	June 30, 2016	Increase in number of schools (+40) using Positive Behavioral Interventions and Supports	MDE	60	
ED	3B	June 30, 2016	Review existing integrated competitive employment data; develop needed technical assistance materials that promote integrated competitive employment	MDE, DEED, DHS	60	
ED	3C	June 30, 2016	DEED, DHS and MDE will formalize agreement to develop a Return on Investment matrix to show how evidence based practices increase integrated competitive employment outcomes for students with disabilities.	MDE, DEED, DHS	60	**Request for Modification (Language change)**
ED	5C.1	June 30, 2016	Report on the number of students who are placed out of state or in juvenile corrections (annual)	MDE, DOC	61	
SS	3G.4	July 1, 2016	Statewide reporting of incidents (quarterly reports)	Subcabinet	55	
SS	3H.2	July 1, 2016	Report on data from incident reports; recommendations on how to reduce emergency use of restraints, and increase positive practices. (annual)	Subcabinet	55	
ED	4A.3	September 1, 2016	Increase in number of students with disabilities (+50) entering integrated postsecondary education and training programs within one year of exiting secondary education.	MDE, DEED, DHS	61	
SS	3G.5	October 1, 2016	Statewide reporting of incidents (quarterly reports)	Subcabinet	55	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
QA	1D.2	December 31, 2016	Quality of life survey repeated to determine whether the Olmstead Plan is improving people's lives (annually)	Subcabinet	28	
TR	3B	December 31, 2016	Complete Greater Minnesota Transit Investment Plan, including Olmstead principles	MnDOT	49	
SS	2D.3	December 31, 2016	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 20%	DHS	54	
HC	2F.2	December 31, 2016	Complete health status reports regarding health care outcomes and track policy and organizational practice changes at the community and state levels. (annual report)	MDH, DHS	66	
HC	2J.2	December 31, 2016	55% of Minnesota's transition age youth with disabilities will receive the services necessary to make transitions to adult health care.	MDH, DHS	67	
EM	1F.2	June 30, 2017	Increase in number of local education agencies (+5) adopting practices to expand integrated employment for transition age students	DEED, DHS, MDE	34	
ED	5C.2	June 30, 2017	Report on the number of students who are placed out of state or in juvenile corrections (annual)	MDE, DOC	61	
SS	1D	July 1, 2017	Establish standards and outcomes for person-centered planning that can be accessed independently of a required assessment and support planning process. Report to the Subcabinet	Subcabinet	53	
QA	1D.3	December 31, 2017	Quality of life survey repeated to determine whether the Olmstead Plan is improving people's lives	Subcabinet	28	

Topic Area	Action #	Deadline	Brief Description of Action	Responsible Agency	Page #	Narrative of current status and Next Steps
SS	2D.4	December 31, 2017	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 15%	DHS	54	
HC	1H	January 1, 2018	Develop system to gather data on quality measures; determine populations to serve; develop plan to develop additional models	MDH, DHS	64	
QA	1D.4	December 31, 2018	Quality of life survey repeated to determine whether the Olmstead Plan is improving people's lives	Subcabinet	28	
SS	2D.5	December 31, 2018	Reduce % of people at Anoka Metro Regional Treatment Center who do not require hospital-level of care and are awaiting discharge to 10%	DHS	54	
TR	3C	December 31, 2019	Complete MnDOT Multimodal Plan.	MnDOT	49	
TR	3D	December 31, 2023	Complete MnDOT ADA 50 year vision	MnDOT	49	

Requests for Modification to add the following new action items:

- Supports and Services action item to develop a plan to expand use of assistive technology
- Supports and Services action item to develop Forensic Assertive Community Treatment (FACT) teams to help address challenges for people with disabilities leaving corrections.
- Health Care and Healthy Living action item for Department of Corrections to establish a baseline of all inmates with disabilities, a legislative proposal to fund the baseline, and an analysis of the baseline once established

APPENDIX 1-B: COMPARISON OF CURRENT MINNESOTA SURVEYS OF PEOPLE WITH DISABILITIES AGAINST OLMSTEAD PLAN REQUIREMENTS

Appendix 1-B: Comparison of Current Minnesota Surveys of People with Disabilities against Olmstead Plan Requirements

Grid Key:

X = meets the standard of the Olmstead Quality of Life survey.

Trends = aggregate changes measured only, not individual impact.

Blank space = unknown or not yet developed.

Random sample only = no baseline established.

Survey	Applicability Across Disabilities/Ages	Validity & Reliability Tested	Tracks Integration	Baseline and Subsequent Sampling
Elderly Waiver Consumer Experience Survey	elderly focus only		trends	random sample only
MN Participant Experience Survey	X	X	trends	random sample only
Minnesota Student Survey	Students only		trends	voluntary survey only
National Core Indicators	developmental disability only	X	trends	random sample only
Moving Home Minnesota (in development)			X	X
MN Choices (phased in implementation)	X			

EXHIBIT 1-1: OLMSTEAD RESOURCE REQUEST TO THE GOVERNOR'S OFFICE

Exhibit 1-1: Olmstead Resource Request to the Governor's Office

Resource Request

*Budget estimates do not include the cost of communications, training and technical assistance.

Personnel/Office Staffing

Olmstead Implementation Office (OIO): Staffing Plan
Functional Analysis of positions per content of the Olmstead Plan
Draft 01/29/14

OIO staff:

1. OIO Executive Director: The Executive Director is responsible for the administration of the Olmstead Office; is the primary contact with the Lt. Governor and the Olmstead Subcabinet and provides administrative support to the Subcabinet; provides leadership in carrying out the Subcabinet's decisions and agenda; creates and oversees the OIO budget and identifies fiscal resources needed to implement the plan; directs the quality assurance and accountability functions of the plan; assures Olmstead related activities are communicated with primary stakeholders and the public; and provides oversight on legislative activities supporting the Olmstead Plan.

2. OIO Deputy Director: The Deputy Director has the primary responsibility for oversight and monitoring of the progress of the Olmstead action plans and assuring deadlines are honored; is the primary contact for agency leads concerning plan performance and obstacles to the plan; convenes agency lead meetings in advance of Subcabinet meetings; receives status reports from agency leads; facilitates cross agency cooperation and mediates problems; and oversees the process of plan modification and approval.

3. OIO Dispute Resolution/Outreach; State Program Administrator: This position is responsible for the development of a neutral entry point for concerns about the provision of government administered services; oversees outcome data concerning dispute resolution efforts and reports to the Subcabinet; this person assures accessibility of OIO information to individuals with disabilities and the general public; and is the developmental lead for OIO communications.

4. OIO Executive Assistant; Office and Administrative Specialist Principal**:** The Executive Assistant provides administrative support for the Olmstead Office and Subcabinet; schedules meetings and manages event/meeting logistics; takes meeting minutes; manages documents and printing/copy needs of the Office; directs callers to the appropriate staff or service for their concerns.

5. OIO Management Analyst/Monitoring: Maintains a detailed tracking system on all Olmstead Plan actions steps and benchmarks. Inputs status reports from agency leads into a management spreadsheet. Provides a feedback loop to agency leads on the progress of Olmstead Plan actions. Tracks issues specific to cross agency and multi-agency actions.

6. OIO Legislative/Policy Analyst: Reviews policies and current and proposed legislation through the Olmstead Plan lens and reports findings to the OIO Executive Director and Olmstead Subcabinet; advocates for an Olmstead driven policy and legislative agenda; coordinates with the legislative liaisons for all agencies contributing to the implementation of the Olmstead Plan.

7. OIO Program Evaluation/Measurement; State Program Administrator: This position is responsible for overseeing the Quality of Life measurements including developing evaluation and survey contracts, selecting implementation agencies, managing those contracts and tracking outcome data for the Subcabinet, the Court Monitor and the Court. This position also assures that baseline measurements in the plan result in measureable goals consistent with the intent of the Olmstead Plan.

The following matrix converts the functional responsibilities and positions into current state classifications matching those responsibilities.

Position	classified/ unclassified	priority ranking	salary	benefits	total
Director	unclassified	1	$105,862	$37,052	$142,914
Deputy Director	unclassified	2	$94,744	$33,160	127,904
State Program Admin. Dispute Resolution	unclassified	3	59,633	20,872	80,505
Office & Admin.	classified	4	42,574	14,901	57,475
Specialist Principal					
Management Analyst	unclassified	5	51,782	18,124	69,906
Agency Policy Specialist	unclassified	6	79,574	27,851	107,425
State Program Admin.	unclassified	7	59,633	20,872	80,505
Totals			**$493,802**	**$172,832**	**$666,634**

- **Office Space & Equipment**

OFFICE SPACE:

3 offices, 4 cubicles, reception area, and conference room

2000 square feet @ $14.18 per square foot = $28,360 monthly or $340,320 annually

[Includes 50% 'circulation rate' to allow freedom of movement for staff / persons with disabilities]

$20,000 annual cost leased copier

Total Office Space = $360,320 annual cost

ONE TIME BUILD OUT COSTS (ESTIMATED):

$2,000 connecting electrical lines

$14,000 data lines

$3,500 wiring data lines

$6,500 installing office furniture

EQUIPMENT:

$7200 computers

$5000 phones

OTHER:

$1700 - table and chairs for conference room

Total Build Out = $39,900 one-time cost

- **Meeting & Travel Cost**

ACCESSIBLE MEETING SPACE (ESTIMATED):
10 public meeting per year, including 6 Sub-Cabinet and 4 public listening sessions $2500 per meeting = $25,000 annually

CART/ASL INTERPRETER SERVICES:
$100 per hour for CART captioning services x 10 meetings, assuming 2 hour meetings continue = $2,000 annually

$115 per interpreter for first 2 hours, $57.50 per hour thereafter; due to the complexity of these meetings 2 interpreters would be needed. X 10 meetings = $2,300 annually, assuming 2 hour meetings continue.

TRAVEL:
$1,000 annually to provide a travel stipend to those that would otherwise not be able to participate in the public meeting.

The standard IRS reimbursement rate for mileage applies to all travel for meetings but it is unclear at this time how much that would be.

TOTAL MEETING & TRAVEL COSTS: $30,300 annual cost

Quality of Life Assessment: Total Request $590,000

2014-2015 costs associated with the Olmstead Quality of Life (QOL) measurement actions are as follows:

- $5,000 for survey tool development by the Center for Outcome Analysis. Funding currently committed by Minnesota Housing and Finance.
- $90,000 to pilot the assessment with a sample of 450 people with disabilities and analyze the outcomes. Funding currently committed by Minnesota Housing and Finance.
- $500,000 to administer QOL assessments in 2015 including the recruitment of disabled individuals as surveyors, training surveyors, inputting information into a data base and providing an analysis of the data including baselines for all the individual data elements and demographic information gathered. Funding for this cost is being requested by the Olmstead Implementation Office*

*The above cost estimate is based on face to face interviews with the respondent, travel to respondent, recruitment and training of surveyors and the creation of a data base and baselines for quality measures. The $500,000 survey cost is a place holder. Actual cost is dependent upon the number of interviews needed to establish the baseline. This number is being developed. Face to face surveys range in cost from $200-$300 per survey. For further detail please see Appendix A.

Editing Olmstead Plan Modifications

Develop a contract with Minnesota Management Analysis and Development to amend the Olmstead Plan to accommodate revisions authorized by the Court Monitor or Court. A proposal of $47,500 has been submitted for editing three iterations of modifications. The cost ($22,000) of the first round of modifications will be borne by MN DHS and the cost of the subsequent two rounds ($25,500) will be assigned to the Olmstead Implementation Office.

DEED Extended Employment Rulemaking costs

The numbers provided for the IPS resource request have several considerations going forward. This request does not include adding staff to the projects. The request also does not provide funding for VRS in areas where there are not counselors assigned to IPS caseloads. Further, the request does not include additional case service dollars for placements. All of these considerations merit review in the planning for the 2015 funding session.

One final note regarding the use of carry forward dollars for IPS: In order to fully utilize existing funding for IPS, the statutory carry forward language applicable to IPS dollars Minn. Stat. 268A.13-14 should be revised to enable the Department to use these funds to advance IPS services. The amount of carry forward is variable each year but the historic language has not allowed sufficient flexibility in the use of these dollars.

SFY 2015

Category	Description	Hourly Rate	Benefits	Cost per Hour	New position	Estimated Additional Cost
VRS Personnel	Anita	$36	26%	$45	Use existing staff time	$0
	John	$39	26%	$49	Use existing staff time	$0
	Technical/Rule Advisor	$36	26%	45.36	1020 hours (half time)	$46,267
	Support Staff	$24	26%	$29	1020 hours *$29	$29,580
	Kim		26%	$0	Use existing staff time	$0
Rule-making Expenses	State Register (RFC)					$2,000
	MMB Consultation				These costs are unknown. Based on expenditures of $46,000 in 1997-1998 for the last rule change; adjusted for inflation, an estimate of $70,000 would be a starting point.	
	OAH					
	Public Forums:					
	Facilities					
	Food/Beverages					
	Staff Travel					$80,000
Post-Rule	PRS Changes				starting in SFY15	$10,000
	Train providers					
Preliminary Request for Rulemaking Costs					**$167,847**	

Transition to Individual Placement and Support (IPS) Costs

SFY 2015

Category	Description	Hourly Rate	Benefits	Cost per Hour	New position	Estimated Additional Cost
VRS Personnel	Claire	$36	26%	$45	Full time additional 50% (1,020 hours)	$46,000
	Trainer/Data support	$36	26%	$45	2,040 hours	$92,000
	Support Staff	$24	26%	$29	1020 hours *$29	$29,580
	Training materials /Travel					$12,000

Preliminary estimate of DEED costs for implementing IPS standards is $179,580

Current projects funded under 268a.13 and 268a.14

Total Request: $347,427

Olmstead Plan Implementation

Minnesota Department of Health

	SFY 2015	Comments
Project Management (0.75 FTE)	**$84,335**	Project management staff to coordinate MDH Olmstead activities, which cross the breadth of the department. Examples of duties include convening internal Olmstead Coordination group; developing plans to address each of the activities specified in the Olmstead Plan; developing and monitoring timelines and deliverables for each activity; organizing meetings; documenting decisions; developing internal communications linkages, assisting the Assistant Commissioner in coordinating with the Olmstead Office; developing and monitoring contracts and contractors; producing and disseminating required reports and materials; monitoring performance measures; and providing meeting facilitation, materials development and synthesizing the efforts of 3 – 4 MDH workgroups formed to address related clusters of Olmstead activities.
Targeted Health Messaging	**100,000**	
Professional Technical Contract	100,000	Vendor will conduct 15 to 18 focus groups throughout the state to solicit information from a broad range of individuals about the extent to which health messaging is targeted to people with all types of disabilities. Submit a report to the OIO by December 31, 2015
Professional Technical Contract	0	Based on the need for better targeting of health messages identified in the report, develop and implement a plan for making necessary modifications for health messaging.

Total **$184,335**

EXHIBIT 1-1A: GOVERNOR'S SUPPLEMENTAL BUDGET REQUEST

Exhibit 1-1A: Governor's Supplemental Budget Request

Governor's 2014 Supplemental Budget Recommendations
All Funds by Omnibus Bill and Agency
(Dollars in Thousands)
3/10/2014 11:38:07 AM

Olmstead Implementation

The Governor recommends funding to implement the state's Olmstead plan, a comprehensive plan supporting people with disabilities with freedom of choice and opportunity in housing, employment, and healthcare in the most integrated setting. Funds will be used to establish a new Olmstead Implementation Office.

		2014	2015	2016	2017
General	**Expenditure**	**$0**	**$500**	**$2,000**	**$2,000**

EXHIBIT 1-2: OLMSTEAD AGENCY LEADS

Exhibit 1-2: Olmstead Agency Leads –

Department of Corrections	Kate Erikson
Department of Employment and Economic Development	Kim Peck
Department of Human Services	Brownell Mack
Department of Transportation	Kristie Billiar
Minnesota Department of Education	Robyn Widley
Minnesota Department of Health	Manny Munson-Regala
Minnesota Department of Human Rights	Christina Schaffer
Minnesota Housing Finance Agency	Tonja Orr

EXHIBIT 1-3: QUALITY OF LIFE ASSESSMENT TOOL

Exhibit 1-3: Quality of Life Assessment Tool

Personal Life Quality Protocol

Outcome Measurement Tools for Tracking Implementation of the Olmstead Integration Mandate

Center for Outcome Analysis
www.eoutcome.org
484.454.3362, email jconroycoa@gmail.com

Table of Contents

INFORMATION ABOUT THE PERSON

Part 1: Individual Information

1. _____ 2. _____ 3. _____
First Name M.I. Last Name

4. Identification number _____

5. _____
Complete Mailing Address, Including Apartment #

6. _____ 7. _____ 8. _____
City or Town State Zip Code

9. _____
Home Area Code and Telephone Number

10. _____ 11. _____
Primary Respondent's Name Title or Relationship

12. _____
Today's Date

Part 2: Demographics, Legal Status, and Disability

1. PERSON'S DATE OF BIRTH

_____ / _____ / _____
Month Day Year

2. PERSON'S AGE

_____

3. SEX
_____ 1 Male
_____ 2 Female

4. ETHNIC IDENTIFICATION

Check All That Apply	
	1 White or Caucasian
	2 Black or African-American
	3 American Indian or Alaska Native
	4 Asian
	5 Native Hawaiian or Other Pacific Islander
	6 Hispanic or Latino
	7 Other
	99 Refused, left blank

5. **PRIMARY** ETHNIC IDENTIFICATION

Check ONE Primary	
	1 White or Caucasian
	2 Black or African-American
	3 American Indian or Alaska Native
	4 Asian
	5 Native Hawaiian or Other Pacific Islander
	6 Hispanic or Latino
	7 Other
	99 Refused, left blank

6. MARITAL STATUS
1 Never married
_____ 2 Married now
3 Married in past, single now
99 Refused, Don't know

7. PARENTAL STATUS

_____ 7a. Number of children
_____ 7b. Number of dependent children

8. LEGAL STATUS

1 No guardian or conservator
2 Guardian
_____ 3 Conservator
4 Don't Know

9. DISABILITIES AND PERCEIVED SIGNIFICANCE

1 = Major disability 2 = Some disability 3 = No disability
Note: Please allow the person and the person's assistants to define what "some" and "major" mean

	Description	**Major Disability 1**	**"Some" Disability 2**	**No Disability 3**	**D/K 99**
9A.	Ambulation (Walking)	1	2	3	99
9B.	Autism	1	2	3	99
9C.	Behavior: Aggressive or Destructive	1	2	3	99
9D.	Behavior: Self-Abusive	1	2	3	99
9E.	Brain Injury	1	2	3	99
9F.	Cerebral Palsy	1	2	3	99
9G.	Communication	1	2	3	99
9H.	Dementia (Including Alzheimer's Disease)	1	2	3	99
9I.	Health Problems (Major)	1	2	3	99
9J.	Hearing	1	2	3	99
9K	Intellectual Disability (Intentionally redundant with Item8)	1	2	3	99
9L.	Mental Illness	1	2	3	99
9M.	Physical Disability Other Than Ambulation	1	2	3	99
9N	Seizures	1	2	3	99
9O.	Substance Abuse	1	2	3	99
9P.	Swallowing: Inability to swallow independently	1	2	3	99
9Q.	Vision	1	2	3	99
9R.	Other (s) _____	1	2	3	99

Part 3: Housing

1. TYPE OF HOME: What type of home is the person living in now?

Check ONE	
	1A. Living with family or friends
	1B. Board and Lodging
	1C. Housing with Services
	1D. Supervised Living Facilities
	1E. Boarding Care
	1F. Shelter
	1G. Transitional Housing
	1H Nursing Homes, Assisted Living
	1I. Adult Foster Care
	1j. ICF/DD

2. HOW MANY PEOPLE LIVE IN THIS HOME RIGHT NOW?
("HOME" can usually be interpreted as a unique MAILING ADDRESS - - a group dwelling or individual home or apartment. If this is a congregate care facility, use cottage or living unit or building or wing or other meaningful sub-unit. If there are vacancies, only count how many people live here RIGHT NOW.)

	2A. People in this home (or cottage or living unit etc.)
	2B. People with disabilities (unpaid cohabitants)
	2C, People without disabilities (unpaid cohabitants)
	2D. Paid staff who live here (paid cohabitants)

3. WITH HOW MANY PEOPLE DOES THIS PERSON SHARE A BEDROOM? _____ People

4. HOW MANY DIRECT CARE STAFF WORK AT THIS HOME? (Counting all shifts.)

4A. _____ Full Time Staff (Enter 0 if none)
4B. _____ Part Time Staff (Enter 0 if none)

5. WHAT WAS THE LAST MONTH AND YEAR IN WHICH THIS PERSON LIVED IN A STATE DEVELOPMENTAL CENTER or STATE PSYCHIATRIC INSTITUTION?

5A._____ / 5B._____ OR 5C._____ Check here if never lived in state institution
Month Year

NOTE: Information about employment/day activity or education setting are collected in next section

COMMUNITY INTEGRATION AND ENGAGEMENT
Part 1: Time, Money, & Integration – During the Day

Please describe your (the person's) past week – if last week wasn't usual, please describe a usual week.

HOURS: Estimate how many hours per week are or were worked, on average, in each kind of work setting

EARNINGS: Estimate how much money per week the person earned or earns from each kind of activity on average

INTEGRATION: Write the number for HOW INTEGRATED the person was:

1	Completely segregated	Never in the presence of people without disabilities
2	Mostly segregated	Some or a little of the time in the presence of people without disabilities
3	In between	In Between
4	Mostly integrated	Often in situation where people without disabilities are, or might be, present
5	Completely integrated	Nearly always in a situation where people without disabilities might be, present

Type of Day Activity	# Hours Work Per Week	$ Earned Per Week	Inte-gration Level
1. Self-Employed: Has His/Her Own Business			
2. Regular Job (Competitive Employment)			
3. Supported Employment – in Regular Community Job			
4. Supported Employment – Enclave or Job Crew model			
5. Sheltered Employment or Workshop Employment			
6. Pre-Vocational Program or Vocational Rehabilitation Program			
7. Day Habilitation Program (Adult Day Program, Non-Vocational Day Program)			
8. Senior Citizen Program			
9. Partial Hospitalization Program - Mental Health Oriented			
10. Volunteer Work			
11. Public School			
12. Private School			
13. Adult Education - GED, Adult Ed, Trade School, etc.			
14. Community Experience			
15. Other _____			
TOTAL HOURS			xxx

COMMUNITY INTEGRATION AND ENGAGEMENT
Part 2: Integrative Activities Scale – In the Past Four Weeks

ABOUT HOW MANY TIMES did this person do each of the following in the past four weeks?
(**Rough estimates are fine.** If the past month was not typical, ask about the average month during the past year. Write DK if "Don't Know.")
Next, what is the AVERAGE group size in which the person had each kind of experience?
Finally, does this person normally have ANY interaction with community members when out?

	How Many Times?	**Average Group Size Including Staff?**	**Does This Person Normally Have Any Interaction with Community Members during this kind of trip or outing? (Neighbors, Shoppers, Travelers, any citizens who are not in the "disability system")**				
			None 1	**Little 2**	**Some 3**	**Much 4**	**Very Much 5**
1. Visit with close friends, relatives or neighbors			1	2	3	4	5
2. Go to a grocery store			1	2	3	4	5
3. Go to a restaurant			1	2	3	4	5
4. Go to a place of worship			1	2	3	4	5
5. Go to a shopping center, mall or other retail store to shop			1	2	3	4	5
6. Go to bars, taverns, night clubs, etc.			1	2	3	4	5
7. Go to a bank			1	2	3	4	5
8. Go to a movie			1	2	3	4	5
9. Go to a park or playground			1	2	3	4	5
10. Go to a theater or cultural event (including local school & club events)			1	2	3	4	5
11. Go to a post office			1	2	3	4	5
12. Go to a library			1	2	3	4	5
13. Go to a sports event			1	2	3	4	5
14. Go to a health or exercise club, spa, or center			1	2	3	4	5
15. Use public transportation (May be marked "N/A")			1	2	3	4	5
16. Other kinds of "getting out" not listed above			1	2	3	4	5

AUTOMONY OVER DAILY LIFE: Decision Control Inventory

Ask the person and/or the person's chosen ally to say who actually makes decisions in each area. Use the "Two Either-Or Questions" approach. (e.g., "How do foods for the home get chosen, by paid staff, or by you and your friends/housemates/family?" Then follow up with "OK, would you say Mostly or All that way?") Once the pattern is clear, this scale can be done quickly with just the numbers.

WHO MAKES DECISIONS?

1	2	3	4	5	99
All or Nearly All Decisions Made by Paid Folks	**Mostly Made by Paid Folks**	**Equally Shared Decisions**	**Mostly Made by Person and/or Freely Chosen Allies**	**All or Nearly All Made by Person and/or Freely Chosen Allies – relatives, friends, advocates**	**D/K, N/A**

	All Paid 1	Most Paid 2	Equal 3	Most Unpaid 4	All Unpaid 5	D/K
FOOD						
1 What foods to buy for the home when shopping	1	2	3	4	5	99
2 What to have for breakfast	1	2	3	4	5	99
3 What to have for dinner	1	2	3	4	5	99
4 Choosing restaurants when eating out	1	2	3	4	5	99
CLOTHES AND GROOMING						
5 What clothes to buy in store	1	2	3	4	5	99
6 What clothes to wear on weekdays	1	2	3	4	5	99
7 What clothes to wear on weekends	1	2	3	4	5	99
8 Time and frequency of bathing or showering	1	2	3	4	5	99
SLEEP AND WAKING						
9 When to go to bed on weekdays	1	2	3	4	5	99
10 When to go to bed on weekends	1	2	3	4	5	99
11 When to get up on weekends	1	2	3	4	5	99
12 Taking naps in evenings and on weekends	1	2	3	4	5	99
RECREATION						
13 Choice of places to go	1	2	3	4	5	99
14 What to do with relaxation time, such as choosing TV, music, hobbies, outings, etc.	1	2	3	4	5	99
15 Visiting with friends outside the person's residence	1	2	3	4	5	99
16 Choosing to decline to take part in group activities	1	2	3	4	5	99
17 Who goes with you on trips, errands, outings	1	2	3	4	5	99
18 Who you hang out with in and out of the home	1	2	3	4	5	99
SUPPORT AGENCIES AND STAFF						
19 Choice of which service agency works with person	1	2	3	4	5	99
20 Choice of Case Manager (or other term such as SSA, SC, etc.)	1	2	3	4	5	99
21 Choice of agency's support persons/staff (N/A if family)	1	2	3	4	5	99
22 Choice of support personnel: option to hire and fire support personnel	1	2	3	4	5	99
ECONOMIC RESOURCES						
23 What to do with personal funds	1	2	3	4	5	99
24 How to spend residential funds	1	2	3	4	5	99
25 How to spend day activity funds	1	2	3	4	5	99
HOME						
26 Choice of house or apartment	1	2	3	4	5	99
27 Choice of people to live with	1	2	3	4	5	99
28 Choice of furnishings and decorations in the home	1	2	3	4	5	99
WORK OR OTHER DAY ACTIVITIES						
29 Type of work or day program	1	2	3	4	5	99
30 Amount of time spent working or at day program	1	2	3	4	5	99

31 Type of transportation to and from day program or job	1	2	3	4	5	99
OTHER						
32 Express affection, including sexual	1	2	3	4	5	99
33 "Minor vices" - use of tobacco, alcohol, caffeine, explicit magazines, etc.	1	2	3	4	5	99
34 Whether to have pet(s) in the home	1	2	3	4	5	99
35 When, where, and how to worship	1	2	3	4	5	99

____ 36. Check here if you wish to report perception of possibly unfair or excessive domination of this person's life by ANYONE.

PERCEIVED QUALITIES OF LIFE

(To Be Answered by the Person or Whoever Knows the Person Best)

RESPONDENT:
Ask the person to rate the qualities of his/her own life. **If the person can't answer, accept answers from whoever knows the person best.** You must find someone who the person will allow to answer, or who knows the person on a **day to day basis** better than anyone else.

METHOD:
Each quality item is approached as two "Either-Or" questions. For example, the first Either-Or question on the first item is "Would you say your health is good or bad?" ("In between" is implied, if the person says "neither" or "OK" or "neither" or any similar response. But answers like that have to be checked by probing with "Oh, so it's in between, not really good or bad?") Once the person answers, for example, "good," the follow-up is a second Either-Or question: "Would you say good or very good?"

1	2	3	4	5	99
Very Bad	**Bad**	**In Between**	**Good**	**Very Good**	**Don't know, N/A**

Life Quality Area	**Very Bad**	**Bad**	**In Between**	**Good**	**Very Good**	Don't know, N/A
1 Health	1	2	3	4	5	99
2 Running my own life, making choices	1	2	3	4	5	99
3 Family relationships	1	2	3	4	5	99
4 Relationships with friends	1	2	3	4	5	99
5 Getting out and getting around	1	2	3	4	5	99
6 What I do all day	1	2	3	4	5	99
7 Food	1	2	3	4	5	99
8 Happiness	1	2	3	4	5	99
9 Comfort	1	2	3	4	5	99
10 Safety	1	2	3	4	5	99
11 Treatment by staff/attendants	1	2	3	4	5	99
12 Health care	1	2	3	4	5	99
13 Privacy	1	2	3	4	5	99
14 Overall quality of life	1	2	3	4	5	99

15. How many of these 14 questions were answered by the Focus Person, even if assistance or interpretation was involved? _____ (from 0 to 14)

EXHIBIT 1-4: NUMBER OF INDIVIDUALS MOVING FROM SEGREGATED TO INTEGRATED SETTINGS

Exhibit 1-4: Number of Individuals Moving from Segregated to Integrated Settings

For the time period of November 1, 2013 through February 28, 2014

Action item	Setting	# of individuals who moved to integrated settings
SS 2B	MSHS – Cambridge	3
SS 2C	Nursing Facilities (under age 65 with stays longer than 90 days)	170
SS 2C	Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs)	25
SS 2D	Anoka Metro Regional Treatment Center (AMRTC)	51 discharged 34% do not meet hospital level of care and await discharge
SS 2F	Minnesota Security Hospital (MSH)	33 discharged 41 are in a stage of the discharge process • 76 % have been in their stage of discharge for 180 days or less • 24% have been in their stage of discharge for more than 180 days --- 0 readmissions within 6 months of discharge

Number of People Who Have Moved from Waiting Lists*

Type of Disability Waiver	Number of recipients on waivers (March 2014)	Number of persons on wait lists (March 2014)	Number of persons starting waiver services (11/1/13 – 3/28/14)
DD	15,279	3,563	137
CADI, CAC, BI (CCB) [1]	18,930	1,355	709

*It is important to note that a person with urgent need does not go on a waiting list but goes directly to receiving waiver services.

[1] Community Alternatives for Disabled Individuals waiver, Community Alternative Care waiver, Brain Injury waiver

EXHIBIT 1-5: VERIFICATION OF COMPLETION FOR SS3A - IMPLEMENT NEW STANDARDS FROM MINNESOTA STATUTES §245D

Exhibit 1-5: Verification for SS 3A – Implement New Standards from Minnesota Statutes §245D Provided on 12/9/13

1. How were providers notified of the need to apply for a 245D license?

There are an estimated 1600 providers of services to be governed under chapter 245D. All providers of services governed under chapter 245D are required to be Minnesota Health Care Program (MHCP) enrolled providers. About a third of the estimated providers currently hold a license under chapter 245B to provide certain DD services. In order to ensure all affected providers received information about the 245D licensure requirements communications were focused primarily through their MHCP providers' MN-ITS mailboxes (MHCP provider updates listed below are sent to the MN-ITS mailboxes). MHCP Providers are all required to have their MN–ITS mailboxes registered. However, both the Licensing Division and the Disability Services Division have provided additional information through various sources. The following communications, trainings, and materials have been provided on the 245D licensure requirements:

- July 9, 2012 – MHCP Provider Update LEG-12-01: 2012 Legislative Changes, Other Changes Affecting HCBS Programs and Services, New §245D License
- October 2012: 245D Amendments & Licensing Fees Webinar, statewide stakeholder participation
- October 2012 245D License Fee Survey: this survey was sent to all MHCP enrolled providers who were billing for services to be governed under 245D
- November 1, 2012 Annual License Renewal memo to 245B license with attachment, Selected Highlights of 2012 Legislation ; providers receive a notice by mail with their invoice for their annual license fee with instructions to review the annual memo and legislative summary online
- November 19, 2012 – MHCP Provider Update WAV-12-01: Provider Record Review – Waiver/AC Program Services
    - Waiver and Alternative Care (AC) Programs Service Request Form; identifies provider qualifications, including when a 245D license is required
- What's new for: Licensing information, Summary of licensing, fraud and abuse legislation posted 2013 legislative summary (PDF); posted after the 2013 legislative session
- Initially established June 2013 - Licensing webpage - Home and Community-Based Services (HCBS) for People with Disabilities and Age 65 or Older – 245D
- June 28, 2013 – MHCP Provider Update WAV-13-08: 245D License
- June 28, 2013 – MHCP Provider Update LEG-13-02: 2013 Legislative Changes, Provider/Service Specific Information, Home and Community-based Services (HCBS) Waivers and Alternative Care (AC) Programs
- July 5th, 2013 – MHCP Provider Updates WAV-13-09 New Required Behavioral Intervention Reporting Form included information about who may be required to have a 245D license
- July 2013 - MHCP Enrolled Providers – Home and Community Based (HCBS) Waiver and Alternative Care (AC) Programs Services
    - Provider Record Review & 245D License - Waiver/AC Program Services; providers were notified of the training
- September 2013 - DHS Bulletin to County Agencies: 13-56-02 Home and Community-Based Services Waiver/Alternative Care Provider Management and Oversight Beginning 2014
- Ongoing - DSD County E-List Announcements

- Ongoing - DSD webpage - HCBS Waiver Provider Standards Provides updates on this initiative, including important provider resources.
- DHS Licensing, Provider Enrollment, and Disability Services Division staff have conducted numerous stakeholder meetings, information sessions, conference presentations, webinars, videoconferences, etc., on the 245D license requirements and HCBS waiver provider standard changes since 2011.
- Ongoing reminder sent out through the MHCP Provider News messages every two weeks through the providers' MN–ITS mailboxes. MHCP also provides access to the previously published provider news at the bottom of each new update. The provider news is updated and placed into the Providers' MN–ITS mailboxes every 2 weeks following the same schedule as the warrants/payments.

2. How many providers have applied for a 245D license to date:

Following is the 245D application status as of Monday Dec 9, 2013. **Of an estimated 1600 providers 1280 have started or completed a 245D HCBS license application**. Those who submitted a complete application by Dec. 1, 2013, will be approved for licensure before Jan. 1, 2014. DHS will make every effort to approve complete applications submitted after Dec. 1 but cannot make any guarantees.

549 CONVERSIONS = Current 245B license holders

- Not required to pay a license application fee as they are not applying for a license, an existing license is being converted
- Required to pay their annual license fee to renew their converted license for 2014
- Not required to submit additional materials
- Not required to initiate background studies for all controlling individuals as they were initiated as part of the required license holder update in 2013 (this is not the MHCP enrolled provider record review requirement; this was a requirement to update certain information in the license holder record per 2012 legislative amendments)
- License reviews will begin in July 2015

145 HYBRIDS = Current DHS license holders including corporate AFC license holders who do not hold a 245B license

- Required to pay a license application fee
- Required to additional required materials
- Not required to initiate background studies for all controlling individuals as they were initiated as part of the required license holder update in 2013
- The initial license review will be a technical assistance visit resulting in a license review report as opposed to a correction order (DHS retains authority to issue licensing actions based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program); technical assistance visits will begin July 2014

586 NEW = Providers who hold no DHS license of any type or who hold only a child foster care license holders or are a family AFC license holders

- Required to pay a license application fee
- Required to submit additional required materials
- Required to initiate background studies for all controlling individuals as are all DHS license applicants regardless of previous background studies initiated under other DHS licenses; these providers were not required to complete the license holder update in 2013

- The initial license review will be a technical assistance visit resulting in a license review report as opposed to a correction order (DHS retains authority to issue licensing actions based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program); technical assistance visits will begin July 2014

EXHIBIT 1-6: VERIFICATION OF COMPLETION FOR SS2F – TIMELINE FOR TRANSITION FROM MINNESOTA SECURITY HOSPITAL

Exhibit 1-6: Verification of completion for SS2F – Timeline for transition from Minnesota Security Hospital

INCREASE IN AVERAGE MONTHLY DISCHARGES AT MINNESOTA STATE SECURITY HOSPITAL

1) By December 31, 2014 increase average monthly discharge rates from 8 individuals per month, to 9 individuals per month (2.4% of average monthly total census).
2) By December 31, 2015 increase average monthly discharge rates from 9 individuals per month, to 10 individuals per month (2.6% of average monthly total census).
3) By December 31, 2016 increase average monthly discharge rates from 10 individuals per month, to 11 individuals per month (2.9% of average monthly total census).
4) By December 31, 2017 increase average monthly discharge rates from 11 individuals per month, to 12 individuals per month (3% of average monthly total census).

MEASURE TIMELINESS OF DISCHARGE PROCESSES AND READMISSION WITHIN 6 MONTHS

A. Judicial Hold; Civil Commitment as Mentally Ill, Developmentally Disabled (with Level 3 Predatory Offender Status), and or Initial Commitment as Mentally Ill and Dangerous:
   - Number of days between date when "treatment team/person decides readiness for discharge" and "discharge".
   - Number and percent of people discharged at:
     - Less than 180 days,
     - More than 180 days.
   - Number of readmissions within 6 months of discharge.

B. Civil Commitment as Mentally Ill and Rule 20.01:
   - Number of days between date when "treatment team/person decide readiness for discharge" and "discharge".
   - Number and percent of people discharged at:
     - Less than 180 days,
     - More than 180 days.
   - Number of readmissions within 6 months of discharge.

C. Final Commitment as Mentally Ill and Dangerous:
   - Number of days between date when "treatment team/person decide readiness for discharge" and "Commissioner's decision and Order".
   - Number of days between "Commissioner's decision and Order" and "discharge".
   - Number of days between "SCAP decision and Order" and "discharge".
   - Number of days between date when "treatment team/person decide readiness for discharge" and "discharge".
   - Number and percent of people discharged at:
     - Less than 180 days,
     - More than 180 days.
   - Number of readmissions within 6 months of discharge.

EXHIBIT 1-7 VERIFICATION OF PROGRESS FOR SS4A – SUBMISSION TO CMS TO REPLACE PCA PROGRAM WITH COMMUNITY FIRST SERVICES AND SUPPORTS (CFSS)

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: CENTER FOR MEDICARE & MEDICAID SERVICES**	1. TRANSMITTAL NUMBER: 13-08	2. STATE Minnesota
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTER FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2014	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: Section 1905(k) of the Act 42 CFR §§441.500 - 590	7. FEDERAL BUDGET IMPACT: a. FFY '14 $112,273,342 b. FFY '15 $276,091,646
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, pages 10a Attachment 3.1-B, pages 9a Attachment 3.1-K, pages 1 - 21 Attachment 4.19-B, page 85	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, pages 10a Attachment 3.1-B, pages 9a

10. SUBJECT OF AMENDMENT:
Community First Services and Supports

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Sean Barrett Minnesota Department of Human Services Federal Relations Unit PO Box 64983 St. Paul, MN 55164-0983
13. TYPED NAME: Ann Berg	
14. TITLE: Deputy Medicaid Director	
15. DATE SUBMITTED: March 22, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:
23. REMARKS:	

FORM CMS-179 (07-92)

MINNESOTA

MEDICAL ASSISTANCE

Federal Budget Impact of TN 13-08

Effective April 1, 2014, Minnesota will provide Community First Services and Supports (CFSS) as described in 1915(k) of the Act. CFSS is a participant-controlled method of selecting and providing community-based services and supports.

Fee for service		FFY ’14	FFY ’15
	Total cost (thousands)	$200,488	$493,020
	FFP	56%	56%
	State Share (thousands)	$88,215	$216,929
	Federal Share (thousands)	**$112,273**	**$276,091**

Managed Care		FFY ’14	FFY ’15
	Total cost (thousands)	$53,565	$127,447
	FFP	56%	56%
	State Share (thousands)	$23,569	$56,077
	Federal Share (thousands)	**$29,996**	**$71,370**

Total		FFY ’14	FFY ’15
	Total cost (thousands)	$254,053	$620,467
	FFP	56%	56%
	State Share (thousands)	$111,783	$273,005
	Federal Share (thousands)	**$142,270**	**$347,462**

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Freestanding Birth Center Services

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

29. Integrated Care Models

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

30. Section 1915(k) – Community First Choice State Plan Option

☒ Provided: _____ No limitations x With limitations*
☐ Not provided.

*Description provided on attachment.

State/Territory: MINNESOTA

AMOUNT, DURATION, AND SCOPE OF
MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY
NEEDY

28. Freestanding Birth Center Services

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

29. Integrated Care Models

☒ Provided: ___ No limitations x With limitations*
☐ Not provided.

30. Section 1915(k) – Community First Choice State Plan Option

☒ Provided: _____ No limitations x With limitations*
☐ Not provided.

*Description provided on attachment.

I. Eligibility

Community First Services and Supports (CFSS) will be provided in a home or community-based setting, which does not include a nursing facility, an institution for mental disease, an intermediate care facility for persons with developmental disabilities (ICF/DD), or a hospital. CFSS services are available and provided to individuals residing in settings that meet the federal and state regulatory requirements for a home and community-based setting and include, but are not limited to single-family homes, duplexes, apartments, congregate independent living communities, and settings that provide room and board.

Community First Services and Supports (CFSS services) are available to an individual who:

A. Is determined to be an enrollee of a group under the state plan with benefits that include nursing facility services; or qualifies for and receives at least one service under a section 1915(c) waiver under the group at 1902(a)(10)(A)(ii)(VI); and
B. Is determined at least annually, that in the absence of CFSS services provided, would require the level of care furnished in a hospital, nursing facility, intermediate care facility for developmentally disabled individuals, a psychiatric hospital providing services to individuals under age 21, or an institution for mental diseases for individuals age 65 or older; and
C. Requires assistance and is determined, based on the person-centered assessment, dependent in at least one activity of daily living and/or as having a Level 1 behavior, meaning physical aggression towards self, others or destruction of property that requires the immediate response of another person.

II. Self-Directed Service Delivery Methods

_x__ Agency-Provider model with service unit allocation – The agency-provider model with service unit allocation is based on the person-centered assessment of need and available to participants who choose to receive their services from support workers who are employed by an agency-provider that is enrolled as a provider with the State. Participants retain the ability to have a significant role in the selection and dismissal of the support workers who deliver the services and supports specified in their person-centered service delivery plan. Agency-providers will provide worker training and development services based on an individual's needs. A participant who requests to purchase goods and supports along with support worker services under the agency-provider model shall continue to have their support worker services delivered by an agency-provider. The participant, along with the provider of consultation services, as requested, shall develop a service delivery plan that specifies the services to be authorized to the agency-provider and the expenditures.

__x__ Budget model as described in 42 CFR § 441.545(c) with individual budget and employer authority– Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers, and obtain other supports and goods as defined in Item B of our service package. Participants will use a financial management services contractor for the billing and payment of services; for ensuring accountability of CFSS funds; and to serve as a vendor/fiscal employer agent in order to maintain compliance with employer related duties. Participants may utilize the consultation service for assistance in developing a person-centered service delivery plan and budget; and for learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

Participants who are unable to fulfill any of their obligations under CFSS may authorize a legal representative or participant's representative to do so on their behalf.

"Agency-Provider" means an agency enrolled with the Department as a CFSS provider and meeting the qualifications described in section X.

"Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

"Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice. The participant's representative may not also be a paid service provider for the participant and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives include:

(1) being available while care is provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;
(2) monitoring CFSS services and supports to ensure the participant's CFSS service delivery is being followed; and
(3) verifying schedule and hours of CFSS service provided

Worker Training and Development Services include a variety of services that assist participants under either model with developing support worker skills as required by the participant's service delivery plan. These required services may be provided or arranged by the employer of the support worker and consist of training, education, direct observation, evaluation, or consultation to direct support workers regarding job skills, tasks, and performance as required for the delivery of quality service to the participant.

III. Service Package

A. The amount of CFSS is determined by the person-centered assessment to be conducted by a certified assessor. Certified assessors will have completed training and the certification processes determined by the Department. Certified assessors are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and consultation for long-term services in the state.

1. The amount of CFSS authorized will be based on the participant's home care rating, which is determined in the course of the person-centered assessment in conformity with the chart below. The home care rating shall be determined by identifying the following for a participant: the total number of dependencies of activities of daily living (ADL's); the presence of complex health-related needs; and the presence of Level I behaviors, meaning physical aggression towards self, others or destruction of property that requires the immediate response of another person.

2. Each home care rating has a base number of minutes assigned. Additional minutes are added through the assessment and identification of the following:
    a. 30 additional minutes per day for a dependency in each critical activity of daily living: eating, transfers, mobility, toileting; and
    b. 30 additional minutes per day for each complex health-related function; and
    c. 30 additional minutes per day for each behavior issue.

3. For participants assessed as eligible for private duty nursing services, CFSS may be authorized above the limits set by the CFSS service methodology. CFSS or private duty nursing services or the combination of CFSS and private duty nursing services may not exceed authorization limits for private duty nursing.

4. Services and supports are authorized under a budget limit. The maximum available CFSS participant budget allocation shall be established by multiplying the number of units authorized by the payment rate established by the Department.

5. Worker training and development services are not subject to the participant's individual service authorization limit. The worker training and development service will be determined per participant need with a minimum of 96 units per annual allocation.

Authorization for PCA Services

Step 1: *Person has one dependency in an Activity of Daily Living (ADL) and/or Level 1 Behavior.*

# Dependencies in ADLs	Level I Behavior	Complex Health Needs	Base Units-Minutes
0	Yes	---	5 u – 75 m
1-3	----	----	5 u – 75 m
1-3	Yes	----	6 u – 90 m
1-3	Yes or No	Yes	7 u – 105 m
4-6	----	----	10 u – 150 m
4-6	Yes	----	11 u – 165 m
4-6	Yes or No	Yes	14 u – 210 m
7-8	----	----	17 u – 255 m
7-8	Yes	----	20 u – 300 m
7-8	Yes or No	Yes	30 u – 450 m
Vent Dependent			$29,016/month

Step 2: Determination of Total Time

If the PCA assessment shows a person has one or more of the following descriptions, add an additional 2 units or 30 minutes to base time per day for **each**:

- Dependency in critical Activity of Daily Living (ADL)
- Behavior issue as defined
- Complex health-related need

Critical ADLs	Behaviors (4 times/week)	Complex Health
Eating	Physical aggression towards self, others, or destruction of property	Tube Feeding
Transferring	Increased vulnerability due to cognitive deficits or socially inappropriate behavior	Wounds
Mobility	Verbally aggressive and resistive to care	Parenteral/IV Therapy
Toileting		Respiratory Interventions
		Catheter
		Bowel Program
		Neurological Intervention
		Other Congenital or Acquired Diseases
Potential Maximum Total 8 units-120 minutes	**Potential Maximum Total** 6 units-90 minutes	**Potential Maximum Total** 16 units-240 minutes

B. The following are included CFSS services:

1. Assistance with ADLs through hands-on assistance and/or constant supervision and cueing.

2. Acquisition, maintenance, or enhancement of skills necessary for the participant to accomplish ADLs, IADL's, and health-related tasks.

3. Assistance in accomplishing instrumental activities of daily living (IADLs) related to living independently in the community and an assessed need: meal planning, preparation, and shopping for food; shopping for clothing or other essential items; cooking; laundry; housecleaning; assistance with medications; assistance with managing money; assist with individualized communication needs; arranging supports; assistance with participating in the community; and other IADL services that are an integral part of assessed CFSS needs.

4. Assistance in health-related procedures and tasks related to the specific assessed needs of an individual.

5. Observation and redirection of behaviors identified in the assessment.

6. Back-up systems or mechanisms (such as the use of personal response systems or other mobile devices selected by the participant) to ensure continuity of the participant's services and supports. Specific risks and levels of back-up support needed are addressed during the participant's initial and annual assessments, in the development of the community support plan and the service delivery plan. Each participant will have an individualized back-up plan that identifies service options and support people, both formal and informal, that can be called on when circumstances interrupt service delivery.

7. Consultation services:
   - provide assistance that empowers the participant to be successful in making informed choices regarding CFSS services in general and self-directed tasks in particular;
   - eliminate barriers to services and streamlines access;
   - assist the person in developing a quality person centered service delivery plan, and
   - offer support with service compliance and quality outcomes.

   Consultation services provided to participants may include, but are not limited to:
   - an orientation to CFSS, including assistance selecting a service model;
   - assistance with the development, implementation, management and evaluation of the service delivery plan;

- assistance with recruiting, selecting, training, managing, directing, evaluating, supervising, and dismissing support workers;
- facilitating the use of informal and community supports, goods or resources.

8. Worker training and development provides services that enhance the support worker's skills as required by the participant's service delivery plan. Services provided to the direct support worker may include but are not limited to: training, education, direct observation, consultation, or performance evaluation.

9. The financial management services contractor provides vendor/fiscal employer agent functions and support for the participant's compliance with federal and state labor and tax regulations; record keeping; billing; payroll; monitoring; and management of spending

C. The State elects to include the following CFSS permissible services(s):

1. __x__ Expenditures for environmental modifications, or goods, including assistive technology. Such expenditures must:
   (i) relate to a need identified in a participant's CFSS community support plan;
   (ii) increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for the human assistance for the participant's assessed needs; and
   (iii) fit within the annual limit of the participant's approved service allocation or budget.

2. __x___ Expenditures for transition costs such as deposits for rent and utility, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need, to the extent that these transition costs are not otherwise covered under any other funding that the person is eligible to receive, are required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for persons with developmental disabilities to a community-based home setting where the individual resides, and fit within the annual limit of the participant's approved service allocation or budget.

D. CFSS identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and provided by school districts to children during the school day.

1. The services must meet all the requirements otherwise applicable in this Attachment if the service had been provided by a qualified, enrolled provider other than a school district, with the following exceptions:
   a. a CFSS support worker need not be an employee of a CFSS provider organization;

b. assessments, reassessments and service updates are not required;
c. authorization under the community support plan is not required;
d. a CFSS support worker provides services under the direction of a support specialist which includes registered nurses, public health nurses, licensed school nurses, mental health professionals, physical therapists, occupational therapists, speech language pathologists, audiologists or physicians, as designated in the IEP;
e. Participants using CFSS at school will use the agency-provider model. CFSS workers in schools need to be employed by or under contract with the school district in which they are providing services. The participant and/or the participant's representative participates in the selection of the CFSS worker at school through the IEP process.
f. The service limits described in III.A. do not apply to CFSS services identified in an IFSP or IEP under IDEA and provided by school districts to children during the school day.

E. Services not covered under Medical Assistance as CFSS:

- Services that do not meet a need identified in the assessment;
- Services that are not for the direct benefit of the participant;
- Health services provided and billed by a provider who is not an enrolled CFSS provider;
- CFSS provided by a participant's representative or paid legal guardian;
- Services that are used solely as a child care or babysitting service;
- Services provided by the residential or program license holder in a residence licensed for more than four persons;
- Services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;
- Sterile procedures;
- Giving of injections into veins, muscles, or skin;
- Homemaker services that are not an integral part of the assessed CFSS service;
- Home maintenance or chore services;
- Services that are not in the participant's service delivery plan;
- Home care services (including hospice if elected by participant) covered by Medicare or any other insurance held by the participant Services to other members of the participant's household:
- Services not specified as covered under Medical Assistance as CFSS;
- Application of restraints or implementation of deprivation procedures;
- Assessments by CFSS provider organizations or by independently enrolled registered nurses;
- Services provided in lieu of legally required staffing in a residential or child care setting;
- Services not authorized by the Department or the Department's designee.
- Services that are duplicative of other paid services in the written service delivery plan

- Services available through other funding sources, including, but not limited to, funding through Title IV-E of the Social Security Act.
- Any fees incurred by the participant, such as Minnesota Health Care Program fees and co-pays, legal fees, or costs related to advocate agencies;
- Insurance, except for insurance costs related to employee coverage;
- Room and board costs for the participant with the exception of allowable transition costs as described in Section III.C.2.
- Special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;
- Assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7 and items that are listed in Section III.C.1.
- Medical supplies and equipment;
- Environmental modifications, except as specified in as described in Section III.C.1.
- Expenses for travel, lodging, or meals related to training the participant, the participant's representative, or legal representative;
- Experimental treatments;
- Any service or good covered by other Medical Assistance state plan services
- Membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the participant's physical condition. The condition must be identified in the participant's CFSS plan and monitored by a physician enrolled in a Minnesota health care program;
- Vacation expenses other than the cost of direct services;
- Vehicle maintenance or modifications not related to the disability, health condition, or physical need; and
- Tickets and related costs to attend sporting or other recreational or entertainment events.

IV. Use of Direct Cash Payments

A. ___ The State elects to disburse cash prospectively to CFSS participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

_____ Only for participants receiving the following options:

B. __x___ The State elects not to disburse cash prospectively to CFSS participants.

V. Disenrollment

A. Voluntary Disenrollment Between Service Delivery Models:
Participants may only disenroll from one model of service to the other model once during the service year and/or upon reassessment. Participants who voluntarily disenroll from the agency-provider model and enroll in the budget model will be able to select a financial management services contractor. In order to support participant health and welfare, there will be no break in service for those disenrolling from one model of service to the other. Participants or their representatives may initiate disenrollment at any time by contacting their agency-provider or financial management contractor or consultation service provider.

B. Involuntary Disenrollment From the Budget Model to the Agency-Provider Model:
Participants who are disenrolled from the budget model shall be transferred to the agency-provider model. Participants who become restricted by the Minnesota Restricted Recipient Program will be enrolled in the agency-provider model.

VI. Assurances

A. The State assures necessary safeguards are in place to protect the health and welfare of individuals provided services under this state plan option, and to assure financial accountability for funds expended for CFSS services.

B. The State assures the provision of participant-directed CFSS services and supports to individuals on a statewide basis.

C. With respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, the State will maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year.

D. The State assures that CFSS is provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable federal and state laws.

E. The State assures that all applicable provisions of state and federal laws regarding the following are met:
- Withholding and payment of state and federal income and payroll taxes
- Provision of unemployment and workers compensation insurance
- Maintenance of general liability insurance
- Occupational health and safety
- Any other employment or tax related requirements

VII. Service Plan

A. Community support plan:

An assessment of functional need will be conducted by a certified assessor using a long-term services and supports assessment established by the Department. The assessment takes a person-centered approach that ensures appropriate support to the participant during the assessment. The assessment will be conducted face-to-face, initially, and at least annually thereafter, or when there is a change in the need for services and supports. A participant not yet residing in a community setting may be assessed and choose CFSS for the purpose of using this option to return to the community.

The community support plan is a result of the assessment and provides information to the participant, documenting assessed need. The determination of assessed need includes:

1. Documentation of dependencies in activities of daily living; presence of complex health-related needs; and presence of specific behaviors including physical aggression toward self or others, or destruction of property;
2. Determination of institutional level of care;
3. Determination of a participant's representative, if needed.
4. Identification of appropriate supports and services;
5. Referrals to appropriate payers and community resources,

If eligible for CFSS, the community support plan will include identification of appropriate CFSS supports and services that would meet the participant's assessed needs, and assists the participant in determining a participant's representative, if needed. It will be communicated in writing by the lead agency's certified assessor to the participant and their chosen provider of consultation services. It will include the participant's right to appeal.

B. Service delivery plan:

1. Following assessment and completion of a community support plan, the participant chooses a provider of consultation services. The consultation service provider:
   a. provides orientation regarding the agency-provider model and the budget model, including information on roles, responsibilities, processes, policies and options available for services and supports;
   b. assures a person-centered planning process;
   c. assists the participant or the participant's representative, if appropriate, in developing, implementing and evaluating a CFSS service delivery plan.

2. The CFSS service delivery plan reflects the services and supports chosen by the participant to meet their assessed needs. The service delivery plan shall be reviewed at least annually upon

reassessment or when there is a change in the need for services and supports. The CFSS service delivery plan is person-centered and:

a. specifies the agency provider or financial management services contractor selected by the participant;
b. reflects the setting in which the participant resides that is chosen by the participant;
c. reflects the participant's strengths and preferences;
d. includes the means to address the clinical and specialized support needs of the participant;
e. includes the individual's identified goals and desired outcomes;
f. reflects the CFSS services and supports that will assist the participant in achieving identified goals, and the providers of those services and supports. This includes a plan for worker training and development as applicable
g. identifies the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;
h. identifies risk factors and measures in place to minimize them, including individualized backup plans;
i. is understandable to the participant, and the individuals providing support;
j. identifies the individual or entity responsible for monitoring the plan;
k. is finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;
l. is distributed to the participant and other people involved in the plan; and
m. prevents the provision of unnecessary or inappropriate care
n. For the budget model a detailed spending budget is included detailing worker related expenses; and other purchases

3. The budget allocation for the budget model or the agency-provider model can be used in a flexible manner over the term of the service authorization. Additional funds shall not be provided in excess of the annual service authorization amount unless a change in condition is assessed and authorized by the certified assessor and documented in the community support plan and service delivery plan.

4. Financial management services (FMS) contractor: Under the budget model, participants have more responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Under this model:
    a. Using a budget allocation, participants may directly employ qualified support workers using a and obtain other supports and goods that:
        i. relate to a need identified in a participant's CFSS service delivery plan;
        ii. increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance related to the participant's assessed needs
        iii. fit within the annual limit of the participant's approved service budget allocation and;
        iv. assist the participant to monitor and manage spending and ensure accountability of funds

5. The financial management services contractor shall provide services that include but are not limited to:
    a. Billing and making payments for expenditures;
    b. Performing vendor/fiscal employer agent functions in accordance with the Internal Revenue Code Procedure 70-6 Section 3504 Agency Employer Tax Liability (regulation 137036-08) that includes assistance with filing and paying payroll taxes, employee personnel file, and obtaining Worker Compensation coverage
    c. Assist the participant to maintain compliance with State and Federal labor laws and regulations; and
    d. Recordkeeping and reporting of individual spending.

6. The financial management services contractor shall:
    a. not limit or restrict the participant's choice of qualified service or support providers;
    b. inform participants of their legal obligations as employers of support workers;
    c. provide the participant with a monthly written summary of the spending for services and supports that were billed against the spending budget;
    d. be knowledgeable of state and federal employment regulations under the Fair Labor Standards Act of 1938, and comply with the requirements under the Internal Revenue Service Revenue Code Procedure 70-6 Section 3504 Agency Employer Tax Liability for vendor/fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support Medical Assistance claims;
    e. have current and adequate liability insurance, bonding and sufficient cash flow;
    f. maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the Department. Claims submitted by the fiscal management services contractor to the Department for payment must correspond with services, amounts, and time periods as authorized in the participant's spending budget and service delivery plan.

VIII. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is outlined below.

A. Recognition of the roles and responsibilities of those involved in delivering CFSS.

Individuals receiving CFSS are active participants in quality assessment and management through support planning and design of the service delivery plan to meet identified needs and mitigate risks. Counties, tribes and managed care organizations under contract with the Department to manage home and community-based services and supports (lead agencies)

perform assessments and develop community support plans that reflect consumer preferences in services and support for self-direction and include risk management, back-up and emergency planning. Lead agencies provide information about service options, choices in providers, and rights and responsibilities, including appeal rights. The consultation service provider under the budget model and the agency under the agency provider model are responsible for providing: orientation; consultation in planning developing, and implementing the service delivery model; and general technical assistance for individuals receiving CFSS. The FMS, agency provider, consultation service provider and CFSS workers are mandated reporters for adult and child maltreatment. The Department establishes and manages the budget methodology for the CFSS authorization, ensures lead agencies perform their roles, ensures provider qualifications and other enrollment requirements are met, authorizes services, develops and implements quality measures and remediation strategies, and periodically analyzes aggregated measurement data for system improvement opportunities. The Department develops and delivers training to lead agencies and providers, manages provider enrollment, pays claims, and oversees county financial eligibility determination for Medical Assistance programs The Department develops and manages contracts with vendors and enrolls providers in Minnesota Health Care Programs.

B. Assurances related to appropriateness of plans and budgets based upon a participant's resources and capabilities.

All CFSS participants will participate in a comprehensive, face-to-face assessment to identify needs, preferences, and strengths. Using a web-based assessment and community support planning application, certified assessors will help the individual identify needs, any risks associated with those needs, and preferences related to services. The assessment includes determination of supports needed for self-direction. The CFSS community support plan is based on this assessment. The web-based application is rules-based, ensuring that all areas of need are addressed in the community support plan, and that back-up and emergency plans are completed.

The FMS or agency provider will ensure that background studies are conducted for all CFSS workers before service delivery begins.

C. Ongoing technical assistance, education materials, and resources for CFSS participants:

Technical assistance for applicants and participants will be available in a variety of modes. The FMS, the consultation service provider and the agency provider will all play a role in the provision of technical assistance.

Educational material will be available to participants related to a variety of topics, including services planning, quality monitoring, employee management, and CFSS information and options. These materials will be web-based and accessible, as well as available in paper and

other formats. Examples of CFSS service delivery plans will available for participants to use as a guide in developing their own tools for managing CFSS.

D. Quality measures

Performance or quality measures will be used by the Department to assess quality in an ongoing manner, as well as to provide aggregate data for quality analysis and improvement purposes.

1. ***Quality Measure***: **Level of care determinations are completed for all CFSS applicants served under the 1915(k) option.**

   Numerator: Number of CFSS applicants with level of care determined per fiscal year.

   Denominator: Total number of CFSS applicants per fiscal year.

2. ***Quality Measure***: **All CFSS participants are reassessed at least annually**.

   Numerator: Number of CFSS participants who are reassessed at least annually, and who have level of care determination per fiscal year.

   Denominator: Total number of CFSS participants for whom annual reassessments should have been completed per fiscal year.

   Desired outcome: All CFSS participants served under the 1915(k) option have been assessed to require an institutional level of care. A participant and certified assessor have reviewed and updated all areas of assessed need at least once a year, including level of care determination.

   QA Function: Lead agencies, DHS. The assessment performed by certified assessors is used to establish eligibility, develop the community support plan, and authorize services. The eligibility span for CFSS can be no longer than 12 months, requiring a reassessment to continue service authorization. The web-based assessment tool is rules-driven and calculates level of care based on statutory criteria. All assessments result in level of care determinations, including no institutional level of care, nursing facility level of care, ICF/DD, neurobehavioral hospital, and acute hospital. Individuals served under the 1915(k) option must meet an institutional level of care.

   Remediation: No remediation is needed since this assurance is part of the functionality of the assessment and support planning application, and is continuous and ongoing.

3. ***Quality Measure***: **CFSS support planning addresses health and welfare needs, reflects assessed needs, and reflects participant choice-making.**

Numerator: The number of CFSS participant assessments and community support plans reviewed for which:

a. Health and welfare needs are identified and addressed in the CFSS community support plan. All assessments will have identified health and welfare needs; all community support plans will address those needs.
b. Risk assessment and back-up plans are included. All community support plans will include risk assessment and back-up plans.
c. Planned services meet an identified need and reflect participant choices. Services included in the community support plan are based on assessed needs and preferences

Denominator: Total number of CFSS assessments and community support plans reviewed.

Desired Outcomes: Individuals will have their health and welfare needs reasonably met. Individuals will have reduced risk through risk assessment and back up planning. Planned services will meet needs identified in the assessment. Individuals are aware of and supported in making choices. For people receiving CFFS in a fee-for-service setting, the community support plan audit occurs as part of an on-site lead agency review. For managed care enrollees, the community support plan audit is conducted annually according to contract requirements established by the Department. During the audit, both assessments and community support plans are audited.

QA Function: Community support plan auditing is the data source and discovery activity for these measures. DHS will perform lead agency reviews including community support plan audits. All lead agencies (87 counties and 4 tribes under contract with DHS) will be reviewed on-site over three years. DHS will issue corrective action plan requirements for lead agency reviews. Managed care organizations (MCO) will conduct internal community support plan audits annually and report results and corrective actions issued to DHS.

Remediation: Both types of community support plan audits use a standardized audit protocol and representative random sampling. Both result in corrective action plans for remediation. Remediation occurs annually for MCO audits. DHS issues corrective actions as indicated at the time of the lead agency review.

4. ***Quality Measure***: **All individuals are notified of their right to appeal.**

All service authorizations letters for the participant include a notice of appeal rights and instructions for filing an appeal.
Numerator: Number of service authorization letters reviewed that include appeal rights and instructions
Denominator: Total number of service authorization letters.

Desired Outcome: All individuals are aware of their right to appeal.

QA Function: DHS, and MCOs.

Remediation: All service authorizations letters include a notice of appeal rights and instructions for filing an appeal. Remediation at the individual level is an appeal or grievance. DHS reviews aggregate data about appeals and grievances for systems improvement opportunities.

5. ***Quality Measure***: **Training on maltreatment and vulnerable adults, maltreatment of minors is completed by all CFSS workers.**

Numerator: Number of support workers who received training on child protection, maltreatment, vulnerable adults and responsibilities as mandated reporters.

Denominator: Number of support workers enrolled annually.

Desired outcome: All support workers are aware of their responsibilities and trained on working with vulnerable adults, and the prevention and reporting of maltreatment of adults and minors.

QA Function: DHS

Remediation: Provider enrollment cannot occur without demonstrated, documented receipt of training provided by DHS.

E. Quality Improvement

1. Quality Monitoring and Management Process.

A team of program and policy staff for DHS Continuing Care Administration will review and analyze collected performance measure and remediation data. This team will make recommendations for systems 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.

2. Methods to continuously monitor health and welfare, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports.

Safeguards are provided under state statute for children and for adults unable to protect themselves from maltreatment which includes, abuse, neglect or exploitation. FMS, agency

providers and CFSS workers are mandated reporters of suspected adult or child maltreatment. Immediate reporting is required by mandated reporters of suspected maltreatment. In addition to mandated reporting, voluntary reports of suspected maltreatment can be made by any person and are encouraged through information, training and education provided by Department.

Remediation: Maltreatment reports are forwarded to the lead investigative agency responsible under statute for investigation and for protective services. Lead investigative agencies include the Department of Human Services, the Department of Health, counties, and law enforcement. If the maltreatment report identifies immediate risk, lead investigative agency contacts the county agency responsible to provide emergency protective services.

When a report of suspected maltreatment is forwarded for investigation, the lead investigative agency is responsible to notify the proper agencies or individuals of the findings. If maltreatment is substantiated, information about the perpetrator is entered into the perpetrator registry maintained by the Department. This information is made available as part of required provider employment background checks. Notification of substantiated maltreatment reports is made to licensing boards. Referrals for criminal prosecution may result. Information on specific categories of providers substantiated for maltreatment is available to the public on web-based information maintained by the lead investigative agencies for those providers.

Methods for addressing individual problems include protective services by local adult and child protective services units; criminal, civil, licensure and/or certification sanctions (as applicable) against substantiated perpetrators; and corrective action requirements for licensed/certified providers.

IX. Risk Management

The risk management process involves the assessment, community support plan and CFSS service delivery plans to identify and mitigate risks to participants.

The certified assessor uses a long-term services and supports assessment established by the Department to identify risks and work with the participant to identify support systems and individuals to assist in mitigating the risks.

In both service models the consultation services provider works with the participant to develop a person-centered service delivery plan that recognizes the risk factors and develops strategies to mitigate them. In the agency model, the agency works with the participant to implement the person-centered service delivery plan. In the budget model the participant implements the person-centered service delivery plan.

X. Qualifications and Duties of Providers of CFSS Services

Provider qualifications for both service delivery models are designed to ensure necessary safeguards have been taken to protect the health and welfare of participants, including criminal background studies and an orientation designed to ensure providers are capable of safely providing required services.

A. Agency and Financial Management Service providers shall:

1. Enroll as a Medical Assistance provider meeting all applicable provider standards;

2. Comply with Medical Assistance provider requirements;

3. Demonstrate compliance with law and policies of Community First Services and Supports to be determined by the Department;

4. Comply with background study requirements;

5. Verify and maintain records of all services and/or expenditures by the participant including hours worked by the support workers and providers of worker training and development;

6. Not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential participants, guardians, family members or participants' representatives;

7. Pay CFSS workers based upon actual hours of services provided that are based upon an assessed need and listed in the service delivery plan;

8. Withhold and pay all applicable federal and state payroll taxes;

9. Make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

10. Enter into a written agreement with the participant or the participant's representative or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided;

11. Report suspected neglect and abuse to the common entry point; and

12. Provide the participant with a copy of the service-related rights at the start of services and supports.

B. CFSS agency-providers enrolled to provide services under the medical assistance program shall comply with the following:

1. Owners who have a five percent interest or more and all managing employees are subject to a background study. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

    a. the organization has not initiated background studies on owners and managing employees; or

    b. the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified, and the owner or managing employee has not received a set aside of the disqualification;

2. A background study must be initiated and completed for all CFSS direct service providers

C. Support workers delivering services under the agency-provider model or the budget model shall comply with the following:

1. Must be at least 18 years of age, except that a 16 or 17 year old may be a support worker if they meet all of the requirements for the position, have supervision every 60 days, and are employed by only one CFSS provider agency; or if employed under the budget model, as allowed under state and federal child labor laws.
2. Must not provide more than 275 hours of CFSS per calendar month, regardless of the number of participants being served or the number of agencies or participants the worker is employed by.

3. Must not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker

4. Must enroll with the department after clearing a criminal background study.

5. Must effectively communicate with the participant, and CFSS provider agency or financial management services contractor.

6. Must provide covered services according to the service delivery plan, respond appropriately to participant needs, and report changes to entities specified in the person-centered service delivery plan.

7. Must maintain daily written records.

8. Must report any suspected abuse, neglect or financial exploitation of the participant to appropriate authorities.

9. Must complete standardized training.

10. Parents, stepparents, or legal guardians of a participant under age 18, or the participant's spouse may be providers of CFSS services, except they may not provide CFSS in excess of 40 hours per 7 day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:
    • number of parents,
    • combination of parent(s) and spouse, or
    • number of children who receive CFSS

    A participant receiving private duty nursing services provided through the private duty nursing hardship waiver may not receive more than 40 hours per week of any combination of services (CFSS or PDN) from parents, stepparents, family foster parents, spouses, and legal guardians.

D. Consultation Services contractor(s) shall:

1. Enroll as a Medical Assistance provider meeting all applicable provider standards;

2. Comply with Medical Assistance provider requirements;

3. Demonstrate compliance with law and policies of Community First Services and Supports to be determined by the Department;

4. Comply with background study requirements;

5. Not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential participants, guardians, family members or participants' representatives;

6. Report suspected neglect and abuse to the common entry point; and

7. Provide the participant with a copy of the service-related rights at the start of services and supports.

The provider qualification for the Consultation Service contractor(s) will be further outlined in the contract with the State. They will be required to provide orientation to CFSS and describe the models, differences between them and how to select the model. This provider will also be required to assist the participant in creating a detailed plan of how to use the authorized amount of CFSS services and will be a resource for participants to get further CFSS information, instruction, planning, remediation, and referrals to CFSS providers.

XI. Permissible Purchases

A. x The State elects to permit participants to use their service authorization to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. ___ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

XII. Interaction with Personal Care Services

Persons receiving CFSS services under this Attachment of the state plan are not eligible to receive personal care assistance services as described in item 26 of Attachments 3.1-A and 3.1-B.

30. Community First Services and Supports.

Payment under the agency-provider model with service unit allocation is the lower of the submitted charge, or the state agency established rate, up to the number of units authorized participant's approved service allocation:

Service provided on or after	04/01/2014
Personal Care 1:1 unit	$3.92
Personal Care 1:2 unit	$2.94
Personal Care 1:3 unit	$2.58
Worker Training and Development	$6.89

[**NOTE**: 1 unit = 15 minutes]

Shared care: For two recipients sharing services, payment is one and one-half times the payment for serving one recipient. For three recipients sharing services, payment must not exceed two times the payment for serving one recipient. This paragraph applies only to situations in which all recipients were present and received shared services on the date for which the service is billed.

Under the budget model, an amount equal to the recipient's authorized service units multiplied by the amount listed in the table above for a 1:1 unit, reduced by an amount necessary to pay for program administration, is deposited with the recipient's financial management services contractor for use by the recipient. Recipients may not pay a base wage that exceeds the community standards for a comparable service as determined by the recipient's financial management services vendor.

Recipients receiving services under the agency-provider model who then transfer to the budget model, will have any remaining service units converted to a service budget as described above.

Community first services and supports identified in an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA) and provided by school districts during the school day to children with IFSPs/IEPs are paid pursuant to the methodology in item 13.d.v Rehabilitative services.

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

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):*

Community First Services and Supports (CFSS)

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

X	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)*:		
	X	The Medical Assistance Unit *(name of unit)*:	Health Care Administration
	O	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.*	
O	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.		

3. 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 State plan HCBS enrollment managed against approved limits, if any	☑	☐	☐	☐
3 Eligibility evaluation	☑	☐	☐	☐
4 Review of participant service plans	☑	☐	☐	☐
5 Prior authorization of State plan HCBS	☑	☐	☐	☐
6 Utilization management	☑	☐	☐	☐
7 Qualified provider enrollment	☑	☐	☐	☐
8 Execution of Medicaid provider agreement	☑	☐	☐	☐
9 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
11 Quality assurance and quality improvement activities	☑	☐	☐	☐

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

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

4. ☒ **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 provider 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):*

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

6. ☒ **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.

7. ☒ **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 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	4/1/2014	6/30/2014	331
Year 2	7/1/2014	6/30/2015	1,689
Year 3	7/1/2015	6/30/2016	2,161
Year 4	7/1/2016	6/30/2017	2,272
Year 5			

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.)

2. Income Limits.

☐ In addition to providing State plan HCBS to individuals described in item 1 above the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for home and community-based services under the needs-based criteria established under 1915(i)(1)(A) or who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. (*Select one*):

☐ The State covers all of the individuals described in item 2(a) and (b) as described below. (*Complete 2(a) and 2(b)*)

☐ The State covers only the following group of individuals described below. (*Complete 2(a) or 2(b)*)

2. (a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit, have income that does not exceed 150% of the federal poverty line, and will receive 1915(i) State plan HCBS.

Methodology used (*Select one*):
☐ AFDC
☐ SSI
☐ OTHER (*Describe*):

For States that have elected the AFDC or the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. (*Specify*):

2.(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d), (e), or section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income federal benefit rate. For individuals eligible for 1915(c), (d), or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c)-like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals found eligible using institutional eligibility rules. (*Select one*):

☐ 300% of the SSI/FBR
☐ (*Specify*) _____% Less than 300% of the SSI/FBR

(*Select one*):
☐ Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible: ___

☐ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible:

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

○	The State does not provide State plan HCBS to the medically needy.	
X	The State provides State plan HCBS to the medically needy *(select one):*	
	○	The State elects to disregard the requirements at section 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, medically needy individuals only receive 1915(i) services.
	X	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
O	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 amount of CFSS service is determined by the person-centered assessment to be conducted by a certified assessor. Certified assessors will have completed training and the certification processes determined by the Department. Certified assessors are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based experience that has received training and certification specific to assessment and consultation for long-term services in the state.

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:

Persons requesting assessment, services planning, or other assistance intended to support community-based living, must be visited by a certified assessor within 20 calendar days after the date on which an assessment was requested or recommended. The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a community support plan that meets the consumer's needs. The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. With the permission of the person being assessed or the person's designated or legal representative, the person's current or proposed provider of services may submit a copy of the provider's assessment or written report outlining its recommendations regarding the client's care needs.

If the person chooses to use community-based services, the person or the person's legal

representative must be provided with a written community support plan within 40 calendar days of the assessment visit. The written community support plan must include:

(1) a summary of assessed needs

(2) the individual's options and choices to meet identified needs,

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

The certified assessor must give the person or the person's legal representative the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual;

(3) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(4) the role of the assessment in eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services;

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the certified assessor;

(7) the person's right to confidentiality under state and federal law;

(8) the certified assessor's decision regarding the person's need for institutional level of care and the certified assessor's decision regarding eligibility for all services and programs; and

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs and incorporating the decision regarding the need for institutional level of care

4. ☒ **Reevaluation Schedule**. *(By checking this box the State assures that):* Needs-based eligibilityreevaluations 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):*

1. The amount of CFSS authorized will be based on the participant's home care rating, which is determined in the course of the person-centered assessment. The home care rating shall be determined by identifying the following for a participant: the total number of dependencies of activities of daily living (ADL's); the presence of complex health-related needs; and the presence of Level I behavior, meaning physical aggression towards self, others or destruction of property that requires the immediate response of another person.

2. Each home care rating has a base number of minutes assigned. Additional minutes are added through the assessment and identification of the following:
   a. 30 additional minutes per day for a dependency in each critical activity of daily living: eating, transfers, mobility, toileting; and
   b. 30 additional minutes per day for each complex health-related function; and
   c. 30 additional minutes per day for each behavior issue.

3. For participants assessed as eligible for private duty nursing services, CFSS may be authorized above the limits set by the CFSS service methodology. CFSS or private duty nursing services or the combination of CFSS and private duty nursing services may not exceed authorization limits for private duty nursing.

6. ☒ **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):*

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
For CFSS service eligibility, the person requires assistance and is determined, based on the person-centered assessment, to be dependent in at least one activity of daily living and/or as having a Level 1 behavior, meaning physical aggression	A person is determined to be NF LOC by the following criteria: - Need for clinical monitoring or - Dependency in four or more activities of daily living or - Need the assistance of another person or constant supervision	A person must meet all of the following: • In need of continuous active treatment • Have a diagnosis of developmental disability or a related condition • Require a 24-hour	A person must meet all four of the following: 1. Need skilled assessment and intervention multiple times during a 24-hour period to maintain health and prevent deterioration

towards self, others or destruction of property that requires the immediate response of another person.	to begin and complete toileting *or* transferring, *or* positioning and the assistance cannot be scheduled or - Significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention or - The person lives alone (or will live alone) and • is at risk of maltreatment or neglect by another or at risk of self-neglect or • has had a fall resulting in a fracture within the last 12 months or • has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.	plan of care • Require aggressive and consistent training due to an inability to apply skills learned in one environment to a new environment	of health status. 2. Have both predictable health needs and the potential for changes in condition that could lead to rapid deterioration or life-threatening episodes. 3. Require a 24-hour plan of care, including a back-up plan, to reasonably assure health and safety in the community. 4. Be expected to require frequent or continuous care in a hospital without the provision of CAC waiver services.

*Long Term Care/Chronic Care Hospital

7. ☒ **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. 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). (*Specify target group(s)*):

The target group is individuals eligible for Medical Assistance under the State Plan, who meet the CFSS eligibility criteria of having at least 1 ADL or 1 Level One behavior, have income that does not exceed 150% of the FPL, but do not require an institutional level of care.

(By checking the following boxes 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. ☒ **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

CFSS services are available and provided to individuals residing in settings that meet the federal and state regulatory requirements for a home and community-based setting and include, but are not limited to single-family homes, duplexes, apartments, congregate independent living communities, and settings that provide room and board.

Person-Centered Planning & Service Delivery

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

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. ☒ Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. 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 physical and mental needs for HCBS. *(Specify qualifications):*

Certified assessors will have completed training and the certification processes determined by the Department. Certified assessors are people with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience, or a registered nurse without public health certification with at least two years of home and community-based

experience

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The provider qualification for the consultation services contractor(s) will be outlined in the contract with the State. They will be required to provide orientation to CFSS and describe the models, differences between the models, and how to select a model. This provider will also be required to assist the participant in creating a detailed plan of how to use the authorized amount of CFSS services and will be a resource for participants to get further CFSS information, remediation, planning, and referrals to CFSS providers.

5. **Supporting the Participant in Plan of Care Development**. 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 plan of care development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Following assessment and completion of a community support plan, the participant chooses a provider of consultation services. The consultation service provider:

a) provides orientation about agency-provider model and the budget model, including information on roles, responsibilities, processes, policies and options available for services and supports;
b) assures a person-centered planning process;
c) assists the participant or the participant's representative, if appropriate, in developing, implementing and evaluating a CFSS service delivery plan.

The CFSS service delivery plan reflects the services and supports chosen by the participant to meet their assessed needs. The service delivery plan shall be reviewed at least annually upon reassessment or when there is a change in the need for services and supports. The CFSS service delivery plan is person-centered and:

a) specifies the agency provider or financial management services contractor selected by the participant;
b) reflects the setting in which the participant resides that is chosen by the participant;
c) reflects the participant's strengths and preferences;
d) includes the means to address the clinical and specialized support needs of the participant;
e) includes the individual's identified goals and desired outcomes;
f) reflects the services and supports, paid and unpaid, that will assist the participant in achieving identified goals, and the providers of those services and supports, including natural supports;
g) identifies the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;
h) identifies risk factors and measures in place to minimize them, including individualized backup plans;
i) is understandable to the participant, and the individuals providing support;
j) identifies the individual or entity responsible for monitoring the plan;
k) is finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;

l) is distributed to the participant and other people involved in the plan; and
m) prevents the provision of unnecessary or inappropriate care.
n) Includes a detailed spending budget, including worker related expenses and expenses related to the purchase of goods (only applicable to recipients who choose the budget model)

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 plan of care):*

The consultation services described above also include information on how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

7. Process for Making Plan of Care Subject to the Approval of the Medicaid Agency. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The consultation services provider described above will submit the service delivery plan to the lead agency responsible for conducting the face to face assessment. The lead agency will input the service delivery plan information into MMIS for approval by the Medicaid Agency.

8. Maintenance of Plan of Care 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):*

☐	Medicaid agency	☐	Operating agency	☐	Case manager
☒	Other (*specify):*	The service delivery plan is maintained by the lead agency for a minimum of three years.			

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:	Community First Services and Supports (CFSS)
Service Definition (Scope)*:*	
Community First Services and Supports are defined in Attachment 3.1-K.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*	
☒	Categorically needy *(specify limits):*
	Services are limited to service units or service budget amounts available as determined through the assessment of the participant's needs. Worker training and development services are not subject to the participant's individual service authorization limit. The worker training and development service will be determined per participant need with a minimum of 96 units per annual allocation. Persons receiving CFSS services under this Attachment of the state plan are not eligible to receive personal care assistance services as described in item 26 of Attachments 3.1-A and 3.1-B.
☒	Medically needy *(specify limits):*
	Services are limited to service units or service budget amounts available as determined through the assessment of the participant's needs. Worker training and development services are not subject to the participant's individual service authorization limit. The worker training and development service will be determined per participant need with a minimum of 96 units per annual allocation. Persons receiving CFSS services under this Attachment of the state plan are not eligible to receive personal care assistance services as described in item 26 of Attachments 3.1-A and 3.1-B.

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Support Workers	N/A	N/A	1. Must be at least 18 years of age; except that a 16 or 17 year old may be a support worker as allowed under state and federal child labor laws, and if employed by an agency the 16 or 17 year old must meet all of the requirements for the position, have supervision every 60

			days, and be employed by only one CFSS provider agency. 2. Must not provide more than 275 hours of CFSS per calendar month, regardless of the number of participants being served or the number of agencies or participants the worker is employed by. 3. Must not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker 4. Must enroll with the department after clearing a criminal background study. 5. Must effectively communicate with the participant, and CFSS provider agency or financial management services contractor. 6. Must provide covered services according to the service delivery plan, respond appropriately to participant needs, and report changes to entities specified in the person-centered service delivery plan. 7. Must maintain daily written records. 8. Must report any suspected abuse, neglect or financial exploitation of the participant to appropriate authorities. 9. Must complete standardized training. 10. Parents, stepparents, or legal guardians of a participant under age 18, or the participant's spouse, may not provide CFSS in excess of 40 hours per 7 day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the: • number of parents, • combination of parent(s) and spouse, or • number of children who receive CFSS • For a participant who is receiving private duty nursing services provided through the

			private duty nursing hardship waiver, the participant may not receive more than 40 hours per week of any combination of services (CFSS or PDN) from parents, stepparents, family foster parents, spouses, and legal guardians.
Consultation Services Contractor	N/A	N/A	1. Enroll as a Medical Assistance Minnesota Health Care Programs provider meeting all applicable provider standards; 2. Comply with Medical Assistance provider requirements; 3. Demonstrate compliance with law and policies of Community First Services and Supports to be determined by the Department; 4. Comply with background study requirements; 5. Not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential participants, guardians, family members or participants' representatives; 6. Report suspected neglect and abuse to the common entry point; and 7. Provide the participant with a copy of the service-related rights at the start of services and supports. Provider qualifications for the consultation service contractor(s) will be further outlined in the contract with the State. They will be required to provide orientation to CFSS and describe the models, differences between them and how to select the model. This provider will also be required to assist the participant in creating a detailed plan of how to use the authorized amount of CFSS services and will be a resource for participants to get further CFSS information, remediation, planning, and referrals to CFSS providers.

Financial Management Services Contractors	N/A	N/A	1. Enroll as a Medical Assistance Minnesota Health Care Programs provider meeting all applicable provider standards; 2. Comply with Medical Assistance provider requirements; 3. Demonstrate compliance with law and policies of Community First Services and Supports to be determined by the Department; 4. Comply with background study requirements; 5. Verify and maintain records of all services and/or expenditures by the participant including hours worked by the support workers and providers of worker training and development; 6. Not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential participants, guardians, family members or participants' representatives; 7. Pay CFSS workers based upon actual hours of services provided; 8. Withhold and pay all applicable federal and state payroll taxes; 9. Make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any; 10. Be knowledgeable of: • state and federal employment regulations under the Fair Labor Standards Act of 1938; • requirements under the Internal Revenue Service Revenue Code Procedure 70-6 Section 3504 Agency Employer Tax Liability for vendor/fiscal employer agent; and • any requirements necessary to process employer and employee deductions; 11. Assist the participant to maintain compliance

			with State and Federal labor laws and regulations 12. Enter into a written agreement with the participant or the participant's representative or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided; 13. Have current and adequate liability insurance, bonding and sufficient cash flow; 14. Report suspected neglect and abuse to the common entry point; and 15. Provide the participant with a copy of the service-related rights at the start of services and supports.
CFSS Agency-providers	N/A	N/A	1. Enroll as a Medical Assistance Minnesota Health Care Programs provider meeting all applicable provider standards; 2. Comply with Medical Assistance provider requirements; 3. Demonstrate compliance with law and policies of Community First Services and Supports to be determined by the Department; 4. Comply with background study requirements; 5. Verify and maintain records of all services and/or expenditures by the participant including hours worked by the support workers and providers of worker training and development; 6. Not engage in any agency-initiated direct contact or marketing in person, by phone, or other electronic means to potential participants, guardians, family members or participants' representatives; 7. Pay CFSS workers based upon actual hours of services provided; 8. Withhold and pay all applicable federal and

			state payroll taxes; 9. Make the arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any; 10. Enter into a written agreement with the participant or the participant's representative or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided; 11. Report suspected neglect and abuse to the common entry point; and 12. Provide the participant with a copy of the service-related rights at the start of services and supports. 13. Owners who have a five percent interest or more and all managing employees are subject to a background study. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if: a. the organization has not initiated background studies on owners and managing employees; or b. the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified, and the owner or managing employee has not received a set aside of the disqualification;

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):*
Support Worker	State Medicaid Agency	The agency verifies qualifications at initial enrollment and receives regular

		notification of incidents that would otherwise lead to a failed background study.
Consultation Services Contractor	State Medicaid Agency	The agency verifies provider qualifications during the contracting process and again during the contract renewal process.
Financial Management Services Contractor	State Medicaid Agency	The agency verifies provider qualifications during the contracting process and again during the contract renewal process.
CFSS Agency-provider	State Medicaid Agency	The agency's provider enrollment division verifies qualifications at initial enrollment and during an annual review.

Service Delivery Method. *(Check each that applies)*:			
☒	Participant-directed	☒	Provider managed

3. ☒ **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):*

(a) – (b) Any provider who meets the qualifications above may provide CFSS services with the following exceptions. Support worker services provided by parents, stepparents, or legal guardians of a participant under age 18, or the participant's spouse, may not provide CFSS in excess of 40 hours per 7 day period. For parents of minor children and spouses, 40 hours is the total amount per family regardless of the:

- number of parents,
- combination of parent(s) and spouse, or
- number of children who receive CFSS

For a participant who is receiving private duty nursing services provided through the private duty nursing hardship waiver, the participant may not receive more than 40 hours per week of any combination of services (CFSS or PDN) from parents, stepparents, family foster parents, spouses, and legal guardians.

(c) The CFSS budget model allows the recipient to choose the provider of support services. This allows the recipient to choose a provider who they believe best meets their needs and who they feel comfortable working with. This is the hallmark of self-direction. Those individuals who choose to receive services through an agency-provider while having a lesser role in the selection of their service provider, still retains a significant role in the selection and dismissal of their support workers.

(d) – (e) Services must be provided within the assessed limits. For recipients receiving services under the budget model, the consultation services provider and FMS will work to ensure that services are provided within the scope of the service delivery plan.

Participant-Direction of Services

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

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

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

Under the budget model, participants accept more responsibility and control over the services and supports described and budgeted within their person-centered service delivery plan. Participants may use their service budget to directly employ and pay qualified support workers and obtain other supports and goods as defined in our service package. Participants will use a financial management services contractor for the billing and payment of services and maintain compliance with employer related duties. Participants may utilize the consultation service for assistance in learning how to recruit, select, train, schedule, supervise, direct, evaluate and dismiss support workers.

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

X	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
Community First Services and Supports	☒	☒

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

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

6. ☒ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

6. 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):*

Participants may only disenroll from one model of service to the other once during the service year and/or upon reassessment. Participants who voluntarily disenroll from the budget model to the agency-provider model will have their remaining service budget converted to service units based on the rate described in Attachment 4.19-B, Item 30.

Participants may be involuntarily disenrolled from the budget model to the agency provider model under the Minnesota Restricted Recipient program. The Minnesota Restricted Recipient Program identifies recipients who have used services at a frequency or amount that is not medically necessary and/or who have used health services that resulted in unnecessary costs. Once identified, such recipients are placed under the care of a designated primary care physician/other providers who coordinate their care for a 24-month period.

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). (*Select one):*

○	The State does not offer opportunity for participant-employer authority.	
X	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). (*Select one):*

○	The State does not offer opportunity for participants to direct a budget.
X	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 how the method makes use of reliable cost estimating information, 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 plan of care):*

	The amount of CFSS authorized will be based on the participant's home care rating, which is determined in the course of the person-centered assessment. The home care rating shall be determined by identifying the following for a participant: the total number of dependencies of activities of daily living (ADL's); the presence of complex health-related needs; and the presence of Level I behavior, meaning physical aggression towards self, others or destruction of property that requires the immediate response of another person. Each home care rating corresponds to a base number of service units. Recipients choosing the budget option shall have their assessed units converted to a budget by multiplying the number of authorized service units by the rate paid under the agency-provider model as described in Attachment 4.19-B, Item 30. The budget is recalculated annually at reassessment. The budget may also be recalculated at any time during the year based on a recipient's change in need.
	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):*
	Recipients choosing the budget model will work with a financial management services contractor (FMS). The FMS will: • bill and make payments for expenditures; • provide employer agent functions in accordance with the Internal Revenue Code Procedure 70-6 Section 3504 Agency Employer Tax Liability (regulation 137036-08) that includes assistance with filing and paying payroll taxes, employee personnel file, and obtaining Worker Compensation coverage; and • keep records and provide recipients with a monthly written summary of the spending for services and supports that were billed against the spending budget. The consultation service provider works with the participant to develop a person-centered service delivery plan that recognizes the risk factors and develops measures and strategies to mitigate them. Risk factors include premature depletion and underutilization of the assessed budget. The FMS will review the risk mitigation plan and track expenditures accordingly. If the FMS determines there is a consultation services through a consultation services provider.

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity that conducts discovery activities)*	**Frequency**	**Remediation Responsibilities** *(Who corrects, analyzes,and aggregates remediation activities; required timeframes for remediation)*	**Frequency** *of Analysis and Aggregation*
Level of care determinations are completed for all CFSS applicants served under the 1915(k) option.	Number of CFSS participants who are reassessed at least annually, and who have level of care determination per SFY / Total number of CFSS participants for whom annual reassessments should have been completed per SFY.	MMIS sampling of all recipients.	State Medicaid Agency	Continuous and ongoing data collection.	No remediation is needed since this assurance is part of the functionality of the assessment and support planning application, and is continuous and ongoing.	Annually
All CFSS participants are reassessed	Number of CFSS participants who	MMIS sampling of all recipients.	State Medicaid Agency	Continuous and ongoing data	No remediation is needed since this	Annually

at least annually.	are reassessed at least annually, and who have level of care determination per SFY / Total number of CFSS participants for whom annual reassessments should have been completed per SFY.			collection.	assurance is part of the functionality of the assessment and support planning application, and is continuous and ongoing.	
CFSS support planning addresses health and safety needs, reflects assessed needs, and reflects participant choice-making.	Number of CFSS participant assessments and community support plans (CSP) reviewed that meet criteria / Total number of CFSS assessments and community support plans reviewed.	Sampling methodology yielding a statistically significant result using data from the CFSS Community Support Plan Audit Data Base.	State Medicaid Agency	Data will be collected continuously with a review of each lead agency once every three years.	Community support plan audits use a standardized audit protocol and representative random sampling resulting in corrective action plans for remediation. Remediation occurs annually for managed care audits. The SMA issues corrective actions as	Annually

					indicated at the time of the lead agency review.	
All service authorizations letters include a notice of appeal rights and instructions for filing an appeal.	Number of service authorization letters reviewed that include appeal rights and instructions/Total number of service authorization letters.	Sampling methodology yielding a statistically significant result using date from MMIS.	State Medicaid Agency	Continuous and ongoing data collection.	All service authorizations letters include a notice of appeal rights and instructions for filing an appeal. Remediation at the individual level is an appeal or grievance. The SMA reviews aggregate data about appeals and grievances for systems improvement opportunities.	Annually
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of	Number of CFSS support workers who complete training on child protection, maltreatment, vulnerable adults and responsibilities as mandated	MMIS sampling of all providers.	State Medicaid Agency	Continuous and ongoing data collection.	Provider enrollment cannot occur without demonstrated, documented receipt of training provided by the SMA.	Annually.

restraints.	reporters/Number of support workers enrolled 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
A team of program and policy staff for DHS Continuing Care Administration will review and analyze collected performance measure and remediation data. This team will make recommendations for systems 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.			

State: §1915(i) State plan HCBS State plan Attachment 4.19–B:
TN:
Effective: Approved: Supersedes:

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)

☒	Other Services (specify below)
	Community First Services and Supports as authorized under 1915(k) of the Act. Payment methodologies are described in Attachment 4.19-B, Item 30.

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

James and Lorie Jensen, et al.,

Plaintiffs,

vs.

Minnesota Department of Human Services, et al.,

Defendants.

Case No. 09-cv-01775 DWF/FLN

CERTIFICATE OF SERVICE

I hereby certify that on April 22, 2014, I caused the First Minnesota Olmstead Sub-Cabinet Report to the Court, with Appendices and Exhibits, to be electronically filed and served by CM/ECF upon:

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Shamus O'Meara, Esq.
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I further certify that the above-named documents were provided electronically to:

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Dated: April 22, 2014.

OFFICE OF THE ATTORNEY GENERAL
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s/ Scott H. Ikeda

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