Quality Improvement Strategy

Reform: Pathways to Independence
Section 1115 Demonstration No. 11-W-00286/5
Alternative Care (2025 – 2030)

Introduction

This is Minnesota's quality improvement strategy for the Reform: Pathways to Independence demonstration (No. 11-W-00286/5) authorized under section 1115 of the Social Security Act. This strategy is being submitted to the Centers for Medicare and Medicaid Services (CMS) by the Minnesota Department of Human Services (DHS) as required by item 8.4 of the demonstration's current Special Terms and Conditions (STC) dated January 2, 2025, and aligns with the demonstration period from February 1, 2025 to January 31, 2030.

Background

The Reform demonstration includes the Alternative Care (AC) program. The AC program serves individuals aged 65 and older who meet the nursing facility level of care criteria and have income or assets above the Medical Assistance (MA)[1] standards. The AC program was established as an alternative to nursing facility placement. By providing community-based services to seniors with modest income and assets who are not yet eligible for MA, people are able to remain in their homes and communities.

DHS' Aging and Adult Services Division is responsible for policy development, program implementation, and oversight of the AC program. DHS delegates assessment and support planning functions to county agencies and federally recognized American Indian tribal human service agencies that contract with DHS.[2] The Aging and Adult Services Division provides oversight and ongoing support to county and tribal human service agencies. It

[1] Minnesota's Medicaid program.

[2] Five tribal human service agencies contract with DHS to administer the AC program: Gaa-waabaabiganikaag (White Earth Nation), Gaa-zagaskwaajimekaag (Leech Lake Band of Ojibwe), Misi-zaaga'iganiing (Mille Lacs Band of Ojibwe), Miskwaagamiiwi-Zaagaiganing (Red Lake Nation), and Zagaakwaandagowininiwag (Bois Forte Band of Chippewa).

also provides ongoing support to providers to assist them in furnishing services in accordance with AC program policies, procedures, and regulations. The objectives of the AC program include:

1. Supporting older people in their homes and communities and supporting informal caregivers;
2. Offering services to enhance self-sufficiency in the community;
3. Offering the opportunity to receive services from formal providers, natural supports and through technology; and
4. Offering the option for participants to direct their own services.

Organizational Structure

The AC program is managed and administered by DHS, the State's Medicaid agency. DHS delegates certain AC program operations to county and tribal human service agencies. Activities delegated include:

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

Members of tribes[3] may elect to be assessed for AC program services and receive case management through their tribal human service agency. The tribe is then responsible for assessment of program eligibility, development of person-centered support plans, and arranging, authorizing, and monitoring services. Participants who do not elect to receive case management through their tribe may choose to have the county provide case management.

Home and Community Based Services (HCBS) Delivery Models

A person-centered support plan is developed for each participant following a comprehensive needs assessment. As described above, the assessment is completed by the county or tribal human service agency. The AC program offers the option for participants to self-direct their services through the consumer-directed community supports (CDCS) service option or to receive services in a traditional[4] manner. Person-centered planning is required in all instances, with additional person-centered planning elements required for participants who elect CDCS.

---

[3] In some instances, due to an individual's relationship to a member of a tribe, the person may be eligible to receive case management through a contracted tribal human service agency.

[4] Traditional goods and services are those available under the AC program that are not provided in a fully consumer directed manner.

Approved HCBS Demonstration Services

The following services are available under AC. Service descriptions and provider qualifications are detailed in attachment D of the current STCs.

- Adult companion services
- Adult day services, including family adult day services
- Adult day services bath
- Case management, case management aide, and conversion case management
- Chore services
- Consumer-directed community supports, including:
  - Community integration and support
  - Environmental modifications and provisions
  - Environmental modifications – home modifications
  - Environmental modifications – vehicle modifications
  - Financial management services
  - Individual-directed goods and services
  - Personal assistance
  - Self-direction support activities
  - Support planning
  - Treatment and training
- Discretionary services
- Environmental accessibility adaptations – home modifications
- Environmental accessibility adaptations – vehicle modifications
- Family caregiver services, including caregiver counseling and caregiver training
- Home delivered meals
- Home care services, including home health aide, home care nursing, skilled nursing, and tele-home care
- Homemaker
- Individual Community Living Supports
- Nutrition services
- Personal care
- Respite
- Specialized equipment and supplies, including Personal Emergency Response Systems
- Transitional services
- Transportation (non-medical)

State Quality Management Activities

DHS designed its quality improvement strategy to address federal requirements and state goals. DHS' primary quality improvement activities are described below.

DHS incorporated existing systems and processes into the framework for the quality improvement strategy, as well as the corresponding discovery and remediation activities. DHS' quality improvement strategy includes activities performed by DHS' Licensing Division, DHS' Adult Protection unit, DHS' Lead Agency Review team, and the Minnesota Department of Health.

The quality improvement strategy includes the following which are then described:

1. Lead agency reviews;
2. Quality assurance plans;
3. MMIS controls;
4. MnCHOICES application;
5. Data analysis;
6. Fair hearing requests;
7. Consumer surveys;
8. Audits of enrolled service providers; and
9. Adult protection system.

1. **Lead agency reviews:** DHS conducts reviews of the functions delegated to county and tribal human service agencies on an ongoing basis. County and tribal human service agencies are randomly selected for review each year. The purpose of the review is to monitor county and tribal human service agency compliance with program requirements, performance of delegated administrative functions, evaluate how the needs of participants are being met, identify best practices and quality improvement opportunities, and identify areas for technical assistance. Each county and tribal human service agency is reviewed at least once every four years.

   The reviews include a randomly selected representative sample of participant case files for the AC program and each of Minnesota's Medicaid Section 1915(c) waiver programs. If DHS finds a county or tribal human service agency deficient in any reviewed activity, the deficiency is documented in a report to the agency and the county or tribal human service agency must submit a corrective action plan to correct 100% of all identified deficiencies. A county or tribal human service agency has 60-days to correct all compliance issues and certify the corrections were made. The corrective action plans are posted on DHS' Lead Agency Review website.[5]

2. **Quality assurance plans:** County and tribal human service agencies submit a Quality Assurance plan (QA plan) to DHS for the AC program (and HCBS waivers) as part of preparation for the review. The QA plan is a self-assessment and self-monitoring tool. Many of the questions in the self-assessment correlate to activities that are assessed during the reviews.

[5] DHS' Lead Agency Review website: https://mn.gov/dhs/hcbs-lead-agency-review/

The QA plan parallels the structure of CMS' quality assurance matrix and includes self-assessment questions concerning AC program operational and administrative activities. If the self-assessment is not fully compliant, the county or tribal human service agency must submit a remediation plan. DHS reviews the remediation plan and discusses with the county or tribal human service agency any areas of concern as part of the technical assistance delivered during the review. DHS also uses the information provided in the QA plans to identify possible regional or statewide trends.

3. **MMIS controls:** DHS' MMIS has multiple editing functions designed to support the integrity of financial and service eligibility, provider qualifications, statewide rate-setting methodology, and financial accountability for the management and administration of AC and all HCBS programs. Level of care and financial eligibility information is entered into MMIS by county and tribal human service agencies. Editing logic is then applied before an applicant is determined and approved eligible for the AC program. Once eligibility is approved in MMIS, the participant's service authorization is entered in MMIS. MMIS has multiple data interfaces to validate participant information including data from provider enrollment, service categories, rate tables, and individual case mix budget amounts. The authorization must be present and approved in MMIS before a claim can be paid. Claims editing assures that claims paid match prior authorizations.

4. **MnCHOICES application:** MnCHOICES is a computer application used by counties and tribal human service agencies to support assessment and support planning work for Minnesotans who may need long-term services and supports, regardless of age, type of disability, or service needs. The application eliminates the need for multiple assessments to receive needed supports and services; helps people choose how they want to live, learn, work and play through the assessment and support-planning process; and supports consistency in completion of the assessment tool, and equal access to services and supports statewide. The MnCHOICES assessment is completed by certified assessors who must meet the qualifications, complete required training, and be certified by DHS.

   MnCHOICES is designed to determine eligibility for a variety of long-term services and supports in a uniform manner. An algorithm is built into MnCHOICES to calculate level of care in a consistent manner for all individuals. When needs are identified through the assessment, they are populated in the support plan to be addressed by the case manager through individualized, person-centered support planning with the participant. The MnCHOICES application supports standardization of assessments and support plans across different county and tribal human service agencies.

5. **Data analysis:** MMIS and MnCHOICES data includes information about assessed needs and planned services for AC program participants. DHS generates several reports using MMIS data such as encumbrance and payment reports that are used to monitor authorization patterns. The reports are available to county and tribal human service agencies as well as DHS staff overseeing the AC program. MMIS and MnCHOICES application information is used for a variety of quality assessment and program improvement purposes. DHS monitors MnCHOICES data to see whether timeframes for assessments and support plans are met, participants are offered a choice between services and providers, and signatures showing participant and case manager agreement with service plans are obtained among other things. Reports are generated

monthly and ad hoc reports are used to research and analyze issues as needed. Custom reports can be created and maintained in MnCHOICES. These reports support county and tribal human service agencies with continuous quality improvement activities and policy compliance monitoring.

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

7. **Consumer surveys:** Minnesota implemented a National Core Indicators - Aging and Disability (NCI-AD) survey that includes AC program participants. Minnesota was one of the original states that piloted the NCI-AD survey, and one of 13 states in 2015-2016 to participate in the first implementation of the finalized survey. Minnesota surveys older adults, including those on AC, through the NCI-AD every other year. Survey results are found on the NCI-AD reports webpage.

8. **Audits of enrolled service providers:** DHS' Provider Eligibility and Compliance Division conducts monthly internal audits to assess compliance with provider screening and enrollment regulations and operational procedures. Twenty percent (20%) of HCBS waiver and demonstration service provider enrollment actions are randomly selected for audit and reviewed each month. All unresolved issues discovered through the audits are resolved by provider enrollment specialists.

9. **Adult protection system:** Minnesota manages intake and response to reports of maltreatment of vulnerable adults through the state's adult protection system pursuant to Minnesota Statutes, sections 626.557 to 626.5573.[6] Maltreatment includes, but is not limited to, criminal acts, actions that cause physical pain, injury or emotional distress, adverse or deprivation procedures not authorized under statute, unreasonable confinement, involuntary seclusion, forced separation, the failure or omission of a caregiver who has assumed responsibility to provide food, shelter, clothing, health care or supervision, failure by the person to meet their own basic needs, and financial exploitation. State law requires immediate reporting of suspected maltreatment by mandated reporters and encourages reporting of suspected maltreatment by any person.

   Mandated reporters include professionals or a professional's delegate engaged in the care of vulnerable adults, those engaged in social services, law enforcement, vocational rehabilitation, licensed health care providers, and those who work in a health care facility or provide a licensed service. DHS provides information and training regarding the reporting of suspected maltreatment. Reports of maltreatment involving vulnerable adults are made to the centralized Minnesota Adult Abuse Reporting Center (MAARC) as required in statute.

[6] https://www.revisor.mn.gov/statutes/cite/626.557

Minnesota's reporting system currently captures all reports of adult maltreatment collected by MAARC and reflects dispositions of county investigations for adult waiver and AC program participants. MAARC operates on a 24-hour basis. MAARC staff assess all maltreatment reports for immediate risk to the vulnerable adult and make an immediate referral to the county for emergency protective services when applicable. All reports of suspected maltreatment made to MAARC are forwarded to the lead investigative agency responsible for investigation and the provision of protective services. If a report is made initially to law enforcement or a lead investigative agency, those agencies are required to take the report and immediately forward it to MAARC. Lead investigative agencies include DHS, the Minnesota Department of Health, and county social service agencies. Reports alleging a crime are also referred to law enforcement for criminal investigation. When an allegation includes death as a result of maltreatment, a referral is also made to the medical examiner and the Ombudsman for Mental Health and Developmental Disabilities.

Training and Support for County and Tribal Human Service Agencies

DHS offers training and other types of technical support to county and tribal human service agencies, including training for new assessors. The trainings include a variety of topics such as changes in program operations, prevention of maltreatment, and other topics related to older populations such as memory loss or prevention of falls. Information gathered from reviews, support plan audits, MMIS reports, stakeholder feedback, and CMS communications to states shapes the focus of training topics each year.

DHS provides web-based training options that can be accessed on demand, replacing previous video streaming methods that occurred at specific times. This makes the delivery of training more accessible and efficient for DHS to develop and maintain, and for county and tribal human service agency staff to access. Webinars, conference presentations and regional meetings continue to be provided by DHS staff to support county and tribal human service agencies, providers, and other interested parties. This includes mandatory training related to the adult protection system and the role of county and tribal human service agencies in assuring the health and safety of participants.

DHS' training and technical assistance, along with written materials such as online manuals and practice guides, supports county and tribal human service agencies in performing delegated administrative and management activities.

State Quality Improvement Strategy

The Data, Policy and Quality Assurance workgroup within the Aging and Adult Services Division is responsible for reviewing the quality improvement strategy and coordinating with other areas of the agency that have similar strategies. The group analyzes data regarding performance measures and identifies remediation processes as needed. Issues requiring intervention beyond existing remediation processes (i.e., system improvements outlined below) are directed to the Aging and Adult Services Division policy team. The policy team completes additional analysis and, if indicated, develops new or revises policies and procedures. The policy team

responsible for this work within the Aging and Adult Services Division meets monthly when issues are identified. The process is outlined below.

AC Program Quality Monitoring and Improvement Process

Input (all identified data sources): Performance Measure and Remediation (monitoring) data

Analysis

1. Is there a problem (single instance or trend) indicated by the monitoring data?
   If yes – test data (step 2).
   If no – return to monitoring.

2. Is the problem real (e.g., not a statistical artifact)?
   If yes – Identify what type of problem is indicated (i.e., policy, process, or an isolated case).
   If no – return to monitoring.

3. Do existing remediation processes address the identified problem?
   If yes – remediate and return to monitoring.
   If no – enter appropriate system improvement realm (i.e., policy or process analysis).

System Improvement

A. Policy Analysis Realm
   1. Can the problem's cause(s) be identified from analysis of the monitoring data?
      If yes – develop data driven policy alternatives.
      If no – develop theory driven policy alternatives.
   2. Test policy alternative(s).
   3. Select "best" policy alternative.
   4. Enact new policy and return to monitoring.

B. Process Analysis Realm
   1. Is the problem an internal (DHS) or external process issue?
   2a. If internal process issue, can the cause(s) be identified from analysis of the monitoring data?
      If yes – develop data driven internal process alternatives.
      If no – develop theory driven internal process alternatives.
   2b. If external process issue, can the cause(s) be identified from analysis of the monitoring data?
      If yes – develop data driven external process alternatives.
      If no – develop theory driven external process alternatives.
   3. Test process alternative(s).
   4. Select "best" process alternative.
   5. Enact new process(es) and return to monitoring.

Systems Design Changes

Using the same process outlined above, staff monitor and analyze the effects of system design changes, and additional systems redesign improvement will be undertaken by the appropriate policy team.

High-level monitoring and trending data is communicated to stakeholders and the public via:

- A web-based performance measure dashboard developed by DHS at Long-term services and supports program performance / Minnesota Department of Human Services
- DHS quality management-related stakeholder groups
- Mandated legislative reports, if applicable