Lead Agency HCBS Assurance Plan

SCALE: 1=Always 2=Most of the time 3=Some of the time 4=Never

I. Participant Access

Indicate how often the Lead Agency…	
Q01	Provides information and referrals about Long Term Services and Supports (LTSS) options.
Q02	Carries out education activity related to the availability of HCBS.
Q03	Provides early intervention activities.
Q04	Provides information about Minnesota Health Care Programs.
Q05	Coordinates with the Senior Linkage Line to conduct telephone screenings and accepts referrals for in-person screenings for nursing facility admission in accordance with First Contact requirements.
Q06	Visits participants under 65 admitted to facilities within timelines as outlined in law.
Q07	Completes nursing facility level of care determination using criteria provided by DHS.
Q08	Makes referrals to appropriate mental health/developmental disability professionals for further diagnostic assessment or evaluation (OBRA Level II).
Q09	Provides information about and referrals for persons residing in institutions that request or are referred for assistance to move into community.
Q10	Conducts a face-to-face LTSS assessment for all persons who request or are recommended to have an assessment regardless of public program eligibility.
Q11	Completes new LTSS assessments within required days of request or recommendation per Minnesota statute.
Q12	Assesses family/informal caregiver concerns and needs as applicable.
Q13	Provides information about employment as required in Minnesota Statute.
Q14	Provides information to the person receiving HCBS about freedom of choice between institutional and community-based services.
Q15	Complies with policy requirements related to payment methodologies as specified by the Commissioner in DHS bulletins and applicable updates.
Q16	Conducts long-term services and supports (LTSS) assessments using appropriate tools: Long Term Care Consultation (LTCC) tool; Development Disabilities screening document; Personal Care Assistance (PCA) Assessment and Service Plan; or MnCHOICES, as applicable.
Q17	Assesses the person receiving HCBS using the required program specific assessment forms and processes (e.g. BI Waiver Assessment and Eligibility Determination form, CAC Primary Physician Certification of Level of Care Form, etc.).
Q18	Determines the person receiving HCBS meets the level of care requirements (including, when applicable, hospital, nursing facility and ICF/DD level of care determinations).
Q19	Indicates within the person's Support Plan the need for a service, in addition to case management, that is only available through one of the HCBS waiver programs.
Q20	Includes services, supports and/or strategies to reasonably maintain the person's health and safety in the Support Plan.
Q21	Verifies that there is no alternative payer for the HCBS waiver service needed.
Q22	Conducts reassessment/re-screening to re-determine eligibility at the required minimum frequency.
Q23	Updates the Support Plan is at least annually or when significant changes occur.
Q24	Provides a Support Plan to the person assess following the LTSS assessment within the timeframe as outlined in MN Statute.

Q25	Reassesses persons on the CAC, CADI or BI waiver at age 65 and indicates the person's choice between their existing waiver and EW on the assessment.
Q26	Conducts all new LTSS assessments for persons located in the county/tribe at the time of assessment.
Q27	Conducts all MnCHOICES assessments with certified assessors.
Q28	Verifies all MnCHOICES assessors are recertified every three years.
Q29	Has a process in place to ensure an adequate number of certified assessors to conduct LTSS assessments and support planning within timelines as required by Minnesota statute.
Q30	Has a process in place to ensure certified assessors meet the education, experience and successful completion of the training and certification process.
Q31	Has developed a team of certified assessors including at least one public health nurse, social worker, and other qualified professionals to complete administrative functions for LTSS assessments, per Minn. Stat. §§ 256B.0911, subdivision 3b.
Q32	Provides to DHS, and updates when needed, MnCHOICES administrative contact information for communication purposes.
II. Person-Centered Service Planning and Delivery	
Indicate how often the Lead Agency…	
Q33	Develops a Support Plan for the person assessed based on the goals, preferences, strengths and assessed needs identified from the assessment.
Q34	Verifies person's choice between waiver services and institutional care.
Q35	Includes identifying information in the plan (facilitator name, person's name, other people involved, date of birth, current living environment).
Q36	Lists planning participants in the plan, and are people who are important to the person (family, friends, etc.).
Q37	Describes quality and frequency of friendships and/or family interactions in the person's plan.
Q38	Describes a person's daily rituals and routines (including quality, choice, and preferences).
Q39	Includes a clear purpose statement about why the plan is created and it is related to the person's preferences.
Q40	Includes a global statement about what the person's dreams are for the future.
Q41	Describes the person's preferred living situation and with whom, if anyone, the person wants to live.
Q42	Includes information on people the person wants to socialize with.
Q43	Includes a description of work, school or retirement activities the person wants to engage in.
Q44	Includes a description of social, leisure or religious activities the person wants to participate in.
Q45	Identifies possible barriers for the person to achieve the life they want to live.
Q46	Documents action steps describing what needs to be done to assist the person to achieve goals.
Q47	Provides the person sufficient information, support and experiences to make informed choices that are meaningful to her/him and to balance and take responsibility for risks associated with choices.
Q48	For individuals in transition: a transition summary and follow-up plan is completed. There is a plan for supporting the person to prepare to move. The plan includes what will be provided, who will do it and when.
The person-centered planning process is driven by the individual. Indicate how often the process…	
Q49	Includes people chosen by the individual.
Q50	Occurs at times and locations of convenience to the indidvidual.
Q51	Prevents the provision of unnecessary or inapprropriate services and supports.
Indicate how often the Support Plan includes services that support the accomplishment of the participant's goals that reflect participant-identified choices and preferences regarding:	
Q52	Community access and inclusion.
Q53	Exercise of service related rights and protection related rights.
Q54	Control over support and services.

Indicate how often the Support Plan…	
Q55	Documents the range of service options or types that will fulfill the person's identified needs (including services available through state plan, person directed community supports, formal and informal means).
Q56	Documents that the most cost-effective alternatives available were offered to the person.
Q57	Documents that all available options and choices for case management services and providers were presented to the person.
Q58	Incorporates assistive technologies that support increased independence or a reduced reliance on human assistance when applicable.
Q59	Documents person's choice between service providers.
Q60	Includes the person's choice of supports as well as professional recommendations for supports.
Q61	Documents how the person will exercise their right to personally manage risks.
Q62	Includes the frequency, mode, and purpose of case management contact.
Q63	Includes provider(s), service type, frequency, and duration of services to be provided to the person.
Q64	Documents that reassessment/rescreening was completed when significant change occurs.
Q65	Documents changes to services that result from a reassessment/rescreening.
Q66	The Support Plan and support planning processes encourage use of volunteers to provide community-based services, as appropriate.
The Support Plan for participants receiving a face-to-face LTSS assessment/screening includes:	
Q67a	Summary of assessed needs
Q67b	Support and service options to meet needs
Q67c	Health and safety risks
Q67d	Referral information
Q67e	Informal caregiver supports, if applicable
III. HCBS Waiver/AC Provider Management and Monitoring	
Q68	Lead Agency maintains records for non-enrolled Tier 2 and/or Tier 3 HCBS waiver/AC providers in accordance with DHS Policy.
Q69	For disability waiver persons (DD, CADI, CAC, and BI), the Lead Agency uses the Disability Waiver Rate System to determine the payment rate for each waiver service.
Q70	The rate calculated by the Disability Waiver Rate System matches the rate listed in the MMIS service agreement.
Q71	For EW and AC persons, the Lead Agency authorizes payments to providers using rate methodologies established by the Commissioner.
Q72	Lead Agency adjusts provider rates in service agreements in accordance with the timelines and the amounts outlined in Minnesota statute.
Q73	Lead agency spends at least 97% of its allocation for waivered services, per Minn. Stat. §§ 256B.0916, subd. 12.
IV. Person Safeguards	
Indicate how often the Lead Agency…	
Q74	Communicates to providers how to contact the Lead Agency or case manager regarding a person.
Q75	Ensures a plan is in place for person's backup assistance when providers aren't available and lack of immediate care would pose a serious threat to health and welfare. (This assurance is intended to be in place at the person level and to reflect individualized planning.)
Q76	Ensures providers have a contingency plan for emergencies when the lack of immediate care would pose a serious threat to health and welfare. (This assurance is directed at community-wide emergencies such as those posed by inclement weather.)
Q77	Monitors the health and safety of the person.
Q78	The case manager has face-to-face or telephone contact with the participant as needed.

Q79	Delivers case management service as indicated in the Support Plan.
Indicate how often the assessment process or support plan…	
Q80	Includes supports, services or strategies to address home conditions determined to be unsafe.
Includes a description of the support, service or strategy to address...	
Q81a	The person's ability to summon assistance when needed
Q81b	The person's means to summon assistance when needed
Q81c	The person's ability to respond in an emergency
Q81d	The service, support or strategy to ensure evacuation in an emergency
Includes a description of the support, service or strategy to address cognitive or behavioral needs including..	
Q82a	Referral for evaluation by appropriate professionals
Q82b	Development of cognitive or behavioral support plans completed by appropriate professionals
Q82c	Training required of staff providing cognitive or behavioral support
Q82d	Use of technology as part of the cognitive or behavioral support plan
Indicate how often the assessment process or support plan…	
Q83	Includes a description of the need for supervision.
Includes a description of the support, service or strategy to address supervision needs that includes…	
Q84a	Type and mode of supervision
Q84b	Frequency of supervision
Q84c	Competencies required of specialized staff providing supervision as necessary
Q84d	Use of technology as part of the supervision plan
Indicate whether the lead agency creates and revises policies and practices as needed that address the following...	
Q85	Prevention, screening, and identification of abuse, neglect, self-neglect and exploitation
Q86	Lead Agency staff report abuse, neglect, self-neglect, and exploitation.
Q87	Case managers monitor behavioral interventions carried out by providers are implemented according to the support team's behavioral strategy for the person and reported to the proper entities.
Q88	Case managers assist in developing positive transition plans required by Minn. Stat. §§ 245D, subd. 23(b).
Q89	Case managers evaluate the implementation of positive support transition plans required by Minn. Stat. §§ 245D, subd. 23(b) at least quarterly and on the basis of (a) phase-out of prohibited procedures, (b) acquisition of skills needed to eliminate prohibited procedures, and (c) accomplishment of identified outcomes.
V. Person's Rights and Responsibilities	
Indicate how often the Lead Agency...	
Q90	Person receives a copy of assessed needs as documented in the Support Plan.
Q91	Person receives information about all HCBS waiver services for which the person is eligible.
Q92	Person receives a copy of service agreements or prior authorizations that includes information about appealing service decisions.
Q93	Person receives a written notice about their rights to appeal each Lead Agency decision regarding determinations, denials or reductions.
Q94	Persons are provided advance notice that adhere to due process requirements related to denial, termination or reduction of services.
Q95	Person receives written notices with any changes to the Support Plan when changes are requested by the person.
Q96	Person receives information about their right to be free from maltreatment and how to report it from materials provided by the lead agency.
Q97	Person receives information about data privacy at the time of assessment/screening.
Q98	Person receives information regarding Ombudsman services.

Q99	Person has access to guardianship or conservator services when needed and appropriate.
Q100	Compliance with documentation, maintenance and retention of client records requirements under the Minnesota Records Retention Law for five years from the date of the last activity on the record, or longer if required under other federal or state statute or rule, per MN Rules Chapter 9505.2160 through 9505.2245.