Quality Management in HCBS 2009: The Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services

A Report to the Minnesota Legislature

Minnesota Department of Human Services
Disability Services Division

March 2009

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes 2008, Minn. Stat. § 256B.096, which requires the Minnesota Department of Human Services to submit a biennial report on the development and activities of the quality management, assurance and improvement system for Minnesotans receiving disability services.

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EXECUTIVE SUMMARY

The Minnesota Legislature requires the Minnesota Department of Human Services to submit a biennial report on the development and activities of the quality management, assurance and improvement system for Minnesotans receiving disability services. *Laws of Minnesota* 2007, Chapter 147, Article 7, Section 18 (Minn. Stat. §256B.096)

Minnesota's four Medicaid home and community-based services (HCBS) waiver programs for persons with disabilities[1] allow the state to use Medicaid funds in providing creative, cost-effective supports and services to individuals in their homes and communities as alternatives to institutional services. Assuring and improving the quality of supports and services for waiver participants is the purpose of quality management in these programs.

Approximately 26,000 people participate in the state's four disability waiver programs, at an annual cost of nearly $1.25 billion. Roughly half of this amount or almost $625 million is federally funded, contingent upon the periodic approval of Minnesota's waiver applications and ongoing compliance with waiver program requirements. To sustain federal approval of its waiver programs, Minnesota must design and implement quality management activities that provide assurance to the Centers for Medicare & Medicaid Services (CMS) that waiver requirements are being met.

The 2007 Legislature enacted law (Minn. Stat. §256B.096) to establish a quality management system for Minnesotans receiving disability services. The purpose of this system is to improve the quality of services provided to individuals, and to meet federal waiver requirements. As foundational system components, the Department of Human Services (DHS) is:

- Developing an annual survey of service recipients to determine the quality and effectiveness of disability services and supports and
- Identifying needed information, data sources and technology to improve Minnesota's system for critical incident reporting, investigation, and analysis.

For the annual survey of service recipients, DHS has chosen to modify and test the Participant Experience Survey (PES) developed for CMS to assist states in meeting waiver quality management requirements. The benefits of basing the survey on the PES include its ability to help states collect and respond to participant feedback, as well to help states demonstrate compliance with waiver requirements. Survey development and field testing in Minnesota are scheduled to be completed by June 30, 2009.

Critical incidents include instances of suspected maltreatment, death and serious injury involving children and vulnerable adults. Under new CMS review criteria, the way in which Minnesota uses critical incident data compromises waiver compliance in three specific areas:

[1] The Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Developmental Disability (DD), and Traumatic Brain Injury (TBI) HCBS waiver programs.

1. Assuring waiver participant health and welfare
2. Assuring non-licensed/non-certified service providers adhere to waiver incident reporting requirements and
3. Assuring DHS exercises appropriate, waiver-specific oversight of the state's critical incident reporting and response system.

To resolve this, Minnesota must:

1. Identify all critical incidents involving waiver participants and
2. Coordinate critical incident data systems so data can be used to support and demonstrate waiver compliance.

Current information technology systems will allow much of this to be accomplished. Up to $50,000 in additional funding may be necessary to integrate important waiver critical incident data from non-DHS sources.

Other identified options with potential to help Minnesota meet locally-defined expectations for quality in its incident reporting systems[2] include:

- Consolidating Minnesota's maltreatment report intake functions and
- Using health information technology and Web-based electronic service records to improve efficiency, quality and cost-effectiveness in incident response and prevention.

Additional DHS activities to enhance quality management in HCBS include:

- Developing provider performance measures for use in assessment and reporting outcomes related to service provider quality and
- Working with an Expert Panel[3] of stakeholders to develop strategies for simplifying and otherwise improving the state's HCBS system.

While meeting new federal compliance criteria for the waiver programs is an immediate need, DHS is using this opportunity to design quality management activities and practices that address common quality assessment and improvement needs across a variety of non-waiver disability services as well, including those provided under the Personal Care Assistance (PCA) and 1915(j) Consumer-Directed Supports Option programs.

[2] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007 (pages 22-24).

[3] See page 24 of this report for more on the HCBS Expert Panel.

I. PURPOSE OF REPORT

The purpose of this report is to update the Minnesota Legislature with regard to:

1. The development of an annual survey of home and community-based disability waiver service participants.
2. The identification of information, data sources and technology needed to improve incident reporting, investigation, analysis and follow-up.
3. Other DHS efforts to improve quality and value in disability services.

Pursuant to *Laws of Minnesota* 2007, Chapter 147, Article 7, Section 18 (Minn. Stat. §256B.096), subdivision 5[4], this is the biennial report on the development and activities of the quality management, assurance and improvement system designed to improve the quality of services provided to Minnesotans with disabilities.

II. BACKGROUND

The scope of services included within the statewide quality management system authorized under Minn. Stat. §256B.096 include the Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Developmental Disabilities (DD) and Traumatic Brain Injury (TBI) home and community-based services (HCBS) waiver programs for persons with disabilities.

The Department of Human Services (DHS) understands the intended outcomes of the quality management system for persons receiving disability services to be:

- Improvement in the quality and value of services provided to individuals participating in these programs and
- Establishment and maintenance of substantial compliance with federal requirements in Minnesota's HCBS waiver programs.

Recommendations and efforts to achieve these outcomes are included within this report.

A. MINNESOTA'S MEDICAID HCBS WAIVER PROGRAMS

Minnesota's Medicaid HCBS waivers[5] allow the state to use Medicaid funds in providing creative and cost-effective supports and services to individuals in their homes and communities as alternatives to institutional services.

[4] See Appendix A to view the language of Minn. Stat. §256B.096.

[5] Including the Elderly Waiver, for persons over 65.

Today, approximately 26,000 people participate in the state's four disability waiver programs, at an annual cost of nearly $1.25 billion. Minnesota is able to make program services available because of federal financial participation (FFP), which currently matches the state nearly dollar for dollar (almost $625 million) of program costs. To obtain FFP, Minnesota submits waiver plans that must be approved by the Centers for Medicare & Medicaid Services (CMS).

B. FEDERAL REQUIREMENTS FOR QUALITY MANAGEMENT IN HCBS WAIVER PROGRAMS

Since the issuance of the 2003 U.S. General Accounting Office (GAO) report[6] critical of federal oversight of quality assurance in states' HCBS waiver programs, CMS has devoted unprecedented effort to holding states accountable for:

- Establishing an effective quality management system within their waiver programs and
- Providing empirical and quantifiable evidence that the desired results or *outcomes* of these programs are being achieved.

The criteria and standards CMS uses to determine states' compliance with federal waiver requirements have increased dramatically since the GAO report was issued. Most notably, CMS has made it clear that certain functions of Minnesota's state-supervised, lead agency-administered HCBS waiver delivery system no longer support compliance with federal requirements for statewide consistency in waiver program administration.[7] Furthermore, requirements for achieving high-quality outcomes continue to evolve. With every waiver review and renewal submitted, CMS expects states to demonstrate improvement upon previous performance, and current improvements in turn set a new and higher baseline for future reviews.

Waiver compliance currently ensures FFP in Minnesota's waiver programs. In addition to lost federal funding, the failure to meet waiver requirements and maintain federal approval would negatively impact Minnesota's ability to conform to the U.S. Supreme Court's *Olmstead v. L.C.* decision and the "integration mandate" (Title II) of the Americans with Disabilities Act. Because CMS "may terminate a waiver when it finds that the state is not meeting one or more waiver requirements (e.g., the state has not assured the health and welfare of waiver participants. . .)," [8] it is fundamental to the integrity of Minnesota's HCBS infrastructure that DHS successfully demonstrate compliance with waiver requirements.

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[6] *Long-Term Care: Federal Oversight of growing Medicaid Home and Community-Based Waivers Should Be Strengthened*. United States General Accounting Office, 2003.

[7] Examples include CMS requirements for Minnesota to: (1) eliminate disparities between lead agencies in rates paid for the same services (2) eliminate lead agency contracts as mechanisms for provider quality management and (3) implement consistent statewide standards for all waiver service providers.

[8] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (page 31).

C. FEDERAL AND LOCAL EXPECTATIONS FOR QUALITY IN HCBS

In addition to the statutory and administrative requirements for waiver programs, it is helpful to examine current *expectations* for quality in home and community-based services to fully understand what quality management is meant to achieve. Demonstrating real quality and value in HCBS waiver programs is not simply a matter of establishing compliance with minimum federal requirements, although that is certainly part of it. Ultimately, what makes a program *worth* administering, a service *worth* receiving, or a price *worth* paying is the achievement of outcomes that show persons with disabilities *and* society as a whole are better off for the services having been provided. DHS recognizes the need to align its programs for persons with disabilities with the desires and expectations of the communities and people they impact, in addition to compliance with federal waiver requirements.

HCBS Quality Framework

To assist states in understanding the federal concept of quality and the comprehensive nature of post-GAO report requirements for quality management in waiver programs, CMS developed the HCBS Quality Framework. In addition to assuring participant health and welfare, the Quality Framework focuses states' attention on seven broad, participant-centered desired outcomes for the delivery of waiver services:

1. Participant Access
2. Participant-Centered Service Planning and Delivery
3. Provider Capacity and Capabilities
4. Participant Safeguards
5. Participant Rights and Responsibilities
6. Participant Outcomes and Satisfaction
7. System Performance[9]

The Quality Framework also establishes state responsibility for implementing three essential elements to assure and improve waiver service quality across all areas of waiver design and operation:

1. **Discovery** – collecting data and direct participant experiences in order to know what outcomes are being accomplished, identifying problems and strengths, and determining opportunities for improvement.
2. **Remediation** – taking action to resolve specific problems on an individual, service or program-level basis.
3. **Continuous Improvement** – using data and quality information to engage in actions that lead to improvements in the achievement of individual, service and program-level desired outcomes.

States must demonstrate compliance with all waiver requirements through measures involving these three elements of quality management.

[9] See Appendix E for further description of the Quality Framework desired outcomes.

National Balancing Indicators

CMS is also developing and testing a set of standard national indicators to assess states' efforts in attaining a person-driven long-term system of services and supports, including HCBS.[10] This work expands the federal concept of quality and what high quality systems of supports and services entail. The hallmarks of a balanced and sustainable long-term support system include methods to ensure that people with disabilities and chronic conditions have choice, control and access to a full array of services that assure independence, optimal health and quality of life.

With the assistance of its National Balancing Indicators contractor, CMS is developing specific indicators to measure states' outcomes according to a set of principles for a balanced system, including:

- Financial Sustainability
- Self-Determination/Person-Centeredness
- Community Integration and Inclusion
- Quality
- Prevention
- Cultural Competence
- Shared Accountability
- Coordination/Transparency

Minnesota Department of Human Services Quality Assurance Activities

Over time, ideas for reform in DHS' approach to quality assurance have acknowledged that Minnesota's process-oriented quality standards do not address the primary issue of consumer outcomes and value of the service rendered.[11] Throughout the late 1990s and early 2000s, DHS undertook a number of projects to aid in the development of a comprehensive quality management system for disability services.[12] Continued focus on quality assurance and improvement is reflected today in the CHOICE Life Domains developed by DHS' Disability Services Division (DSD) to guide the shaping of disability services and define their desired outcomes. Part road map, part yardstick, these domains allow DSD to gauge the success of programs and services by measuring how well their outcomes reflect participant achievement of the following:

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[10] See the *Conceptual Framework for the Long-term Services and Support System: National Balancing Indicator Contract* for further description of the Balancing Indicator principles.

[11] "Thoughts on Regulatory Reform." DHS Health Care, 1995.

[12] Including, for example: the convening on an internal Quality Steering Committee (1997) to develop "a quality assurance framework of support" for persons with disabilities; participation in the National Core Indicators Project (1999); Development of a Quality Assessment Survey (2000-2001) to provide a snapshot of participants' experience with their waiver services; the "Pathways to Choice: Minnesota's Systems Change Initiative" (2001-2004), which used federal grant money to (a) develop the Disability Linkage Line and (b) develop a model for participant-designed and driven quality assurance and improvement functions within Minnesota's long-term care delivery system, and; the development of a "Quality Architecture" (2007) that is shaping future quality management efforts.

- **Community membership** that is grounded in both participation and actual group membership
- **Health, wellness and safety** with an emphasis on features of communication, relationships and trust
- **Own place to live** where people choose both the place and whoever else lives or provides support in their home
- **Important long-term relationships** that are reciprocal and provide for safety
- **Control over supports** including, whenever possible, control over the funding for personal supports, housing and transportation
- **Employment earnings and stable income,** the generation of private income through typical jobs or self-employment or stable income from public and private sources

National and Local Stakeholder Activities

At the national level, the topic of *quality* is frequently raised in the intensifying discussion around health care reform. In recent policy papers and reports, a number of national stakeholder organizations have issued recommendations and key principles for ensuring persons with disabilities are effectively and efficiently served by HCBS and other long-term care services.[13] Recommendations and key principles have consistently included:

- **Quality of Services**: Quality management must go beyond protecting health and safety. It must measure the effectiveness of services in achieving personal outcomes.
- **Quality of Life**: People must be better off for having received services. Quality management mechanisms must be designed to ensure that supports and services maximize the achievement of desired outcomes in participants' lives based on their personal experiences as well as measured results.
- **Information Technology**: Technology applications can streamline labor-intensive activities of assessing need and risks, service planning and monitoring. Individuals and families could better direct their own services, enabling public managers to monitor utilization and cost. Collection of data on utilization, satisfaction and personal outcomes would inform policy development and service design. Just as in acute care, investment in information technology must be a core feature of any system of long-term supports and services.[14]

Locally, Minnesota's community of disability service participants, families, advocates, service providers, researchers and local government entities are as savvy as any in the nation with regard to quality assurance and improvement. As such, it is not surprising that their understanding of quality and their expectations for effective quality management generally reflect the national and local perspectives on quality outlined above.

[13] See Appendix D for References and Resources.

[14] *Health Care Reform: Long-Term Services and Supports for Citizens with Developmental Disabilities*. National Association of State Directors of Developmental Disabilities Services, 2008.

Whether participating in formal processes under state agency auspices or working together on a more grass roots basis, Minnesota's disability services stakeholders have long maintained consistent discussion and activity involving quality assurance and improvement.[15] Achieving quality and value in HCBS and other long-term supports has inspired Minnesota's community of stakeholders to envision and actively support quality management that is efficient, effective and more satisfying to common sense.

D. MINNESOTA QUALITY ASSURANCE PANEL AND THE QUALITY ASSURANCE STAKEHOLDER ADVISORY GROUP

In 2005, responding to increasing federal pressure and long-standing local support to elevate quality management as a priority within the waiver programs, legislation requiring study and recommendations for a quality management system for disability services was passed.[16] In response, DHS established a Quality Assurance (QA) Panel whose recommendations included:

1. A **State Quality Commission** to assure that quality and quality improvement in services and supports for persons with disabilities are approached with seriousness, integrity, creativity and cost effectiveness in all parts of Minnesota.
2. Six **Regional Quality Councils** to provide leadership in setting and responding to regional and statewide priorities for establishing and maintaining high quality and continuously improving home and community-based services.
3. An **annual survey of service recipients** to determine and report the quality and outcomes of services and supports provided to individuals with disabilities.
4. An **outcome-based quality review program** to assess measures that are directly related to service quality and to the program improvements that make people's lives better.
5. An **improved system for critical incident reporting, investigation and analysis** that provides necessary protections, assures timely and appropriate response, and gathers and analyzes data to guide quality improvement initiatives.[17]

Requirements involving two of the QA Panel's recommendations – an annual survey of service recipients and an improved system for critical incident reporting, investigation and analysis – were passed into law in 2007 as the foundational components of a statewide quality management, assurance and improvement system for persons receiving disability services.[18]

To advise DHS in the development of the statewide quality management system, a Quality Assurance Stakeholder Advisory Group (Advisory Group)[19] was convened under the authority of

[15] See Appendix D for References and Resources.

[16] *Laws of Minnesota* First Special Session 2005, Chapter 4, Article 7, Section 57.

[17] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007.

[18] *Laws of Minnesota* 2007, Chapter 147, Article 7, Section 18 (Minn. Stat. §256B.096).

[19] See Appendix B for participants of the 2008 Quality Assurance Stakeholder Advisory Group.

Minn. Stat. §256B.096, subd. 2. Advisory Group participants represent major constituencies with vested interests in the design, implementation and effectiveness of HCBS quality management practices in Minnesota. During 2008, the Advisory Group met on twelve occasions to consult with DHS on the development of the statewide quality management system. Within the Advisory Group, two subgroups were created (Survey Development and Incident Reporting) to focus the energy and expertise of stakeholders upon both of the foundational quality management components included in Minn. Stat. §256B.096.

III. DEVELOPMENT AND FIELD TESTING OF AN ANNUAL SURVEY

In its 2008 report to the Legislature on HCBS quality management,[20] DHS identified a set of options being considered for the development of a survey instrument that would satisfy the provisions of Minn. Stat. §256B.096, subd. 3. In consultation with the Advisory Group, DHS reviewed the potential benefits and drawbacks of either developing an entirely new survey, tailored specifically to the requirements of statute, or adopting and modifying any of three pre-existing HCBS quality surveys for use with disability waiver participants. In January 2008, DHS chose to adopt and modify the Participant Experience Survey (PES) instruments – developed under CMS' National Contract for Quality to assist states in meeting waiver quality management requirements. The principal benefits of choosing the PES include:

- Clear ties to CMS efforts in response to the 2003 GAO waiver oversight report to provide better tools and guidance for states in meeting waiver requirements
- Proven track record in assisting states to collect, analyze, report and respond to actionable information obtained from waiver program participants
- Built-in capability of PES to help states demonstrate compliance with federal waiver requirements and the HCBS Quality Framework
- Design to include a broad range of program participants (including individuals with intellectual and developmental disabilities, brain injuries, physical disabilities and persons over age 65), while other survey instruments have been developed with single waiver participant populations in mind.

Ways in which DHS envisions the PES being modified to better meet Minnesota's quality management needs include incorporating:

- Feedback and experiences of other states to improve existing PES items
- Previous work done locally to identify outcome-based indicators of quality [21]

[20] Quality Management 2008: The Development and Activities of the Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services. DHS Disability Services Division, 2008.

[21] "Proposed Outcome Indicators for the Survey of Program Participants." Minnesota Quality Assurance Panel, 2007; "MN Region 10 Quality Assurance Standards." Minnesota Region 10 Quality Assurance, 2000.

- Principles regarding *quality of life* and *quality of services* developed within DHS to guide quality management efforts in HCBS
- HCBS provider performance measures being developed in connection with other DHS quality management initiatives[22] and
- The valuable and continuing input of the Advisory Group.

DHS has contracted with Thomson Reuters Healthcare (formerly The Medstat Group, Inc.), developer of the original PES instruments for CMS, to conduct the necessary research, modification, field testing and final development of Minnesota's PES (MN-PES). Local assistance to the Thomson Reuters project team is being provided by staff from the Institute on Community Integration at the University of Minnesota. Drawing upon their experience and expertise as the CMS National Quality Contractor for HCBS, Thomson Reuter's staff will also assist DHS in determining how data collected with MN-PES can be used to measure program and service performance in a way that demonstrates Minnesota's level of compliance with waiver quality management requirements.

A significant number of quality indicator questions included for testing in MN-PES closely mirror items found in DHS' Comprehensive Assessment (COMPASS)[23] tool. Implementing COMPASS for participant assessment and service planning purposes on a statewide basis would allow the size and scope of MN-PES to be reduced considerably without affecting the state's overall ability to gather and use participant feedback in measuring quality and effectiveness in disability services. Additional benefits to quality assessment brought about by COMPASS include:

- Reducing the scale, cost and logistic complexity involved in implementing a participant-focused quality survey to capture key waiver compliance and service quality and outcome measures
- Reducing respondent burden - the time and effort service participants would spend responding to a QA survey and
- Allowing DHS to track and identify trends over time in participants' experience of quality, both individually and more generally across programs and services.

Formal work on survey development did not begin until July 2008 as a result of delays associated with a freeze (to manage budget restrictions) on new DHS professional-technical contracts in early 2008, and from an extended proposal evaluation and selection process for this particular project. Despite a condensed timeline to complete development and testing of the survey by June 2009, the initial round of field testing began in February 2009, putting this project slightly behind the schedule set by statute.

More detailed information on the development and testing of Minnesota's quality survey of

[22] DHS Priority for HCBS, and the State Long-Term Care Profile and HCBS Expert Panel (see page 24 - 25 of this report).

[23] See Appendix C for a Glossary of Selected Terms.

disability service participants is included in the Thomson Reuters preliminary progress report on survey development (December 2008) is included as an appendix to this legislative report.

IV. IMPROVEMENTS FOR INCIDENT REPORTING, INVESTIGATION, ANALYSIS AND FOLLOW-UP

Throughout 2008, DHS consulted with the Incident Reporting subgroup of the Quality Assurance Stakeholder Advisory Group (Advisory Group) in identifying information, data sources and technology needed to improve the state's systems for incident reporting, as required by Minn. Stat. §256B.096, subd. 4.

Although the Advisory Group was composed and convened specifically to consult with DHS on matters of quality management and federal compliance in the disability waiver programs, stakeholders and DHS project staff found it difficult to consider ideas for improving the incident reporting system that would not extend beyond the scope of waiver services alone. Minnesota's current incident reporting systems were developed to serve all minors and vulnerable adults without regard to whether an individual is a waiver program participant or not. That said, Advisory Group members participated in these discussions representing positions and principles from within the disability services community for improvements to an incident reporting system that must (a) reliably safeguard the safety, health, rights and dignity of *all* vulnerable Minnesotans, as well as (b) help Minnesota meet and maintain substantial compliance with federal requirements specific to the HCBS waiver programs.

Reflecting both federal waiver requirements and local expectations for quality in incident reporting and response, the QA Panel identified a set of essential characteristics for effective incident reporting, investigation analysis and follow-up systems.[24] These characteristics served as a consistent reference point for the Incident Reporting Advisory subgroup throughout the past year's work.[25]

A. CRITICAL INCIDENT REPORTING: FEDERAL WAIVER REQUIREMENTS

As with all federal waiver requirements, CMS identifies certain prerequisites for program design and quality management (i.e., discovery, remediation and continuous improvement) in assuring the health and welfare of waiver participants. For a state to comply with federal waiver requirements:

1. "A waiver's design must provide for continuously and effectively assuring the health and welfare of waiver participants. Processes that are important for assuring participant health and welfare include but are not necessarily limited to:

[24] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007 (pp. 22-24).

[25] See Appendix G for recommendations of the Incident Reporting Advisory subgroup not included in the body of this report.

- Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants and
- Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights."

2. "The renewal of a waiver is contingent on CMS determining that the state has effectively assured the health and welfare of waiver participants during the period that the waiver has been in effect. In its application, the state must specify how it monitors performance in assuring health and welfare . . ."

3. "Discovery consists of monitoring and data collection activities that identify whether and to what extent the state addresses compliance with the assurances. Relevant discovery sources may include . . . compilation of operations data such as incidents and complaints, [etc.]. . . A measurable representation of the assurance compliance, consisting of a numerator/denominator, is the preferable method of reporting on discovery activities. Such an approach provides a clear and concise evidence-based representation of a State's compliance with an assurance."[26]

4. "For each performance measure/indicator the State will use to assess compliance with [a] statutory assurance . . . data must be waiver specific."[27]

B. BARRIERS TO WAIVER COMPLIANCE

Applying enhanced waiver compliance requirements issued by CMS in January 2008[28], DHS has identified specific areas in which Minnesota's reliance upon a state-supervised/county-administered system for tracking and responding to aggregated critical incident data is no longer adequate. For waiver compliance purposes, capture, analysis and response to critical incident information must be strengthened at the state agency level.

Waiver Requirement: Health and Welfare – *The State, on an on-going basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

Minnesota has not used its critical incident data *on a waiver-specific basis* to identify, address and seek to prevent these events from occurring. Furthermore, the coordination necessary to share incident report data electronically between quality management partners[29] and their data systems in a way that enables waiver-specific discovery and remediation is only partially in place.

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[26] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (pp. 8-9).

[27] Application for a §1915 (c) HCBS Waiver: HCBS Waiver Application Version 3.5. Centers for Medicare and Medicaid Services, 2008 (Application Appendices A, B, C, D, H, I).

[28] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008.

[29] See Appendix C for a Glossary of Selected Terms.

Waiver Requirement: Qualified Providers – *The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*
Per Minnesota Statute and state waiver requirements, all formal waiver service providers are subject to the Maltreatment of Minors and Vulnerable Adult Acts. Many disability waiver participants receive services from non-licensed/non-certified providers. Because DHS does not identify these incidents or their follow-up on a waiver-specific basis, Minnesota's ability to conduct waiver-specific monitoring of adherence to waiver incident reporting and response requirements among these providers is significantly limited.

Waiver Requirement: Administrative Authority – *The Medicaid Agency* [DHS] *retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

DHS does not monitor or assess the performance of non-state entities (i.e., local intake, protective and investigative entities) in fielding and responding to critical incidents *on a waiver-specific basis* because, without waiver-specific data, DHS cannot know the extent to which the work they do applies to waiver participants.

C. SOLUTIONS TO ENABLE WAIVER COMPLIANCE

To address the barriers to waiver compliance, Minnesota must:

1. Begin to reliably identify all critical incident reports involving waiver participants according to the specific waiver in which they participate.

2. Effectively coordinate incident management data systems so the critical incident data collected within Minnesota can be used by DHS to support and demonstrate compliance with federal requirements.

Minn. Stat. §256B.096, subd. 4 requires DHS to identify the information, data sources and technology needed to improve the system of incident reporting. To this end, DHS has identified areas where changes are currently underway and where additional improvements are needed.

1. Information

DHS needs to know:

- If a critical incident involves a waiver participant and
- What the person's waiver affiliation[30] is.

[30] See Appendix C for a Glossary of Selected Terms.

With this information, DHS can conduct waiver-specific discovery and analysis in a way that supports enhanced remediation and improvement outcomes for individuals, as well as compliance with waiver requirements.

2. Data Sources

For critical incident reports, potential sources of an individual's waiver affiliation are:

- Incident reporters themselves and
- Existing data bases containing waiver participant information.

Options to enable reliable identification of a participant's waiver affiliation include:

1. Modifying maltreatment, death and serious injury report intake forms to include data fields that capture a person's:

   - Specific waiver affiliation (CAC, CADI, DD, Elderly Waiver[31], TBI, unknown, n/a) and
   - Unique recipient identification number

2. Conducting automated matching[32] of participant data collected from incident reports with existing waiver participant data in DHS' data warehouse.[33]

Experience among local maltreatment report intake workers has shown that family members, mandated reporters and members of the general public who make maltreatment reports often do not know an individual's waiver affiliation or identification number. *Requiring* this information from mandated reporters and service providers would likely entail changes in maltreatment reporting statutes,[34] as well as substantial costs to the state, local lead agencies and service providers in updating data systems, changing policies and procedures and providing training and orientation as required.[35]

The information technology and systems necessary to more effectively and cost-efficiently identify a person's waiver affiliation already exists within DHS. The following section explains how they are being developed to accomplish this through automated matching.

[31] As federal waiver requirements are no different for the Elderly Waiver (EW), being able to capture waiver-specific incident data for EW participants will also be necessary.

[32] See Appendix C for a Glossary of Selected Terms.

[33] See Appendix C for a Glossary of Selected Terms.

[34] Reporting of Maltreatment of Minors (Minnesota Statutes §626.556, Subd. 7); Reporting of Maltreatment of Vulnerable Adults (Minnesota Statutes §626.557, Subd. 4).

[35] Maltreatment of Vulnerable Adults (Minnesota Statutes §245A.65, Subdivision 1).

3. Technology

According to CMS, "A critical element of effective oversight is the operation of data systems that support the identification of trends and patterns in the occurrence of critical incidents or events in order to identify opportunities for improvement and thus support the development of strategies to reduce the occurrence of incidents in the future."[36] Currently, Minnesota's various critical incident reporting and data systems are not sufficiently coordinated to enable development of evidence-based, waiver-specific remediation and improvement activities to assure the health and welfare of waiver participants. In terms of technology, what is at issue is how effectively DHS and other quality management partners can access more complete critical incident data for each to perform its duties within the quality management system. The integration and coordinated use of critical incident report and investigation data from all source data systems will allow DHS to perform waiver-specific discovery, remediation and improvement activities necessary to achieve and demonstrate basic federal compliance.

Within the scope of Minnesota's waiver programs, establishing interoperable links between existing critical incident data systems[37] and enabling appropriate electronic access to this information across waiver quality management partners (including DHS Disability Services Division[38]) will ensure DHS has the integrated data it needs to fulfill its waiver quality management obligations.

HCBS Quality Management Data Mart

To facilitate the coordination of existing incident management data systems applicable to HCBS participants, DHS is continuing work on an HCBS quality management data mart to capture and house critical incident information from various databases. A data mart allows people, in this case, DHS waiver quality management staff, quick and easy access to the specific data they need, without having to search for it throughout the entire universe of data held within the larger data warehouse. It is not unlike using a local convenience store to quickly pick up a few specific things instead of going across town and searching through a major shopping center for the same one or two items.

Already, local intake and investigative agencies enter maltreatment report and investigation data into the Social Services Information System (SSIS). On a regular basis, this information is loaded into and housed within the data warehouse. Work is underway to capture investigative outcome and other data from DHS Licensing and the Minnesota Department of Health (MDH) in SSIS as well. Using the HCBS quality management data mart, this information can be extracted

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[36] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (pp. 229).

[37] Including: the Social Services Information System (SSIS) and those held by DHS Licensing, the Office of the Ombudsman for Mental Health and Developmental Disabilities (OOMHDD), and the Minnesota Department of Health (MDH) Office of Health Facility Complaints.

[38] In Minnesota's CMS-approved disability waiver program applications, DHS Disability Services Division is vested with "state line of authority for [disability] waiver operation" and responsibility for disability waiver program oversight.

from the data warehouse and reports can be generated to allow analysis of SSIS maltreatment report and investigation data according to:

- Persons and populations
- Programs and waivers
- Services and providers
- Locations, counties and regions
- Outcomes of investigations.

To make waiver participant-related death and serious injury information from the Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities (OOMHDD) accessible to the quality management data mart, work to identify and select relevant data elements and construct an information technology interface between the OOMHDD's database and the DHS data warehouse will need to occur. It is estimated this would cost less than $50,000.[39]

As development proceeds, the HCBS quality management data mart will automatically capture critical incident-related information from these databases – via the data warehouse – on a regular schedule, enabling electronic access among waiver quality management partners to critical incident and response data across all five waiver programs. Automated matching to identify a person's waiver affiliation will also be accomplished within the data mart by comparing and joining person-specific incident report information (within a specified confidence level; e.g., 95% or greater) to waiver participant data housed within the data warehouse.

Fully developed, the HCBS quality management data mart will drastically reduce reliance upon cross-divisional and cross-agency sharing of critical incident data through paper and Portable Document Format (PDF) based (read only) reports and files, as well as duplicative data entry into multiple, unconnected data bases. The coordination of critical incident data bases will reduce staff time and resources spent completing redundant tasks.

Data Sharing

With the establishment of an electronic data sharing capability across Minnesota agencies, appropriate data sharing agreements would also be necessary to realize the technology's full promise. For example, understanding and working within data privacy requirements,[40] establishing an agreement between DHS and the OOMHDD to electronically share data of mutual benefit would present DHS with access to certain waiver-specific critical incident information to aid in the achievement of improved protective and preventive outcomes.

[39] Funding for the development of this information technology interface is included in the Governor's budget recommendation for DHS (Federal Compliance for HCBS Waivers, pp. 67-69).

[40] Because the OOMHDD has a statutory obligation to protect the identity of reporters and service participants involved in incidents and service complaints brought to its attention, there must be assurances that only enough person-specific data to determine waiver affiliation is accessed by DHS from this source. Undertaking individual-level analysis, remediation and/or improvement activity in response to the reports *it* receives is the responsibility of the OOMHDD.

D. INCIDENT REPORTING: AREAS FOR FURTHER STUDY

To more fully meet local expectations for an effective incident reporting and follow-up system, enhancements in collecting and responding to critical and other incident information might also be achieved by streamlining certain quality management activities, and by enabling broader electronic reporting and access to incident data by local lead agency and provider organizations. Two areas for further study are identified below, with descriptions of the quality management implications and possible benefits associated with each.

1. Common Entry Point and Web-Based Maltreatment Reporting

DHS and the Advisory Group recognize and appreciate the efforts of *all* individuals and entities involved in protecting children and vulnerable adults from abuse, neglect and exploitation. They deserve the state's full measure of support for the work they do, without reservation. As in any large-scale system of services or supports, though, there inevitably exist gaps and opportunities for improvement.

Under the Vulnerable Adults Act, all 87 counties are required to staff and maintain a Common Entry Point to which reports of suspected maltreatment involving vulnerable adults are made.[41] For reports involving minors, the Maltreatment of Minors Act requires an even wider network of entities related to health and human services, public safety and education to provide intake functions.[42] The result is a *thorough* network for beginning the protective response process, but also one that is seen by many as fragmented, inconsistent in its operation from county to county, and confusing to stakeholders and the general public.

During meetings with the Advisory Group, anecdotal reports were heard about inconsistent performance between Minnesota's county-based Common Entry Points, such as:

- Reports of suspected maltreatment not being accepted and passed along to the appropriate local or state lead investigative agency for assessment and investigation as necessary and
- Delays exceeding 24 hours between calls placed to report suspected maltreatment and receiving return calls from the local Common Entry Point to take the reports.[43]

Though DHS does not have objective, system-wide data on how often or to what extent these lapses occur, instances like these would represent a serious gap in the basic protective infrastructure enacted under the Vulnerable Adults Act. The failure of a common entry point to accept a report of maltreatment that has occurred or is occurring would, on its face, deny a vulnerable adult his or her full mandated measure of protection. Situations like these, when they

[41] Reporting of Maltreatment of Vulnerable Adults (Minnesota Statutes §626.557, Subd. 9).

[42] Reporting of Maltreatment of Minors (Minnesota Statutes §626.556, Subd. 7).

[43] For additional anecdotal reports and experiences (pro and con) related to Common Entry Point performance, see "Survey for the Vulnerable Adult Act." Vulnerable Adult Justice Project, 2008 (pages 24-25).

occur, also adversely affect the confidence of reporters who rely on the Common Entry Point to serve its intended purpose within the adult protective services system.

Other known examples of inconsistency affecting the integrity of the Minnesota's maltreatment report data include instances where report intake information has been improperly entered into SSIS and even cases where reports are not being documented in SSIS at all.
Some stakeholders believe Minnesota could reduce inconsistent performance, achieve increased efficiency and realize improved performance in maltreatment report intake and triage across the state by (a) centralizing the Common Entry Point function under the auspices of a single State agency (e.g., DHS) and (b) implementing a Web-based reporting system to facilitate expanded reporting options.[44] Thirty-one states currently have a centralized (single, state-operated) incident reporting system for one or more specific populations (e.g., minors, persons with disabilities, persons over 65, etc.), while another ten states have a single centralized system applicable to all vulnerable citizens. A small but growing number of states also allow for Web-based reporting of suspected maltreatment and other critical incidents.[45]

A formal study of the quality and performance of Minnesota's Common Entry Point system, building upon research now underway within DHS Aging and Adult Services Division regarding the effectiveness of the current system and options for its centralization, would assist DHS and other stakeholders in:

- Determining appropriate steps to address identified problems and
- Strengthening Minnesota's ability to effectively receive and respond to reports of maltreatment involving vulnerable adults.

A similar quality assessment process could also be applied to the Maltreatment of Minors incident reporting system, to the extent deemed appropriate.

2. Health Information Technology and Web-Based Electronic Case Records

Minnesota possesses a robust information technology capacity for financial record-keeping and reporting across waiver programs, administrative and service entities, and waiver participants. Minnesota, however, does not possess a similar capability for tracking, analyzing or responding to information on outcomes pertaining to health, welfare or the quality of services received by waiver participants. Across the country,[46] states are beginning to develop and implement Web-based HCBS case file and service record systems to house and provide appropriate electronic access to participant health and electronic case records. This reflects a growing local and

[44] See Appendix G for a list of potential benefits of a centralized Common Entry Point and Web-based reporting. Web-based reporting of suspected maltreatment is also supported by the Minnesota Disability Health Project: see *Promoting Better Health for Minnesotans with Disabilities: Ending Exclusion*. Minnesota Department of Health, 2006 (pp. 33).

[45] In Minnesota, MDH requires Web-based incident reporting by federally-certified nursing facilities and hospitals with swing beds to comply with federal incident reporting requirements for these provider types. Florida, New Mexico, and Texas allow Web-based reporting across all programs and populations. Indiana maintains a Web-based incident reporting system for waiver service providers.

[46] Including, for example: Maine; Massachusetts; Missouri; Pennsylvania; Washington.

national interest in using integrated health information technology and electronic medical records to achieve both health and financial benefits through improved efficiency and safety in health care services.[47]

In Minnesota, HCBS participants frequently access formal, publicly funded health and support services, many on a daily basis, that enable them to live in their own homes, in their chosen communities, and avoid the need for more costly institutional services. If Minnesota envisions health information technology and electronic records improving quality, reducing costs and increasing individual choice and direction in health care across the general population, one might imagine the same benefits magnified in a system so heavily used (and funded, publicly) as HCBS.

Benefits of electronic case record systems to participant health and welfare come in part from the enhanced ability they provide to identify, respond to and track *non*-critical incidents (i.e., those not meeting statutory thresholds for maltreatment,[48] death or serious injury[49]), enabling early and targeted intervention to prevent more serious incidents from occurring. In Minnesota, events that frequently do not meet critical incident criteria, like medication errors, use of restraints and seclusion, violence between participants in service settings, and instances of aggression or violence toward self or others, would fall into this category. These events often precede more serious and critical incidents, and more intensive and costly interventions (including medical, crisis and/or protective services) if their underlying causes or antecedents are not identified and addressed at an early stage. In states that have them, Web-based electronic case record systems have enabled service providers, case managers and other local quality management partners to systematically analyze and review serious non-critical incidents that might otherwise go without formal remediation. This helps create what the QA Panel called a *culture of improvement*:

> "A data management system reinforces engagement in it by creating a culture of quality improvement based on it. It creates incentives for reporting because the information is used to make changes that improve services to individuals and more generally. It challenges providers, counties, Regional Quality Councils and other system participants to identify and respond to problems, rather than simply awaiting investigations."[50]

Other benefits of electronic case record systems include a reduction in activities that are inefficient and represent little *value added* to the supports and services waiver programs are meant to deliver. For example:

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[47] See *Minnesota e-Health Initiative: Roadmap and Preliminary Recommendations for Strategic Action.* Minnesota Department of Health, 2005; and *Recommendations Submitted To: Governor Tim Pawlenty And the Minnesota State Legislature*. Health Care Transformation Task Force, 2008.

[48] Reporting of Maltreatment of Minors (Minnesota Statutes §626.556, Subd. 2); Definitions (Minnesota Statutes §626.5572).

[49] Definitions (Minnesota Statutes §245.91, Subd. 6).

[50] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007 (page 24).

- When critical incidents occur, separate reports are made by telephone, fax and mail to one or more state agencies, local protective and case management agencies, other providers involved in a person's services, legal representatives and/or advocates, and participants themselves. The same process applies to non-critical incidents, minus reports to state and local protective agencies. This happens many hundreds of times a month, all around the state, publicly funded. A Web-based electronic case record system accessible to various state, local and provider agencies could streamline the making, distribution and effective use of incident reports – and free provider staff to spend more time actively supporting waiver participants.

- Increased efficiency might also be realized within state and local oversight activities, administrative and regulatory, that rely largely on paper file reviews. Through automated, in-office record audit activities an electronic case record system could support, less time and resources might be spent on labor-intensive on-site paper file reviews, and greater time and attention spent determining the quality- and value-related outcomes people (e.g., participants, providers, local lead agency staff) demonstrate and achieve.

Developing an electronic case record capability would represent a true innovation in the way service record, incident and/or critical incident information is used and made useful around the state. Minnesota is currently exploring the use of health information technology and electronic case records in its HCBS programs. Enabling local reporting, distribution, collection and analysis of non-critical incident data to support greater emphasis on prevention and early intervention will be considered in these efforts.

V. OTHER HCBS QUALITY MANAGEMENT EFFORTS

In addition to the activities taking place under the mandate of Minn. Stat. §256B.096, other tasks and projects underway within DHS Continuing Care Administration are being coordinated to take full advantage of effort and resources currently directed toward quality management in HCBS. These include the following:

A. DHS PRIORITY FOR HCBS: 2008-2009

As one of its priorities for 2008-2009, DHS has established a priority to improve home and community-based services by establishing and using measures of service provider performance:

> *"**Improve home and community-based services for the elderly and people with disabilities by establishing and using performance measures and standards.** The department will improve the performance data it collects for home and community-based services so that consumers and government can make informed purchasing decisions. As a result, services will be more efficient, effective and appropriate in meeting the needs of consumers."*

As the Minnesota Nursing Home Report Card was designed to do for nursing facilities, it is anticipated that collecting and publishing performance- and quality-related measures for HCBS providers will not only help program participants choose among service providers, but also promote a high standard of quality among providers striving to achieve the best scores possible.

DHS is also cognizant of federal goals for states to gather and use performance data to improve choice and quality in services. Minnesota is striving to collect and mine data needed to determine effective care, as a precursor to payment for *outcomes*, not simply *processes*.

Coordination between the HCBS Priority and other quality management projects includes:

- The **HCBS Quality Survey**[51] is being developed to serve as a tool for gathering input from disability waiver service participants to help measure provider performance.
- The **HCBS Expert Panel** (see below) is providing DHS with input on the development of candidate provider performance measures, applicable to both processes and outcomes.

B. STATE LONG-TERM CARE PROFILE AND THE HCBS EXPERT PANEL

DHS has received a three-year grant from CMS to develop a Minnesota Long-Term Care Profile. The Long-Term Care Profile is a description of Minnesota's overall system of services and programs to support persons with long-term needs, across population groups. Minnesota will use a profile tool , which incorporates the domains of a balanced and person-centered long-term care system identified by CMS.

An HCBS Expert Panel will assist DHS in developing its Long-Term Care Profile. The panel members include representatives from statewide organizations whose constituents include the range of Minnesota citizens and service providers that will be included in the State Profile. A work plan has been developed that describes the work of the consultant and the HCBS Expert Panel over the three-year grant period.

CMS requires all State Profile grantees to work with the National Balancing Indicators Contractor in developing national indicators of a person-centered long-term support system. This gives DHS a basis for influencing the types of measures CMS will use in the future to hold states accountable for implementing person-centered reforms in their long-term care systems.

Coordination between the State Long-Term Care Profile, HCBS Expert Panel and other quality management projects includes:

- Aspects of quality in HCBS, identified by the Expert Panel as important and meaningful to stakeholders, have been incorporated into the development of the **HCBS Quality Survey**.
- **Thomson Reuters** serves as the primary consultant for both the State Long-Term Care Profile and HCBS Quality Survey development projects. This facilitates coordination

[51] Described on pages 12-13 of this report.

and shared use of expertise between consultant staff, the HCBS Expert Panel, the QA Stakeholder Advisory Group and DHS in meeting congruent project goals.

DHS Disability Services Division also envisions establishing an advisory State Quality Commission, drawing substantial membership from current HCBS Expert Panel participants. It is expected that the purpose and function of this State Quality Commission will approximate those proposed by the QA Panel.[52]

VI. CONCLUSION AND LOOKING AHEAD

The anticipated completion of basic HCBS Quality Survey development and field testing in June 2009, and the identification of information, data sources, and technology needed to improve Minnesota's incident reporting systems described herein represent the foundational activities for establishing a statewide quality assurance, management and improvement system for Minnesotans receiving disability services as required under Minn. Stat. §256B.096.

Short Term Efforts (0 to 2 years)

DHS will use the products and results of these activities to meet federal waiver requirements under enhanced CMS review and compliance requirements. Specifically:

- Questions developed for the HCBS Quality Survey that can yield measures of Minnesota's level of compliance with waiver requirements will be identified. DHS will seek to implement these questions and collect participant responses via existing face-to-face interviews or assessment tools and processes.
- DHS will explore options for using the survey to gain participant input and feedback about the effectiveness and quality of services provided under the state's Personal Care Assistance (PCA) and 1915(j) Consumer-Directed Supports Option programs.
- DHS will continue work on integrating DHS- and MDH-held critical incident data into SSIS, the data warehouse and the HCBS quality management data mart to enable *discovery* and support *remediation* and *improvement* activities on a waiver-specific basis.
- DHS will continue work on establishing appropriate and effective data sharing agreements and capabilities with the OOMHDD and other partners in waiver quality management.

HCBS quality management will also be impacted by additional activities which CMS requires DHS to complete by January 2011 to meet waiver requirements. These include:

- The elimination of local lead agency-established provider rates and contracts

[52] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007 (pages 9-12).

- The establishment of uniform statewide rate-setting methodologies for waiver services and
- The development and implementation of consistent statewide standards and oversight methods for all waiver service providers.

Longer Term Efforts (2 to 5 years)

DHS will use sampling, implementation, and cost-estimate data provided in the HCBS Quality Survey consultant's final report (due June 2009) as well as timelines associated with the implementation of COMPASS to:

- Identify viable and cost-effective options for conducting the survey in accordance with Minn. Stat. §256B.096, subd. 3 and
- Implement strategies to utilize the participant input and feedback obtained.

DHS will also continue to identify and research ways in which information technology and information technology supported systems and processes can support quality management across disability services, including improvements in incident prevention, reporting and response.

Continuing Efforts

In addition to helping Minnesota meet federal waiver requirements, the quality management system being developed is also meant to support the achievement of outcomes and results that matter in the lives of participants, their families and their communities. DHS understands the need to address both federal and local expectations for quality in disability services, and it will continue to identify and pursue opportunities that align with these as well as with federal and state requirements. The involvement of stakeholders is a key component in this process. DHS expects to incorporate and benefit from the ideas and insight community members involved in disability services can bring to future planning, systems change and quality improvement efforts.

Cost Projections

Limited Costs:

- Continuing work to capture investigative outcome and other data from DHS Licensing and MDH in SSIS, the data warehouse and the HCBS Quality Management Data Mart – **$25,000, currently budgeted from federal funding to the Office of the Ombudsman for Long-Term Care**

- Construct an information technology interface between OOMHDD data bases and the DHS data warehouse to capture, as appropriate, death and serious injury information involving waiver participants – **estimated at less than $50,000** (included in the Governor's 2009 proposed budget)

More Substantial Costs/Investments:

- Statewide implementation of Minnesota's Participant Experience Survey, with cost estimates ranging from:
  - Minimum statistically significant sample across all four disability waiver programs – **$37,900 annually**
  - Ten percent waiver service participant sample (per Minn. Stat. § 256B.096, subd. 3) – **$256,400 annually**[53]
  - Survey support, printing and computer software costs – **$185,000 to $205,000 annually**[54]

- Centralization of Common Entry Point function and Web-based maltreatment reporting:
  - Development – **estimated $3.5 million (first year)**
  - Continuing operation – **estimated $2 million annually**

- Development and operation of an electronic case record system:[55]
  - Development – depending on system scope, features and functionality, **estimated $3.5 million to $20 million**
  - Continuing operation – **estimated $500,000 to $5 million annually**

[53] Preliminary estimates based on projected cost and sampling data (*Preliminary Progress Report: Development and Testing of a Participant Experience Survey for Minnesota*.) Thomas Reuters, 2008 (pages 16-17) Updated sampling and cost estimates will be provided by Thomson Reuters in their final report on survey development and field testing, due June 2009.

[54] *Quality Management 2008: The Development and Activities of the Quality Management, Assurance and Improvement System for Minnesotans Receiving Disability Services*. DHS Disability Services Division, 2008 (page 6).

[55] Based on estimated or actual development and annual operating costs of electronic case record systems in Maine, Missouri, Pennsylvania and Washington. More detailed estimates will become possible as state e-Health authorities and local health care providers and hospitals report costs involved in meeting Minnesota's 2015 interoperable electronic health record mandate.

Appendices

Appendix A: Minnesota Statutes §256B.096

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow-up for disability services.

The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service-related

assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

Subd. 5. **Biennial report.** The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

History: *2007 c 147 art 7 s 18*

Appendix B: 2008 Quality Assurance Stakeholder Advisory Group

Meeting participants	Organizations/Stakeholders represented
John Wayne Barker	Minnesota Developmental Achievement Center Association
Les Bauer	Family representative/Advocate
Cynthia Carlson	Hennepin County Adult Protection
Julie Faulhaber	Medica
Kevin Hansen	ElderCare Rights Alliance
Elizabeth Hartmann	DHS DSD Pathways to Employment
Barb Jacobson	Association of Residential Resources in Minnesota
John Jordan	Family representative/Advocate
Nancy Jurgensen	Local Public Health Association of Minnesota
Jerry Kerber	DHS Licensing Division Director
Pete Klinkhammer	Brain Injury Association of Minnesota
Patricia Kuehn	Minnesota Association of County Social Service Administrators
Lori Laflin	DHS Survey Research Coordinator
Steve Larson	The Arc of Minnesota
Sarah Myott	DHS Aging and Adult Services Division Quality Assurance
Gerry Nord	DHS DSD Supervisor
Lynn Noren	Minnesota Habilitation Coalition
Roberta Opheim	Ombudsman for Mental Health and Developmental Disabilities
Nancy Rosemore	Lutheran Social Services
Bud Rosenfield	Minnesota Disability Law Center
Scott Schifsky	Arc Greater Twin Cities
Deb Siebenaler	DHS Aging and Adult Services Division Adult Protection
Thomas Skarohlid	DHS DSD Quality Assurance
Stephanie Strickland	Self advocate
Rachel Tschida	AXIS Healthcare
Kim Weaver	Hennepin County Human Services and Public Health Department
Mike Williams	Self advocate
Dan Zimmer	Region 10 Quality Assurance Commission

Project Officer

Jason Flint	DHS DSD Quality Assurance

Project Staff and Consultants

Steve Eiken	Thomson Reuters
Sara Galantowicz	Thomson Reuters
Lisa Gold	Thomson Reuters
K. Charlie Lakin	University of Minnesota
Sheryl A. Larson	University of Minnesota

Appendix C: Glossary of Selected Terms

Automated Matching – using information technology based programming to join person-specific incident report information with existing waiver participant data housed in the data warehouse to determine a person's waiver affiliation.

Centers for Medicare & Medicaid Services (CMS) – federal agency, within the U.S. Department of Health & Human Services, responsible for approval and oversight of all state Medicaid home and community-based services waiver programs.

Common Entry Point – entity, designated by each county that is responsible for receiving reports regarding suspected maltreatment (i.e., abuse, neglect, financial exploitation).

Comprehensive Assessment (COMPASS) – a set of standards and protocol for assessing the needs of persons with disabilities who need long-term care services. COMPASS is designed to replace disparate assessment and eligibility tools in use across State Plan long-term care and home and community-based services waiver programs, and to reduce duplication in the questions asked and paperwork required to determine program eligibility and support needs.

Data Warehouse – data collection and analysis support system that facilitates timely and flexible analysis by providing direct access to single sources of data or to data across systems. Data warehouse is designed to assist decision making throughout DHS by copying source system data and optimizing it for reporting.

HCBS Quality Assurance Data Mart – specific location or "room" in the DHS Data Warehouse where DHS can store, organize, table and query data that has been extracted, transformed and loaded from other source databases.

HCBS Quality Framework – developed by CMS, is a uniform national format that enables states to describe the key components of *discovery*, *remediation* and *continuous improvement* in their quality management strategies across seven domains of HCBS program design:

- Participant access
- Person-centered service planning and delivery
- Provider capacity and capabilities
- Participant safeguards
- Participant rights and responsibilities
- Participant outcomes and satisfaction and
- System performance.

Home and Community-Based Services (HCBS) – services offered to states as an alternative to institutionalization so that persons with disabilities can receive individualized and flexible services in their own homes or communities. Home and community-based waiver programs available to persons with disabilities who meet eligibility criteria include:

- **Community Alternative Care (CAC) Waiver**, for chronically ill and medically fragile persons who need the level of care provided in a hospital
- **Community Alternatives for Disabled Individuals (CADI) Waiver**, for persons with disabilities who require the level of care provided in a nursing facility
- **Developmental Disability (DD) Waiver**, for persons with developmental disabilities who require the level of care provided in an Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR) and
- **Traumatic Brain Injury (TBI) Waiver**, for persons with traumatic or acquired brain injures who need the level of care provided in (a) a nursing facility that provides specialized service for persons with TBI or (b) a neurobehavioral hospital.

Interoperable – ability for diverse information technology systems to work together.

Quality – the degree to which services and supports for individuals and populations increase the likelihood for desired health and quality of life outcomes and are consistent with current professional knowledge. The goal of quality is to maximize the quality of life, functional independence, health and well-being of the population (CMS).

Quality Assurance – systematic monitoring and after-the-fact evaluation of the various aspects of a project, service or facility to ensure that minimum thresholds of acceptable quality are met.

Quality Assurance Panel (QA Panel) – 2005-07 legislatively directed work group comprised of citizen experts responsible for making recommendations on approaches to quality management in HCBS and related disability programs.

Quality Assurance Stakeholder Advisory Group (Advisory Group) – 2007-09 legislatively directed work group to consult with DHS on: (a) the development of a survey to determine the effectiveness and quality of disability services; and (b) identification of information, data sources and technology to improve the system of incident reporting.

Quality Improvement – desired result of programs and systems designed and organized to support the best possible outcome (i.e., maximization of quality of life, functional independence, health and well-being of the population served).

Quality Management – multi-faceted strategy for organizing, tracking and improving HCBS programs to deliver quality outcomes. Encompasses the three functions of:

- **Discovery** – collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement
- **Remediation** – taking action to remedy specific problems or concerns that arise and
- **Continuous Improvement** – utilizing data and quality information to engage in actions that lead to continuous improvement in the home and community based-services program.

Quality Management Partners – state and local lead agencies responsible for carrying out waiver quality management functions.

Social Services Information System (SSIS) – software application for all 87 counties that provides an automated way to refer cases of alleged maltreatment for investigation by preparing required alerts, notifications and reports during, and as the result of, an investigation.

Waiver Affiliation – indication of the specific waiver program in which an individual participates.

Appendix D: References and Resources

Publications, research and other resources consulted in the completion of this report include:

Federal and Local Expectations for Quality In HCBS

- *Final Report and Recommendations*. Medicaid Commission, 2006.
- *From Isolation to Integration: Recommendations to Improve Quality in Long-Term Care.* National Commission for Quality Long-Term Care, 2007.
- *The Minnesota Vulnerable Adult Act: An Outline for Reform*. Working Group, 1994.
- *A Plan of the Developmental Disabilities Community for A Cost-Effective Quality Future for Minnesotans with Developmental Disabilities – Executive Summary*. Developmental Disabilities Community Working Group, 1995.
- *Region 10 Stakeholder Report on Service System Changes for Persons With Developmental Disabilities – Executive Summary*. Region 10 Stakeholder Steering Committee, 1996.
- Minnesota Region 10 Quality Assurance – QA History
- *An Independent Evaluation of the Quality of Services and System Performance of Minnesota's Medicaid Home and Community Based Services for Persons with Mental Retardation and Related Conditions – Executive Summary*. Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota, 2000.
- Vulnerable Adults Justice Project

Health Information Technology and Web-Based Electronic Service Records

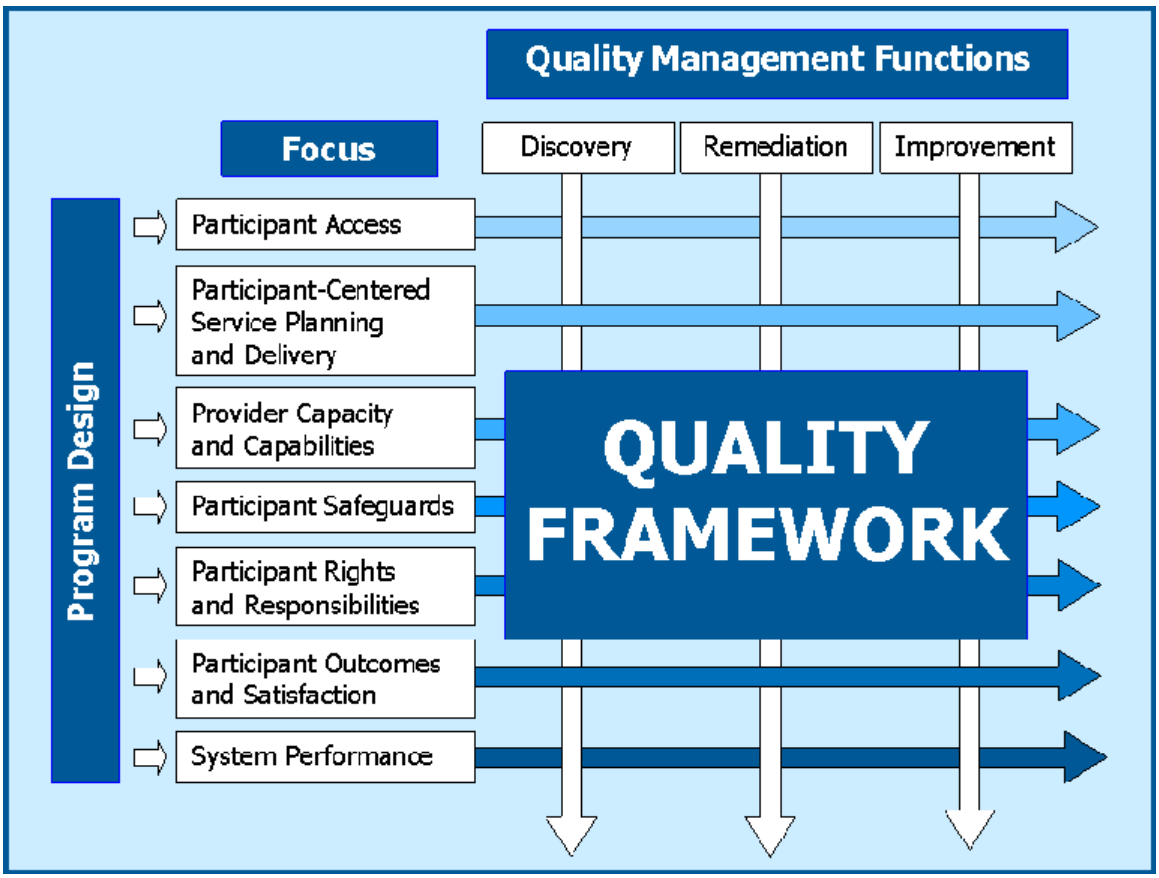
Business Technology Strategic Plan 2008-2012: Technology Planning for Better Human Services. DHS, 2008.

Recommendations of the Incident Reporting Advisory Subgroup: Annual HCBS Quality Management Report

- *2004/2005 Biennium Report to the Governor on Agency Activities*. Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities, 2005.
- *Legislative Report: Maltreatment Report*. DHS Licensing Division, 2008.
- *Minnesota's Child Welfare Report, 2007*. DHS Child Safety and Permanency Division, 2008.

Appendix E: HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public pro-grams, and additional factors.
The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

HCBS QUALITY FRAMEWORK QUALITY FOCUS AREAS

Focus I: **Participant Access**
Desired Outcome: *Individuals have access to home and community-based services and supports in their communities.*

I.A Information/Referral
Desired Outcome: *Individuals and families can readily obtain information concerning the availability of HCBS, how to apply and, if desired, offered a referral.*

I.B. Intake and Eligibility

I.B.1 User-Friendly Processes
Desired Outcome: *Intake and eligibility determination processes are understandable and user-friendly to individuals and families and there is assistance available in applying for HCBS.*

I.B.2 Referral to Community Resources
Desired outcome*: Individuals who need services but are not eligible for HCBS are linked to other community resources***.**

I.B.3 Individual Choice of HCBS
Desired Outcome: *Each individual is given timely information about available services to exercise his or her choice in selecting between HCBS and institutional services.*

I.B.4 Prompt Initiation
Desired Outcome: *Services are initiated promptly when the individual is determined eligible and selects HCBS.*

Focus II: Participant-Centered Service Planning and Delivery
Desired Outcome: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*

II.A Participant-Centered Service Planning

II.A.1 Assessment
Desired Outcome: *Comprehensive information concerning each participant's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a personalized service plan.*

II.A.2 Participant Decision Making
Desired Outcome: *Information and support is available to help participants make informed selections among service options.*

II.A.3 Free Choice of Providers

Desired Outcome: *Information and support is available to assist participants to freely choose among qualified providers.*

II.A.4 Service Plan
Desired Outcome: *Each participant's plan comprehensively addresses his or her identified need for HCBS, health care and other services in accordance with his or her expressed personal preferences and goals.*

II.A.5 Participant Direction
Desired Outcome: *Participants have the authority and are supported to direct and manage their own services to the extent they wish.*

II.B Service Delivery

II.B.1 Ongoing Service and Support Coordination
Desired Outcome: *Participants have continuous access to assistance as needed to obtain and coordinate services and promptly address issues encountered in community living.*

II.B.2 Service Provision
Desired *Outcome*: *Services are furnished in accordance with the participant's plan.*

II.B.3 Ongoing Monitoring
Desired Outcome: *Regular, systematic and objective methods – including obtaining the participant's feedback – are used to monitor the individual's well being, health status, and the effectiveness of HCBS in enabling the individual to achieve his or her personal goals.*

II.B.4 Responsiveness to Changing Needs
Desired Outcome: *Significant changes in the participant's needs or circumstances promptly trigger consideration of modifications in his or her plan*.

Focus III: Provider Capacity and Capabilities
Desired Outcome: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*

III.A Provider Networks and Availability
Desired Outcome: *There are sufficient qualified agency and individual providers to meet the needs of participants in their communities.*

III.B Provider Qualifications
Desired Outcome: *All HCBS agency and individual providers possess the requisite skills, competencies and qualifications to support participants effectively.*

III.C Provider Performance
Desired Outcome: *All HCBS providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individual's plan.*

Focus IV: Participant Safeguards
Desired Outcome: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*

IV.A Risk and Safety Planning
Desired Outcome: *Participant health risk and safety considerations are assessed and potential interventions identified that promote health, independence and safety with the informed involvement of the participant.*

IV.B Critical Incident Management
Desired Outcome: *There are systematic safeguards in place to protect participants from critical incidents and other life-endangering situations.*

IV.C Housing and Environment
Desired Outcome: *The safety and security of the participant's living arrangement is assessed, risk factors are identified and modifications are offered to promote independence and safety in the home.*

IV.D Restrictive Interventions
Desired Outcome: *Restrictive interventions – including chemical and physical restraints – are only used as a last resort and subject to rigorous oversight*.

IV.E. Medication Management
Desired Outcome: *Medications are managed effectively and appropriately.*

IV.F Natural Disasters and Other Public Emergencies
Desired Outcome: *There are safeguards in place to protect and support participants in the event of natural disasters or other public emergencies.*

Focus V: Participant Rights and Responsibilities
Desired Outcome: *Participants receive support to exercise their rights and in accepting personal responsibilities.*

V.A Civic and Human Rights
Desired Outcome: *Participants are informed of and supported to freely exercise their fundamental constitutional and federal or state statutory rights.*

V.B Participant Decision Making Authority
Desired Outcome: *Participants receive training and support to exercise and maintain their own decision-making authority.*

V.C Due Process
Desired Outcome: *Participants are informed of and supported to freely exercise their Medicaid due process rights.*

V.D Grievances
Desired Outcome: *Participants are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.*

Focus VI: Participant Outcomes and Satisfaction
Desired Outcome: *Participants are satisfied with their services and achieve desired outcomes.*

VI.A Participant Satisfaction
Desired Outcome: *Participants and family members, as appropriate, express satisfaction with their services and supports.*

VI.B Participant Outcomes
Desired Outcome: *Services and supports lead to positive outcomes for each participant.*

Focus VII: System Performance
Desired Outcome: *The system supports participants efficiently and effectively and constantly strives to improve quality.*

VII.A System Performance Appraisal
Desired Outcome: *The service system promotes the effective and efficient provision of services and supports by engaging in systematic data collection and analysis of program performance and impact.*

VII.B Quality Improvement
Desired Outcome: *There is a systemic approach to the continuous improvement of quality in the provision of HCBS.*

VII.C Cultural Competency
Desired Outcome: *The HCBS system effectively supports participants of diverse cultural and ethnic backgrounds.*

VII.D Participant and Stakeholder Involvement
Desired Outcome: *Participants and other stakeholders have an active role in program design, performance appraisal, and quality improvement activities.*

VII.E Financial Integrity
Desired Outcome: *Financial accountability is assured and* p*ayments are made promptly in accordance with program requirements.*

Appendix F: Potential Benefits of a Centralized Common Entry Point and Web-Based Reporting System for Vulnerable Adult Maltreatment Reports

- Consistent staffing and around the clock (24/7) response to reports of suspected maltreatment of vulnerable adults statewide.

- One statewide telephone number for reporting suspected vulnerable adult maltreatment, 24 hours a day, seven days a week.

    - Currently, there are more than 160 telephone numbers throughout Minnesota's 87 counties for the intake of suspected vulnerable adult maltreatment reports.
    - One number for reporting would clarify confusion with regard to which number to call.

- Ability to train, supervise and consistently monitor intake staff performance to ensure full implementation of Common Entry Point requirements at all times.

- Ability to allow both telephone and Web-based reporting. MDH currently operates a Web-based incident reporting system for nursing facilities and hospitals with swing beds to comply with federal incident reporting requirements. Web-based reports have the potential to:

    - Reduce intake data entry burden and errors. By allowing service providers to submit electronic incident reports online, certain data entry will not have to be duplicated by Common Entry Point staff. Errors in transcribing participant and incident data that sometimes occur while taking and entering verbal reports may also be reduced.
    - Increase completeness of information received. DHS-Licensing notes, "Many [suspected maltreatment] reports received do not include adequate information to determine: the harm or risk of harm presented to the vulnerable adult or child by the reported events or conditions; or whether the issue reported represents possible maltreatment or a licensing violation."[56] To ensure receipt of incident information that is as complete as possible, a Web-based reporting module could incorporate required fields that must be completed before an electronic report can be submitted.

- Potential to eliminate the dual reporting requirement for nursing facilities and other providers to both local Common Entry Points and MDH.[57]

    - By integrating state and federal incident data requirements and enabling the submission of one report to a centralized Common Entry Point, all state and federal reporting requirements could be met simultaneously.

[56] Legislative Report: Maltreatment Report. DHS Licensing Division, 2008.

[57] MDH Information Bulletin 08-04

- Use of call center and other technology to facilitate local emergency response when necessary. The DHS Disability Linkage Line[58] is able to connect persons calling for information or assistance directly with other agencies and public resources without the caller having to be put on hold or told to hang up and call a different number.

    - Similar technology could be used to connect a reporter directly with local protection or emergency response personnel when immediate action is necessary to protect a person's health or safety. Language Line services could also be accessed to facilitate reporting by non-English speakers.

- Estimated staff requirement to implement a centralized Common Entry Point: 25 FTEs.[59] Currently, there is approximately 437 staff around the state trained and performing the function of Common Entry Point, on a full or part time basis, during normal business hours. This does not include after hours Common Entry Point coverage provided by local law enforcement and other contracted entities.

[58] 1 (866) 333-2466 (www.minnesotahelp.info).

[59] Source: DHS-Adult Protection.

Appendix G: Additional Recommendations of the 2008 Quality Assurance Stakeholder Advisory Group's Incident Reporting Subgroup

1. State Quality Commission

The Incident Reporting Advisory subgroup reiterated the QA Panel's recommendation to convene an *independent* State Quality Commission "to provide the needed leadership, attention, commitment and public awareness of the strengths and limitations, the successes and challenges in the services provided to Minnesotans with disabilities."[60]

While CMS supports an approach that incorporates stakeholder and community input into a state's waiver quality management strategy, federal waiver regulations dictate that DHS must retain ultimate authority for all waiver quality management functions:

> "It is necessary that the Medicaid agency be the source of the delegation of activities . . . and the recipient of the monitoring, remediation and system improvement reports that pertain to meeting the assurances. The Medicaid agency must also perform its own monitoring of all delegated activities."[61]

With this understanding, DHS Disability Services Division plans to convene an *advisory* State Quality Commission, under the auspices of DHS, initially drawing from members of the current HCBS Expert Panel[62].

2. Annual HCBS Quality Management Report

The Incident Reporting Advisory subgroup spent considerable time discussing the benefits of compiling and publicly issuing a consolidated HCBS Quality Management Report. CMS instructs that states "should be able to verify to its stakeholders and CMS that it has measured [waiver program] performance against the assurances no less than annually."[63] An annual quality management report could serve this purpose, providing concise, easy to understand information on the performance of Minnesota's disability waiver programs. As part of an ongoing quality improvement process, stakeholders, legislators, and the general public could use this information to engage with the Department in identifying:

- Areas where the system is working and people are satisfied with services
- Areas where remediation and improvement may be needed and

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[60] *Quality Assurance 2007: Findings and Recommendations of the Legislatively-Mandated Quality Assurance Panel – Final Report*. Minnesota Quality Assurance Panel, 2007 (page. iv).

[61] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (page 12).

[62] The HCBS Expert Panel is described on page 26 of this report.

[63] *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*. Centers for Medicare and Medicaid Services, 2008 (page 11).

- Areas where further analysis or more information would be helpful.

Measurements to determine waiver compliance would serve as an essential core of data to be included in such a report. Like other states that issue regular and comprehensive HCBS quality reports,[64] Minnesota could use administrative, regulatory, claims, and participant and provider survey data to measure and address program performance in other areas as well, such as those identified in the HCBS Quality Framework or in DHS Disability Services Division's CHOICE Life Domains.[65]

[64] Including, for example: Maine; Massachusetts.

[65] See page10 of this report.