Chapter 26

**Home and Community-Based Services (HCBS) Waivers and the Alternative Care (AC) Program**

**Introduction**

HCBS waiver programs are Medical Assistance (MA) services offered through the Minnesota Department of Human Services (DHS). In providing these services, DHS uses MA and state funds to provide services and supports for people to live in their homes, or a community setting, as an alternative to a hospital, intermediate care facility for recipients with mental retardation or related conditions (ICF/MR), or nursing facility (NF) care. The purpose of the HCBS Waiver Programs is to promote community living and independence based on the individual needs and choices of the recipient through providing various services or additional services beyond what is otherwise available through MA. With the exception of the Alternative Care (AC) Program, all applicants must qualify for MA as a basis of eligibility.

**Recipient Eligibility**

**Determining Eligibility**

Any recipient may request an HCBS assessment for themselves or another recipient by making a referral to the local lead agency (Public Health, tribal agency or Human Services, and for some people, their health plan). The lead agency will determine eligibility for HCBS Programs. Each waiver program has different application processes, eligibility requirements and covered services.

With the exception of the Alternative Care (AC) program, all program applicants must qualify for MA. All applicants must meet the service eligibility criteria for the specific HCBS program in which they anticipate receiving services. Refer to the [MHCP Provider Manual, Chapter 2](#) for more information about MA and eligibility.

The county provides Long Term Care Consultation (LTCC) services including a community assessment of the needs of the recipient, assistance with the application process, and development of a community support plan. A recipient approved for an HCBS waiver program will receive service coordination from a public health nurse or social worker that implements and monitors the community support plan. The lead agency must ensure that the health and safety needs of all recipients are reasonably met under their community support plans. In addition, the lead agency also authorizes the funds for all the HCBS services provided to an eligible recipient.

**Eligibility Criteria by Program**

HCBS Programs provide home and community based services necessary as an alternative to institutionalization that promotes the optimal health, independence, safety and integration of a recipient into the community. In addition, the recipient, and/or their legal representative/guardian, has made an informed choice to receive home and community based services.
The following HCBS programs are currently available for a recipient who is under the age of 65 at the time of enrollment and who has a disability. Click into each Program to learn more about recipient eligibility.

- CAC (Community Alternative Care Waiver)
- CADI (Community Alternative for Disabled Individuals Waiver)
- MR/RC (Mental Retardation/Related Conditions Waiver)
- TBI (Traumatic Brain Injury Waiver)
  [http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_003908.hcsp](http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_003908.hcsp)

The following HCBS programs are currently available for a recipient who is over the age of 65 at the time of enrollment and who requires the level of care a nursing home provides. Click into each program to learn more about recipient eligibility.

- EW (Elderly Waiver)

AC (Alternative Care Program): A state-funded program for people who are not financially eligible for Medical Assistance, but who meet AC financial and service eligibility requirements


**Informed Choice**

Individuals seeking waiver or AC services will be provided, by the county lead agency as required by DHS, with the necessary information to make an informed choice among the services for which they are eligible and the county agency will document the information given. Assuring that a recipient is given informed choices is an important responsibility of the case manager/service coordinator.

When a recipient is likely to require the level of care provided in an institution such as a hospital or nursing home, the case manager/service coordinator must inform the recipient and their legal representative of home and community supports as an alternative. In addition, the case manager/service coordinator must take reasonable steps to provide the information is in a format the recipient can understand.

**Turning 65**

A recipient, receiving waiver services before age 65, remains eligible for the respective waiver after their 65th birthday if all other eligibility criteria are met. The case manager/service coordinator must inform a recipient nearing age 65 of the other community support options so that the recipient can choose which alternative will best meet their needs. Options may include the Elderly Waiver, remaining on their current HCBS waiver or other alternatives that may meet the needs and preferences of the recipient.
HCBS Program Services Provider Information

Enrollment/Licensure/Certification

HCBS Program providers must enroll with DHS Provider Enrollment and meet specific standards in order to bill and receive payment for waiver services. More information about Provider Enrollment can be found at: http://www.dhs.state.mn.us/provider/enrollment/

Providers must also determine which program services they are qualified to provide. Specific provider qualifications are found in this manual within each service description.

Some waiver services require one or more of the following:
• License(s) from DHS or MN Department of Health
• Medicare Certification
• Certification or registration
• 245B-WS (waiver services) for some MR/RC services. This license is specific to the county where services are provided. A separate waiver license must be obtained for each county in which waiver services will be provided.

For more information please refer to one or more of the following:
• Social Services department of the county in which you will be providing services’
• DHS Licensing at 651-296-3971 or http://www.dhs.state.mn.us/Licensing/default.htm.
• MN Department of Health at 651-215-5800 for general information or their web site home page at http://www.health.state.mn.us/index.html

County Contracting

DHS specifies that counties and tribal agencies will contract for waiver services with qualified providers. State statutes require contracts for providers who wish to provide services under the AC program. The County and Lead Agencies are required to:
• Contract with waiver and AC providers.
• Ensure that providers meet the appropriate qualifications and standards of the Program.
• Identify any additional competencies in the recipient’s Individualized Service Plan
• Monitor provider performance. This must occur on an ongoing basis with case manager/case manager/service coordinator oversight regarding the well being of the recipient and related provider performance. Additionally, local agencies are responsible for systematic provider performance monitoring.

Under no circumstances may a provider initiate service delivery prior to the execution of a contract for waiver or AC services.

Authorization of Services (Prior Authorizations)

Waiver and AC services require prior authorization from a case manager/service coordinator in the form of a completed service agreement (SA). The SA allows the provider to bill DHS and receive payment
after services are provided. Only services on the SA can be paid, however an approved SA is not a guarantee of payment. The case manager/service coordinator is ultimately responsible to make sure that the SA is accurate when it is entered into the DHS computer system (MMIS).

Providers should verify program eligibility for each recipient each month through phone or MN-ITS eligibility verification.

The SA for CAC, CADI, EW, MR/RC, and TBI Waivers may include the following:
- Medical Assistance (MA) home care services of SNV, HHA, PDN, PCA
- Waiver services consistent with the county contract

Each line item on the SA lists the following:
- Minnesota Health Care Programs (MHCP) enrolled provider who is authorized to provide the needed services
- The rate of payment for the service
- The number of units approved
- Date or date span of authorization of service and
- The approved procedure code(s)

### County Health and Human Service or Lead Agency Responsibilities

County agencies acting as agents for the HCBS Program are responsible for providing program access and local program administration.

Local program administration includes the following:
- Case Management/Service Coordination for recipients receiving services including assessment and service plan development
- Assistance to help people access, coordinate and evaluate available services
- Determine financial and program eligibility of recipients for services and programs
- Input of consumer enrollment data (screening document) and service authorization into MMIS
- Authorize and monitor services to reasonably assure health and safety
- Monitor the on-going provision of services for efficacy, consumer satisfaction, continued eligibility, adjusting as necessary
- Contract management and supervision of services
- Sign provider agreements with DHS to assure that all providers meet state standards for licensing or certification relevant to their area of service
- Systematic monitoring or provider performance
- Work in partnership with DHS and other organizations to provide information, services, and assistance to people with disabilities
- The case manager is responsible for any changes made to a recipient’s SA. If the rate, procedure code(s), or begin and end dates on the SA are incorrect, contact the case manager. If an SA line item is changed and approved, DHS will automatically generate a revised SA letter to the provider. Letters are generated overnight and mailed the following day.
• The agency is able to generate additional copies of provider SA letters, if needed. Agencies have the option of allowing the DHS generated letter to be sent to the recipient or to suppress the letter and send an agency generated letter.

**Billing for Services**

Waiver services must be billed using the CMS-1500. Refer to the Billing Policy chapter (Ch. 4) for more information. Under no circumstances may a provider initiate and bill for service delivery prior to the execution of a contract for waiver services.

Providers are recommended to verify program eligibility of a recipient on a monthly basis through phone or MN-ITS eligibility verification.

**Diagnosis Codes (ICD9-CM)**

Diagnosis codes will be required on most of the new HIPAA national codes, including waiver services. Please refer to Provider Bulletin # 04-25-10, Bulletin 04-56-04 and Provider Update # WAV-04-02 for details about implementation and actual codes.

MMIS was modified so that the service agreement letter for CAC, CADI, MR/RC, EW, AC, and TBI Waivers to the provider will display the diagnosis code of the recipient if the diagnosis **is needed for billing**. The diagnosis will be pulled from the primary diagnosis field on the last approved screening document or from the SA for MA Home Care. Note: it is not necessary to use the diagnosis code listed on the service agreement letter if you have a more recent or correct diagnosis code.

**Authorized Services vs. Non-Authorized Services:** Services that require a SA cannot be billed on the same claim as services that do not require a SA. For example, home care therapy services (physical, occupational, repertory and speech therapy) do not require a SA and cannot be billed on the same claim form as waiver services.

DHS requires counties to enter SAs prior to the start of service to ensure provider payment. There are many advantages, for both providers and counties, to coordinate their efforts to ensure that a recipient receives their necessary services, and that providers receive timely payments for services rendered.

**Payment Rates**

DHS establishes upper rate limits for HCBS waiver services. Upper limits are published in DHS bulletins at [http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs_id_000305.hcsp](http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs_id_000305.hcsp)

For upper limit rates specific to Home Care, CAC, CADI, MR/RC, TBIW, EW and AC Waivers are listed in 04-25-06.

Lead agencies for HCBS waiver programs negotiate contracts with providers and set service provider payment rates. Negotiated service rates may not exceed the DHS published maximum allowable service rate and may be negotiated lower than the maximum rate allowed.

**Exceeding Waiver Funding Limits for EW:** Refer to Bulletins 04-25-08 and 04-56-09 for additional information.
**EW Obligation:** Some EW recipients have chosen to replace their medical spenddown with an EW spenddown. This means the recipient will have to pay a portion or all of their EW service costs through a waiver obligation.

The EW obligation is structured like the potluck spenddown. The county financial worker will enter the EW obligation into MMIS. DHS will report the amount the provider can bill the recipient on their remittance advice. Claims that are reduced due to the EW obligation will show claim adjustment reason code PR 142 on the remittance advice form. See Bulletin 99-16-02 for more information on the EW obligation.

Effective December 15, 2000, a recipient can select a designated provider to pay their obligation. The recipient should notify their financial worker if they wish to choose this option.

**Payer Determination:** All providers and lead agencies are responsible for billing available payers for services. The Payer Determination Form (PDF) [http://edocs.dhs.state.mn.us/lfs/legacy/DHS-3273-ENG](http://edocs.dhs.state.mn.us/lfs/legacy/DHS-3273-ENG) is used to determine the appropriate payer source. The case manager/service coordinator keeps this form on file. The order of payers is as follows:

1. Third party payers (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, workers’ compensation law or plan, no-fault or liability insurance policy or plan);

2. Medicare and Medigap Policies (Medicare must always be billed unless the item is a Medicare non-covered service);

3. Minnesota Health Care Programs; and

4. Waiver Programs.

**Home Care Services provided for an MA Eligible Recipient receiving Waiver Services**

Any recipient receiving waiver services is expected to maximize access to other federal or private program benefits for primary health care coverage either through Medicare benefits, private insurance, Medicare Supplement policies, and long term care insurance policies. All recipients receiving waiver services must first access MA State Plan benefit services to the highest extent before using waiver services.

MA covers the following home care services:

- Personal Care Assistant (PCA)
- PCA Supervision
- Home Health Aide (HHA)
- Skilled Nursing Services (SNV)
- Private Duty Nursing (PDN)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Respiratory Therapy (RT)
- Speech Therapy (ST)
CAC, CADI, and TBI Waivers:
- With the exception of therapies, which are paid directly through MA, the case manager/service coordinator determines the amount of home care services and approves the service agreement.
- For Prepaid Medical Assistance enrollees, the designated PMAP provider is responsible for approval and provision of all home care services.

MR/RC Waiver:
The public health nurse:
- Conducts all PCA assessments/reassessments
- Recommends the necessary amount of PCA services
- Determines the appropriate level and amount of all other home care services
- Participates in the development of the Individualized Service Plan/Community support plan.

EW Waivers:
- With the exception of therapies, the case manager determines the amount of home care services and approves the service agreement.
- For Prepaid Medical Assistance enrollees, the designated PMAP provider is responsible for approval and provision of all home care services.

Extended Home Care Services:
- A recipient must first access needed home care services through MA home care or PMAP before “extended home care” benefits may be approved.
- Home care service needs, which exceed the limits those programs impose, may be approved and billed to the waiver as “extended MA services.”
- These extended services include extended PCA, extended Home Health Aide, extended Home Health Nursing (RN/LPN) and for CAC, CADI and TBI extended therapies. For EW, this also includes extended supplies and equipment and extended transportation.

Refer to Home Care Services chapter (Ch. 24) for more information about MA Home Care services.

Waiver Services, Billing Codes, and Provider Standards
Each home and community-based waiver program requires certain questions be asked about services:
- Are the services necessary to ensure the health, welfare and safety of the person?
- Are the services selected by the person as an alternative to institutionalization?
- Is the service covered by any other funding source?
- Is the cost of the service considered reasonable and customary and the least costly to reasonable meet the need(s) of the recipient?
The following waiver service descriptions include a definition, covered and non-covered services, provider qualifications and standards, and secondary information. In some of the information you will find a process and procedure that has been developed. These services and requirements are the minimum guidelines. Individual Counties and Lead Agencies may negotiate with providers in their contracts to have higher provider standards under each service category than those noted below.

**Covered Services**

<table>
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<tr>
<th>Service</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
<th>AC</th>
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Service | CAC | CADI | MR/RC | TBI | EW | AC
---|---|---|---|---|---|---
Relocation Service Coordination | X | X | X | X | X | X
Residential Care | X | X | X | X | X | X
Respite Care | X | X | X | X | X | X
RN Supervision of PCA | X |  
Specialist Service | X |  
Structured Day | X |  
Supplies and Equipment | X | X | X | X | X | X
Supported Employment | X |  
Supported Living | X |  
Telehomecare | X |  
Therapies (MA & Extended) | X |  
Transitional Supports | X |
Non-Medical Transportation | X | X | X | X | X | X
24-Hour Emergency Assistance | X |

### Adult Day Care and Adult Day Care Bath

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
<th>AC</th>
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</thead>
</table>
Adult Day Care  
• S5100 – 15 minutes | X | X | X | X | X | X |
• S5102 – Daily | X | X | X | X | X | X |
Adult Day Care Bath  
• S5100 with modifier TF – 15 minutes | X |  
• limited to two units per day | X |  

### Definition

Health and social services provided to recipients who are 18 years of age or older ARE PROVIDED in accordance TO the recipient’s community support plan to ensure their optimal functioning. The plan identifies the needs of the recipient and is directed toward the achievement of specific outcomes.

**Covered Services & supports include:**

- Supervision
- Care
- Assistance
- Training
- Activities
- Meals
- Adult Day Care Bath (excluded by MR/RC)

**CADI additional service description includes:**

- Nutritional Counseling
- Home and safety practices
- Emotional supports of the recipient and family in remaining independent
Transportation/Adult Day Care

CADI, TBI and MR/RC:

- When Transportation between the recipient’s place of residence and the adult day care center is not included in the adult day care rate, it can be billed separately, using HCPC codes S5100 and S5102.
- Transportation costs may be reimbursed using the Transportation Service as appropriate.

Secondary Information

Adult Day Care Bath (CADI & TBI):

A recipient may receive a bath provided by an adult day care provider. The bath must be required by the recipient and specified on the community support plan. This service is limited to two, 15-minute units of service per day. This limit does not apply to MDHO enrollees.

Clients enrolled in a Prepaid Medical Assistance Program (PMAP) may not access this service as they receive baths as part of their basic PMAP benefit.

Meals (CADI, MR/RC and TBI):

Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day).

Parameters of Service for Adult Day Care (CADI and TBI):

- Services may be furnished two or more hours per day on one or more days per week, on a regularly scheduled basis
- Services cannot exceed 12 hours in one 24 hour period
- Must be in an outpatient setting
- These parameters do not apply to MDHO enrollees

MR/RC Only:

When it is determined that adult day care is the most appropriate service, in order to be reimbursable under the waiver, the adult day care service must:

An adult day care must provide the following for people on the MR/RC Waiver:

- Tasks and materials that are age-appropriate for people without disabilities who are the same or near the same chronological age as the recipient
- Community inclusion opportunities by offering or providing community integration services designed to increase and enhance each recipients social and physical interaction with individuals without a disability who are not paid caregivers or staff members.
- Offer or provide opportunities for a recipient to access community agencies such as senior citizen centers or clubs, generic service organizations and adult education.
- Provide specialized therapies and alternative communication or other adaptive equipment as determined by the service planning team to be necessary.
Additional MR/RC Waiver standard:

Adult Day Care may be provided only when the service planning team has determined that adult day care is the most appropriate service for the recipient. This determination must be based on documentation that day training and habilitation services as defined in MN Statutes section 252.41, subdivision 3 are no longer the most appropriate services for the recipient based on the following:

- The recipient or their legal representative has made an informed choice to no longer participate in or to retire from employment or employment related activities.
- The recipient’s health care and active treatment needs can more appropriately be met by an adult day care service and
- The recipients daily needs include:
  1. Living skills as defined under MN Rule, part 9555.9710, subd. 5.
  2. Social, recreational, recipient interest, language and conceptual skills as defined under MN Rule, part 9555.9710, subp. 7, and
  3. Structured exercise program

AC and EW – Adult Day Bath

- Adult Day Bath is Limited to 30 minutes per day
- The second unit may be provided only if the recipient requires longer than 15 minutes to complete the bath; this code may only be used if the recipient has a separate adult day care service approved for the same time period.
- Adult day care providers may provide a bath to a recipient attending adult day care if required, and if the bath is specified on the recipient’s individual plan of care
- EW only: Recipients enrolled in a PMAP may not access this service as they receive assistance with a bath as part of their basic PMAP benefit. (The health plan may choose to contract with and pay the adult day care provider to provide a bath.)

AC and EW – Adult Day Care

- A licensed adult foster care provider may provide family adult day care under their foster care license if the recipients are 55 years and older, none of the recipients are seriously and persistently mentally ill or developmentally disabled and the combined number of people receiving adult foster care and adult day care does not exceed the number licensed for adult foster care. The commissioner may grant a variance which would allow up to seven individuals to receive adult day care services if the variance is requested as defined in Minnesota Statutes 245A.04, subdivision 9, a second caregiver is present whenever six or more clients are being served and the variance is recommended by the LEAD agency in the county where the provider is located.
- The provider cannot be the same provider of adult or corporate foster care.
- Adult Day care services provided in the license holders primary residence, when the license holder is the primary provider of care, must be licensed under Minnesota Statutes, section 245A.143 (Family Adult Day Services)
  The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.
Provider Standards and Qualifications

Provider type: Adult day care providers include hospitals, nursing homes, medical clinics, family homes, and freestanding centers.

License: Adult day care centers must be licensed under MN Rules, parts 9555.9600 to 9555.9730 and MN Statutes, 245A.01–245A.17.

Assisted Living Services

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
<th>AC</th>
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<td>• X5604 – daily</td>
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<td>• CADI, EW &amp; AC providers</td>
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</table>

Definition

A group of individualized supportive services provided to a recipient residing in a residential center (apartment buildings) or other congregate living setting licensed as a home care provider or a Housing with Services establishment or contracted for by the agency with a Class A home care agency.

Housing with Services Establishment or Establishment means:

An establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or An establishment that registers under section 144D.025.

Covered Services

Assisted Living services include “individualized” supports that are chosen and designed specifically for each resident’s needs. The services include:

- Up to 24-hour supervision and oversight
- Home care aide tasks
- Home management tasks including laundry and meal prep
- Arranging for or providing transportation
- Assisting the recipient with setting up meetings or appointments
- Socialization
- Assisting the recipient with personal fund management.
Additional services may be available through providers licensed to provide MA home care services:

- Home health aide;
- Incidental nursing; and
- Central storage of medications

**Non-Covered Services**

- Room and Board
- EW and AC funded homemaker and respite are not allowable services during the period that the person is receiving Assisted Living services.
- EW providers cannot bill for full days on which the client is absent.
- Payment for assisted living services when the recipient is not in the setting (see Leave Day Policy)

**Secondary Information:**

Service delivery is directed by the recipient, or the provider, with oversight from the case manager/service coordinator.

The case manager/service coordinator is the primary party that is responsible for negotiations with the provider to assure that the needs of the recipient are fully met through the package that is created specifically for that recipient.

All homemaker and chore services are a part of the Assisted Living Services package that is initially negotiated with the provider, and meets all of the homemaker and chore service needs for the recipient.

Assisted Living Services may be provided in any number of apartments in a residential center for recipients who rent or own distinct units.

Lead Agencies should negotiate rates based on the level of service provided. For example, if 24-hour supervision is provided the rate may be negotiated up to the monthly limit. If less than 24-hours of supervision are provided (Assisted Living or Residential Care), the rate should be negotiated at a lesser amount.

**Size and Location**

Assisted Living Service may not be authorized for recipients residing in a living setting adjoined to or on the same property as a nursing facility, hospital, ICF/MR, or institute for mental disease.

For recipient under the age of 55 years, the total number of individuals residing in a living setting cannot exceed four (4). This means 4 people unrelated to the principal care provider.

**Exception** – Residence was developed before May 1, 2001 and has continuously provided waiver services.
AC and EW

- Assisted living services are paid for through a recipient’s program. Room and board or rent, while a recipient receives assisted living services, may be paid for through the recipient’s income sources first, which may include: Social Security Disability Insurance, General Assistance, Minnesota Supplemental Aid, or Supplemental Security Income. If the recipient has inadequate income for room and board or rent charges, he/she may be eligible for Group Residential Housing (GRH) payment to the provider.

- EW and AC funded homemaker and respite are not allowable services during the period that the person is receiving Assisted Living services.

Provider Standards and Qualifications

Must be furnished by a provider who holds one of the following:

- **Class “A” Licensed Home Care Agencies**
- **Class “E” Licensed Assisted Living**
- **Assisted Living Home Care Providers** licensed by the MN Department of Health under MN Rules, parts 4668.0002 to 4668.0870 only available to a setting registered as a Housing with Services establishment
- **Assisted Living Service Providers** who are not licensed under MN Rules, parts 9555.5105 to 9555.6265 (adult foster care), and who provide services in settings of one to four or five residents, must comply with MN Rules, parts 9555.6205, subparts 1 to 3, and parts 9555.6225, subparts 1, 2, 6 and 10.

Home care licenses are issued under Minnesota Rules, Chapter 4668 and 4669. Provider must be registered with the State under Minnesota statutes Section 144D “Housing with services Registration Act”.

Staff Qualifications

- **Home Care Aides** qualifications are listed in MN rules parts 4668.0100, subp. 2.
- **Home Health Aide** qualifications are listed in MN Rules parts 4688.0100, subp 5.

- **Staff providing supervision, oversight and supportive services must be able to:**
  - Read, write and follow written or oral instructions
  - Have had experience and/or training in caring for individuals with functional limitations
  - Have good physical and mental health, and maturity of attitudes toward work assignments
  - Have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation
  - Understand, respect and maintain confidentiality
  - Have a valid state driver’s license if they provide transportation to waiver clients.
Assisted Living Plus

<table>
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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
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<th>MR/RC</th>
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</thead>
<tbody>
<tr>
<td>Assisted Living Plus Services</td>
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<td>X5362 – monthly</td>
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<td>X5604 – daily</td>
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</tbody>
</table>

Definition

A group of individualized supportive services provided to a recipient residing in a residential center (apartment buildings) or other congregate living setting licensed as a home care provider or a Housing with Services establishment or contracted for by the county with a Class A home care agency

Must include 24 hour on site supervision in addition to services provided by home care aides, home health aides or residential staff.

Housing with Services Establishment or Establishment means:
An establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or An establishment that registers under section 144D.025.

Covered Services

Assisted Living Plus services include individualized supports that are chosen and designed specifically for each recipient’s needs and can only be provided in a registered housing with services establishment. The services include:

- 24-hour supervision and oversight
- Home care aide tasks
- Home management tasks
- Meal preparation
- Arranging for or providing transportation
- Assisting the recipient with setting up meetings or appointments
- Socialization
- Assisting the recipient with personal fund management

Additional services available through providers that are licensed to provide home care.

24-hour on site supervision means:
- Ongoing awareness of recipient’s needs and activities provided by an employee of the assisted living provider, and
- A method for the recipient to summon assistance, and
• Assisted Living Plus employee available to respond, in recipient, to the request within a reasonable amount of time.

**Non-covered Services**

• Room and Board
• EW and AC funded homemaker and respite are not allowable services during the period that the person is receiving Assisted Living services.
• EW providers can not bill for full days on which the client is absent.
• Payment for Assisted Living Plus Services when the recipient is not in the setting ([Leave Day Policy](#))

**Secondary Information**

The Assisted Living Plus employee provides supervision for residents as a primary job and cannot be a recipient of services.

Service delivery is directed by the recipient, or the provider, with oversight from the case manager/service coordinator.

The case manager/service coordinator is the primary party responsible for negotiations with the provider to assure that the needs of the recipient are fully met through the package that is created specifically for that recipient.

All home management task services are a part of the Assisted Living Plus Services package initially negotiated with the provider, and meets all of the home management task service needs for the recipient.

County Agencies should negotiate rates based on the level of service provided. For example, if 24-hour supervision is provided the rate may be negotiated up to the monthly limit. If less than 24-hours of supervision are provided (Assisted Living or Residential Care), the rate should be negotiated at a lesser amount.

**Size and Location**

Assisted Living Service **may not** be authorized for recipients residing in a living setting adjoined to or on the same property as a nursing facility, hospital, ICF/MR, or institute for mental disease.

**CADI Program**

For recipient under the age of 55 years, the total number of individuals residing in a living setting **cannot exceed four** (4). This means 4 people unrelated to the principal care provider.

**Exception** – Residence was developed before May 1, 2001 and has continuously provided waiver services.
Provider Standards and Qualifications

Must be furnished by a provider who holds one of the following:

- **Class “A” Licensed Home Care Agencies**
- Assisted Living Home Care Providers licensed by the MN Department of Health under MN Rules, parts 4668.0002 to 4668.0870 only available to a setting registered as a Housing with Services establishment
- Assisted Living Plus Services can only be provided in settings registered as “Housing with Services” establishments under MN Statutes, Chapter 144D.
- Assisted Living Service Providers who are not licensed under MN Rules, parts 9555.5105 to 9555.6265 (adult foster care), and who provide services in settings of one to four residents, must comply with MN Rules, parts 9555.6205, subparts 1 to 3, and parts 9555.6225, subparts 1, 2, 6 and 10.

Home care licenses are issued under Minnesota Rules, Chapters 4668 and 4669. Providers must be registered with the State under Minnesota statutes Section 144D “Housing with services Registration Act”.

Staff Qualifications

- **Home Care Aides** qualifications are listed in MN rules parts 4668.0100, subp. 2.
- **Home Health Aide** qualifications are listed in MN Rules parts 4688.0100, subp 5.
- **Staff providing supervision, oversight and supportive services must be able to:**
  - Read, write and follow written or oral instructions
  - Have had experience and/or training in caring for individuals with functional limitations
  - Have good physical and mental health, and maturity of attitudes toward work assignments
  - Have the ability to converse on the telephone, to work under intermittent supervision, to deal with minor emergencies arising in connection with the assignment, and work under stress in a crisis situation
  - Understand, respect and maintain confidentiality
  - Have a valid state driver’s license if they provide transportation to waiver clients.

Class E, assisted living program licensed providers, **may not** provide Assisted Living Plus services.

**Assistive Technology**

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
<th>AC</th>
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<tbody>
<tr>
<td>Assistive Technology</td>
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<tr>
<td>• X5671 – per item See Equipment and Supplies chapter (Ch. 23) for examples of MA covered and non-covered items.</td>
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</table>
Definition

A device or equipment or combination of methods which improve the ability of a recipient in their home or community to perform activities of daily living, to control/access and communicate in the community.

Covered Services
- Assessment of a need for assistive technology, including software
- Most appropriate product from the available options
- Equipment rental during a trial period, customization, training and technical assistance
- Ongoing training and evaluation for the recipient and caregiver about the product
- Maintenance, repair of devices and rental of equipment during periods of repair

Non-covered Services

Services cannot be duplicated with other Minnesota State plan covered service or waiver services.

MA covered equipment for MA eligible recipients.

Secondary Information

1. The item must be of direct, specific and exclusive benefit to the recipient due to their disability.
2. Various agencies the recipient is involved with coordinate with each other to provide consistency in the assistive technology services used.
3. The Individual Service Plan assures that there is no duplication with other services provided to the recipient, regardless of funding.
4. All items must meet applicable standards of manufacture, design and installation.

CAC, CADI and TBI assistive technology is not covered within this service description – it is covered under Specialized Supplies and Equipment. See that service description below for further details.

Provider Standards and Qualifications
- Provider must have a contract or a purchase agreement with the local agency
- Recipient must have an assessment completed by someone who is trained and/or familiar with assessing the need for the assistive technology and who can assure the recipient has the ability to use, and learn to use the assistive technology being assessed
- Provider should comply with all relevant statutory references and rules/regulations of the items they may be selling.
Behavioral Programming

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
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<td>Behavioral Programming</td>
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<tr>
<td>• X5582 – 15 minutes, by a specialist</td>
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<td>X</td>
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<tr>
<td>• S5135 with the U9 modifier – 15 minutes, by an aide</td>
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Definition

Individually designed strategies that decrease severe maladaptive behaviors that interfere with the ability of a recipient to remain in the community. Behavioral Programming may be provided in the home or community.

Covered Services

Behavioral Programming includes:

• Completing an individualized assessment of maladaptive behaviors
• Developing a structured behavioral intervention plan
• Implementing the plan
• Ongoing training and supervision of caregivers and behavioral aides
• Periodic reassessment of the plan

Non-covered Services

Services cannot be duplicated with other Minnesota State plan covered service or waiver services.

Secondary Information

• Services of the behavior professional may be in-recipient (including travel), consultative or by telephone contact.
• Master prepared professionals may be reimbursed at 80% of the maximum rate.

Provider Standards and Qualifications

Behavioral Professional – Minnesota Statutes, Chapter 148

A psychologist, licensed under sections 148.88 to 148.98, who has stated to the board of psychology, competencies in areas related to the diagnosis and treatment of brain injury

A clinical social worker licensed under section 148B.21, subdivision 9 as an independent clinical social worker

A Behavioral Professional is responsible to:
Complete an individualized assessment
Develop an individualized behavior support plan that identifies specific proactive and reactive strategies
Distribute the plan to those with a need to know
Provide interventions, interpret results of the service and modify the plan as may be necessary
Train staff
Supervise behavioral staff (includes behavioral analyst, behavioral specialist and behavioral aide)

**Behavioral Analyst**

A recipient who has received a baccalaureate degree in a social services discipline and has three years experience working with recipients with behavioral deficits. Two years experience as a behavior analyst may substitute for the preceding education requirements.

A behavior analyst is responsible to:
Oversee consistent implementation of the behavior support plan in coordination with the behavioral professional
Provide training, direction for data collection and data analysis
Ensure feedback and communication with the behavior professional

**Behavioral Specialist**

A recipient who has received an associate degree in a social services discipline or has two years experience working with recipients with behavioral deficits

A behavior specialist is responsible to:
Provide consistent implementation of the behavior support plan and data collection
Communicate questions or concerns to the behavior professional or specialist

**Behavioral Aide**

A recipient who has received a minimum of four hours training in understanding the cognitive/behavioral effects of brain injury and 20 hours of instruction in behavior modification techniques is determined by a psychologist or behavioral analyst to have the skills required to provide behavioral modification intervention to the recipient who receives behavior programming.

A behavioral aide is responsible to:
Consistently implement the behavior support plan, collect data, and report behavioral concerns or questions as they arise

### Caregiver Training and Education

<table>
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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
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</table>

**Definition**

A service that provides training, education and counseling services for caregivers who provide direct and ongoing services to waiver recipients. This can include a parent, spouse, children, relatives, foster family, in laws or other informal primary caregivers when the primary caregiver is not employed by a corporation to provide supervision and care for the recipient. Training includes instruction about treatment regimens, disease management, nutrition, personal/physical cares, behavioral management, care coordination, family dynamics, and caregiver roles and the use of equipment specified in the care plan – and shall include updates as necessary to safely maintain the individual at home. Counseling includes coaching, guidance or instructions directly related to providing care to the person receiving services through the waiver.
Covered Services

Reimbursement* will be made for enrollment fees, materials and any mileage, hotel and meal expenses related to attendance by the parent or primary caregiver. Caregiver training and education services must be prior authorized by the case manager and the least costly option to reasonably meet the need(s) of the recipient, prevent institutionalization and assure health and safety.

*EW – This service is limited to paying for the cost of training and counseling (paying professional or course or conference registration fees and materials) Costs related to transportation, travel and lodging are not covered.

Non-covered Services

Services cannot be duplicated with other Minnesota State covered service or waiver services.

Secondary Information

EW and AC

Acceptable providers are health care professionals, such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, pharmacists, vocational and technical colleges offering home health aide and certified nursing assistant training. Training and education of caregivers must be provided by health care professionals such as public health nurses, registered nurses, licensed practical nurses, physicians, social workers, rehabilitation therapists, gerontologists, or pharmacists who have at least one year of experience in providing home care or long term care service to the elderly or at least one year of experience providing training or education to caregivers of elder persons.

Physical cares requiring a specific technique for the safety of both the caregiver and care receiver must be taught by a professional specializing in such techniques such as public health nurses, registered nurses, and licensed practical nurses. Training and education of caregivers may also be provided by vocational and technical schools offering courses such as home health aide and certified nursing assistant training or provided by care or support related organizations (e.g. Alzheimer’s Association) when it is determined by the case manager that the content of the training or conference directly applies to the care and well being of the recipient.

Reimbursement

The following must be documented for this service to be reimbursed:

• Requested areas of training and education
• Potential sources of training
• Identified methods by which the parent or primary care giver will receive information about training and educational opportunities
Documentation of the training or education (such as the course syllabus, workshop description, or training objectives) and receipts for any fees and expenses must be submitted to the local county social service or lead agency prior to payment.

The local county social services or lead agency, as an enrolled MA provider, may pay the parent or primary care giver directly then submit claims to MMIS for reimbursement of the service.

All caregiver training and counseling must be included in the individual’s written plan of care.

**Provider Standards and Qualifications**

Caregiver training and education providers must be individuals, agencies or educational facility staff who have demonstrated expertise in topics that relate to the needs of the recipient or the ability of the caregiver(s) to provide care and support to the recipient. Topics include developmental disabilities, community integration, parenting, family dynamics, stress management, intervention strategies or mental health issues.

**Case Management/Service Coordination**

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
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</table>

**Definition**

Service that will assist recipients on a waiver program to gain access to needed waiver and State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source.

**Covered Services**

The following case management service activities are covered under the waivers programs:

- Development of a service plan
- Informing the recipient or the recipient’s legal guardian or conservator, or parent if the recipient is a minor of service options
- Assisting the recipient in the identification of potential providers
- Assisting the recipient to access services
- Coordination of services
- Evaluation and monitoring of the services identified in the plan
- Annual reviews of service plans

**Case Management Administrative Activities**

Case management administrative activities are not billable under any HCBS program. Case management administrative activities include:
Intake
Screening activity
Service authorization
Review of eligibility for services
Responding to requests for conciliation conferences and appeals
Diagnosis

Non-covered Services

Case management service activities cannot be duplicated with other Minnesota State plan covered services.

Secondary Information

All case management services billed to the HCBS programs must be based on a service actually provided to the recipient. Services must be planned and delivered based on individual need and may not be billed based on averages of the number of billable units provided to a recipient, nor across waiver recipients.

Payments will not be made for case management services by more than one provider. Payment is made to the provider as indicated on the service agreement.

Some recipients receiving case management under a waiver may also be determined to be eligible for other forms of case management. In these situations, the department recommends:

- A case manager/case manager/service coordinator is designated as the primary contact
- There is coordination among the case managers
- Roles and responsibilities of each case manager are clearly defined so efforts are not duplicated

Recipients eligible for and receiving case management under one of the waivers are not eligible for the following forms of case management:

- Targeted Case Management for Vulnerable Adults and Adults with Developmental Disabilities (VA/DD-TCM)
- Relocation Service Coordination (RSC)

Case Management Access/Conversion (AC)

- AC case management conversion is available when the AC program will serve as the primary payer for services in the community; it is rare for AC clients to be eligible for this service
- It is used to provide case management activities while the recipient is admitted to a nursing facility and it is anticipated that the recipient will return to the community but only when the AC program is the primary payer of services.
- Access to this service is limited to 100 consecutive days.
Provider Standards and Qualifications

Recipients authorized for and receiving service under the HCBS programs may choose to receive case management services from qualified and approved vendors that have provider agreements with the agency or State. If the provider is a federally recognized tribal government, the case management contract may be between the tribal government and the department. Based on the standards contained in the waiver plans, only county agencies are qualified to provide or contract for case management services. However, choice of the recipient cannot be limited to the county of financial responsibility. This means the recipient may choose to receive case management services from another county or lead agency. Please note this applies to case management service activities only. Case management administrative activities are not directly billable under any waiver.

The provider of case management services must not have a financial interest in other services provided to an individual, unless it is the county or lead agency that provides the case management services.

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<tr>
<th>CAC/CADI/TBI</th>
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<tr>
<td></td>
<td>• Licensed under Minnesota Statute, section 148.171, subdivision 18</td>
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<table>
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<tr>
<th>Registered Nurse</th>
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<tbody>
<tr>
<td></td>
<td>• Licensed under Minnesota Statutes, Chapter 148, sections 148.171 - 148.285</td>
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<table>
<thead>
<tr>
<th>CAC Waiver only</th>
<th>Social Worker</th>
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<tbody>
<tr>
<td></td>
<td>• Graduate of a School of Social Work and</td>
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<tr>
<td></td>
<td>• Meet the minimum qualifications of a Social Worker under the Minnesota Merit System (per Minnesota Rule 9575) or county civil service system in Minnesota</td>
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<tr>
<th>CADI/TBI Waivers (Not CAC, see above)</th>
<th>Social Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Graduate from an accredited four-year college with a major in Social Work, Psychology, Sociology, or a closely related field; or a graduate from an accredited four-year college with a major in any field and one year experience as a social worker in a public or private social service agency and</td>
</tr>
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<td></td>
<td>• Social Workers must meet the minimum qualifications under the MN Merit System (per Minnesota Rule 9575) or county civil service system</td>
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</tbody>
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<table>
<thead>
<tr>
<th>MR/RC Waiver</th>
<th>A Case Manager/Case manager/service coordinator must meet the following requirements:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• At least a bachelor degree in social work, special education, psychology, nursing, human services or other fields related to the education or treatment of recipients with mental retardation or related conditions and</td>
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<td></td>
<td>• One year of experience in the education or treatment of recipients with mental retardation or related conditions</td>
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</tbody>
</table>

24 August 2005
**AC & EW**

- If the case manager is not a county or tribal agency employee, then the provider of services will be required to execute a contract with the agency in order to provide case management.
- Case Managers, with the exception of county or tribal agency employees, may not have a financial interest in the provision of services.

---

**EW**

Case Management/Service Coordination may be provided by the following individuals who are employed by, or contracted with, the local agency:

- Public Health Nurse or
- Registered Nurse licensed under Minnesota Statutes, sections 148.171 to 148.285 or
- Social Worker graduate of an accredited four year college with a major in social work, psychology, sociology, or a closely related field; or be a graduate of an accredited four year college with a major in any field and one year experience as a social worker in a public or private social service agency. Social workers must also pass a written exam through the Minnesota Merit System or a county civil service system in Minnesota. Standards are authorized under Minnesota Rules 9575.0010 to 9575.1580. Authority to set personal standards is granted under Minnesota statutes, section 256.012.
- Different credential standards can be applied to services provided by Tribal Governments under Minnesota statutes, section 256B, subd. 7.

**Case Management Aide/Paraprofessional**

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<th>Service/HCPC</th>
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</table>

**Definition**

Assistance to the case manager/service coordinator, in carrying out administrative activities of the case management/service coordination function.

**Covered Services**

Case management aides shall perform only those tasks delegated and supervised by the case manager/service coordinator, which do not involve professional expertise or judgment.

Examples of duties case aides can perform:

- filing
- Contacts to vendors to schedule services
- Phone contacts
Non-covered Services

A case management aide must not assume responsibilities that require professional judgment.

Case management aides must not conduct assessments, reassessments or develop care plans.

Secondary Information

The case management aide must understand, respect and maintain confidentiality concerning all details of each case. The case manager or case aide cannot have a financial interest in the services provided to the individual unless the case manager is a county staff recipient. The case manager is responsible for providing oversight to the case aide.

All case management related tasks that are not professional in nature must be billed as case aide services and not as case management services. Duplicate payments will not be made for case management services by more than one provider.

Provider Standards and Qualifications

The case management aide must:
- Be a high school graduate
- Have one year of experience as a case aide or in a closely related field or one year of education beyond high school (for example, business school or college)
- Be employed by the agency providing case management
- Receive oversight by the case manager of delegated tasks

Chore Services

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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
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<tr>
<td>Chore Services</td>
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</table>

Definition

Services to maintain the home of a recipient as a clean, sanitary, and safe environment.

Eligibility

Chore services will be covered only if both of the following conditions are met:
- Neither the recipient nor anyone else in the household is capable of performing or financially providing for the chore services
- There is no relative, caretaker, landlord, local county agency, community volunteer/agency or third party payer capable of or responsible for the provision of the chore services

Additional eligibility provisions for MR/RC Waiver recipients

Chore services will be provided only when:
The recipient and/or his/her primary care giver is not capable of performing the household tasks or
The provision of the chore services allows the care giver to provide other needed supports to the recipient

**Covered Services**

Examples of chore services include:
- Heavy household chores such as washing floors, windows and walls, tacking down loose rugs and cementing tiles
- Moving heavy items to provide safe access inside the home
- Shoveling snow to provide access and egress to and from the home

**Non-covered Service**

Services cannot be duplicated with other Minnesota State plan covered services or waiver services or in the case of rental property where the service may be the responsibility of the landlord.

**Secondary Information**

Other sources of funding will be investigated the county authorizes a chore service. Other sources of funding can include CSSA/Title XX or in the case of rental property, the responsibility of the landlord pursuant to the lease agreement.

**EW and AC Programs:**

Chore services will be covered only if both of the following conditions are met:
- Neither the recipient nor anyone else in the household is capable of performing or financially providing for the chore services
- There is no relative, caretaker, landlord, local county agency, community volunteer/agency or third party payer capable of or responsible for the provision of the chore services

The payment of grocery delivery service charged may be funded by the Elderly Waiver and Alternative Care if all of the following conditions are met:
- The amount of the service charge is common and customary within the recipient’s community;
- The products delivered represent the majority of the consumers total grocery needs for a minimum seven day period;
- Payment of a grocery deliver fee is the most cost effective method available to procure consumer required grocery store products; and
- Any assistance the person may require ordering, receiving, or storing the groceries is available to them.
Provider Standards and Qualifications

The county agency approves the provider of chore services and assures the chore services are:

- Provided by individuals who meet the unique needs and preferences of the recipient who will receive the chore services
- Delivered in a cost-effective manner
- Directed at the outcomes desired by the recipient
- Designed to meet the health and safety needs and preferences of the individual as specified in the Individual Service Plan or recipient support plan

Companion Services – Adult

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<tr>
<th>Service/HCPC</th>
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Definition

Non-medical care, assistance, supervision and socialization provided for an adult in accordance with a therapeutic goal in the community support plan.

Covered Services

The goals of adult companion services are directed at companionship, assistance or supervision of the recipient in the home or community

Adult companion services may include the assistance or supervision of the recipient with such tasks as:

- Meal Preparation
- Laundry
- Shopping
- Light housekeeping tasks incidental to the care and supervision

Non-covered Services

Adult companion services do not include:

- Hands-on nursing care
- Tasks as a discrete service
- Activities that are not directed at a goal

Secondary Information

Adult companion services providers who receive payment cannot be the legal guardian or related to the recipient such as a spouse or other relatives. A recipient must be over the age of 18 years to receive adult companion services.
Provider Standards and Qualifications

The local county social services agency is responsible to assure that whomever provides services (individual and/or agency) meets the following minimum standards and:

- Is able to read and write
- Is able to follow written and oral instruction
- Has had experience and/or training in homemaking skills and/or in care of recipients with qualifying conditions
- Has the ability to converse effectively on the telephone
- Has the ability to work under intermittent supervision
- Has the ability to manage emergency and/or crisis situations
- Is able to understand, respect and maintain confidentiality in regard to the details of any circumstances surrounding the recipient

An individual may be required to pass a job-related physical examination before starting to provide services.

Cognitive Rehabilitation Therapy

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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
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</table>

Definition

Services and interventions specifically designed to improve cognitive functions.

Covered Services

Those services identified in a recipient’s approved community support plan and provided on an outpatient basis or in the community.

Examples of services designed to improve cognitive function include:
- Attention and concentration
- Information processing skills
- Learning and memory
- Planning
- Problem solving
- Executive functions (processes by which a recipient plans, prioritizes, organizes, sets goals, executes strategies and monitors personal behavior)
• Self-control
• Visual-spatial deficits

**Provider Standards and Qualifications**

**Provider types**

• Licensed psychologist
• Occupational Therapist
• Speech-Language Pathologist

**License:** Psychologist must be licensed under Minnesota Statutes, sections 148.88 to 148.98 who has stated to the board of psychology, competencies in areas related to the diagnosis and treatment of brain injuries.

**Other Standard:** A recipient who has obtained a baccalaureate degree in one of the behavioral sciences or related fields from an accredited college or university and who must be under the supervision of a psychologist licensed as above.

**Consumer Directed Community Supports (CDCS)**

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<tr>
<th>Service/HCPC</th>
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</table>

An individual who wishes to receive CDCS must either already be receiving services on a HCBS program or must meet all eligibility criteria for that program and be added by the county agency as a recipient.

For more information see Bulletin 04-56-07 or refer to the DHS Public Web Pages below:

• CDCS Overview: [http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_017635.hcsp](http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_017635.hcsp)
• CDCS Case Management Function:  
• CDCS Allowable/Unallowable Expenditures:  

### Consumer Training and Education

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<tr>
<th>Service/HCPC</th>
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</table>

#### Definition

Training and education provided to a recipient with disabilities to help that recipient develop self-advocacy skills, exercise civil rights, and acquire skills to exercise control and responsibility over the supports received.

#### Covered Services

Enrollment fees, materials, transportation, hotel and meal expenses related to attendance by the recipient, which were incurred as part of the training or education and are the least costly to reasonably meet the need of the recipient.

#### Secondary Information

The local agency must prior-authorize financial resources to allow a recipient to attend a needed training or educational experience.

The requested areas of training and education are to be documented. Potential sources of training are to be recorded as are identification of methods by which the recipient will receive information about training and educational opportunities.

Documentation of the outcomes and benefits of the recipient’s participation in specific education and training will be entered in the recipient’s service plan.

County or Lead Agencies will reimburse expenses providing:

- Documentation of the training or education (such as the course syllabus, workshop description or training objectives) has been submitted and the training has occurred.
- Receipts for any fees and expenses have been submitted prior to payment.

#### Provider Standards and Qualifications

Training and education is provided by individuals, agencies and educational facilities that have demonstrated expertise in such areas as:

- Consumer empowerment
- Consumer-directed community supports
- Self-advocacy
• Community inclusion
• Relationship building
• Problem solving
• Decision making

**Crisis Respite**

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<tr>
<th>Service/HCPC</th>
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**Definition**

Specialized services that provide specific short-term care and intervention strategies to a recipient due to the need for relief and support of the caregiver and/or protection of the recipient or others living with that recipient. This includes addressing both medical and behavioral needs.

**Covered Services**

Crisis Respite services cover the following:

• Assessment of the recipient and situation to determine precipitating factors contributing to the crisis
• Development of a provider intervention plan in coordination with the service planning team
• Consultation and staff training to the provider(s) and/or care givers as necessary to assure successful implementation of the plan
• Development and implementation of a transition plan to aid the recipient to return home (if crisis-respite is provided out of the recipient’s home)
• On-going technical assistance to the caregiver or provider in the implementation of the intervention plan
• Provision of recommendations for revisions to the 24-hour service plan to prevent or minimize future crisis situations to increase the likelihood of maintaining the recipient in the community

**Secondary Information**

Crisis-respite services are a necessary component of the 24-hour service plan developed and monitored by the case manager/case manager/service coordinator. Services provided through case management are not to be duplicated.

Crisis-respite services may be provided to a recipient as:

• In-home respite or
• Out-of-home respite in a specialized licensed foster care facility developed for the purpose of providing short-term respite and crisis intervention

**Eligibility for Crisis Services**

The following criteria must be met for a recipient to receive crisis-respite services:

- The caregiver and service providers are not capable of providing the necessary intervention and protection of the recipient or others living with that recipient
- The crisis-respite service(s) will enable the recipient to avoid institutional placement
- The county or lead agency must assure and document that the crisis-respite service(s) will not result in the recipients inability to return home or to an alternative home in the community, and that the continued use of the crisis-respite service is a cost-effective alternative to institutionalization
- The recipient has been screened and authorized as eligible to receive home and community-based services

Payment for out-of-home crisis-respite will include payment for room and board costs when the service is provided in such licensed facilities.

When out-of-home crisis respite is used, long-term strategies are to be developed to prevent reoccurrence. Such services are directed toward maintaining the recipient in the community.

**Provider Standards and Qualifications**

**In Home** Crisis Respite services are to be provided by entities licensed under Minnesota Statutes, Chapter 245B Crisis Respite Services (residential habilitation).

**Out-of-Home** Crisis Respite services are to be provided by entities licensed under Minnesota Statutes, chapter 245B Crisis Respite Services (residential habilitation) and in a location licensed under Minnesota Rules, parts 9545.0010 to 9545.0260 or Minnesota Rules, parts 9555.5105 to 9555.6265 (Child and Adult Foster Care licensing rules).

The service planning team has the ability to require additional provider qualifications when determined necessary to the crisis-respite provider to appropriately meet the recipient’s needs, and shall be specified in the recipient’s service plan.

**DD Screening**

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<tr>
<th>Service/HCPC</th>
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<tr>
<td>DD Screening</td>
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**Definition**

For a recipient with a diagnosis of mental retardation or a related condition, screening teams are convened to evaluate the level of care needed by the recipient when the assessment indicates that the recipient is at risk of placement in an Intermediate Care Facility for recipients with mental
retardation or related conditions (ICF/MR), nursing facility or is requesting services in the areas of residential, training and habilitation, nursing facility or family support.

**Covered Services**

An evaluation that addresses whether home and community-based services are appropriate for recipients who are at risk of placement in an ICF/MR or for whom there is reasonable indication that they might require this level of care.

A resource for DD Case Managers is the DD Screening Codebook found at: [http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/DHS_id_008530.hcsp](http://www.dhs.state.mn.us/main/groups/county_access/documents/pub/DHS_id_008530.hcsp)

**Secondary Information**

County social service agencies may contract with a public or private agency or individual, who is not a service provider for the recipient, for the public guardianship representation requirement of the service planning team. The contract shall require compliance with the commissioner’s instructions and may be for paid or voluntary services.

For recipients under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs.

If a recipient with a developmental disability is referred to a screening team and is the subject of a commitment proceeding, the screening team shall make recommendations to the court as needed and make recommendations and a report available to the pre-petition screening unit.

**Provider Standards and Qualifications**

**Screening Team**

The screening team shall consist of the case manager for recipients with mental retardation or related conditions, the recipient, their legal guardian or conservator or the parent if the recipient is a minor and a qualified mental retardation professional (QMRP). The case manager may also act as the QMRP if the case manager meets the federal definition.

For recipients determined to have overriding health care needs and are seeking admission to a nursing facility, ICF/MR or are seeking access to home and community-based services, a registered nurse must be designated as either the case manager or the QMRP.

The case manager, with the concurrence of the recipient or their legal representative, may invite other recipients to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service interest.

**Duties**

The screening team shall:

- Review diagnostic data
• Review health, social and developmental assessment data using a uniform screening tool specified by the commissioner
• Identify the level of services appropriate to maintain the recipient in the most normal and least restrictive setting that is consistent with the recipient’s treatment needs
• Identify other non-institutional public assistance or social service that may prevent or delay long-term residential placement
• Assess whether a recipient is in need of long-term residential care
• Make recommendations regarding placement and payment for social service or public assistance support to maintain a recipient in the recipient’s own home or other place of residence, training and habilitation service, vocational rehabilitation, employment training activities, community residential placement, regional treatment center placement or home and community-based service alternative to community residential placement or regional treatment center placement
• Evaluate the availability, location and quality of the services listed above, including the impact of placement alternatives on the recipient’s ability to maintain or improve existing patterns of contact and involvement with parents and other family members
• Identify the cost implications of recommendations made regarding needed social services or public assistance
• Make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of recipients with MR/RC and
• Inform the recipient and their legal guardian or conservator, or the parent if the recipient is a minor, that an appeal may be made to the commissioner pursuant to Minnesota Statute, Section 256.045.

The screening team shall determine the level of care needed by the recipient and identify the least restrictive service types. If it is determined that the recipient is eligible for ICF/MR and home and community-based services, an informed choice between those services must be made by the recipient or their legal representative.

The screening team shall complete and sign the DD Screening Document prescribed by the Department of Human Services (DHS) and submit the document to DHS for authorization of Medical Assistance payments.

**Timelines**

It is the case manager’s responsibility to convene the screening team. The screening team shall make an evaluation of need within 60 working days of the request for service by a recipient with mental retardation or related conditions and within five working days of an emergency admission of a recipient to an ICF/MR.

The case manager is responsible for notifying the screening team members of the meeting date and convene the meeting at a time and place that ensures the participation of all screening team members.

Full team screenings must occur when:
• A recipient is identified to be at risk of ICF/MR or nursing facility placement
• A recipient or their legal representative request services
• Service needs of a recipient have changed effecting the level of care needed
• A recipient enters or exits Minnesota Extended Treatment Options (METO)
• Guardianship status of a recipient has changed
• A child reaches the age of five and has a current diagnosis of unspecified mental retardation
• The last full team screening is six years old (adult) or three years old (child)
• Entry into waivered services is anticipated in thirty days or less

**Family Training and Counseling**

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<tr>
<th>Service/HCPC</th>
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<th>MR/RC</th>
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<td>S5110 – 15 minutes</td>
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</table>

**Definition**

Services provided for the recipient and/or the family as identified in the individual plan of care.

**Covered Services**

**Training** may include:
• Instruction about treatment regimens
• Use of equipment specified in the plan of care
• Updates in instruction and use of equipment as appropriate

**Counseling** may include helping the recipient and/or family members with any of the following:
• Problem solving
• Communication techniques
• Conflict management
• Relationships
• Family roles
• Boundary issues

Services authorized must be the least costly to reasonably meet the identified need.

**Non-Covered Services**

Registration and expense for conferences and other classes that do not meet the examples in covered services.

**Secondary Information**

For purposes of this service, “family” is defined as the recipients who live with or routinely provide care to a recipient served on the waiver and may include a:
• Parent
• Spouse
• Child(ren)
• Relatives
• Foster family, or
• In-laws

“Family” does not include individuals who are employed to care for the recipient.

Provider Standards and Qualifications

Family Training and Counseling can be provided by individuals or agencies approved by the local agency.

Social Workers must be a graduate of a School of Social Work accredited by the Council on Social Work Education and must meet the minimum qualifications of a Social Worker under the Minnesota Merit System or a County Civil Service System in Minnesota.

Physicians must be licensed under Minnesota Statutes, Chapter 147.

Registered Nurses and Public Health Nurses must be licensed under Minnesota Statutes, sections 148.171 to 148.285.

Mental Health Professionals must be licensed and/or qualified according to Minnesota Statutes, sections 245.462 or 245.4871.

Physical Therapists must be a graduate of a program of Physical Therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association, or its equivalent. Physical Therapists must be registered under Minnesota Statutes 148.70.

Occupational Therapist must currently be registered by the American Occupational Therapy Association as an occupational therapist.

Respiratory Therapist must be a graduate of a program in Respiratory Therapy approved by the Council of Medical Education of the American Medical Association in collaboration with the American Respiratory Therapy Association, or its equivalent.

Medical Equipment Supplier must be authorized by case manager/service coordinator to provide training in use of equipment and must be a provider under Minnesota Rules, part 9505.0195.

Speech-Language Pathologist must have a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association.

Nutritional Therapist must have a bachelor’s degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.
Independent Practitioner who provides counseling services and who have been determined by the lead agency to:

- Have a general knowledge of disabilities and chronic illnesses that may affect individual or family functioning;
- Have skills in mental health assessment, including client interviewing and screening;
- Have skills in mental health management that include treatment planning, general knowledge of social services, record keeping, reporting requirements, confidentiality rules, and any federal or state regulations which apply to mental health services;
- Have skills in individual or group counseling, including crisis intervention;
- Provide proof that:
  1. The individual possesses at least a bachelor’s degree with a major in social work, nursing, sociology, human services, or psychology and has successfully completed 960 hours of experience as a counselor supervised by a licensed psychiatrist or psychologist (as a student, volunteer or employee).
  2. The individual has successfully completed two years of supervised experience as a counselor or therapist.

Foster Care

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
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<tr>
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Definition

Individual waiver services provided to a recipient living in a home licensed as foster care. Foster care services are individual and are based on the individual needs of the recipient, and service rates must be determined accordingly.

When placing a child or adult into a licensed foster care setting, all federal, state, county, and/or licensing agency rules and regulations must be followed.

Adult foster care is defined as a licensed, adult-appropriate, sheltered living arrangement for up to four functionally impaired adults in a family-like environment.

Covered Services

Those services and supports identified in the community support plan of the recipient and in the county contract with the provider.
These services may include, but are not limited to:
- Assistance with activities of daily living
- Community integration
- Medication assistance
- Homemaking services
- Behavioral aide services
- Supervision and ensuring individual safety

**AC and EW**

Adult foster homes provide:
- Food
- Lodging
- Protection
- Household services.

They may also provide:
- Living-skills assistance or training
- Medication assistance
- Assistance safeguarding cash resources
- Care giving
- Homemaking
- Oversight and supervision
- Transportation

**Non-Covered Services**

The payment for the waiver service of foster care does not include:
- Room and Board
- Duplication of services paid by other sources
- Items of comfort or convenience
- Costs of facility maintenance, upkeep and improvement
- Payment for foster services when the recipient is not in the foster setting ([Leave Day Policy](#))
- EW and AC respite are not allowable services during the period that the person is receiving Assisted Living Services care services.
- EW and AC programs do not allow the foster care provider to provide Adult Day Care services to the same recipient concurrently.
- EW and AC programs do not cover homemaker services during the period that the person is receiving Assisted Living Services.
Secondary Information

Unit of service is defined by the Individual Service Plan/Community Support Plan or contract.

Size and Location

CADI Program

For recipients under the ages of 55 years, the total number of individuals residing in a living setting cannot exceed four (4). This means 4 people unrelated to the principal care provider.

AC/EW Programs

Adult foster care providers may be licensed for up to five adults per home if all foster care recipients age 55 or older, have neither serious persistent mental illness nor any developmental disability.

Exceptions:

- Residence was developed before May 1, 2001 and has continuously provided waiver services
- Temporary exception to size of setting

Provider Standards and Qualifications

Payments will be made only to those entities or recipients that meet current legal foster care licensure requirements.

| CAC | Adult foster care: licensed under MN Rules, parts 9555.5105 – 9555.6265, MN Statutes, chapter 245A
| CADI | Adult foster care: licensed under MN Rules, parts 9555.5050 – 9555.6265
| TBI | Adult foster care: licensed under MN Rules, part 9555.5105 – 9555.6335
| AC | Adult foster care: licensed under MN Rules, part 9555.5105 – 9555.6335
| EW | Adult foster care: licensed under MN Rules, part 9555.5105 – 9555.6335

- Family foster care and Group family foster care: licensed under MN Statutes, section 245.802, subd. 1.
# Habilitation

**(In-Home Family Support Services, Supported Living Services, Day Training and Habilitation Services)**

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
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<tr>
<td>• X5679 – Partial Day</td>
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<td>• X5680 – Full Day</td>
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## Definition

**Day Training and Habilitation (DT&H):** Licensed supports to provide persons with help to develop and maintain life skills, participate in community life and engage in proactive and satisfying activities of their own choosing. Most persons have mental retardation or a related condition and some have traumatic brain injury or mental illness.

**Habilitation:** Health and social services directed toward increasing and maintaining the physical, intellectual, emotional and social functioning of persons with mental retardation or a related condition.

**Supported Living Services during the day:** Services or supports provided to a person that enables the person to be fully integrated into the community. Services during the day may include a variety of supports to enable the person to exercise choices for community integration and inclusion activities.

**In-Home Family Supports:** Habilitation services are provided to recipients with mental retardation or related conditions and their families, including extended family members who are...
not providing licensed foster care, in the family’s home and in the community, to enable the recipient to remain in or return to the home.

Covered Services

DT&H Services

DT&H services include the supervision, training or assistance of a person to develop and maintain life skills, engage in productive and satisfying activities of their own choosing and participate in community life. DT&H services are designed and implemented in accordance with the individual service and individual habilitation plans to help a person reach and maintain their highest level of independence, productivity and integration into the community. The following are DT&H services:

- Supervision, training and assistance in the areas of self-care, communication, socialization and behavior management
- Supported employment and work-related activities
- Community integrated activities, including the use of leisure and recreation time
- Training in community survival skills, money management and therapeutic activities that increase the adaptive living skills of an individual
- Non-medical transportation services to enable persons to participate in above listed services

Leaving the Residence:

For each person that requires a 24-hour plan of care, the Individual Service Plan shall identify services during the day outside the residence unless the plan otherwise specifies. The case manager will coordinate all DT&H and residential habilitation services.

The 2003 Minnesota Legislature removed the requirement that DT&H services be provided in a place other than the home or residence of the person unless medically contraindicated. This new legislation means that a person may now receive DT&H services in their own home or residence.

ICF/MR Non-DT&H Service Option:

Persons who reside in an Intermediate Care Facility for persons with mental retardation or related conditions (ICF/MR) now have the flexibility and choice to receive an alternative habilitative service during the day that best meets their needs as identified in the ISP. This means that ICF/MR recipients have a choice of day services as do persons who receive a home and community-based waiver.

The active treatment criteria for persons who reside in an ICF/MR remains in place no matter what option is chosen.

Non-Covered Services:

DT&H services may not include special education and related services as defined in the Education of the Handicapped Act (20 U.S.C. 1401(6), (17)) which otherwise are available through a local educational agency or vocational services funded under Section 110 of the
Rehabilitation Act of 1973 (29 U.S.C. 730) as amended. A finding that such services are not otherwise available through a program funded under Section 110 of the Rehabilitation Act of 1973 must be based on written documentation that the person:

- Is not considered an appropriate referral to the Division of Rehabilitation Services (DRS) because the individual satisfies one or more of the Screen-Out Criteria or presents an unfavorable Applicant Profile as described in Section 26520.025 of the Social Security Administration Program Operations Manual System
- Has been referred to the DRS but was found to be ineligible for vocational services under Section 110 of Rehabilitation Act
- Has been a recipient of Section 110 services provided by the DRS but is no longer eligible for such services
- Is a current client of the DRS but the activities that are provided under the definition of supported employment services are not typically available as Section 110

**In-Home Family Supports:** Services include training the recipient and family to increase their capabilities to care for and maintain the recipient in the home.

**Supportive Living Services**

**Services for Children** includes daily staff intervention due to severe behavioral problems, medical conditions, physical deficits, and/or lack of adequate survival skills which result in the family’s inability to maintain them in their home. Services will be provided outside the biological or adoptive family homes in family style settings for up to four recipients and in the community.

**Services for Adult** includes daily staff intervention to train or assist a recipient in the following areas:

- Self-care
- Sensory/motor development
- Interpersonal skills
- Communication
- Maladaptive behavior
- Community living
- Mobility

Services will be provided in the recipient’s home, adult foster care home or in a group home for up to four recipients.

**Secondary Information**

**DT&H Eligibility:**

Services are available to persons who:

- Are age 18 years or older and have a diagnosis of mental retardation or a related condition
• Receive a screening for HCBS services or reside in an Intermediate Care Facility for Persons with Mental Retardation or Related Conditions (ICF/MR)
• Have their health and safety in the community addressed in their plan of care
• Make an informed choice to receive DT&H as part of their Individual Service Plan (ISP)

Provider Standards and Qualifications

DT&H providers must be under contract with the county where the services are delivered by a licensed vendor.

The Consolidated Standards sets standards for licensing DT&H services for adults with mental retardation or related conditions.

County and Lead Agency Responsibilities:

The 2003 Minnesota Legislature enacted the Children and Community Services Act that replaces the Community Social Service Act (CSSA) beginning July 1, 2003. The repealed statute included the mandate for DT&H services. The new Children and Community Services Act requires that counties:

• Assess the needs of the people they serve
• Prioritize the services they will provide over a two year period
• Meet with local constituents to review their plans
• Submit a plan to the DHS Children and Family Services Division detailing how they intend to best meet the needs of their residents with the funds available

For DT&H services identified in an ISP, counties are responsible to:

• Contract with licensed vendors and re-determine the need for this service on a four year cycle
• Develop an Individual Service Plan (ISP)
• Authorize the delivery of services according to the ISP and individual habilitation plans (required as part of the county’s provision of case management services)
• Set payment rates
• Ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible

For persons who do not have Medical Assistance, the new law requires counties to provide DT&H services to the degree that it is:

• Identified as a needed service in the ISP of the person and
• Something they can afford to provide given the funding available

See Minnesota Statute on County Board Responsibilities

State Responsibility:

The State is responsible to:
Supervise county boards in the provision of DT&H services to adults with mental retardation and related conditions
Determine the need for DT&H services
Approve payment rates established by a county

See Minnesota Statute on State Responsibilities

Provider Responsibilities:

A vendor under contract with a county board to provide DT&H services shall:
- Provide the amount and type of services authorized in the Individual Service Plan
- Design the services to achieve the outcomes assigned to the vendor in the Individual Service Plan
- Provide or arrange for transportation of persons receiving services to and from service sites
- Enter into agreements with community-based intermediate care facilities for persons with mental retardation and related conditions to ensure compliance with applicable federal regulations

See Minnesota Statute on Provider/Vendor Responsibilities - the responsibility under clause (1), (2) and (3) extends only to the provision of services that are reimbursable under state and federal law.

Related Links:
Implementing the MFIP and CCSA Consolidated Funds
MHCP Provider Manual, Chapter 25 Day Training and Habilitation (DT&H)
2003 Legislative Changes for Day Training and Habilitation Services

Home Care – Extended Services

<table>
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<tr>
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<tr>
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<td>• G0156 – 15 minutes</td>
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<td><strong>LPN Regular Extended</strong></td>
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<td>• LPN Regular, T1003 with modifier UC – 15 minutes</td>
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- S9129 with modifiers UC and TF – visit
  - X X X X

### PCA – Extended
- 1:1 – T1019 with modifier UC – 15 minutes
  - X X X X X

### Service/HCPC
- 1:2 – T1019 with modifier UC & TT (a “Y” in the Shared Care field of the SA) – 15 minutes
  - X X X X X
- 1:3 – T1019 with modifier UC & HQ (a “Y” in the Shared Care field of the SA) – 15 minutes
  - X X X X X

### Physical Therapy, Extended
- S9131 with modifiers UC and TF – visit
  - X X X X

### Physical Therapy Assistant, Extended
- S9131 with modifiers UC and TF – visit
  - X X X X

### RN, Regular, Extended
- T1002 with modifier UC – 15 minutes
  - X X X X
- RN Regular Shared 1:2, T1002 with modifiers TT and UC and a “Y” in the Shared Care field of the SA – 15 minutes
  - X X X X

### RN Complex, Extended
- T1002 with modifiers TG and UC – 15 minutes
  - X X X X

### Respiratory Therapy, Extended
- S5181 with modifier UC – visit
  - X X X X

### RN Supervision of Independent Private Duty Nurse (PDN)
- X5441 – 15 minutes
  - X

### Speech Therapy, Extended
- S9128 with modifier UC – visit
  - X X X

See [Chapter 24](#) for more detailed information about MA State Plan services.

### Home Delivered Meals

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<th>Service/HCPC</th>
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<th>CADI</th>
<th>MR/RC</th>
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</table>

See [Chapter 24](#) for more detailed information about MA State Plan services.
Definition

Appropriate and nutritionally-balanced meals that are delivered to the place of residence of a person.

Covered Services

The case manager must approve home delivered meals as a part of the individual plan of care. In addition, the registered dietician must review and approve all menu plans.

All home delivered meals must contain at least one-third of the current Recommended Dietary Allowance (RDA) established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. Modified diets, when appropriate, will be provided to meet the individual requirements of a person.

Non-Covered Services

The waiver cannot supplant other funding sources or pay for meals in residential settings where room and board costs are part of the residential reimbursement, for example, foster care, assisted living and adult day care settings.

Secondary Information

Eligibility

Home delivered meals are provided to a person who is unable to prepare his or her meals and has no other person(s) available to do so or when the home delivered meals is the most cost-effective method to provide a person with a nutritionally adequate meal.

EW and AC specific funding requirements: Providers of home delivered meals may have multiple funding sources to support their business. To assure the AC or EW programs are not supplanting other funds, understanding the funding source(s) and funding amounts each HDM provider receives is critical in developing provider contracts. In particular, funding distributed to HDM providers through contractual agreements with Area Agencies on Aging (AAA’s) should not be supplanted by EW or AC funding.

- **Title IIIC Funding:** Home delivered meal providers who contract with Area Agencies on Aging (AAA’s) for funding to support their program may be receiving funds available from Title IIIC of the Older Americans Act, USDA funding, or state grants. These funds are all distributed by AAA’s through a contractual agreement with the provider. Specific revenue sources may be defined, including all other grants and anticipated client contributions in these contracts. Counties Agencies may find these contracts helpful in identifying provider revenue resources in determining the portion of the meal cost met by other revenue sources.

- **No Receipt of Title IIIC Funding:** Although some HDM providers do not receive any Title IIIC funding, USDA funding, or state grants funding, they may receive funding from other sources such as grants from organizations (such as United Way) and grants from local government or revenue from client contributions. Information about providers’ other funding sources is critical in developing provider contracts.
sources is essential to assure waiver and AC funds are not supplanting other funds and negotiated rates do not exceed the cost of the home delivered meal.

Neither AC nor EW clients may be required to make a contribution to their meal cost or be asked to pay for a portion of their meal cost.

**Provider Standards and Qualifications**

The following providers may offer home delivered meals:

- Hospitals
- Schools
- Restaurants
- Any agency that provides home delivered meals

Any agency that provides home delivered meals must comply with all state and local health laws and ordinances that regulate preparation, handling and serving of food as defined under Minnesota Rules, [Chapter 4626](#).

**Homemaker Services**

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</table>

**Definition**

General household activities provided by a trained homemaker, when a person is unable to manage the home or when the person regularly responsible for these activities is temporarily absent or unable to manage the home.

**Covered Services**

Homemaker services are listed in the community support plan of the person and may include:

- Meal preparation
- Shopping and errands
- Routine household care
- Assistance with activities of daily living
- Transportation arrangement
- Companionship
- Emotional support
- Social stimulation
- Monitor the safety and well being of the client

**Non-covered Services**
Services cannot be duplicated with other State plan covered service or waiver services

**Provider Standards and Qualifications**

Providers of Homemaker Services must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46. Homemakers are to meet the minimum training requirements. Homemakers must meet the standards under Minnesota Rules, part 9565.1200, subpart 2.

There is a minimum training requirement of 24 hours during the first year, and 6 hours thereafter annually. Such training includes courses in homemaking skills, child and personal care, human growth and development, the aging process, nutrition, home management, and training in working with persons who have physical and/or mental disabilities.

**Housing Access Coordination**

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<th>Service/HCPC</th>
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</table>

**Definition**

Coordination to help a person make choices about where to live, the type of home they wish to have, and who will be a roommate(s), if any.

**Covered Services**

This service helps the person to identify affordable, accessible housing and assures that housing needs are provided for separately from other service needs.

It may also include assistance in identifying options and making choices, planning for ongoing maintenance and/or repair of the home, and identification of financial resources such as eligibility for housing subsidies and other benefits.

**Non-Covered Services**

Services cannot be duplicated with other Minnesota State plan covered services or waiver services.

No provider of Housing Access Coordination may provide adult foster care to any person of their service.

**Secondary Information**

**Provider Standards and Qualifications**

Persons or agencies must have knowledge of local housing resources and must not have a direct or indirect financial interest in the property or housing the person selects.
## Independent Living Skills

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
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</table>

### Definition

Services that develop and maintain the individual’s living skills and community integration of a person. Independent Living Skills (ILS) are provided in the home of a person or in the community.

### Covered Services

Independent living skills include:
- Supervision
- Training
- Assistance to an individual with self-care
- Communication skills
- Socialization
- Sensory/motor development
- Reduction/elimination of maladaptive behavior
- Community living and mobility

See also [Independent Living Skills (ILS) - TBI Therapies](#).

### Non-Covered Services

Services cannot be duplicated with other Minnesota State plan covered services or waiver services.

### Secondary Information

#### Provider Standards and Qualifications

- **Home health agencies** that are Medicare certified.
- **Rehabilitation agencies** must meet the standards under Minnesota Rules, parts 9505.0385 to 9505.0386.
- **Comprehensive outpatient rehabilitation facilities** must meet the standards under Minnesota Rules, parts 9505.0386 to 9505.0390.
- **Mental health community support programs** covered under Minnesota Statutes, sections 245.461 to 245.486 or 245.487 or 256.045.
- A **person** may provide independent living skills if the lead agency determines the person can meet **all** of the following requirements:
- General knowledge of disabilities and chronic illnesses that affect the ability of a person to live independently in the community
- Ability to complete a needs assessment of the skills a person with disabilities must develop to live independently in the community
- Knowledge of independent living skills management that include service planning, general knowledge of social services, record keeping, reporting requirements and confidentiality
- Ability to provide assistance, supervision and training in the area of independent living
- Proof that they received all of the following, a minimum of:
  1. Five hours of classroom training in recognizing the symptoms and effects of certain disabilities and health conditions
  2. Twenty hours of classroom instruction in providing supervision of, training to and assistance with independent living skills services
  3. A determination by the supervisor that the person has the skills required to provide independent living skills services as stated in the individual care plan

**Independent Living Skills – TBI Therapies**

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<tr>
<th>Service/HCPC</th>
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<th>MR/RC</th>
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</table>

**Definition**

Therapies are specified in the individual plan of care and have specific therapeutic goals and outcomes established. They are **not** merely diversional in nature. Independent living skills - TBI (ILS - TBI) therapies may be provided in the home of the recipient or in the community.

**Covered Services**

ILS -TBI therapies include:
- Recreation
- Music
- Art therapies

See also [Independent Living Skills Service](#) for CADI and TBI.

**Non-Covered Service**

Services cannot be duplicated with other Minnesota State plan covered services or waiver services.
Secondary Information

Provider Standards and Qualifications

Providers of individual therapies must meet all of the certification requirements under one of the following organizations or associations:

National Council for Therapeutic Recreation Certification
- Graduate from an accredited baccalaureate program
- Complete an internship of 360 hours under the supervision of a certified therapeutic recreation specialist
- Pass the National Council for Therapeutic Recreation Certification (NCTRC) exam
- Certify as a Certified Therapeutic Recreation Specialist

National or American Association for Music Therapy
- Graduate from an institution accredited by the National Association for Music Therapy or the American Association for Music Therapy
- Pass the National Association for Music Therapy board exam
- Certify as a Music Therapist - Board Certified

National Association for Therapeutic Art
- Graduate from a master’s program in art therapy or related degree plus 21 additional graduate level art therapy credits
- Complete an internship of 700 hours
- Have a minimum of 100 hours of supervised direct client contact hours
- Register with the National Association for Art Therapists

In-Home Family Support (see Habilitation section)

Live-In Personal Care Giver Expenses (also called Caregiver Living Expenses)

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<th>Service/HCPC</th>
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<th>CADI</th>
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</table>

Definition

The portion of the rent and food that may be reasonably attributed to the live-in personal caregiver, when the live-in personal caregiver also provides one of the following approved support services:
- Residential habilitative services
- Personal support services
- Extended personal care attendant services
• Consumer-directed community supports

**Covered Services**

Certain expenses incurred by a caregiver that resides in the same household as the person receiving waiver services.

This service must be documented in the Community Support Plan as being necessary to meet the needs of the person.

**Non-Covered Services**

Medicaid reimbursement is **not** allowed in situations in which the person lives in the caregiver’s home or residence owned or leased by the provider of Medicaid services.

The live-in personal caregiver must not be related to the person receiving care.

Live-in personal caregiver expenses will not duplicate other services that are provided to the person.

**Secondary Information**

The local agency must document the live-in caregiver expenses to assure the portion of rent and food attributed to the live-in caregiver is reasonable. To determine that portion of the food and lodging that can be claimed as a live-in caregiver expense, use the “Live-In Personal Caregiver Expenses” form.

For purposes of this service, “board” is defined as three meals a day or any other full nutritional regimen.

**Provider Standards and Qualifications**

A license under MN Statutes, Chapter 245B (program standards for residential and vocational services serving person with MR/RC) is **not** required for this service.

A live-in personal caregiver must meet the provider qualifications for the approved waivered service (listed above) that they are providing for the person.

**Modifications and Adaptations**

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<th>Service/HCPC</th>
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</table>
Definition

Physical adaptations to the home and/or vehicle for the person.

Environmental Modification: Modification items that are not permanently attached to the residence or vehicle and can be transitioned with the client to another location.

Covered Services

Modifications and adaptations which:
- Are necessary for the health, welfare and safety of the person
- Enable the person to function with greater independence
- Are of direct and specific benefit due to the person’s disability
- Are the most cost effective solutions

Adaptations to present residence or new construction may include, but are not limited to:
- The installation and maintenance of ramps and grab-bars, widening of doorways
- Modification of bathrooms and kitchens
- Installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment
- Shatterproof windows
- Floor coverings (i.e. allergy flooring/accessibility flooring)
- Modifications to meet egress
- Alarm systems and other requirements of the applicable life safety and fire codes, if any

Vehicle modifications to the person’s primary means of transportation may include, but are not limited to:
- Door handle replacements
- Door widening
- Roof extensions
- Lifting devices
- Wheelchair securing devices
- Adapted seat devices
- Handrails and grab bars

The service will reimburse the purchase, installation, maintenance and repairs of environmental modifications and equipment provided that the repairs are cost efficient compared to replacement of the item.

Environmental Modifications and Adaptations for AC & EW Programs

Environmental modifications may include modifications to items that are not permanently attached to the living setting or building itself, and can be transitioned with the client to a new
setting location. Items that may be needed for independent living may include, but are not limited to, adaptive furniture, adaptive cooking utensils, portable ramps, adaptive cleaning devices, etc.

**MR/RC Waiver Only**

Equipment such as:
- Adaptive couches, chairs, tables and beds
- Adaptive bikes and strollers
- Portable ramps

**CAC/CADI/TBI Waivers Only**

Equipment is not provided under this service description and would be provided under Specialized Supplies and Equipment Service description

**EW & AC only:** Physical adaptations to the home that are required in the individual’s plan of care to prevent institutional care. Changes that are necessary to ensure the health, welfare, and safety of the individual with mobility, sensory, behavioral needs, or which enable the individual to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies.

Modifications are permitted for a motor vehicle which enables greater independence and mobility in the community. Modifications may include, but is not limited to, wheelchair lifts, adapted seating, door widening, door handle replacements, steering wheel, acceleration, and breaking controls, wheelchair securing devices.

**Provider Standard:** Must be provided in accordance with applicable state and federal safety and motor vehicle standards.

**Secondary Information**

An assessment is required to determine/evaluate need and appropriate modification and/or adaptation

**MR/RC Waiver Only:**

Home refers to a person’s primary place of residence.

Exceptions to the requirement that home modifications be limited to the person’s primary place of residence may be authorized by the case manager when documented in the Individual Service Plan as meeting the following criteria:
- The service would enable reunification of the person with family members, and
- The item is portable and can be used in a number of settings or there is documentation that portable methods are not appropriate, and
• The modification is cost effective compared to other services that would be provided in an accessible environment

**Non-covered Services**

Adaptations or improvements that are not of direct medical or remedial benefit to the individual or are of general utility are excluded from payment. These include such items as carpeting, roof repair, air conditioning, or modifications which add to the total square footage of the setting.

**Authorization Criteria**

The item is:

- Not able to be funded through any other source;
- Necessary to avoid institutionalization of the person. (e.g., widening of a doorway to allow access to a bathroom);
- For the sole utility of the person. (e.g., installation of a wheelchair-accessible shower). (Individuals in the residence may use the modified shower.);
- Determined by prevailing community standards or customary practice and usage to be:
  - Medically necessary: appropriate and effective for the medical needs of the person, health and safety (e.g., purchase of a room air conditioner may be necessary for some individuals with acute respiratory difficulties);
  - Remedially necessary: appropriate to assist a person in increased independence and integration in their environment/community;
  - Appropriate and effective for the medical needs, diagnosis, and condition of the person (e.g., installing an alarm system to alert caregivers when a confused/vulnerable person is attempting to wander outside of the home);
  - Of an acceptable quality (e.g., use of an individual who has the proper credentials and experience to provide the modification, such as an electrician to upgrade wiring to accommodate medical equipment such as ventilators);
  - Timely: the accommodation is provided at the time it is needed (e.g., safe egress from the residence at the time the individual moves in);
  - The most cost-effective health service available to meet the medical needs of the person. (e.g., use of treated wood for ramp construction versus a higher grade of lumber); and
- An effective and appropriate use of MA waiver funds. When cost-effective, waiver funding is available for the following modifications:
  - Purchase or rental
  - Installation
  - Maintenance and repairs

**EW & AC:** Modifications and adaptations are limited to a combined annual total per service plan per state fiscal year (July through June). The total purchase may be distributed among the months within the program span of participation to remain within monthly cost-effectiveness requirements; however, clients must continue to meet all eligibility criteria for all months within
the span. The service must be cost-effective and not greater than comparable community charges; the bidding process among providers is optional.

Authorization Procedures

Review and authorization must occur prior to the purchase and the description of the minor environmental adaptation or modification is to be included in the community support plan/file of the person:

- It is recommended that local agencies consider bids from a minimum of two contractors/vendors;
- All services must be provided in accordance with applicable state and local building codes; and
- If it is determined by the county agency that all of the criteria are met and the bid for the work is reasonable, the local agency enters a line item and amount on the person’s service agreement using procedure code X5419.

If the local agency determines that the item requested does not meet the authorization criteria, documentation regarding the determination and rationale is to be kept on record at the local agency. A person must be notified of determinations and given information regarding appeal procedures.

The annual limit on modifications for CAC, CADI, and TBI waivers has been removed. Costs may be averaged over the span of a service agreement (up to 12 months) provided the person is expected to remain on the waiver program for the full span of the service agreement. However, should the cost of an item be spanned beyond the month the cost was authorized and incurred and the person exits the program, the program cannot pay for any service or time billed after the individual’s exit date (e.g., the date the person is no longer waiver or AC eligible).

County Agency Contract or Purchase Agreement

Counties Agencies must contract with or secure agreements with qualified providers of modifications and supplies. Home modifications must be provided in accordance with applicable state or local building codes.

Provider Standards and Qualifications

Provider Type: Dependent on type of modification

Other Standards

- Modification providers must have a current license or certificate, if required by Minnesota Statutes or administrative rules, to perform the service
- A provider must meet all professional standards and/or training requirements which may be required by Minnesota Statutes or administrative rules for the services that they provide
- Local agencies are responsible for assuring that provider is qualified to provide the necessary modifications
• Modifications to the home must be completed in accordance with all applicable state and city building codes

The provider must have a contract or a purchase agreement with the local agency for the service must be provided in accordance with applicable state and local building codes by a qualified and bonded provider.

**Night Supervision Services**

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<tr>
<th>Service/HCPC</th>
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</table>

**Definition**

Overnight assistance and monitoring in the home of a person of no more than 12 hours in a 24-hour period.

**Covered Services**

Night supervision carries out behavior programming and plans as they relate to the living skills and interventions of the person and include the following:

- Reinforcing independent living skills
- Assisting with incidental daily activities

**Non-Covered Services**

Services **cannot** be duplicated with other Minnesota State plan covered services or waiver services.

**Provider Standards and Qualifications**

Providers of night supervision **must** have the ability to provide a consistent approach when interacting with the person. The local county human services agency is responsible to assure that the person and/or agency providing services meet the minimum standards and:

- Is at least 18 years of age and has received a high school diploma
- Has experience and/or a minimum of 8 hours training in caring for persons with traumatic brain injuries
- Has the ability to understand the program(s) of the person and provide intervention when necessary
- Has good physical and mental health and maturity of attitudes towards work assignment(s)
- Has the ability to converse on the telephone
- Has the ability to work under intermittent supervision
- Has the ability to deal with emergencies that arise in connection with the person they serve
- Has the ability to work under stress in a crisis situation
- Is able to understand, respect and maintain confidentiality
Nutritional Therapy

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<th>Service/HCPC</th>
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Covered Services

Nutrition counseling is one or more individual sessions in which a qualified professional provides advice or guidance in solving a person's diet-related needs.

Examples include:
- Planning diabetic meal patterns
- Therapeutic diet instructions such as low sodium, and low cholesterol
- Suggestions for persons who are chronically underweight have severe weight loss, have difficulty chewing or swallowing, or chronic health issues related to obesity.

Nutrition education is an individual or group event, which provides formal or informal opportunities for individuals to acquire knowledge, experience and skills about foods and nutrition.

Examples of nutrition topics are:
- Wise food choices in shopping, food selection and preparation
- Methods for therapeutic diets
- Menu planning
- Cooking for one or two
- Tips for eating well on a limited budget

Secondary Information

The extended state plan service will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply.

Provider Standards and Qualifications

CAC Program

Provider must be a Qualified Nutritional Therapist

A qualified nutritional therapist must have a bachelor’s degree in nutrition and foods or a closely related field and is registered as a dietitian with the Commission of Dietetic Registration.

AC Program

Nutritional services must be provided by a registered dietitian, qualified dietitian, or registered nurse.
Personal Support

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<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
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Definition

Supervision and assistance provided in the home of the person or in the community to achieve increased independence, productivity and inclusion in the community in accordance with outcomes identified in the service plan, but when training is determined not to be necessary to attain these outcomes.

Covered Services

Supervision and assistance needs as documented in the service plan that which are the least costly to reasonably meet the need of the person. This may include supervision and assistance in accessing community services and participating in community activities.

Non-Covered Services

Services cannot be duplicated with other Minnesota State plan covered services or waiver services.

Secondary Information

This is not a habilitative service (active treatment), and it must be documented in the individual service plan of the how the habilitative need is being met for that person.

MA State Plan Services, such as PCA, should be considered before accessing the waiver service of Personal Support.

The case manager/service coordinator is to assure monitoring of services provided.

Provider Standards and Qualifications

The provider must meet the following requirements:

- The provider is not disqualified as a result of a background study.
- Training in first aid, vulnerable adult law and medication administration if applicable as a responsibility set forth in the service plan.
- Any further training, experience and/or supervision standards specific to the needs of the person as set forth in the service plan or contractual arrangements.

The local county social service agency must verify that the provider has met these requirements.

A license under MN Statutes, Chapter 245B is **not** required for this service.
Prescription Drugs, Extended

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<th>Service/HCPC</th>
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</table>

**Definition**

For purposes of the CAC Waiver, a prescribed drug is:
- Found on the National Formulary
- Prescribed by a physician licensed to practice medicine in Minnesota
- Used in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans

**Covered Services**

CAC Waiver program participants are eligible for prescription medications in accordance with current State Plan requirements except that limitations on the number of prescriptions that may be filled or refilled per month do not apply.

**Secondary Information**

Prescription drug products available to the individual as an inpatient will be available to participants, subject to prior authorization, by the attending physician as evidenced in the patient care plan.

CAC Waiver funding may be used for prescribed drugs not reimbursed through MA State Plan Services or third party payers and dispensed by an eligible provider.

**Access**

A CAC Waiver recipient must access funding for prescribed drugs from other payers before waiver funding is used. This may be third party payers and MA State Plan authorized services/drugs.

**Current MA State Plan Authorized Drugs**

A list of drugs available through MA State Plan services along with authorization criteria is found in Chapter 22.

**Provider Standards and Qualifications**

A provider eligible to dispense prescribed drugs must be:
- A pharmacist licensed under [MN Statutes, Chapter 151](https://www.revisor.mn.gov/statutes/text/151), or
- A physician licensed under [MN Statutes, Chapter 147](https://www.revisor.mn.gov/statutes/text/147) and only used where there is no Medicaid enrolled pharmacy available in the local trade area.
A pharmacist or physician dispensing prescribed drugs must meet the standards as specified under the Medicaid State Plan.

**Case Manager/Service Coordinator Responsibility**

- Determine if the CAC Waiver is an appropriate payer for the prescribed drug
- Determine if the requested drug meets the criteria for the CAC service of “prescribed drug”.
  - The drug relates to diagnosis and/or disability recorded in the medical record of the person
  - Medically necessary criteria is established
  - There is an order for the drug written on an annual basis by a physician licensed to practice medicine in the State of Minnesota
  - The prescribed drug is found on the community support plan of the person
  - The drug is being dispensed from a qualified provider (see provider standards in this service description)
  - Maintain documentation in the file of the person
- Annual requirement – compete steps 1 through 2.
- Authorization Criteria
  - After confirming the drug meets the criteria for the CAC Waiver Service of Prescribed Drug, the prescribed drug may be authorized to be purchased from a qualified provider.
  - Enter the CAC extended HCPC code for Prescription Drugs, Extended on the MMIS Service Agreement.

**Prevocational Services**

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<th>Service/HCPC</th>
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</table>

**Definition**

Services designed to prepare individuals for paid or unpaid employment and are reflected in the plan of care.

**Covered Services**

People may access these services providing that:

- The service exceeds that available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142 and
- The person is expected to require this service for more than a year and
- The service need and eligibility are re-evaluated annually

Teaching concepts for job performance success with goals directed at assisting the person towards greater independence, such as:
• Attendance
• Task completion
• Communication
• Problem solving
• Personal hygiene, and
• Safety

Non-Covered Services

Activities directed at teaching specific job skills.

The waiver does not pay any compensation directly to the person.

Secondary Information

Individuals may be compensated at a rate not to exceed 50% of the minimum wage. The prevocational service provider or other source may provide compensation.

All prevocational services are included in the plan of care and reflect goals directed at assisting the person toward greater independence.

Provider Standards and Qualifications

Provider type:
• Rehabilitative agencies
• Comprehensive outpatient rehabilitation facilities
• Adult day care centers or programs
• Providers of vocational rehabilitation services
• Providers of training and habilitation services
• Community health centers

License:
• Adult day care centers must be licensed under MN Rules, parts 9555.9600 to 9555.9730
• Adult day care programs are established under MN Statutes, sections 245A.01 to 245A.17

Providers of training and habilitation services are licensed under MN Statutes, section 245B (TBI) and MN State Statute section 245B and MN Rules, parts 9525.1580 to 9525.1600 (CADI). License is only for DD but with 245B license can provide under CADI and TBI.

Certification:

Vocational rehabilitation services providers, which are so certified by the Commission of Accredited Rehabilitation Facilities (CARF)
Other Standard:

- Rehabilitation agencies must meet the standards under MN Rules, parts 9505.0385 to 9505.0386 (CADI) and MN Rules, parts 9505.0385 (TBI).
- Comprehensive outpatient rehabilitation facilities must meet the standards under MN Rules, parts 9505.0386 to 9505.0390.
- Community mental health centers are defined under MN Statutes, section 245.62 and must meet standards under MN Rules, part 9505.0260 and parts 9520.0750 to 9520.0870.

Residential Care Services

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
<th>EW</th>
<th>AC</th>
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<tr>
<td>Residential Care Services</td>
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<td>X</td>
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</tbody>
</table>

Definition

Supportive and health supervision services provided in a licensed residential setting as identified in the community support plan.

Covered Services

Supportive services for the person include:

- Up to 24 hour supervision
- Meal preparation
- Individualized home management tasks
- Socialization
- Assistance in setting up meetings and appointments
- Assistance in arranging medical and social services
- Assistance with management of personal funds
- Arranging for or providing transportation

Health supervision services are limited to minimal assistance with:

- Dressing, grooming and bathing
- Reminding a person to take medications that are self-administered
- Storing medications, if requested

The service coordinator is the primary party responsible for negotiations with the provider to assure the needs of the person are fully met through the package created specifically for that person.

Non-Covered Services

- PCA
- Homemaking
• Chore
• Services duplicated by other State plan covered services or waiver services
• Items paid for under room and board cannot be duplicated in residential care costs
• EW and AC funded homemaking, respite, and AC Cash Grant services are not allowed while the recipient is receiving Residential Care services.

Secondary Information

Service delivery is directed by the person, or the provider, with oversight from the service coordinator. The unit of service is defined by the Individual Service Plan/Community Support Plan or contract.

If medications are to be distributed or stored, the residence must comply with Department of Health licensing regulations.

Counties should negotiate rates based on the level of service provided.

Size and Location

Residential Care Services may not be authorized for persons residing in a living setting adjoined to or on the same property as a nursing facility, hospital, ICF/MR, or institute for mental disease.

For persons under the age of 55 years, the total number of individuals residing in a living setting cannot exceed four (4). This means 4 people unrelated to the principal care provider.

Exception – Residence was developed before May 1, 2001 and has continuously provided waiver services.

Provider Standards and Qualifications

Residential care services are provided to individuals in residential care homes licensed as board and lodging establishments and are registered with the MN Department of Health as providing specialized services. MN Statutes 157.17

Staff who provide health supervision services are required to have eight hours of training and orientation by a registered nurse.

Staff providing residential care services must be able to:
• Read and write and follow written and oral instructions
• Have experience and/or training in caring for persons with disabilities
• Have good physical and mental health
• Converse on the phone
• Work with only intermittent supervision
• Deal with emergencies
• Work under stress in a crisis situation
• Understand, respect, and maintain confidentiality
• Have a valid Minnesota state drivers license if providing transportation for a person receiving waiver services

**Respite Care**

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
<th>TBI</th>
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</table>

**Definition**

Services provided to persons unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

**Covered Services**

In-home and out-of-home respite care in settings that have appropriate licensure and qualifications.

Continuation of services that are already been defined in the plan of care, to assure continuity of services for persons while receiving respite care services.

**EW & AC only**

Respite care is limited to 30 consecutive days per respite stay in accordance with the plan of care.

**CAC/CADI/TBI Waiver Only**

Respite Care is limited to 30 consecutive days per respite stay in accordance with the plan of care and is based on the person’s needs and may cover day or night respite needs.

**Non-Covered Services**

Respite Care is not provided for persons residing in corporate foster care settings

Room and board payments will not be made for respite care provided in the person’s home or other private residence.

For all waivers there are places where respite is not covered.

**MR/RC Waiver Only:**

Room and board payments will not be made for respite care provided in the person’s family home or in an unlicensed, private residence.
Secondary Information

CADI and TBI Only:

Use the nursing facility’s per diem rate for the case mix classification of the person for respite provided in a nursing home.

MR/RC Waiver Only:

Respite care is only provided for a primary caregiver meeting the following criteria:

- Responsible for the care and supervision of the person and
- Maintain his/her primary residence at the same address as the person and
- Named as an owner or lessee of the primary residence.

Provider Standards and Qualifications

Within this service category, all four of the waivers have differences and similarities between their respite providers and locations. Below is a comparison grid that shows these similarities and differences.

Listed below is information about the locations and providers of each waiver and links to the statutory references.

CAC, CADI and TBI

In-home respite care: providers must be a registered or licensed practical nurse, home health aide, or personal care assistant under the supervision required by their respective license or service standard. In addition, TBI in home respite providers can also be behavioral staff (see Behavioral Programming Support for all staff options)

Out of home respite care must be provided in a facility approved by the county or lead agency.

- Facilities must meet all licensing and/or certification requirements to provide out-of-home respite care in MN
- Hospitals are acute care institutions as defined in Minnesota Statutes, Chapter 144, section 144.696, subd 3 and licensed under MN Statutes, sections 144.50 to 14.58

CAC:

- Adult day care programs are established under Minnesota Statutes, sections 245A.01 to 245A.16 and must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730
- Adult foster care is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265
- Camps should be certified by the MN Department of Health and regulated under Minnesota Statutes, sections 144.71 to 144.76
- Family day care homes and group family day care homes are licensed under Minnesota Statutes, section 245A.01 to 245A.17
- Family foster care/group family foster care/group homes are licensed under Minnesota Statutes, section 245.802, subd. 1
- **Home health aides** must meet the standards under Minnesota Rules, [part 9505.0290, subp. 3, B](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec290.pdf)
- **Nursing facilities** must meet the standards under Minnesota Rules, [part 9505.0175, subp 23](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec175.pdf)
- **PCA’s** must meet the standards under Minnesota Statutes [256B.0627](https://www.revisor.legis.mn.us/laws/minnesota/256B.0627.html)

**CADI:**

- **Adult day care** programs are established under Minnesota Statutes, [sections 245A.01 to 245A.16](https://www.revisor.legis.mn.us/laws/minnesota/245A.01-245A.16.html) and must be licensed under Minnesota Rules, [parts 9555.9600 to 9555.9730](https://www.revisor.legis.mn.us/pdfs/mnrules/part9555/ch05sec9600.pdf)
- **Adult foster care** is licensed under Minnesota Rules, [parts 9555.5105 to 9555.6265](https://www.revisor.legis.mn.us/pdfs/mnrules/part9555/ch05sec5105.pdf)
- **Assisted living services/assisted living plus service** providers must be licensed as a home care provider and the standards as delineated in [Assisted Living](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec175.pdf) and [Assisted Living Plus](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec23.pdf) waiver service descriptions – Link to assisted living and assisted living plus service descriptions within this chapter
- **Camps** should be certified by the MN Department of Health and regulated under Minnesota Statutes, [sections 144.71 to 144.76](https://www.revisor.legis.mn.us/laws/minnesota/144.71-144.76.html)
- **Child foster care** must meet current state licensure requirements under Minnesota Rules, [parts 9560.0500 to 9560.0670](https://www.revisor.legis.mn.us/pdfs/mnrules/part9560/ch05sec0500.pdf)
- **Family day care homes** and **group family day care homes** are licensed under Minnesota Statutes, [section 245A.01 to 245A.17](https://www.revisor.legis.mn.us/laws/minnesota/245A.01-245A.17.html)
- **Home health aides** must meet the standards under Minnesota Rules, [part 9505.0290, subp. 3, B](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec290.pdf)
- **Licensed practical nurses** must be licensed under Minnesota Statutes, sections [148.29 to 148.299](https://www.revisor.legis.mn.us/laws/minnesota/148.29-148.299.html)
- **Long term care facilities/skilled nursing facilities/intermediate care facilities** must meet the standards under Minnesota Rules, [part 9505.0175, subp 23](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec175.pdf)
- **PCA’s** must meet the standards under Minnesota Statutes [256B.0627](https://www.revisor.legis.mn.us/laws/minnesota/256B.0627.html)
- **Residential care facilities Residential Care Providers** must meet all applicable licensing standards and the standards delineated in [Residential Care](https://www.revisor.legis.mn.us/pdfs/mnrules/part9505/ch05sec23.pdf) waiver service description

**MR/RC:**

- **Adult foster care** is licensed by Minnesota Rule, [parts 9555.5050 to 9555.6265](https://www.revisor.legis.mn.us/pdfs/mnrules/part9555/ch05sec5050.pdf) (Rule 203 standards govern adult foster care)
- **Child foster care** is licensed by Minnesota Rule, [parts 9545.0010 to 9545.0260](https://www.revisor.legis.mn.us/pdfs/mnrules/part9545/ch05sec0010.pdf) (Rule 1 standards govern child foster care)
- **Child day care** is licensed by Minnesota Rule, [parts 9545.2000 to 9545.2040](https://www.revisor.legis.mn.us/pdfs/mnrules/part9545/ch05sec2000.pdf)

**Out-of-home respite** providers reimbursed through home and community-based services who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the person receiving services:
The provider is physically able to care for the person receiving services
The home is appropriate for the persons needs
The provider has completed training identified as necessary in the Individual Service Plan
The provider complies with applicable standards in Minnesota Rule, part 9525.1850 (Rule 41)
The provider complies with monitoring procedures as described in the Individual Service Plan

County or lead agencies will certify that the provider has met qualification standards to provide out-of-home respite services and will be documented in the county file.

- Minnesota Rule, parts 9525.1800 to 9525.1930 (Rule 41) standards govern funding and administration of Home and Community-Based Services
- Additional training requirements can be determined by the service planning team
- Training standards are incorporated in each rule

Minnesota Statutes, section 245A.03, subd. 2, item 22 excludes from licensure requirements respite care services provided as a home and community-based service to a person with mental retardation or a related condition, in the person’s primary residence.

Minnesota Statutes, section 245A.03, subd. 2, item 21 excludes from licensure requirements those unrelated person who provide out-of-home respite care services to person with mental retardation or related conditions from a single related family for no more than 90 days in a 12-month period and the respite care services are for the temporary relief of the person’s family or legal representative.

A license under MN Statutes, Chapter 245B (program standards for residential and vocational services serving persons with MR/RC) is not required for this service.

TBI:

- **Adult day care** programs are established under Minnesota Statutes, sections 245A.01 to 245A.16 and must be licensed under Minnesota Rules, parts 9555.9600 to 9555.9730
- **Adult foster care** is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265
- **Assisted living services/assisted living plus service providers** must be licensed as a home care provider and the standards as delineated in Assisted Living and Assisted Living Plus waiver service descriptions
- **Camps** should be certified by the MN Department of Health, and regulated under Minnesota Statutes, sections 144.71 to 144.76
- **Family day care homes** and **group family day care homes** are licensed under Minnesota Statutes, section 245A.01 to 245A.17
- **Family foster care/group family foster care/group homes** are licensed under Minnesota Statutes, section 245.802, subd. 1
- **Home health aides** must meet the standards under Minnesota Rules, part 9505.0290, subp. 3, B
• **Licensed practical nurses** must be licensed under Minnesota Statutes, sections 148.29 to 148.299

• **Long term care facilities/skilled nursing facilities/intermediate care facilities** must meet the standards under Minnesota Rules, part 9505.0175, subp 23

• **PCA’s** must meet the standards under Minnesota Statutes 256B.0627

• **Registered nurses**, providing **in-home respite care**, must be licensed under Minnesota Statutes, section 148.171 to 148.285

• **Residential care facilities - Residential Care Providers** must meet all applicable licensing standards and the standards delineated in Residential Care waiver service description

**EW & AC**

**Out-of-home respite care**

• Must be provided in a facility approved by the local lead agency such as a hospital, nursing facility, foster home, camp, or community residential facility.

• When respite care is provided in a non-MA certified facility, that facility must meet applicable state licensure standards.

• May be provided in a currently registered housing with services establishment when services are delivered by a licensed home care agency or in a private unlicensed home when it is determined by the case manager that the service and setting can safely meet the recipient’s needs. The case manager must take into account the accessibility and condition of the physical plant, ability and skill level of the caregiver, and the recipient’s needs and preferences. The unlicensed home and caregiver cannot otherwise be in the business or routine practice of providing respite services.

**In-home respite care providers**

• must be individuals who meet the state qualifications of registered or licensed practical nurses, home health aides, or personal care assistants who have been specifically trained to provide care to the recipient.

• Respite care workers must have had first-aid training and cardiopulmonary resuscitation training.

• A respite care worker who is a home health aide or personal care assistant must be under the supervision of a registered nurse. The registered nurse must assure that the respite care worker is able to read and follow instructions, able to write clear messages, and has the level of skill required by the recipient’s needs.

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<table>
<thead>
<tr>
<th>Respite Care Services Provider standards and qualifications</th>
<th>CAC</th>
<th>CADI</th>
<th>TBI</th>
<th>MR/RC</th>
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<tr>
<td>I indicates an in-home provider/location</td>
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<td>1. <strong>Certified Hospitals – Hospitals</strong> are acute care institutions defined in Minnesota Statutes, section 144.696, subdivision 3, licensed under Minnesota Statutes, sections 144.50 to 144.58</td>
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</table>
2. **Registered Nurses** providing in-home respite care must be licensed under MN Statutes, section 148.171 to 148.285

3. **Licensed Practical Nurses** must be licensed under MN Statutes, sections 148.29 to 148.299

4. **Adult Foster Care** is licensed under MN Rules, parts 9555.5105 to 9555.6265

5. **Adult Day Care Programs** are established under MN Statutes, sections 245A.01 to 245A.16 and must be licensed under MN Rules, parts 9555.9600 to 9555.9730

6. **Family Day Care homes and group family day care homes** are licensed under MN Statutes, section 245A.01 to 245A.17

7. **PCA’s** must meet the standards under MN Statutes 256B.0627

8. **Home Health Aides** must meet the standards under MN Rules, part 9505.0290, subpart 3, B

9. **Camps** should be certified by the MN Department of Health, and regulated under MN Statutes, sections 144.71 to 144.76

10. **Certified Nursing facilities – Nursing facilities** must meet the standards under MN Rules, part 9505.0175, subpart 23

11. **Family Foster Care/Group Family Foster Care/Group Homes** are licensed under MN Statutes, section 245A.802, subd. 1

12. **Child Foster Care** must meet current state licensure requirements under MN Rules, parts 9560.0500 to 9560.0670

13. **Child Foster Care** MN Rule, parts 9545.0010 to 9545.0260 (Rule 1 standards govern child foster care)

14. **Assisted Living Services/Assisted Living Plus** Service Providers must be licensed as a home care provider and the standards as delineated in Assisted Living and Assisted Living Plus waiver service descriptions

15. **Person’s home or place of residence**

16. **Certified ICF/MR** – must meet the standards under 256B.5011 to 256B.5015 and rate settings according to 256B.501

17. **Residential Care Facilities – Residential Care Providers** must meet all applicable licensing standards and the standards delineated in Residential Care waiver service description
18. **Behavioral Staff** – Behavioral professional (Psychologist and Clinical Social Worker), Behavioral Analyst, Behavioral Specialist, Behavioral Aide. See [Behavioral Programming/Support](#) for details regarding all of these professionals and their licensing requirements.

19. **The home of an unlicensed caregiver** when the county and family agree that the caregiver has met criteria to assure the health and safety of the recipient. In these situations, room and board payment will not be made as part of the respite rate.

20. **Child Day Care** MN Rule, parts 9545.2000 to 9545.2040

21. **Out-of-home respite providers reimbursed through home and community-based services** who are excluded from licensing requirements must meet the following qualifications to ensure the health and safety of the person receiving services:

   - The provider is physically able to care for the person receiving services
   - The home is appropriate for the persons needs
   - The provider has completed training identified as necessary in the ISP
   - The provider complies with applicable standards in MN rule, part 9525.1850 (Rule 41)
   - The provider complies with monitoring procedures as described in the ISP
   - County agencies will certify that the provider has met qualification standards to provide out-of-home respite services and will be documented in the county file
   - MN Rule, parts 9525.1800 to 9525.1930 (Rule 41) standards govern funding and administration of Home and Community-Based Services
   - Additional training requirements can be determined by the service planning team
• Training standards are incorporated in each rule

• MN Statutes, section 245A.04, subd. 2, item 22 excludes from licensure requirements respite care services provided as a home and community-based service to a person with mental retardation or a related condition, in the person’s primary residence

• MN Statutes, section 245A.03, subd. 2, item 21 excludes from licensure requirements those unrelated individuals who provide out-of-home respite care services to person with mental retardation or related conditions from a single related family for no more than 90 days in a 12-month period and the respite care services are for the temporary relief of the person’s family or legal representative

• A license under MN Statutes, Chapter 245B (program standards for residential and vocational services serving persons with MR/RC) is not required for this service

Specialist Services

<table>
<thead>
<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
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Definition

The provision of services that extend past the scope and duration of available Waiver and state plan services. This includes Medicaid State plan option services because of a need of a person in the area of behavior management, augmentative communication, personal health, functional motor skills, social skill, leisure and recreational skills or independent living skills and requires specialized services.

Covered Services

Those services which provide the following:

• Assessments
• Program development
• Training and supervision of staff and caregivers
• Monitoring of specific program implementation
• Evaluation of service outcomes in areas specific to the needs of a person to assure competency by staff and caregivers in service provision

These services may be directed solely to one area of a need or may be authorized as a Qualified Mental Retardation Professional (QMRP) function as long as the QMRP function does not duplicate that provided as part of a habilitation service to the person.

Non-Covered Service

Services cannot duplicate with other Minnesota State plan covered services or waiver services.

Secondary Information

These services must be documented in the community support plan of the person

Provider Standards and Qualifications

Services are to be provided by individuals who meet QMRP standards, have demonstrated expertise in a person's areas of need of the person, meet standards in Minnesota Rule, part 9525.1850, and are not disqualified as a result of a background study.

The service planning team:
• Identifies the specific experience and skills required of a specialist to meet the needs of the person.
• Identifies the qualifications of that specialist and documents the qualifications in the service plan or in a contractual agreement.
• Monitors and evaluates the services provided based on the identified outcomes to be accomplished.

Structured Day Program

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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
<th>CADI</th>
<th>MR/RC</th>
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Definition

Structured day program is a service designed for persons who may benefit from continued rehabilitation and community reintegration directed at the development and maintenance of community living skills. Structured day program services take place in a non-residential setting separate from the home of the person.

Covered Services

Structured Day Program services include supervision and specific training to allow the person to attain maximum potential and include:
• Social skills training
• Sensory/motor development
• Reduction/elimination of maladaptive behavior

Services aimed at preparing the person for community reintegration such as teaching concepts, which may include but are not limited to:
• Attending
• Task completion
• Problem solving
• Safety
• Money management

Rehabilitation therapies will be provided in addition to the structured day program if needed and as documented in the approved community support plan, such as:
• Physical
• Occupational
• Speech
• Cognitive

Services will normally be furnished 2 or more hours per day on a regularly scheduled basis, for 1 or more days per week.

Secondary Information
Structured day program services are distinguished from Adult Day Care because of the intensive therapeutic nature of the program.

Provider Standards and Qualifications
Providers must have demonstrated knowledge of brain injury in order to develop specific programs for individuals with brain injury. Providers may be:
• Rehabilitative agencies
• Comprehensive outpatient rehabilitation facilities
• Adult day care centers or programs
• Providers of vocational rehabilitation services, and providers of training and habilitation services
• Community health centers

License/Certification/Standards:

Adult day care centers must be licensed under Minnesota Rules, part 9555.9600 to 9555.9730.

Adult day care programs are established under Minnesota Statutes, sections 245A.01 to 245A.17.
Providers of training and habilitation services are licensed under Minnesota Statutes 245B.01 - .08 and Minnesota Rules, parts 9525.1580 to 9525.1600.

Vocational rehabilitation services are certified by the Commission of Accredited Rehabilitation Facilities (CARF).

Rehabilitation agencies must meet the standards under Minnesota Rules, parts 9505.0385 to 9505.0386.

Comprehensive outpatient rehabilitation facilities must meet the standards under Minnesota Rules, parts 9505.0386 to 9505.0390.

Community mental health centers are defined under Minnesota Statutes, section 245.62 and must meet standards under Minnesota Rules, part 9505.0260 and parts 9520.0750 to 9520.0870.

Specialized Equipment and Supplies

<table>
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<tr>
<th>Service/HCPC</th>
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See Chapter 23 for clarification on covered and non-covered items and regulations. This service only available as an extended service; MA funding must be accessed first.

Definition

Devices, controls or appliances, specified in the plan of care, that enable the person to increase their ability to:

• Perform activities of daily living
• To perceive, control or communicate with the environment in which they live

State plan medical equipment and supplies are defined under Minnesota Rules, parts 9505.0310.

Covered Services

The service covers:

• Items necessary for life support
• Ancillary supplies necessary for the proper functioning of such life support items
• Durable and non-durable medical equipment not available under the Medicaid State plan
Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan. Supplies and equipment that exceed the limits set for State plan covered services may be covered through the waiver. MHCP Provider Manual, Chapter 23 Equipment and Supplies

**Enteral nutritional products**

**EW & AC**

Supplies and equipment include durable and non-durable medical supplies and equipment that are provided as a necessary adjunct to direct treatment of the recipient’s condition. This may also include grab bars, handrails, stair lifts or ramps, if these items are essential to keep the recipient in the community.

**Non-Covered Services**

Items that are covered by Medical Assistance, Medicare, private insurance and/or other funding resources and item that do not provide direct medical or remedial benefit to the person.

**Secondary Information**

**Authorization Criteria:**

Service coordinators must ensure and document, in the persons file/community support plan, prior to the purchase of the medical supply or equipment, that the item meets all of the following criteria:

- Not able to be funded through any other source. If an item is never covered by MA, it is not necessary to seek a written denial from MA. If an item may be covered by MA, the medical supplier must seek authorization from MA prior to seeking authorization of coverage under a waiver program;
- Necessary to avoid institutionalization;
- For the sole utility of the person;
- Determined by prevailing community standards or customary practice and usage to be:
  - Medically necessary: appropriate and effective for the medical needs and health and safety of the person;
  - Remedially necessary: appropriate to assist a person in increased independence and integration in their environment/community;
  - Appropriate and effective for the medical needs, diagnosis, and condition of the person;
  - Of an acceptable quality;
  - Timely (e.g., the accommodation is provided at the time it is needed);
  - The most cost-effective health service available to meet the medical needs of the person; and
  - An effective and appropriate use of MA waiver funds.

When cost-effective, waiver funding is available for the following modifications:

- Individual evaluation or assessment
• Purchase or rental
• Installation
• Maintenance and repairs

Medical supplies and equipment are available through the MA state plan but with limitations. When an item is covered by MA, bill MA first to the extent of the limitations. If an item is never covered by MA, the case manager may decide to cover this item under the appropriate waiver if it meets criteria. Once an item is purchased, it becomes the property of the person it is purchased for.

Add-ons vs. Upgrades:

An add-on is an MA non-covered service that the provider adds to an MA-covered service. In this case, the MA-covered item is billed to MA. The add-on may be billed to the waiver, or the person may choose to pay for the add-on out of other funding sources they have available to them.

Example: A person wants an MA non-covered basket added to an MA-covered walker. The supplier can bill MA for the walker and bills the person for the basket; or

The service coordinator may determine that the basket is covered by the waiver program but the supplier still must bill MA for the MA-covered service.

For both fee-for-service and managed care person, the provider may receive payment for the covered service under MA and charge the person or waiver program for the add-on.

An upgrade is a non-covered MA service (and often a more desirable service) that substitutes for a covered service:
• The provider may choose to provide the upgrade and receive payment for the basic service as payment in full for the upgrade;
• The person may choose an upgraded service instead of an MA-covered service, even though MA will not pay for this item. The person is responsible for the entire cost of the upgraded item as long as the provider informed them that they are responsible before providing the service. In this case DHS recommends that the provider have the person sign a waiver acknowledging that the item is not covered by MA, and agrees to pay the entire cost for the upgraded item before the service is provided; or
• The service coordinator may authorize an upgraded item to be covered under a HCBS program, if determined to be medically necessary, and cover the entire cost of the item under the HCBS program.

Example: A person wants a total electric bed, but does not meet the medical necessity criteria for MA to cover the bed. MA will only cover a semi-electric bed.

A service coordinator may elect to cover the entire cost of a total electric bed under a waiver services program.
If the supplier will not accept MA semi-electric bed payment, and the service coordinator does not approve the upgrade for payment under a HCBS program, the person may still get the total electric bed, but is responsible for the entire charge for the bed as long as the provider informed them that they are responsible for payment before providing the service.

The supplier may not provide a total electric bed to the person, bill MA and charge the difference relating to the upgrade to the person, or to the HCBS program.

The service coordinator may need prior approval from DHS for some extended supplies depending on the cost of the item. The item must be entered on the SA.

Add-ons and upgrades do not apply to the AC program.

**County Contract or Purchase Agreement:**

Counties or Lead Agencies must contract with or secure purchase agreements with qualified providers of supplies and equipment.

For equipment or supplies provided on a routine basis by the same provider, local agencies may choose to develop contracts if the monthly amount paid to the provider by the waiver is less than $250. However, if the provider receives more than $250 (cumulatively) in waiver reimbursement each month, a contract with the local agency is required.

**Cost of Providing Supplies and Equipment Under a Recipient’s Waiver or AC Cap:**

The cost of supplies and equipment must be included in the waiver cap. Costs may be averaged over the span of a SA provided the person is expected to remain on the HCBS program for the full span of the SA. The HCBS program can only pay for these items when the person is eligible. For example: if the cost of an item spanned beyond the month that the cost was authorized and incurred, and the person exits the HCBS program, the HCBS program cannot pay for any service or item billed after the exit date (the date the person is no longer eligible).

**Doctor’s Orders for Medical Supplies and Equipment:**

When a doctor’s order is needed for MA/Medicare reimbursement, the medical supply and equipment provider is responsible to gather and send whatever documentation is needed to DHS before ordering/billing. Generally, doctor’s orders are not required for purchases through waiver or AC funds. The provider is ultimately responsible to bill the appropriate payer (insurance, Medicare, MA, etc.) if the item is reimbursable through those payers, regardless of whether the service coordinator has authorized waiver reimbursement through a SA or not. When other sources of payment are exhausted, the provider must submit copies of the denials from those payment sources to the service coordinator. If inappropriate billing shows up in an audit, the provider is responsible and risks payment recovery.
Incidental Maintenance on Adaptive Equipment and Supplies While Providing A Direct-Care Service:

MA only covers maintenance on a few items. Maintenance on adaptive equipment and supplies can be covered through all of the waivers if that service is not MA-reimbursable. For example, if a waiver provider does incidental maintenance on a wheelchair during the course of providing direct care, they cannot bill for this through the HCBS program or MA as a separate service, as this is considered duplicate billing.

Long Term Care Facility/Providing Supplies and Equipment Before Discharge:

Providers cannot bill through a waiver program for supplies and equipment before a person goes home from a nursing facility or leaves an ICF/MR to go to a community setting. A provider could bill for assistive technology, adaptations/modifications, and extended medical supplies and equipment on the date of discharge, as long as the item(s) is/are provided after the time of the person’s discharge.

Rental:

Rental contracts or supplies and equipment may only be approved when it is determined, for items that meet authorization criteria, as cost-effective. For example, the item is needed for a defined amount of time and rental is less expensive than purchase. All rental contracts should include a “rent to purchase” clause. The cost of renting a supply or equipment must not exceed the cost of purchase. The written contract should also be clear that the vendor is responsible for repairs over the duration of the rental agreement.

Once the rental fee equals the purchase price, the item is considered to be the property of the person (normally after 10-12 months’ rental).

Repair and Maintenance:

The HCBS program can pay for repair of equipment when the equipment meets the authorization criteria and the repair is a cost-effective alternative (e.g., is expected to last and without repair, the equipment would have to be purchased new at a great cost). A maintenance agreement may be purchased by the HCBS program for items that meet authorization criteria when the maintenance agreement is expected to be cost-effective.

For example, a maintenance agreement that covers evaluating an item but not actual repair may not be cost-effective. Consideration should also be given to other payment sources for repairs. MA covers the repair costs of certain items such as communication devices, wheelchairs, etc.

Shipping, Handling, and Installation:

Shipping and handling costs may be paid by a HCBS program if the shipping cost is included in the price of the item, and the waiver is purchasing the item.
Installation can be covered regardless of who purchased the item, if the item meets HCBS program authorization criteria. If installation involves attaching an item to, or altering the existing physical structure of a home or vehicle, the costs are billed under minor environmental adaptations and modifications.

**Used Equipment:**

Used equipment may be purchased if the county determines that all authorization criteria are met and the item is considered of adequate quality, expected to be durable, and the cost is commissariat with the age and condition of the item (e.g., if a new item could be purchased at the similar cost, it may be worthwhile to purchase the new item).

**Provider Standards and Qualifications**

A supplies and equipment provider must have a contract or a purchase agreement with the local county agency. The following agencies have signed a Medical Supply Performance Agreement:

- Home Health Agencies
- Pharmacies
- Medical suppliers (including wheelchair and oxygen vendors)

Entities approved by the local county agencies are also eligible to sign a purchase agreement.

**Supported Employment Services**

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<th>Service/HCPC</th>
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<th>MR/RC</th>
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**Definition**

Services for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, needs intensive ongoing support to perform in a work setting. The person receiving services must be in a paid employment situation.

**Covered Services**

Services such as:

- Individualized work related assessment
- Individual and group counseling
- Individual job development and job placement activities that produce an appropriate job match for the person and the employer
- On-the-job training in work and related work skills required for job performance
- Ongoing supervision and monitoring of a person’s performance
- Long-term support services to assure job retention.
• Training in related skills essential to obtaining and retaining employment such as the effective use of community resources
• Training in the use of break and lunch areas
• Mobility training
• Training to access various transportation resources

Transportation

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<th>Service/HCPC</th>
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<th>MR/RC</th>
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The County or Lead agency determines the transportation needs and resources and may authorize transportation through one of the following ways:
• Through SES contract in which transportation is provided by SES as a part of the negotiated contract rate
• Arranged through the waiver service of transportation

Non-Covered Services

Incentive payments, subsidies, or unrelated vocational training expenses such as the following:
• Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program
• Payments that are passed through to users of supported employment programs
• Payments for vocational training that is not directly related to a supported employment program of the person

Payment for the typical administrative supervisory function activities provided, as a normal part of the business setting, will not be included in this service payment.

Services that otherwise would be accessible through the Rehabilitation Act of 1973; P.L.94-142; and IDEA.

SES is not available to a person who is currently enrolled in the secondary educational system.

Secondary Information

This service is intended to:
• Provide opportunities for paid employment in a community setting.
• Provide opportunities that routinely, as part of the person’s job tasks; expose them to interactions with coworkers without disabilities who are not paid caregivers.
• Increase a person’s support network by providing opportunities for building ongoing relationships at work.
• Promote choices for persons to choose their supported employment provider and where they want to work.
• Provide opportunities for persons to receive individual (1:1) support in the amount and frequency needed to secure and retain employment.
• Create opportunities for person to have freedom and authority to direct their supports.
• Support independence, health and safety at work.

**PROCESS AND PROCEDURE**

**Access:**

Before supported employment services can be paid by CADI or TBI, you **must** have determined that SES services are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation **must** be maintained in the file of each person receiving this service that the service is **not** otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

A finding that such services are not otherwise available through a program funded under Section 110 of the Rehabilitation Act of 1973 must be based on written documentation that the person:

• Is not considered an appropriate referral to the Division of Rehabilitation Services because the person satisfies one or more of The Screen-Out Criteria, or present an unfavorable Applicant Profile as Described in Section 26520.025 of the Social Security Administration Program Operations Manual System or
• Has been referred to the Division of Rehabilitation Services, but was found to be ineligible for vocational services under Section 110 of the Rehabilitation Act or
• Has been a recipient of Section 110 Services provided by the Division of Rehabilitation Services, but is no longer eligible for such services or
• Is a current client of the Division of Rehabilitation Services, but the activities that are provided under the definition of supported employment services are not typically available as Section 110 Services

Service may **only** be authorized after the local agency determines and documents that there is no other funding source including school district funding for persons under the age of 21 years and/or the Department of Economic Security for persons of any age. See non-covered SES services (link to supported employment services non-covered services section above).

The case manager/service coordinator makes a referral to a service provider to begin the process. The person has a choice of providers of service.

Previous residential restrictions regarding MR/RC no longer apply.
Supported employment services can be authorized by the case manager as part of an individual care plan/service agreement only when:

- The persons engage in paid employment in a variety of settings where persons without disabilities are also employed;
- Public funds are necessary for the purpose of providing ongoing training and support services throughout their period of employment; and
- The persons have the opportunity for social interactions with persons who do not have disabilities and who are not paid caregivers

**Assessment:**

Case manager/service coordinator requests a work assessment from the potential provider, who in conjunction with the person, recommends the amount of services needed, based on their needs, functioning and preferences.

**Service Planning:**

After the access criteria are met, the person and case manager/service coordinator meet to review assessment information, which include the recommendations from the provider, to make service decisions. The work objectives and plan are then developed by the person, their representative, case manager/service coordinator, and the provider.

Case manager/service coordinator has to determine the source of funding for transportation. See covered SES services.

The case manager/service coordinator coordinates vocational service plans with the residential services of the person when applicable.

No minimum amount of service is required. For example, a person who has a stable employment situation may only require one to two hours of follow up in a month.

**EW and AC Only**

Extended transportation is available for EW and AC recipients to access community services, activities and resources as specified in their individual plan of care. Whenever possible, family, neighbors, friends, or community agencies should provide the service without charge. For common carrier transportation standards and reimbursement, refer to Transportation Services (ch. 21).

**MR/RC Only:**

When a person purchases both residential and supported employment services under the MR/RC waiver from the same provider, the following must be addressed.

**County case manager/service coordinator and service planning team responsibilities:**

- Identify and address potential conflicts of interest
• As part of the personal support plan, establish an alternative plan(s) to address the person’s support needs in the event of a lay off or job loss including, but not limited to:
  − Level of support and supervision the person needs
  − Type and frequency of supports that will be provided
  − Identification of each provider’s responsibility
  − Criteria for identifying when alternative arrangements need to be made to achieve the person’s outcomes (e.g., if a new job is not found within two weeks, the county will seek alternative job supports for the person)

Provider responsibilities:

Notify the employer in writing who, other than the provider, should be contacted if there are concerns regarding the person or about the supported employment services. For example, the contact may be a guardian or a family member.

Provide and document training for the employer on the Vulnerable Adult Act and the phone number of the county common entry point.

Authorization:

After assuring the access criteria, assessment and service planning have been completed, services can be authorized as part of the care plan.

Enter the information from the individualized service plan into the MMIS Screening Document and Service Agreement. The service may be authorized by the number of units required or by the daily rate.

Limitations

If the daily rate is used, it is expected that it would only be authorized for a time limited basis. For example, a person may need intensive services when beginning a new job and full day support may be appropriate; however, it is expected that this level of support would be reduced as the person acclimates to the work environment.

Services provided through the MR/RC waiver are to be provided on an individual basis and are not reimbursable if delivered in a work enclave.

Provider Standards and Qualifications

MR/RC Only:

To provide supported employment services under the MR/RC Waiver all providers must be issued a license specifically for supported employment services. To obtain a supported employment license, submit an application to DHS Licensing Division.

The supported employment license will be issued according to Minnesota Statutes, Chapter 245B, Consolidated Standards.
Providers that are licensed under the Consolidated Standards to provide day training and habilitation (DT&H) or residential-based services must also obtain a specific license to provide supported employment services.

Qualified providers that are not licensed to provide DT&H or residential-based services under the Consolidated Standards, may also apply for and be issued a specific supported employment license.

Applicability of other MN Statutes

Minnesota Statutes, sections 252.40 through 252.46. Service principles and rate-setting procedures for day training and habilitation does not apply to supported employment services option under the MR/RC Waiver.

License:

Minnesota Statutes, Chapter 245B - SES - Supported Employment Services for Persons with Mental Retardation or Related Conditions.

CADI and TBI Only

Provider type:
- Rehabilitative agencies
- Comprehensive outpatient rehabilitation facilities
- Adult day care centers or programs
- Providers of vocational rehabilitation services
- Providers of training and habilitation services, and
- Community health centers

Rehabilitation agencies must meet the standards under Minnesota Rules 9505.0385 to 9505.0386.

Comprehensive outpatient rehabilitation facilities must meet the standards under Minnesota Rules 9505.0386 to 9505.0390.

Adult day care centers must be licensed under Minnesota Rules 9555.9600 to 9555.9730. Adult day care programs are established under MS 245A.01 to 245A.17.

Vocational rehabilitation services providers, which are so certified by the Commission of Accredited Rehabilitation Facilities (CARF).

Providers of training and habilitation services are licensed under MS 245B.

Community mental health centers are defined under MS 245.62 and must meet standards under Minnesota Rules 9505.0260 and 9520.0750 to 9520.0870.
Supported Living Services (SLS)  
(refer to the Habilitation Services section)

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Transitional Services

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Transportation

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Definition

Transportation necessary to gain access to waiver or AC services as specified in the individualized service plan and is provided by common carrier or special transportation vehicles.

- **Common carrier transportation** is the transportation of a person by bus, taxicab, other commercial carrier, or by private automobile.
- **Special transportation** is the transportation of a person, who is unable to safely use a common carrier and does not require ambulance service.

Covered Services

**Transportation Service**

Transportation to access community services and activities as stated in the individualized service plan.
Transportation to access waiver or AC services that do not include transportation as part of the contracted rate for the service. Please refer to the specific service to learn the details:

- **Adult Day Care**
- **Residential Services**
- **Supported employment**

Payment for the seat on the transporting vehicle, for an attendant who is accompanying the person.

**Non-covered Services**

Transportation access to health care available through MA State Plan Service [http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_008991.hcsp](http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_008991.hcsp)

Transportation reimbursement already included in the contracted rate for other waiver services such as Adult Day Care, Residential Services, and Supported Employment Access to DT&H is never covered under this service

Non covered services for a personal vehicle include:

- Any payment beyond negotiated mileage or trip reimbursement
- Reimbursement to a person for the purpose of transporting self or the use of their own vehicle

**Secondary Information**

Private individuals may be designated to provide transportation when they meet a person’s needs and/or preferences in a cost-effective manner. Examples may include natural supports such as family, neighbors, friends, or community agencies.

The intent of the transportation service is to pay for the transportation expense and not staff time.

**Transportation Process and Procedures:**

**Access:**

A referral is made by the case manager/service coordinator to the transportation vendor or to the natural supports identified and selected by the person. The county agency is to have a contract or purchase of service agreement with each transportation vendor.

**Assessment:**

An assessment for the need for transportation to a waiver or AC service or community site is completed through the LTCC or DD Screening Process.
Service Planning:

The case manager/service coordinator identifies the unmet need for transportation on the individualized service plan and looks for potential resources. Transportation resources include the following:

- Natural supports
- Medical Assistance payment for transportation to help people access MA health services

Responsibilities of the case manager/service coordinator include:

- Determining if need for transportation meets MA State Plan criteria for access to health care sites
- Determining if the contracted rate for the other needed service does not include transportation
- Determining if person will use a natural support, common carrier, or special transportation, and if an attendant is required
- Confirming the person is certified for special transportation using phone or MN-ITS eligibility verification

Authorization/Billing:

The case manager/service coordinator completes the Service Agreement by adding the vendor’s name, provider number, appropriate HCPC code, and number of units and rate authorized. Transportation to waiver and community services under MR/RC can be reimbursed similar to the other waivers although there is only a trip rate.

Provider Standards and Qualifications

Drivers must have a valid driver’s license and required insurance coverage.

Providers of special transportation who are not excluded in Minnesota Statutes, section 174.30, must be certified by the Minnesota Department of Transportation under Minnesota Statutes, section 174.29 to 174.30.

Other Resources

It is recommended the case manager/service coordinator review the Health Care Program Manual, Chapter 21 to learn about MA State Plan transportation services and the certification for use of special transportation.

http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_008991.hcsp

24-Hour Emergency Assistance

<table>
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<tr>
<th>Service/HCPC</th>
<th>CAC</th>
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<th>MR/RC</th>
<th>TBI</th>
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</table>
**Definition**

Provision of ready access to assistance, as identified in the Individual Service Plan, for a person requiring extensive supports to secure help in the event of an emergency.

**Covered Services**

This service is available to a person living in their own home, are not receiving 24-hour supervision and would otherwise require extensive, routine supervision or who live with a family member or primary caregiver requiring extensive supports.

- On-call counseling and problem solving
- Immediate response for assistance at the home of the person
- An electronic personal emergency response system

**Non-Covered Services**

Services cannot be duplicated with other Minnesota State plan covered services or waiver services.

Not available to a person receiving 24 hour supervision.

**Secondary Information**

The service may be provided by:

- The same vendor providing residential habilitation or
- A different vendor than the one providing residential support or
- Other organizations such as those with supporting electronic personal emergency response systems

In addition to identifying the need for the service, the service plan must also:

- Describe how the service will be provided
- Identify what patterns of usage indicate the need for other services, thus prompting a reconvening of the service planning team
- Set forth specific qualifications necessary for the service provider to meet the needs of the person
- Identify the party or entity responsible for the provision of assistance

If this service is being utilized differently than outline in the Individual Service Plan, a review of the service plan must be completed within five days of the first date of service initiation, and any necessary amendments to meet the needs of the person should be documented and implemented.

**Provider Standards and Qualifications**

Services are to be provided by persons, organizations or other entities meeting the standards identified through the service planning process.
Providers are to have professional certification or professional licensure as appropriate based on contractual agreements for the provision of the service.

**Provider Quick Reference**

**Service Agreement Changes**

The case manager/service coordinator is responsible for any changes made to the SA of any recipient.

- If the rate, procedure code(s), or begin and end dates on the SA are incorrect, contact the case manager/service coordinator to initiate corrections.
- If additional services are necessary, the provider must communicate with the case manager/service coordinator prior to providing any additional services.
- If a SA line item is changed and approved, MMIS will automatically generate a revised SA letter to the provider. Letters are generated overnight and mailed the following business day.

**Service Agreement Letters**

- The county has the ability to generate additional copies of the provider SA letters as needed.
- Agencies may suppress the DHS-generated service agreement letter and send their own letter to the recipient.

**Multiple Providers Providing the Same Service at the Same Time**

More than one provider may be authorized to provide the same service for the same recipient. Each provider has a separate line item on the recipients SA.

Some services may also be provided by more than one provider, on the same date of service, except if the service has a daily or monthly procedure code.

If two providers are providing the same service to one recipient, services must be coordinated. Each provider bills for the actual dates of service. Use date spans on claims when services are provided on consecutive days. In addition, case manager/service coordinators should contact all providers who will bill for the same daily or monthly procedure over the same time period to coordinate services.

**Changes in the Status of a Recipient**

- Case manager/service coordinators inform providers and the county financial worker of any status changes of the recipient, such as the MHCP ID number, living arrangement, address and/or phone number, or an incorrect birth date.
- The county financial worker also notifies the case manager/service coordinator of any changes.
- Providers and case manager/service coordinators notify one another when a recipient is hospitalized, so that a provider can bill around the dates of hospitalization.
• They should also notify one another when a recipient is admitted to a long term care facility, so the financial worker can update the living arrangement and appropriate changes can be made to the SA line items.

**Change in Recipient Need**

Providers need to contact the case manager/service coordinator when the needs of a recipient change. The case manager/service coordinator is responsible for reassessing the recipient and amending the Community Support Plan. This may include change of provider, increasing or decreasing services, addition of a new service, and other appropriate assessed needs.

**Transitioning from MA Home Care to Waiver Services OR Waiver Services to MA Home Care Services**

Refer to the [Home Care Services chapter](#) (Ch. 24) for more information.

**Waiver Recipients Enrolled in Prepaid Health Plans**

All regular MA-covered services must be billed through the health plan. Contact the health plan for coverage information. All other services not covered under the health plan should be listed on the SA and billed to DHS under the waiver.

**Recipient’s enrolled in MSHO and MnDHO**

All regular MA-covered and waiver services are covered by the health plan. No service agreement should be entered for recipients enrolled in MSHO and MnDHO.

**Private Duty Nurse (PDN) Payment for Spouses**

Refer to the [Home Care Services chapter](#) (Ch. 24) for more information.

**Individual Education Plans (IEP)**

- Refer to [Children’s Services chapter 9](#) for basic information about IEPs
- Refer to [Home Care chapter 24](#) for more details about coordination of Home Care services and IEP services.

**Waiver Recipient Who Elects Hospice**

When a recipient who receives CAC, CADI and TBI waiver services elects the MA hospice benefit, waiver services needed by this recipient that are unrelated to their terminal illness, may be covered by the waiver program. Refer to the [Hospice Services chapter](#) (Ch. 28) for more information regarding covered services and coordination of services to avoid duplication.

**Waiver Services in an Institutional Setting**

Waiver services are not covered during a hospital, nursing facility, or ICF/MR stay. Providers may bill DHS for waiver services provided on the date of the admission and/or the date of discharge, if services were provided prior to the time of admission or after the time of discharge.
Exceptions:

- **CAC, EW, AC, & CADI Waiver** allows payment for respite care services provided in a hospital or long term care facility utilizing waiver respite care procedure codes. See respite service description.

- **CAC** waiver allows payment for regular case management/service coordination only for the first 30 days of a hospitalization.

- **AC** case management conversion may be provided, up to 100 days, during the nursing facility stay and billed against the AC service agreement for AC recipients.

It is important to bill for the dates services were provided (e.g., if the recipient was hospitalized from 1/15 through 1/25, bill 1/1 through 1/14 or 1/15 on line one of the claim, and 1/25 or 1/26 through 1/31 on line two). In this case if the entire month is billed, the claim will be denied. In addition, if the waiver claim is paid prior to the hospital or long term care facility claim, DHS will automatically take back the waiver payment.

**Waiver Services in a Residential Setting**

Waiver services provided in a residential setting, such as assisted living, assisted living plus, residential care services, foster care, and supported living services, are covered. Waivers do not pay for room and board. Room and board may be covered by other sources such as:

- The income of the recipient;
- Social Security Disability Insurance (SSDI);
- General Assistance (GA); and
- Supplemental Security Income (SSI).

When the above sources do not cover the total cost of room and board, Group Residential Housing (GRH) funding may be accessed up to the base rate. The county financial worker must determine all appropriate payment sources for room and board.

**Billing for Leave Days in an Assisted Living, Residential Care, Foster Care, or Assisted Living Plus Setting**

**Background:**

Payment for leave days is **not** allowed through the Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Mental Retardation or Related Conditions (MRRC) Waiver, Elderly Waiver (EW), Alternative Care (AC), and Traumatic Brain Injury (TBI) Waiver.

The Centers for Medicare and Medicaid Services (CMS) has stated that Medicaid may only make payment for waiver or state plan services **actually provided** to an eligible recipient, which does not include leave days.

**Definition:**

Days when recipient is **not** receiving residential services.
• **MR/RC Waiver** - Days when the residential service provider is not responsible for the 24-hour plan of care as indicated in the Individual Service Plan.

• **CAC, CADI, EW, TBI Waivers and AC program** - Days a recipient is **not** in the residential setting.

**Secondary Information:**

Examples of Leave Days include days for:
- Hospitalization
- Therapeutic leaves
- Crisis services
- Any days away such as home visits and vacation days

Leave Day policy affects the following HCBS services:
- [Residential Care](#)
- [Foster Care](#)
- [Assisted Living](#)
- [Assisted Living Plus](#)
- [Supported Living Services](#)

**CMS Policy:**

CMS policy states Medicaid payment is made for services actually provided to an eligible recipient which does not include leave days.

Things to consider about this policy:
- The overhead expense of days when the recipient is away from a residence is accepted by CMS as a part of a provider’s cost of doing business
- Overhead expenses may be factored into a provider’s rate

**Process and Procedure:**

When negotiating individual rates with providers, counties and lead agencies are allowed to take a variety of overhead expenses into consideration. The cost of absences may be considered an overhead expense.

- **MR/RC Waiver**- Decisions to apply occupancy adjustments to provider rates must be made within the county’s unique allowable budget

- **CADI, CAC, and TBI Waivers** - The authorized monthly limits apply

- **EW and AC Program** – the authorized monthly limits and case mix caps apply

Rates can be determined either:
- Daily for CAC, MR/RC and TBI Waivers
- Monthly for CAC, CADI, EW, MR/RC and TBI Waivers and AC Program
- Semi-Monthly for MR/RC Waiver
Daily Rates:

Daily rates for CAC, CADI, MR/RC and TBI Waivers can be determined in two ways:

Method 1
- Negotiate an annual rate with the provider. The county may take into account overhead expenses.
- Based on a recipient’s history, determine the estimated number of days that the recipient is expected to be in the residence. (Because overhead expenses are included in the negotiated annual rate, the number of days cannot equal a full year.)
- Divide the negotiated annual rate by the estimated number of recipient days to determine the daily rate.
- Using the daily procedure code, enter the estimated number of recipient days (units) at the daily rate on the line item of the service agreement. The provider bills up to the number of days entered. If the recipient is in the residence for more days than entered, the provider cannot bill for the additional days.

Method 2
- Negotiate a monthly rate with the provider. The county may take into account overhead expenses.
- Determine the daily rate based on the actual days that services were provided for the recipient.
- After services are provided, enter the actual days (units) at the daily rate on the line item of the service agreement.

Monthly Rates:

Monthly rates for CAC, CADI, MR/RC, and TBI Waivers and may be negotiated with the provider.
- In the contract, include a description of the package of services being purchased and the process that the county will use to adjust the negotiated monthly rate for the days on which services are not actually provided for the recipient. The county may take into account overhead expenses.
- Using the monthly procedure code, enter the negotiated rate per month (unit) on the line item of the service agreement. If applicable, adjust the rate at the end according to the process outlined in the contract.

Semi-Monthly Rates:

Semi-monthly rates for MR/RC Waiver may be negotiated with the provider.
- In the contract, include a description of the package of services being purchased and the process that the county will use to adjust the negotiated semi-monthly rate for the days on which services are not actually provided for the recipient. The county may take into account overhead expenses.
• Using the monthly procedure code, enter the negotiated rate per half-month (unit) on the line item of the service agreement. If applicable, adjust the rate at the end according to the process outlined in the contract.

EW and AC - Billing for Leave Days in an Assisted Living, Residential Care, Foster Care, or Assisted Living Plus Setting:

Bulletin #00-56-30 dated November 8, 2000; titled “DHS Clarifies Policy on Leave Days used by Persons on HCBS Waivers and AC” must be reviewed for policy interpretations of “leave days.”

Claims for the above mentioned community settings cannot include periods that overlap with a period of hospital confinement, nursing facility stay, or other periods defined as “leave days.” In order for a provider to be paid for days in which the person was not in the community, the county contract must include a provision allowing for payments in a month that includes leave days.

• Electronic or paper claims must include one line item that represents the adjusted negotiated monthly rate as identified in the county contract;
• The unit field must be one (1);
• The period is a time span that does not overlap with any leave days; and
• The total amount field is the total number of days in the setting for that month multiplied by the adjusted negotiated monthly rate.

If the person is on a leave day status for more than one period during the month (example: 4/6/02 - 4/12/02 and 4/20/02 - 4/25/02) you must choose a period that does not overlap these time spans. A notation on the claim form and in your records must explain why you are unable to bill multiple periods and that the total amount represents the correct number of days the person was in the community setting.